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Management in Collaborative and Integrated Healthcare
Service Systems: Concept and Practice

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VOLUME 1

DECLARATION OF ORIGINALITY

I hereby declare that this thesis has been composed in its entirety by myself and is a result of my own work. To the best of my belief and knowledge this work contains no material previously published or written by another person or persons, except where due reference is made. The work has not been submitted for any other degree or professional qualification other than as specified here to the University of Edinburgh. Preliminary results of this research were presented at conferences and have been accepted for publication. In all cases, they are a result of my own work and research. These are as follows:

Memon, A.R. and Kinder, T. (2016: forthcoming) Management in an increasingly integrated Public Sector: Implications for learning and development. *Public Money and Management*. (Accepted/In-print).

Memon, A.R. and Kinder, T. (2015: forthcoming) Management in new public service systems: Reframing the position of managers and their training and development. *International Journal of Public Administration*. (Accepted/In-print).

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ABSTRACT

This study explores how managers are coping within a changing public healthcare service context and how the role of service managers and the nature of Management Development are being transformed.

With the public healthcare sector in the UK facing complex challenges including financial constraint and increasing service demand, it is inevitable that collaborative partnership working and service integration are viewed as a means of addressing such challenges.

Using the views and experiences of service managers from Scottish Community Health Care Partnership cases, the study highlights the experiences of managers in relation to partnership working and service integration and explores the potential implications of this for managerial learning, training and development.

The research evidence establishes the importance of changing roles, responsibilities and relationships for managers in a changing healthcare service environment and takes on board a Service-Dominant approach and propositions from New Public Governance theory to explain these and to address attendant issues.

Specifically, the challenges surrounding the learning, training and development of managers in an increasingly integrated services environment are explored and reconceptualised through a Services-as-Systems approach. The outcomes of this study allow for a better understanding of the changing nature of work that managers do and attempts to reframe Management Development in such a context for the future.

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This thesis in print is divided into two volumes:
Volume 1 contains within it, preliminary sections and Chapters 1 to 6.
Volume 2 contains within it, Chapters 7 to 8 and supplementary Annexes.

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LIST OF ABBREVIATIONS

A&E: Accident and Emergency

ALS: Action Learning Set

C&As: Complexities and Ambiguities

CBM: Competence Based Management

CGT: Constructivist Grounded Theory

CHCP: Community Health and Care Partnership

CHP: Community Health Partnership

CHSCP: Community Health and Social Care Partnership

eKSF: e-Knowledge Skills Framework

GD: Goods-Dominant

GT: Grounded Theory

H&SC: Health and Social Care

HEAT: Health, Improvement, Efficiency, Access and Treatment

IPA: Interpretive Phenomenological Analysis

L&D: Learning and Development

LA: Local Authority

MD: Management Development

M-LTD: Management Learning, Training and Development

NHS: National Health Service

NPG: New Public Governance

NPM: New Public Management

PA: Public Administration

PSO: Public Service Organisation

RRRs: Roles, Responsibilities and Relationships

SD: Service-Dominant

T&Cs: Terms and Conditions

T&D: Training and Development

1. INTRODUCTION

1.1 Focus of this Thesis

This thesis focuses on managers and their development in a changing public healthcare services context. The modernisation agenda in British public services is a complex one, with various drivers, including concerns with costs, efficiency and effectiveness. Amongst the consequences of the modernisation agenda is the emergence of new service delivery models that focus on collaborative forms of working and on integration, which give rise to attendant changes in thinking about how management should be 'done' in public service organisations. In the NHS 'modernisation' has been a consistently dominant theme since the turn of the century, which for example can be traced through annual reports of the NHS Modernisation Agency (National Archives, 2009).

These changes are evident across the UK. In the case of Scottish healthcare service delivery, there is a strong political drive for joint working and service integration as a means of not only achieving cost efficiencies, but also service innovation and improvement. As new forms of service organisation and delivery emerge, it is necessary to explore the implications this presents service managers: as the nature of managing healthcare services changes, so will the work of managers. How managers learn for this new setting and how they can be trained and developed for it is under explored territory – hence my interest in Management Development for such managers.

I clarify at this early stage, the choice to use the term 'healthcare' services as opposed to 'health' services is based on the official definition of both terms. Based on the Oxford dictionary 'Health' is defined as *the state of being free from illness or injury,* implying that management of 'health' services relates to the task and effort of keeping people and society free of illness or injury. 'Healthcare' on the other hand is defined as *the organized provision of medical care to individuals or communities,* implying that management of 'healthcare' services relates to the task and effort of organised provision of medical care to people and society. To gain further confidence about my choice to use 'healthcare' as a term for this research, it is further observed that literature in the area of management in the NHS largely adopts the term 'healthcare' while literature in the area of medical science in the NHS adopts the term 'health'.

In this chapter, I set out the background to and context of my study of these issues, articulate the research questions, explore the possible significance of the research and outline the structure of the thesis as a whole.

1.2 Research Background

Three areas of concern emerged from early consideration of the focus of the thesis and initial review of the literature: the changing nature of public services; managerial work in an evolving service system and of course - Management Development and its relevance.

1.2.1 The Changing Nature of Public Services

When this study commenced, public services in the UK were facing the consequences of austerity following the global economic crisis of 2008. Constraints on and restraint within public expenditure of course came to the UK's National Health Service on top of ongoing increases in need and demand (particularly those associated with an ageing population), increasing healthcare costs (Scottish Government, 2005; 2011) and an established agenda for improved performance.

What has emerged from these forces is an increasing emphasis on joint working and service integration, the intention of which is quality improvement, service efficiency and cost-effectiveness. The motivation and direction here is to personalise public services where users are involved in the design of services that cater to their different needs (i.e. localised service delivery) rather than a "one size fits all" approach (Cottam and Leadbetter, 2004; Scottish Government, 2005; Rainey, 2009). This advocates the involvement of various stakeholders to co-determine the service yet, at the same time, addresses budgetary pressures by promoting for example, resource pooling, co-production, co-location and joint accountability (Osborne and Brown, 2005; CIHM, 2006; Kinder, 2010; Osborne et al., 2013).

Joint working and integration of public services are thus seen to have the potential to resolve service delivery challenges and the need for innovation in public service delivery (Maddock, 2011). In Scotland, joint working and service integration in the NHS is deemed a promising way forward in response to an ageing population and budget constraints. Annex 1 provides further information on Health Services in Scotland and the Integration Agenda.

As organisations attempt joint working and attempt integration, they – and their managers – face multiple complexities and challenges. These include unclear definitions, unclear processes and unclear boundaries as service managers work in different and innovative ways

to deliver services though as managers are the agents of change (Shacklady-Smith in Walshe and Smith, 2006) and the medium through which services are delivered, what managers do and how they do it becomes important. It therefore becomes necessary to explore how management development can enable managers to deal with (and operate in) this changing public service context.

An important starting point for this research is the claim that as the nature of public service delivery changes, managers in a post New Public Management (NPM) era need to learn and do different than before (see Annex B for background on Public Sector Management and the NHS, which places NPM in context).

In building on this claim, the research adopts a service-dominant approach, based on Vargo's (2004) service-dominant logic theory and propositions from a New Public Governance (NPG) framework (Osborne et al, 2013) arguing that these provide a sound theoretical foundation with which to move forward in understanding future public service delivery and its management. This viewpoint advocates that the managerial challenges associated with service change (i.e. integrated services) can, and have to, be addressed by treating service delivery as inter-connected and inter-dependent where multiple services provided by multiple organisations are systems in themselves: essentially because they share the same purpose and end user (Osborne et al. 2012 and Kinder, 2012).

This service dominant logic challenges public service organisations like the NHS to rethink its purpose and gives a new context to public service delivery; that of delivering more relevant healthcare services. The NPG framework advocates services as systems experienced by users built around broader service goals. This implies, therefore, that public value and the management of public services ought to be determined by social outcomes and effectiveness. This is something that prevailing New Public Management (NPM) approaches (e.g. "lean management") are failing to do because of their focus on efficiency and because they ignore the interconnectedness and interdependence of public services (Hood, 1991; Kelly, 1998; Lynn, 1998; O'Flynn 2007; Stoker 2006; Radnor and Walley, 2008; Kinder and Burgoyne, 2013; Osborne et al., 2012, Osborne et al., 2013). The fact that we live in reflective societies where people have access to information, are more aware of issues and increasingly wish to be involved in service design, calls for a new governance of public services.

Yet as a result of NPM ideology and methodology, management development theory and prevailing practices are rooted in and derived from private-sector theories created out of the experiences of for-profit industry, particularly manufacturing, which are by nature

efficiency-driven (Osborne *et al* 2012). I will elaborate further on this argument at a later stage of this thesis.

1.2.2 Managerial Work in an Evolving Service System

What managers are faced with is a public service context where change and complexities are constant. Particularly, the challenge faced is of healthcare services moving towards inter-organisational delivery forms (i.e. collaborated and integrated) while the way in which managers operate and how they are trained and developed is dominated and influenced by single-organisation management. As services continue to become more inter-agent and boundaries of operation become increasingly blurred, managers are increasingly required in the nature of their roles, responsibilities and relationships to move away from bureaucratic forms of managing towards enabling forms. This is because they must bring increasingly interdependent professionals together to deliver services (Salamon, 2002). Hence, the role of the service manager and their skills and behaviours will be crucial since the change which integration demands must come through these (Huxham, 1993, 2010; Burnes, 1992; O'Leary and Vij, 2012).

Attempts to distinguish and classify such managerial skills and behaviours that cater to collaborative, inter-agent and integrated service environments have been forthcoming (Kickert and Koppenjan, 1997, Agranoff and McGuire, 2001a, 2001b; Williams, 2002; McGuire, 2002; McGuire, 2006). As within Scottish healthcare services management increasingly becomes more about inter-organisational group managing, Management Development must also evolve to facilitate it; that is, the learning, training and development that managers encounter must be that which enables new ways of being and doing (McGuire, 2006; Memon and Kinder, 2016: forthcoming).

Why managers must face this changing service context is because of the potential these new service design and delivery models carry as a response to challenges like austerity and growing service demand, which single organisations cannot meet (Maddock, 2011; O'Leary and Vij, 2012). Even where cost efficiencies or inflated service demand are not a concern, service integration in itself is a means of organisational innovation (Kinder 2002). This is because the management practices service integration encourages (i.e. co-production and co-location) are catalysts in themselves for service improvement (Memon and Kinder, 2015: forthcoming) Increased inter-agency joint working improves the capacity of services and demands new forms of learning and capability enhancing on part of managers. What changing service systems (integrated service systems) create are complex governances and

accountabilities making PSOs messy and making healthcare service delivery complex (Hudson 2002; Flinders 2004; Segar et al., 2013 and Land, 1991). This has implications for the managerial role and their associated skills and behaviours. What managers do and how they do it becomes increasingly of concern (Memon and Kinder, 2015: forthcoming). Key policy documentation such as the Scottish Government's Force for Improvement highlights this need:

> *"Service transformation and redesign is dependent on cultural and behavioural change…..It depends on partnership working, effective professional and managerial leadership, skills development, empowerment and ongoing organisational support….. This means some change in what people employed in the NHS are doing through service and role redesign. …. there also needs to be change in how people fulfil their roles and how they relate to others…"*
>
> (Scottish Government: A force for improvement, 2009, p.19)

Despite the role of the individual manager being crucial to delivering change processes (Clarke, 1994), it has received little attention (O'Leary and Vij, 2012). Particularly in British healthcare services, the role of the individual manager and their training and development in an integrated context is under-researched. Huxham's (1993; 1990) early work on collaboration for example, explicitly mentions focusing not on collaboration between individuals, but on collaboration between organisations. Managers carry the potential to eradicate organisational separation by integrating their work and efforts which will require them to go beyond organisational siloes in terms of how they think, learn and do. To support this, Kinder's (2010) argument for reducing *psychic distance* between inter-agency managers is vital to change and innovation since managers must think beyond organisational boundaries and remit. This is because integration requires them to operate in an inter-woven collection of organisations that are more than mere networks, but are rather joint-up service systems in themselves.

Advocating service systems thinking, this research will argue that effective integrated service delivery must go beyond inter-agency 'networks' to 'services-as-systems' (Memon and Kinder, 2016: forthcoming). This is because networks imply and are restricted to a collection of organisations coming together in some defined manner to deliver services but belonging as separate entities that maintain degrees of separation. If different organisations and their managers are coming together as only inter-agency networks to deliver services to the same end user, then essentially they are only collaborating services rather than integrating them. In other words, they are loosely coupled service networks. Therefore, inter-agency service networks (as a form of collaboration) may just complement rather than eradicate separate organisations (McGuire, 2006). Services are only truly integrating service

delivery when different organisations and their managers realise that they belong collectively as one service system to share the responsibility of managing service delivery to the same end user. They must go beyond organisational separation both in practice and identity towards collective service delivery; in other words becoming tightly coupled service systems (Memon and Kinder, 2015: forthcoming). Managers must therefore learn and develop the skills and abilities with a services-as-a-system mind-set.

To clarify, 'Services-as-a-System' refers to a single system comprised of services, while 'Services-as-Systems' refers to more than one system comprised of services. In other words, the distinction is between the singular and the plural, one system or several.

Bardach (1998) crucially notes that besides generic and transferable management skills, the skills and styles required in a collaborative setting will differ from those of the single organisation. Even though plausible suggestions are found for skillsets and behaviours that managers may require for collaborative public management (Salamon, 2002; O'Leary and Vij 2012) such as negotiation, facilitation and conflict management, these still complement rather than eradicate separate organisational set-ups. Thus more understanding is required if integrated service systems are to transform service design and delivery that is valuable and effective (i.e. co-produced) with managers' roles becoming increasingly about leading radical change and innovation that goes beyond functional and organisational siloes (Kinder, 2010; Memon and Kinder, 2015: forthcoming).

At this point and at the outset of this thesis, it is useful to point out that joint working and integration as terms and practices are blurred because they lack clear definition and boundary. It therefore becomes difficult to distinguish between formations such as collaboration, coordination, cooperation, networks, civic engagement, alliances, partnerships and so on (O'Leary and Vij 2012; McGuire, 2006; WHO, 2008). For instance, 'collaborative' working and 'partnership' working are both terms used simultaneously as representative of joint working in the British NHS. The World Health Organisation (WHO) states that integration has been a relatively polarised debate with integrated health services meaning different things to different people (WHO, 2008). This ambiguity represents a key moment in the evolution of public services management as Hartley and Alison (2000) argue that the balance of time between leading, managing and administering alters at such key moments and that such moments suggest the genesis of new public governances (Osborne, 2010a). As service systems evolve, there is the need to negotiate new nomenclatures and meanings (Tsoukas, 2005).

Based on a service-dominant logic (SDL), I argue in this thesis that new inter-organisational forms will flourish as local service providers move beyond inter-organisational management towards a whole service systems approach (Services-as-a-System) to address user needs; and that this will fundamentally alter the skills and training needs of service managers. As a shift in value moves from internal efficiency to outcome effectiveness, service managers in integrated settings must learn and act in different ways than before in increasingly messy and complex environments where roles, relationships and responsibilities are blurry and always in transition because agency boundaries and relationships keep altering (Stoker, 2006; O'Flynn 2007 and Segar et al, 2013). And so, joint working and integration can be a frustrating experience even when it intends to address social problems (Tschirhart et al, 2009).

In the case of British healthcare service delivery, the desire to innovate service and redesign structures are motivated by multiple factors (that also pose challenges) including political agenda and reform, austerity, changing user demography (i.e. increase in elderly population), increased service demand and different local dynamics such as population types and co-terminosity between service providers (Mark and Scott, 1992; Scottish Government 2010). This illustrates the importance of localism in public service delivery where the local context (challenges and opportunities) of users must be accounted for in any attempt to change (innovate) service design and delivery. How well managers can understand and embrace these complexities is likely to facilitate the success of integration in healthcare services (Segar *et al* 2013:1); highlighting once again the importance of individuals in the change process (O'Leary and Vij, 2012). Further to this, it is important to acknowledge that despite the wide array of managerial skills and behaviours proposed for such a context (Denis *et al.,* 2010; Broussine 2003; Entwistle and Martin, 2005), service integration contexts will differ as will the skills and values of managers who deliver integration (Bardach, 1998; Agranoff and McGuire 2001a, 2001b). Hence this research maintains a position of caution towards generalisable notions of what service integration may entail and the skills and behaviours that may be appropriate; because it is never that straight forward.

1.2.3 Management Development

In the scenario of a complex and messy healthcare service (discussed later), attempts to develop service managers in the NHS are undermined (Head, 2010; Van der Wal et al., 2011; Powell et al.,2013; Hyde et al., 2013). Much existing research questions the ability of the NHS to train and develop managers appropriately for the future (Sambrook 2007;

Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Alimo-Metcalfe and Alban-Metcalfe 2003a; Collins and Holton, 2004; Hamlin and Cooper, 2005).

In a changing public service context, a great deal of importance is placed on management and leadership development in the modernisation agenda for British health services, of which the healthcare service constitutes a major portion (Hamlin and Cooper 2005). The importance here of management development in transforming local public services into integrated service-as-systems models becomes much about not only just new ways of doing but also new ways of learning. Learning by individual managers in inter-agency service systems become both a critical resource and process (Kinder, 2010; Memon and Kinder, 2015; 2016: forthcoming). To reframe management development for this purpose, it first becomes essential to re-think and re-define the role of managers and the associated responsibilities and relationships as well as accountabilities (Hamel, 2007; Kinder, 2010 and 2012). This may entail an unlearning of previous roles and relationships and the need to become reflective practitioners capable of reviewing and revising their ways of working (Fenwick, 2008). The potential lies in treating learning as multidimensional, interdependent and co-produced with users (Fenwick 2010; Poell and Krogt, 2007) in an evolving public service context. Successful integrated service delivery therefore must be conscious and aware of the context in which it is designed and delivered (Kinder et al., 2008) – this is where managerial learning and innovation from local inter-connected inter-dependent service set-ups can occur (Brown, 2007).

This transformation of roles and relationships and new learning that must occur has implications for other phenomena such as managerial identity and authority, which too are in a state of flux (Hall, 1996; Harman, 2011). Management T&D for service managers in new service systems must account for these complexities and must embed this new learning and the skills and behaviours required. And so, this study concerns itself with researching the extent to which current training and development practices in healthcare services reflect the challenges of service integration.

1.3 Research Motivation

I am interested in managerial learning, training and development from both academic and practical perspectives, which I see as two sides of the same coin. Opportunistically, given my return to Scotland to pursue study for a PhD, I have selected change in the Scottish NHS as a setting for the study. In Scotland, an aging population and increasing healthcare costs are drivers of change with the service integration agenda being a constant factor in defining

Scottish public services and the government's strategic outlook. This has implications for management as managers will have no choice but to embrace the change and cope as the healthcare service becomes more integrated and complex. Challenges arise for the managerial role as workforces from different organisations attempt to merge. Managers will be required to work in different yet innovative ways in an attempt to manage making learning, training and development of increasing relevance in a changing healthcare service system.

In the context of healthcare services, this research explores how managerial roles, responsibilities and relationships will change; what new learning this may entail; what skills and behaviours will be required and the training and development that will be necessary to facilitate changes in a service system that is increasingly integration-driven. The SDL approach can provide a useful foundation for understanding what managers will do; how they will do it; and the Training & Development (T&D) this may require.

This research recognizes the challenges of organisational culture and the domination of single-organisation management which prevail in the Scottish healthcare service. It also recognizes the need for a shift in management development policy and practice as the transfer is made from managing in single organisations to managing in inter-organisational settings in the Scottish healthcare service (McGuire, 2006). The study attempts to address these challenges for the public service manager by adopting the propositions from systems thinking; service dominant logic and new public governance.

1.4 Research Context: NHS Scotland

The 'Force for Improvement' (Scottish Government, 2009) policy document sets out an agenda better health and better care highlighting five key ambitions related to five core workforce challenges among which is that:

> *"NHS Scotland will develop and implement multi-disciplinary and multi-agency models*
> *of care which are more responsive, more accessible and more joined up to meet the*
> *needs of local communities and ensure efficient utilisation of skills and resources"*
> (Scottish Government: A force for improvement, 2009, p.3)

The prime agenda and intent which arises out of this (and other) policy document is moving towards an integrated workforce and partnership working as a means of improving the quality of care while acknowledging that this is not independent of tensions and challenges (Scottish Government: A force for improvement, 2009). These tensions and challenges I

shall address in the next subsection. The document also highlights that shifting towards better healthcare will arise out of multidisciplinary and multi-agency team working (Scottish Government: A force for improvement, 2009). The policy document also recognises the training and professional development of NHS workforce as key to supporting new roles and new models of service delivery with a multidisciplinary approach, suggesting that NES and other external agencies such as universities and colleges will a play part in this (Scottish Government: A force for improvement, 2009). NHS workforce being able to 'lead change' is emphasised upon which links in with another key policy document, *Delivering through Leadership* that sets out a Leadership Development Framework for healthcare service delivery and signifies the need to develop leadership capacity and capability among NHS managers (Scottish Executive, 2005). Another key piece of policy is the Knowledge and Skills Framework (2006) that applies to staff employed under the 'NHS Agenda for Change' terms and conditions. It provides useful but broad guidance about the knowledge, skills and learning and development that service managers require to do their job well and serves the purpose of supporting personal development planning using a consistent approach (MSG, 2014). Evident across reforms by the government is the will to amalgamate public services:

> *The Scottish Government's vision is to achieve collaboration and joint-working between public services, which is essential for delivering better services, facilitated through less heavy formal structures and fewer organisational boundaries cutting across decision-making*
>
> (Scottish Government, 2008)

What is worth highlighting in relation to this study is that the national healthcare service in Scotland and Britain on the whole remains fragmented with a long history of being subjected to change, political reform while full of competing values (i.e. those between primary and heath care), complexity, messiness, and 'wicked' problems (Brown et al. 2010).

1.5 Possible Significance of this Study

In this thesis, I will attempt to identify the extent to which the nature and function of management in Scottish Healthcare Service delivery (i.e. NHS) is seen by its managers as changing as a result of increasing joint working and service integration. The study aims to explore managers views of their managerial learning, training and development experience within an integrated health and social care context and how they have used this to cope with the challenges associated with service integration. Furthermore I will explore the appropriateness and effectiveness of current MD practice in integrated Scottish healthcare service delivery and propose ideas and recommendations for reframing MD that can support

the learning, training and development of managers in integrated Scottish healthcare services.

1.5.1 Existing Knowledge and its Limitations

Public sector management and service delivery has spawned an era of NPM where performance management and efficiency have dominated thinking and practice. This privatisation era of government reforms (referred to also as the Thatcher era) saw the healthcare service in Britain adopt management practices and techniques that grew to favour organisation specific targets rather than broader service goals. This featured private sector models and instruments of performance management (i.e. Lean Methodology) that failed to pay attention to the interconnectedness of the public sector and its services (Stoker, 2006; O'Flynn, 2007; Radnor and Osborne 2013; Kinder and Burgoyne 2013). NPM continued to apply a goods-dominant logic (GDL) to how services were viewed and delivered; as products of standardised production and management (Osborne 2010). The result of this was management exercise which became more complicated and ambiguous for managers rather than becoming simplified (Vakkuri, 2010). This is because standardised performance techniques and metrics that were being used failed to account for the complexity of varied service settings and the diversity of users and their needs (Segar et al, 2013). This as a result has failed to work since service processes are rarely subject to simple linear planning and normally transgress a multiplicity of environments (McGuire 2006:35).

As a result of this tradition, much of the management learning and development practice in healthcare is based on NPM-driven internal efficiency rather than the creation of effectiveness and value (Osborne *et al* 2012). There is considerable evidence to suggest that NPM orientated T&D methods have been unable to develop managers in the NHS (Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Collins and Holton, 2004; Hamlin and Cooper, 2005). The training and development of service managers has been criticised as bring formal and unrelated to practice (Khurana 2007; Locke and Spender 2011; Thomas et al 2012). Other criticisms include a focus on technical rationality (Schön, 1983; 1987) or formulaic MBA thinking (Mintzberg, 2004). Much research now questions the ability of the NHS to train managers appropriately drawing attention to multiple logics, unclear purpose, problematic measures and conflicting purposes in managing the national healthcare service (Sambrook, 2007; Powell *et al,* 2013; Hyde *et al,* 2013)

As public services evolve to become more integrated, involve more co-production with management practices becoming inter-connected and inter-dependent across agencies, there is insufficient knowledge regarding how managerial roles, responsibilities and relationships will alter and particularly, how service managers will be prepared for this. Traditionally, managerial learning, training and development for service managers has been siloed and dominated by single-agency agendas and NPM techniques adopted from practices in private manufacturing sectors (Osborne, 2010). We are limited in our knowledge as to the move towards integrated inter-agency service systems and this has implications for knowing what is required of service managers and how they can be prepared (O'Flynn, 2007). In Hartley and Alison's (2000) terms, such change adjusts the balance between the management and administration of middle managers, resulting in new public governances (Osborne, 2010a).

There is limited understanding both conceptual and practical on how public sector service managers are re-equipped to perform constantly changing roles in an environment of joint working that creates complexity. To date, it is established that these service managers are not adequately equipped (trained and developed) for the healthcare service delivery context (Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Collins and Holton, 2004; Hamlin and Cooper, 2005). The learning, training and development of public service managers to deliver new services (such as integrated ones) is a gap in the envisioning especially when we realise that it is the integration of services-as-a-system that we are dealing with. Management Development theory and practice lacks in its propositions and offerings for integrated service systems.

More broadly, it is also worth noting that services as just inter-agency networks also limits us in understanding the modern day complexities and dependencies of delivering integrated healthcare services. This is because networks in services have taken on a multitude of forms and meanings creating difficult dichotomies. Networks also imply that organisations come together to deliver coordinated services but maintain individual organisational identities and authorities. I do not negate this philosophy but on the contrary, vouch for the advantages that networks have for service delivery. But I argue that delivering holistic user-led services demands that organisations think beyond their agency and think beyond just functioning in networks. Instead, they need to think and practice as part of a tightly coupled service system made up of multiple organisations all different in their approach and offering, but nevertheless, all providing services as a whole system that serves the user.

This is where organisations will develop the ability to take upon themselves the need to innovate. Taking a leap forward from systems thinking, we are encouraged to think of

integrated service delivery not as different organisations (and their services) as networked formations (reductionist), but more as organisations (and their services) as a system that is holistic. Essentially, this leads us beyond the 'management of public service delivery' to 'management of services delivered to the public': an incremental conceptual shift.

1.5.2 Theoretical Challenges

The theoretical challenges lie in rethinking public service delivery models that can be value-driven and which are about integrating service delivery rather than simply merging organisations or (re-)structuring.

There is also the challenge of understanding and theorising what managers do and how they do it in new service systems. That is, operating in services-as-a-system and managing of services delivered to the public.

Associated with this is the need to rethink and reframe Management Development (in form and content) so that it can be of relevance to the work of managers in new service systems and can actually contribute to their learning, training and development.

It is hoped that this thesis makes a contribution to these areas.

1.6 Research Questions

The overarching aim of this research is to enquire how the nature of managerial work is changing as healthcare service delivery becomes increasingly integrated and how Management Development can be reframed to facilitate managers. The objectives and research questions of this exploratory study are:

Objective 1: To explore the issues and complexities service manager's face in engaging with joint working and service integration and how this affects the roles, responsibilities and relationships of service managers.

To fulfil this research objective, I propose the following research questions:

What challenges and opportunities arise from joint working and service integration for service managers in Scottish healthcare services?

How do joint working and service integration influence the role, responsibilities and relationships (referred to as remit) of service managers and what does this implicate for managerial skills and behaviours?

Objective 2: To explore the changing nature of managerial learning, training and development brought upon by joint working and integration in healthcare services and to assess how Management Development can be altered to facilitate managers for such new service systems.

To fulfil this research objective, I propose two further research questions:

What are the implications of joint working, service integration and an altering remit for managerial learning, training and development?

How can Management Development (in form and content; as concept and practice) be reframed with the future needs of an integrated healthcare service system to prepare and enable managers to deliver effective services?

1.7 Practical Significance

This research has significance for better understanding and improving the design and delivery of Management Development policies and for practice in organisations involved with healthcare service delivery. For example, both the HR function and the OD function in organisations could benefit from the findings with respect to their attempts to make learning, training and development efforts more effective for service managers given the realities of integration. At the policy level, it is hoped that the insights developed will be of interest to policy makers.

1.8 Overview of Research Process

I started this research with an initial review of relevant literature. Given the complex field of the NHS, even in Scotland, this led to the design and implementation of a pilot study (*fieldwork Phase 1*), in which I interviewed 3 NHS middle managers to establish a context for the study. What motivated this was a need to empirically explore the current service environment in which managers operate and to gain an understanding of the main issues that surrounded their work and their development. This pilot study provided focus and direction as to the design of my research and established a line of enquiry.

This saw me study four Community Health Partnerships (CHPs) based in mainland Scotland and conduct in-depth cognitive interviews with 37 service managers involved in delivering health and social care services across the four CHPs (*fieldwork Phase 2*). The findings that arose from these interviews were further scrutinised and issues explored in more depth with

service managers (selected participants from phase 2) through conducting five focus groups across the four CHP Cases involving 19 service managers (*fieldwork Phase 3*). Upon analysing the collected data, analysing outcomes and establishing emerging themes, these findings were reflected upon and ideas further explored through an interview discussion with a field expert involved with Management Development in the Healthcare service (*fieldwork Phase 4*).

The fieldwork was followed by a revisit of the literature. In light of the findings and the themes that emerged, it became necessary to view issues in a different light and made it necessary to rethink and critique theories, hence some other literature was incorporated.

The research then progressed to an analysis of the findings using an in-case and cross-case analysis followed by a discussion of the research findings and outcomes.

In the end, conclusions are provided where the main research outcomes are explained, a self-evaluation of the research study is conducted and contributions as well as recommendations of this research are set out.

1.9 Structure of Thesis

The following is the structure and layout of this thesis:

Chapter 1 has provided an introduction to this research study.

Chapters 2 to 4 provide a review of literature and provide the conceptual and theoretical foundations for the research. A comprehensive literature search helped identify the most significant sources in light of the objectives set out for the research. However, as with any enquiry into a rapidly changing field and the volume and speed of new publications, there is probably no question of either the search or review being absolutely definitive. Rather the aim is to provide a fit-for-purpose review.

Chapter 2 is organised into five subsections namely the evolution of public management and service delivery in healthcare; NPM and beyond-the NPG movement; From GDL-driven services to SDL-driven services; Joint working and integration in Scottish healthcare services; Beyond networks to services-as-a-system

Chapter 3 focuses on a review of literature in relevance to managers, their remit and their skills and behaviours in the context of a changing public service system. This is organised into six subsections namely What managers do and How they do it; the rise of the

collaborative public manager; Changing managerial remit; Dilemmas of inter-agency managing an integrated service delivery; The future of the manager; The managerial footprint in Service Innovation.

Chapter 4 reviews literature on Management Development, particularly the learning, training and development of managers in Scottish healthcare services. This is organised into four subsections namely the evolution of MD in British Healthcare Services; The increasing relevance of present MD form and content; Professional Wisdom, Improvisation and Absorptive Capacity; MD in the new world of service systems; chapter summary and theoretical framework

Chapter 5 of this thesis lays out the research design and methodology used to conduct the fieldwork and to collect and analyse data and highlights limitations of the research process adapted.

Chapter 6 presents and analyses the findings of the primary research at the heart of this thesis engaging with both an in-case and cross-case analysis.

Chapter 7 discusses the outcomes and emerging themes of the research and proposes a new theoretical framework and conceptual ideas.

Chapter 8 provides a conclusion, where the main outcomes of the study, a self-evaluation of the study and gaps in the literature, in theory and in practice are discussed. The chapter also highlights the substantive contributions made by this study and identifies implications for management development practice and policy as well as providing directions for future research.

2. PUBLIC MANAGEMENT AND SERVICE DELIVERY: A CHANGING TRAJECTORY

2.1 Management Theory and Practice in Healthcare Service Delivery

2.1.1 New Public Management

New Public Management (NPM), a term that encapsulating a management ideology and paradigm, shaped by neo-classical economic principles and dominated by a set of governmental reforms, encourages management practices seeking the efficiency imperative in delivering public services. NPM arose as a response to previous laggard approaches to public administration of the past, with emphasis on performance that could replace Max Weber's ideals of centralised bureaucratic control and compliance (Page, 2005). The breadth and scope of NPM is vast, complicated and that which has changed over time (Pollitt and Bouckaert, 2000). Lapsley (2009) describes it as a 'set of management techniques drawing on private sector performance criteria and practices' that the government has adopted over time in order to modernise public services. As Stoker (2006:46) notes, NPM looked to:

> ....dismantle the bureaucratic pillar of the Weberian model of traditional public administration. Out with the large, multipurpose hierarchical bureaucracies, [NPM] proclaims, and in with the lean, flat, autonomous organizations drawn from the public and private spheres and steered by a tight central leadership corps.

Greve (2002) suggests that NPM has institutionalised in various forms: as idea and tendency; as a reform movement; as a management tool; as policy and governance; as contract theory and discourse (cited in Nygaard and Braaming, 2008:401). From the outset, it is worth mentioning the counter argument (which this research takes on board) is that modern government and public service delivery is about more than just efficiency. It is equally as much about relationships and accountabilities between the state and citizens with citizens desiring input and preferences of their values (Minogue et al., 1998). Hence modern public administration becomes more about participation and empowerment (Minogue et al., 1998).

Even though it becomes a challenge to work out where NPM begins in the British Public sector (Lapsley, 2009), the main establishing and attestation of NPM are found is Hood's (1991; 1995) propositions that emphasize on a few key elements:

- Organising the public sector into corporatized units by product.
- Competition and Contracting with an internal market structure
- Adopting and emphasising on private sector management styles.
- Measurable standards and performance with emphasis on output controls.

The transfer of reforms through successive UK governments over the last four decades has increasingly relied on NPM ideology and practices which stem from economic crisis and New Right ideology to improve the NHS (Hannigan, 1998). This has shaped both Public Service Organisation (PSO) culture and management practice to operate in ways that treat public services as efficient delivery of products rather than effective delivery of processes. I will later argue that these NPM practices, adopted from private sector practices do not pay attention to or take into account the complexity, values and inter-connectedness of public services or those who use them. But before critically examining NPM, it is important to understand why NPM has been advocated and adopted for practice in the public sector for such a long time.

2.1.2 The Prevalence of New Public Management

Taking on the managerial reforms of twentieth century American public policies, the neo-conservative UK government in the 1970's adopted managerialism in the bid to reduce costs of public service delivery because it offered an administrative science to doing things: that was making rational choices, setting goals and performing in measureable ways against those goals (Pollitt, 1990; Lynn, 2006; Minogue et al, 1998). It is worth pointing out here that the term 'managerialism' as used now to describe the management ideology and practice of the time was not conceptualised at the time. The conservative government of the 1970's with its enthusiasm for reform programmes dominated by a market orientation looked to reduce government involvement in the managing of public services and encouraged privatisation with the intention to make them leaner, hence reducing public spending (Rhodes, 1997). With the intention to change the management of public services, a wave of NPM programmes such as the Next Steps Initiative and the introduction of internal competition and tendering in the NHS that introduced corporate management into the public sector (Lynn, 2006:117). The critical elements of this movement were the restructuring the public sector through privatisation, introducing competition, contracting of services and improving efficiency through performance management; which meant managing with a concern for results rather processes and a change in management culture (Minogue, 1998). NPM over an era has been seen as the plausible way to do and manage better because with time, the

demand for services and the role of government to meet that demand has become too big and too expensive while the growing population places burden on health service provision. Therefore, NPM offers a way out of this financing pressure since government cannot continue to afford the management of services unless dealt with through efficiency. As public services become more user focused with consumers becoming more aware, the quality imperative places more burden on service delivery to meet user expectations. NPM assumes that public services otherwise are inefficient because PSOs inadequately utilise resource and perform bureaucratically which raises costs: which otherwise can be improved when networks of organisations are fragmented and made efficient (Minogue, 1998).

2.1.3 Fit for Service Purpose?

NPM in its attempts to standardise performance and achieve outcomes regresses on its very purpose because it disregards the variance found in delivering services due to factors such as local community and organisational set-ups, demographic differences and resource availability. As Gray and Jenkins (1995:87) state, '*efficiency is valued over accountability, and responsiveness over due process*'. Added to this, Lynn (2006:108) points out that:

> the '*popularity of NPM has distorted understanding of public management adaptation, change and reform*' because '*there has been the tendency to neglect transformations in administrative institutions, notable devolution and deconcentration, which, while not regarded as managerial, nonetheless has significant ramifications for the practice of public management*'.

Added to this, unsystematic change in environment and the inter-connectedness of public services (e.g. better primary education leading to better health) cannot be ignored when NPM attempts to standardise performance – hence attempting to standardise responses to varied challenges. As Lynn points out further, because of this 'the path dependence of change – the fundamental continuity of administrative institutions – has been obscured, with a resulting loss of sight into the change process itself and future prospect for reform' (Lynn 2006:108)

In giving managers more autonomy to perform better, NPM at the same time advocates that they perform using set criterias and be appraised against them: implying pre-set accountability (Walsh et al, 1997).

As a theory and practice that offers better and beyond Public Administration through superiority of private-sector managerial techniques, the key elements of NPM were attention to private sector management techniques that would enable service improvement in efficiency and effectiveness, allow more hands on management with detachment from

policy-makers and emphasize input and output control and evaluation as well as a performance management and audit culture (Osborne, 2010). Agreeing with Osborne (2010), what concerns one here is why NPM's desire for detachment from the policy maker/political administrator is necessarily something positive and beneficial in a public services context? It may not be. On the contrary, it may be negative and harmful. This is because representation of the policy maker (elected by the public) and of the user (the public) feeds both ways: the former devises health policy to influence positive change in healthcare service and the latter consumes the health service and acknowledges the positive change by voting the policy (and the policy maker) democratically successful. Both depend on one another to create value. In this value exchange, both parties are influenced by their actions and share the consequences of the NHS improving or worsening. This very nature of the public sector is fundamentally what makes it different to the private sector where it would make sense to detach from policymakers and focus on performance management. This is because, in the private sector context, the policy maker is not required since the value exchange involves profit for the producer and a best value-for-money transaction for the consumer.

In attempting to make services efficient, it becomes important to define and measure customer satisfaction and for this, standardised service provision (performance) must be set out to which the organisation and its managers commit to (Minogue, 1998). What arises from this is a plethora of standardised service provision targets in the NHS (i.e. A&E waiting times, consultation waiting times, national HEAT targets), benchmarks and charters that determine best-quality (i.e. Citizens Charter) and standardised performance management techniques found in the NHS (i.e. LEAN management techniques and eKSF framework for performance management). Not to forget, the approach also advocates competition as means of making services efficient on the assumption that privatisation and contracting out ensures competitiveness. The agendas and actions of NPM extend out further: competition enables deregulation, the elimination of bureaucracy, giving value for money and consumer choice, while making government an enabler rather than provider (Minogue, 1998).

For the case of the NHS, NPM thinking and practice has rooted itself over the past three decades (Hannigan, 1998). More recent NPM doctrines have emphasized upon partnerships, networks, decentralisation, cross-functional and inter-organisational collaboration as the new NPM forms of organising and practice (Page, 2005; O'Toole and Meier, 2010). The desire for such arrangements is rooted in the belief that they will induce better performance and maximise utility. However, it may be noteworthy to mention that progress made via arrangements such as partnerships and networks (in the public sector) are in their early years

and we do not know enough about how they shape public service performance (O'Toole and Meier, 2010). We know that partnerships and networks matter and are meant to influence positively but are in the process of learning still about how they impact upon better performance and service delivery in the public sector context. This has attracted ideas and theoretical developments such as Systems thinking (Seddon, 2008) that advocates more holistic approaches to service delivery but which nevertheless remain appreciative of NPM techniques because it treats the organisation as a system that has causality in its relationships between technical and social variables within the system (Haynes, 2003). As Osborne (2010, p.8) highlights, these approaches '*draw upon open rational systems theory and models the production of public services as an intraorganisational process that turn inputs into outputs (services) with emphasis on the economy and efficiency of these processes in producing public services*'. Page's (2005) analogy of 'old wine in new bottles' exhibits this point well. I will come onto discussing systems theory in more detail in the next chapter.

NPM ideology and practice in its past and present forms represent a hollowed out state of the public sector justified by efficiency measures and involving techniques and practices driven by the private-sector market-driven approaches (Osborne, 2010; 2010a, 2010b). Considerable research argues that NPM approaches for policy reform and the management of public services (i.e. the NHS) fails to deliver on multiple accounts that I present further.

Prevailing traditions and practices stemming out of NPM have placed focus on output controls and competition models for public service delivery (Hood, 1991) and the NHS has been subject to much policy and strategy in this manner. As stated by O'Flynn (2007:357):

> "*the NPM paradigm encompassed specific assumption about human behaviour centred on individualism, instrumentality, and individual rationality and from here came new performance motivated administration and institutional arrangements, new structural forms and new managerial doctrines*".

A criticism of NPM which Milgram (1974) calls an agentic shift – the aiming towards upward responsibility, without downward and personal responsibility and which focuses on administrative processes rather than social outcomes. Under the NPM paradigm, management and managers are encouraged to pursue organisation specific targets rather than broader service goals (Stoker, 2006). Overtime, the NPM approach has failed to give positive results because it reflects wholesale applications of private sector models (O'Flynn, 2007) and applies manufacturing logic to public services (Osborne, 2010a, 2010b). NPM theory and practices are focused on specific targets for service provision and are efficiency-driven. In the case of managing public services and the NHS, using NPM approaches such as

lean management have failed because they ignore the interconnectedness and interdependence (of service purpose; outcomes and values) in the public sector (Hood, 1991; Kelly, 1998; Lynn, 1998; O'Flynn 2007; Stoker 2006; Radnor and Walley, 2008; Kinder and Burgoyne, 2013; Osborne et al., 2012). Evidence also suggests that NPM approaches have failed due to factors such as high costs of contract administering, monitoring and enforcement (Entwistle and Martin 2005; O'Flynn, 2007).Furthermore, they fail because NPM advocated performance models such as Sink and Tuttle (1989) fail to establish causal linkages between strategy and performance; and simple profit-oriented metrics (e.g. Stern, 2000) fail to capture the complexity of public sector strategy and performance. Just as firm strategy cannot be generalised (Neely, 2001), performance measurement and management is often contextual - referencing particular capabilities and opportunities and presuming active involvement by staff and stakeholders.

While service delivery objectives can and should be objective in nature, user satisfaction is a subjective experience. To treat user experiences and satisfaction as 'standardised' limits human nature and disregards human variance. Hence the focus should be on delivering *effectiveness* and *service outcomes* that satisfy the user rather than a focus on standardised (therefore measureable) *efficiency* and *service outputs* that satisfy organisations. There is nothing wrong with learning from NPM or from successful practices in the for-profit sector but such learning has to focus on sectoral characteristics and overall purpose, mission and values. It is only then that the focus can shift to service effectiveness. More so, it is only when NPM practices can be modified to circumstances (rather than standardised) that PSOs will innovate in response to change which comes in varied and unstructured forms. As Minogue (1998:33, 34) suggests:

> *'NPM as a model should not be inflexibly applied but adopted to different administrative and political contexts'*

> *'Both efficiency and accountability gains are possible. There is much scope for institutional experiment, particularly in relation to local* governance

2.1.4 NPM Practices: A Misfit in the Public Services Context?

Management in the NHS has involved top-down programmes of change using toolkits such as lean and total quality management. This perspective aligns closely with Power's (2003) critique of top-down public sector targets and is at odds with inwardly focused NPM techniques, such as Kaplan and Norton's (1992) balanced score-card that establish parameters and constrain innovative service management.

A large number of case examples of NPM implementation from UK's public sector are evident in relation to their reliance of private sector style management techniques (i.e. the use of management consultants), technological changes (i.e. e-government projects), audit techniques and the increased emphasis on risk management; all which have disappointed in the delivery of public service (Lapsley, 2009; Power 1997). While this research is limited and unable to give coverage to the large number of examples present, one that exemplifies this disappointment in the NHS is the increasing practice of target setting as a means of management and performance. The example of this is the case of ambulance crews which have a specific target of eight minutes in which they must respond to emergency calls. The target would mean that a call made within eight minutes in which the patient dies of heart failure is regarded as a success. However, it is deemed to be a failure if the target of eight minutes is exceeded even if the life of the patient has been saved (Moss, 2007). Similar logic is found under an NHS target whereby a patient must be treated within four hours of admission to the accident and emergency (A&E) unit of a hospital irrespective of the nature of condition or the context at given times (i.e. season or holiday period health emergencies or staff shortage over holiday periods) (Hawkes, 2007b). As for service performance that is based against the accomplishment of such a target, its achievement is seen as the cornerstone of managerial 'grip'; but managers who fail to achieve this target are deemed 'bad' managers (Royce, 2014). I would argue that this demonstrates the classic case of NPM dominated mentality and practice where the problem fundamentally occurs when such tick in the box or target-obsessed practices undermine the effectiveness of the service to users and also demoralises managerial efforts. The attention (and managerial effort) channels into delivering measureable outputs rather delivering a valuable outcomes. The focus turns to operational efficiency for the organisation, not service effectiveness for the user.

As a proponent of NPM practice, Lean management also thrives on the principals of optimum efficiency and cost reduction, has been vastly applied to UK healthcare services (Radnor et al, 2013). Lean thinking is the preferred tool for improvements in the NHS (Kinder and Burgoyne, 2013:273) and so, many examples of Lean techniques are visible across the NHS including e-prescribing (Schade et al, 2006), NHS-Direct (McKenna and Reynolds, 1999), e-prescribing and telemedicine (Kinder et al, 1999). Radnor and Walley (2008) identify a high failure rate in the use of Lean projects in the NHS. In reviewing this extensive use of traditional Lean Management tools in the public sector and the NHS, Radnor and Osborne (2013) argue that they do not have the potential to have substantial impact upon public service reform because Lean in its current forms fails to engage with end-users of public service. Added to this, Kinder and Burgoyne (2013) using the help of

information processing theory argue that many NHS lean healthcare projects fail. This is because local factors and the absence of support from staff, especially clinicians, jeapordises lean NHS initiatives that require time, training and complex information processing (Kinder and Burgoyne, 2013) as evident in the case of patient database integration at an NHS Trust (Lodge and Bamford, 2008).

The benefits of NPM are seen as partial and contested (Pollitt and Bouckaert, 2004) while it is viewed as a failed paradigm for managing public services and a disappointment for both policy makers and users (Farnham and Horton, 1996; Lapsley, 2009). This Lapsley (2008; 2009) argues is because NPM fails to relate with the complexity and diversity of the local context of PSOs in an era of public spending cuts.

2.1.5 Moving Beyond Conventional NPM

Good management and innovation in public services cannot occur without paying attention to the local service context (Housden, 2013). Osborne's (2010:5) and Rhodes (1997) analysis of the current state of NPM suggests that it begins to look like a partial theory that is limited in its ability to contribute to the management and governance of public services and PSOs in increasingly fragmented and inter-organisational environments. With its focus on the organisation alone and adherence to outdated private-sector techniques for delivering public services, NPM is increasingly viewed as inapplicable to public management and public service delivery (Metcalfe and Richards, 1991). Keeping in line with this critique, I will return to the argument further in this chapter. But what stands out is the need to move beyond NPM in the management of public service delivery because it fails to take into account the complexity of designing, delivering and managing public services in the twenty first century (Osborne, 2010).

In making a transition from NPM given its increasing irrelevance, clarification of roles and responsibilities both for organisations and individuals will be needed in how healthcare services are managed and delivered; for this training remains a crucial mechanism for transmitting new skills and values and for creating capacity (Minogue, 1998): a focus of this thesis. Housden (2013, p.73) points out that in an outcome driven environment, 'traditional roles and assumptions are challenged' and an organisation has to 'think, plan and act differently about its management and governance'. As O'Flynn (2007:363) highlights:

> *Such change, however, would redefine the role of managers within the public sphere and present a series of challenges to the existing capabilities which have developed with the NPM paradigm. Considerable attention will be required to be devoted to the*

development of new skills if managers are to effectively navigate the complexities that come with paradigmatic change.

Moving beyond NPM theory and practice is the need of the day if public services are to keep up with change and be sustainable. For healthcare services that means managing in different ways to keep up with the changing environment rising pressure and more user expectations. Exworthy (2010) notes that there are limitations in relying solely on the NPM approach as health service users will increasingly demand on-going improvements and budgets will constrain; therefore, new ways of thinking and doing (innovating) must be sought to meet rising expectations. As Kinder foresees (2013:422):

> *Since the age of austerity will reshape the public sector, it is opportune to reflect upon how PSOs might respond and in particular whether a post-NPM paradigm will emerge and how this may be characterised.*

In light of the critique presented towards NPM, Osborne (2010) suggests the 'need for a more sophisticated understanding and integrated approach to public policy implementation and public service delivery. Kinder (2013) using case analysis is suggestive that progress lies with new ways of learning in PSOs at the local level and in using a whole system approach to designing and delivering services. To add here, Lovelock (1983) has argued that there has been a lack of generalizable understanding of service processes. This can be owed to the reliance on manufacture-led, private-sector processes and procedures to manage and deliver public services. New ways of 'doing' management and service innovation will be required in this age of austerity because it demands more with less while users demand better quality personalised services.

Moving on, I present aspects of New Public Governance (NPG) theory and propositions of a service dominant approach as viable ways beyond NPM for a better and more relevant approach to managing public healthcare services.

2.2 Moving to the Future: NPG for Public Services Management

In making the transition from traditional Public Administration to NPM and thereafter, NPG refers to the shift and evolution beyond NPM thinking and practice as public services become more user-focused and user-engaged (Osborne, 2010). NPG in its literal terminology of 'new' and 'governance', does not intend to be a new paradigm that supersedes NPM and neither does it intend to be the best way to address public service

delivery challenges. Rather, it should be viewed as a pragmatic leap forward and as a conceptual tool that can provide a better understanding of the challenges and complexities of managing public services for public managers (Alford and Hughes, 2008; Osborne, 2010). NPG could be treated best as a paradigm transition and shift. With regards to governance that is understood and theorised in varied ways, NPG has been a developing element of the NPM regime that has now evolved to become a distinct regime in its own right (Osborne, 2010). Public governance over time can be treated in different strands: i.e. *administrative* governance relating to practice of policy implementation and service delivery (Salamon, 2002) and *policy* governance relating to processes of developing policy (Klijn and Koppenjan, 2000), both developments during the PA era, while i.e. *contract* governance to determine contractual and outsourcing arrangements for delivering public services (Kettl, 2000) and *network* governance to determine inter-organisational set-ups for delivering public services (Entwistle and Martin, 2005), both gaining prominence under NPM regime and the third way era.

Having morphed out into a substantial domain in its own right (public service governance) with distinctive strands (i.e. types of governances that apply exclusively to public services), the intention and potential here for NPG is to 'suggest and explore a distinctive niche that captures the realities of public service delivery within the plural and pluralist complexities of the state in the twenty-first century' (Osborne, 2010:7). Rightly so, NPG intends to help understand and address the complexities of public service delivery policy and processes (i.e. service integration) and the challenges these pose for public service managers. It is desirable here to develop upon a NGP theory in an era of public spending cuts, growing healthcare service demand and increasing user awareness and engagement. Therefore, NPG becomes an alternative discourse in its own right that is not integral to NPM (Osborne, 2010). The NPG paradigm gains support from a wider theoretical perspectives of co-produced public services (Cottam and Leadbetter, 2004) and citizen participation in public policy and decision making (Bingham et. al, 2005) that advocate new governances to be approaching that involve citizen and user who actively participate. Bingham et al. (2005) suggest the rationale for this is on the basis of right to democratic participation and determining what is best for them and how it can best be achieved.

Contrasting theoretical foundations of NPG to those of NPM, the latter is conceived out of neo-classical economics and rational choice theory that is wholly focused upon intra-organisational management and performance management. It assumes that competition in a horizontal marketplace is the best means of running public services where resource

allocation is driven by competition, pricing and contractual relationships in the marketplace (Osborne, 2010). The notion of value creation in NPM is 'formed around the logic of accounting and is contained with its belief that this marketplace, and it's working, provides the most appropriate place for the production of public services' (Osborne, 2010:8). Drawing upon open natural systems theory, NPG concerns itself with both institutional and environmental pressures that affect public policy implementation and public service delivery.

NPG as a paradigm is rooted in institutional and network theory and draws upon the work of Ouchi (1979) that questions the purpose of organisations and the ambiguity in measuring individual performance; Powell (1990) who contrasts the advantages of network forms of organisation opposed to market and hierarchical governance structures; and Powell and DiMaggio (1991) who advocate an institutional approach to understanding organisations from a sociological perspective. NPG acknowledges a state in which multiple inter-dependent actors contribute to the delivery of public service delivery and where multi processes inform policy and action. Given the acknowledgement of this realistic nature of public services, NPG is concerned with, and pays attention to, organisational relationships (both intra and inter) and process governances. And so, it focuses on the interaction of PSOs with their environment and emphasising upon service effectiveness and user focused outcome (rather than efficiency and output) as purpose. A recent example of an NHS failure to meet the 4 hour A&E waiting target in Scotland which leads to an apology from its Chief Executive, demonstrates success of service being judged exclusively on output and efficiency terms (target achievement). It highlights that management is struggling to deliver on such NPM terms. A NHS user responds to this failure event (Metro, 2015) highlighting the very shortcomings of the system and NPM practice and demonstrates the argument made by the NPG paradigm: the lack of relevance and focus for user-needs and effective outcomes:

Paul Gray, the chief executive of NHS Scotland, has apologised for the crisis in A&E at Paisley's Royal Alexandria hospital. So Scotland's A&E's are struggling too – what a surprise. What's the Scottish Government's solution? More clinical staff? Looking at social care to reduce demand on hospitals looking after elderly patients who are otherwise well? Explaining to patients that a cold or being unable to get to a GP appointment isn't an accident or an emergency? No, apparently it's to send in even more managers to tell under-staffed and over worked departments how we are doing things wrong. That will fix everything. Why don't we focus on staff and patients not targets! (Metro, 2015)

2.2.1 The Relevance and Viability of NPG: Beyond NPM

NPG, with more realistic propositions, considers networks not as equal and positivity induced alliances but as unequal and power negotiated alliance arrangements that must reach to effective working rather than predetermine and design effective working. Hence, the value base in such networks is often dispersed and contested (Osborne, 2010).

The emergence of NPG as a theory and tool is a response to increasingly complex and fragmented service design and delivery. Nevertheless, present day policy arrangements, service design and delivery are set within the NPM regime that is characterised by 'intra-organisational efficiency and effectiveness' (Osborne, 2010).

Critically, Osborne (2010) argues here that if NPG is going to conceptualise and theorise public service management of the modern day (which is complex and interrelated), then it becomes necessary to move towards an integrated body of knowledge. This will require asking new questions about the fundamentals of NPG which focus upon the principles of public service delivery in a pluralist state and on public service systems rather than individual PSOs. Some of these questions relevant to this study are (Osborne, 2010:11):

- *The fundamental question*: what should be our basic unit of analysis in exploring public policy implementation and public services delivery – and what are the implications of this for theory and practice?
- *The architectural question*: what organizational architecture is best-suited to delivering public services in the plural state?
- *The Values question*: What values underpin public policy implementation and services delivery in such systems?
- *The relational skills questions*: what key skills are required for relational performance?
- *The accountability question*: what is the nature of accountability in fragmented plural and pluralist systems?

Once again, it is important to point out that this is not a post-NPM argument, but rather it is a means of conceptualising public services in a different way that takes account of changing society and changing values. At a later part of this thesis, the findings and discussions from this research shall hopefully be able to reflect on and respond to these fundamental questions as a contribution. As it remains, for NPG to contribute to the evolution of public service management and delivery, it needs to explore the present day challenges of a changing

public service environment and be able to inform (as well as benefit) managerial practice. I present below the core elements of NPG in contrast with NPM:

Paradigm / key elements	Theoretical Roots	Nature of the state	Focus	Emphasis	Resource Allocation mechanism	Nature of the service system	Value base
NPM	Rational/public choice theory and management studies	Regulatory	The Organisation	Management of organisational resources and performance	The market and classical or neo-classical contracts	Open rational	Efficacy for competition and the marketplace
NPG	Institutional and Network theory	Plural and Pluralist	The organisation in its environment	Negotiation of values, meaning and relationships	Networks and relational contracts	Open closed	Dispersed and contested.

Table 1: Contrasting core elements of NPM and NPG; Source: Osborne, 2010:10

Taking ideas forward and borrowing Osborne's (2010) fundamental questions posed under the NPG paradigm, the *value question* encourages one to enquire *what* public services should deliver? and the *relational skills question* encourages to enquire *how* to deliver it under the NPG. These two enquiries are important to the context of this research study because i wish to explore the changing nature of *what* (integrated healthcare services) is to be delivered and *how* this affects the work and capabilities of service managers to deliver it. In this context, it becomes important to think about the values that public healthcare service users and healthcare service managers consider important as the nature and organising of healthcare service delivery become more complex and contested and takes up new forms (i.e. integrated). Furthermore, the training and development of managers in PSOs, particularly in the NHS, have undergone substantial transformations and variations over decades of the PA and NPM era. These have included traditional personnel development techniques such as formal qualifications and training programs, competency based models for the intra-organisational manager, and more recently, techniques that cater to and facilitate the collaborative manager in inter-agency networks such as action learning and 360 degree appraisals. I will discuss aspects of managerial learning, training and development in more detail in the forthcoming chapters. But the important issue here is that complex and changing public services (i.e. healthcare) will require different skills, capabilities and behaviours of service managers to perform in ways that can deliver healthcare service in future public service systems. Bingham et al. (2005, p.555) reaffirm the importance of this:

Public administrators are thinking creatively about how to engage the public in deliberative democracy and collaborative decision making. Schools of public administration...owe it to future public managers and administrators to provide better training in these processes. .... Public practitioners and scholars must engage the public in governance .... and move our research and teaching agendas in a direction that supports these new governance processes…

Below, I move onto discussing aspects of the Service-Dominant (SD) Approach in contrast to the Goods-Dominant (GD) Approach which lends support to the NPG paradigm. The SD Approach, representing an ideology and direction that gives purpose to the design and delivery of service in line with the notion of what actually constitutes value in public services. The GD Approach on the other hand, suggests an ideology and direction that takes on industry-dominant and private-sector techniques dominant in NPM practice for the management and delivery of public services.

2.3 From Goods-Dominance to Service-Dominance

The SD approach or perspective for public services emphasises on user experiences and aligns closely with service personalisation (Osborne *et al.,* 2012). This approach is grounded on Normann's (2002) view that services are intangible, consumed at the point of production, are subjective experienced by user and most importantly, are co-produced by providers and users. Since the introduction of the Service-dominant Logic (SDL) concept in marketing (Vargo and Lusch, 2004a) there has been adoption of principles of SDL for application to public management and public service improvement.

Re-conceptualising public management and PSO purpose with the SD approach recognises services as systems experienced by users. The SD approach is critical of the efficiency agenda promulgated by (NPM) that promote effectiveness and innovative models of service design and delivery. Instead the SD approach bids for user satisfaction with outcome driven models of service design and delivery (Kinder and Burgoyne, 2013). This is a stark difference from NPM theory and practice that focuses on specific targets for service provision and is efficiency-driven.

In the case of managing public services, this is progressive thinking since evidence indicates that NPM approaches to managing public services have failed because they ignore the interconnectedness and interdependence of the public sector (Hood, 1991; Kelly, 1998; Lynn, 1998; O'Flynn 2007; Stoker 2006; Radnor and Walley, 2008; Kinder and Burgoyne, 2013; Osborne et al., 2012). They fail particularly because they apply a goods-dominant approach which excludes users from the service system in which public value is determined

by social outcomes rather than mere internal efficiency (Osborne et al., 2012). That is, the service system which is organic and made up of inter-related agencies (PSOs) which share similar purposes to deliver to similar end users. From a service dominant perspective, the viewpoint and trajectory here is that new inter-organisational forms will flourish as local service providers move beyond fragmented inter-organisational managerialism towards a whole systems approach to address service user needs. Of course they will have to do this will lesser resources and more innovation. This fundamentally will require that public service managers alter their skills and behaviours to operate in a service system that carries a service-dominant logic; implying that they think and do beyond the organisation with a focus on effectiveness.

To re-capture, the GD approach which advocated NPM practices is based on traditional manufacturing-driven product design and delivery ethos using private-sector management techniques that deliver products (or services as products) to markets, but the SD approach is based on the ethos of user and provider experiences and treats services as processes rather than as artefacts.

Under the NPG and using a SD approach to public service design and delivery, I would place further emphasis upon the *services-as-systems* approach as a step beyond inter-organisational collaboration (i.e. networks) for integrated healthcare service delivery. The approach advocates that the design and delivery of services occur through co-determined and co-produced means with involvement of users and providers that operate in the service system; while pragmatically recognising that services are subjectively experienced by users, values are contested and where new governance forms are reached upon rather than pre-arranged (Osborne et al, 2012; Radnor et al. 2013). This context can be related with since in the modern day, professional relationships and ways of governing are altering in light of more user engagement (i.e. co-production) and personalised service delivery (i.e. independent living). This need for services to have a service-orientation (based on user input) rather than a goods-orientation is endorsed by Edvardsson et al. (2011) who in their extensive examination of service projects point out that practitioners (managers) engaged at the ground-level realising the importance of user co-creation is most important to success with new service development and that user involvement is the missing link in improving service. Manschot and Sleeswijk Visser (2011) argue that social return on investment of services is best evaluated by how much value organisations place on outcomes and the experiences of users in processes. Furthermore, closer proximity and engagement between providers and users (co-produced services) offers an opportunity to innovate services because it reduces the

gap between them. Kinder (2010) refers to this dimension as the reducing of psychic distances: the greater the trust, empathy and shared values set among providers and users, the greater the chances for better co-produced service design and delivery. Precisely, learning which is socially situated occurs in close psychic distances when all the stakeholders in the service are interacting in close proximity. Such a reconceptualization of public service management stands opposed to the GD approach to managing public services that treats users as being outside the service design and delivery process and as advocated by NPM approaches.

2.3.1 The Difference of Service Logic

The SD approach with its roots in the SDL stands opposed to the GD approach rooted in a GDL. Where the GDL suggests supply-driven organisations with value embedded in the product (service treated as a deliverable product), the SDL presumes demand-driven organisations with value being experienced by users and being co-produced between providers and users of the service (Vargo and Lusch, 2004; Lusch and Vargo, 2006; Vargo and Lusch, 2008. This would imply that value-creation in services is pulled-in by users rather than pushed-out by providers (supply-led); in other words, users pulling service design and delivery (e.g. what we need and how we would like to receive it) instead of providers pushing service design and delivery (what we think you need and how we think you should receive it). Since the user 'pulls' service design and delivery, users and providers become a service system, the outcome of which ceases to be supply-led, and which instead 'couples' supply and demand around user needs. The SD approach focuses on bottom-up learning and doing rather than top-down programmed management.

Âkesson and Skålen (2011) in their empirical findings from Swedish public services argue that successful SDL driven organisations privilege customer orientation, close interaction between users and providers and staff empowerment to socialise SDL. Certainly, operationalising the SDL (and therefore a SD approach) in public services poses methodological challenges as for example, Edvardsson et al's (2011) study of Singaporean bus services based on a GDL/SDL ranking of attributes reveals that professional subjectivity makes replication difficult. But this in my view, only points to (and validates) the very nature of public services being complex in nature, having contested values and being dependent upon local factors and circumstances that must critically inform service design and delivery: so that it can be made relevant. For this reason, service design and delivery models with a SDL to them are likely to be unsystematic and unplanned; to phrase differently, they are likely to emerge rather than happen out of different contexts. Brown

(2008) similarly argues that good service design varies with complexity and empathy between users and providers. As Housden (2013) crucially notes, opportunity lies in acknowledging the local context and responding to it. Furthermore, he states that it is at the locality level from where innovation must come. This is a point that the Scottish government and policymakers certainly recognize and attribute future public sector success to.

> *Let me begin where Frank Stacey (PAC Honorary secretary 1968-71) would – in localities. Areas have different mixes of need, characteristics and patterns of assets. Local actors need to be able to respond to these particularities. It is also at local level that the energy and commitment necessary to the highest quality of services and to innovation is generated. The Government has placed therefore a great deal of emphasis on the effective working of Community Planning Partnerships at local level, and on the role of the community and voluntary sector at this strategic level. (*Housden, 2013, p. 73)

Lusch and Vargo's (2004) SDL offers a viable way to conceptualise public services than the GDL instilled in NPM. Vargo and Lusch (2008) highlight that an overly managerial approach to managing services as being a challenge as well as a lack in acknowledging that value creation is phenomenological and experiential in its nature. Similarly, they highlight the need to 'more explicitly recognise the interactive, networked nature of value creation' (Vargo and Lusch, 2008:2). The essential point here is to understand that value in services is phenomenologically determined (i.e. to co-create, to co-produce, to experience are all subjective and personal experiences). Services are subjectively experienced, influenced and shaped and collated through individual user perceptions. As Housden (2013:74) notes, 'how we think about public services changes over time, as our needs and ambitions change'. I would say in theoretical terms, value in public services arises through an inductive unstructured process rather than any deductive structured procedure. I also take the position that value is context based in public services supporting Brown's (2008) argument that good service design varies with context and understanding between users and providers within that context.

Edvardsson *et al* (2013) in a study examining 500 new service developments in EU countries, showed that users/customers were viewed as the most important source of ideas (8.9 out of 10) followed by employees (7.2), competitors (6.5) and suppliers (6.4). Yet formal service development strategies underplay the importance of user/customer involvement. Intellectual acceptance that users/customers best play an active role is quite different from emotionally empowering users/customers, hence Edvardsson *et al* (2013) suggest 43% of newly launched services are withdrawn within three months, since as in 'A', users are excluded from design. 79% of hybrid organisations (creating both goods and

services) fail in their services strategy according to Ulaga and Reinartz (2011): the GDL mindset sits uneasily with active user involvement. Figure 1(a) represents this GD-driven service model. However, based on a SDL where service systems are built around relationships that are subjectively evaluated, service value propositions are reached upon through user and provider discourse on service value, purpose and processes over time. 'B' is not therefore a steady or stable state and will always be incrementally improving to meet changes in context and with users/customers being active recipients with whom the organisation and management intertwine. Fig 1(b) represents this SDL-driven service model. The SDL-driven service model treats services and their management on a relational rather than transactional basis.
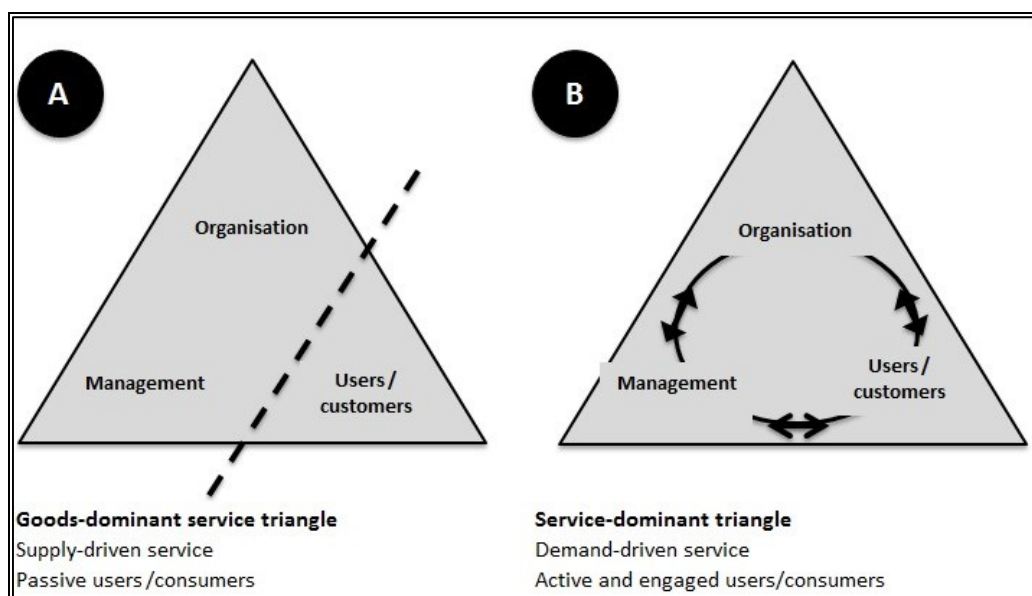
Figure 1: Goods-Dominant and Service-Dominant Models:, adopted from Haywood-Farmer's 1988; Ghobadian et al. 1994; Villarreal, 2010

2.3.2 Approaching Future Public Services from a Service-Dominant Perspective

While NPM emphasised the transfer of off-the-shelf best practices from the private sector to the public sector for managing public services and creating value, the services-as-systems approach (based on a SD approach) encourages a diversity of service models arising from opportunities in varied but particular contexts (i.e. localised service design and delivery). The public sector in the last 50 years has largely borrowed its theoretical concepts, models and practices from the GDL paradigm while enacting private-sector management techniques. The future potential and ability for the public sector lies with the SDL paradigm and a SD approach to designing and delivering public services. Distinct management models and

practices must arise from this new paradigm, as advocated by the NPG. My adoption and contribution here is to take into account the SD approach and explore what managers must do differently and what their changing training and development needs will be as healthcare service delivery move towards newer integrated service delivery models.

Based on the ideas reviewed, I suggest that for managing inter-organisational public services (i.e. integrated healthcare services), the vision and focus should turn to a services-as-systems approach that is tightly-coupled with providers, users and inter-dependent agencies that collaborate and integrate primarily for the benefit of the service and its user. This would be an evolution beyond the present state: that is, collaborative network arrangements for services and PSOs that are loosely-coupled for delivering services but with organisational self-interest as prime concern (a system with inter-related yet separate agenda organisations). I suggest a comparative analogy here that would be most befitting to contrast these two approaches: *Managing services for the public* instead of *Managing public services*. I return to this set of ideas in the last section of this chapter.

For now, I give further coverage to joint working and integration as a system of service delivery in Scottish healthcare services in the next section which provides the context for this research study.

2.4 Joint working and Integration in Scottish Healthcare Services

From the onset, I would like to point to the use of the word *joint-working* as simultaneously representing both *collaboration* and *partnership* forms of working and/or operating. I use these three words simultaneously to refer to the same thing while the word *integration* I refer to in itself. Such use of words simultaneously is commonly the case in the context of the Scottish NHS, where these different terms are used to refer to the joined up delivery of NHS and Social care services (Robson, 2013).

With health being a devolved matter for Scottish Government, delivering healthcare services through collaboration and integration remains a national agenda reflected in the majority of official strategy and policy of the Scottish Government's department of health and the NHS thereafter (both nationally and local NHS Board level). As a fairly new phenomenon with little (yet complex) conceptual boundary, there exist a multitude of definitions and descriptions of integration that complicate the debate on integrated care (Armitage et al,

2009). Nevertheless, to observe a definition of integration in healthcare that most suits this study, it is defined as:

> *"Integrated care refers to a coherent and co-ordinated set of services which are planned, managed and delivered to individual service users across a range of organisations of co-operating professionals and informal carers. It covers the full spectrum of health and healthcare-related social care"*
>
> (van Raak et al., 2003:11)

Of course, integration can be approached conceptually from various angles in terms of its purpose and composition and the evidence base for integrated care remains weak. This is since sceptics question the value of integration efforts given issues like size of organizations, their structural and geographical differences, cultural differences and the different nature of their service and staff: all which create challenges (Boone, 2000; Robertson, 2011;). But in the context of integrating healthcare services and attempting to gain some conceptual parameter, I adopt from Roberston (2000:6) on what 'integrated' care can refer to or mean:

- Health and social services delivered by a single organisation
- Joint delivery of health and social services by more than one organisation
- Joining care at different levels within a single sector
- Joining prevention and treatment services or linking primary and secondary care
- Jointly commissioned and/or funded services, delivered by multi-disciplinary teams in which team members are employed by more than one organisation, or delivered by multi-disciplinary teams in which members are employed by the same organisation.

2.4.1 The Basis for Joint-Working and Integration as Service Delivery Models

The concept which has initiated this direction is to personalise public services where users of the service are involved in designing and delivering a service that fits with their needs rather than having a one for all service (Cottam and Leadbetter, 2004). At the organisational level this means moving away from a top down command and control service system in the health sector and the NHS (Scottish Government, 2005:3). This would help delivering a health service that is organised and delivered locally and is responsive to community needs (Scottish Government 2005:3). It also encourages a service delivery where health promotion and care interventions are negotiated and co-determined by involving users and providers so that all can be better informed about health and its delivery (Scottish Government, 2005,

National Framework for Service Change in NHS Scotland). Compared to the rest of the UK, partnership working is emphasized in Scotland as a key policy driver to deliver public services particularly in the case of health and social care services (Forbes and Evans, 2008:87).

The inclination towards joint-working and integrated models of healthcare service delivery is owed to reasons that include (Lang, 2011; Ham et al. 2012):

- the impact of the global economic crises (recession in 2008/09) which has created an age of austerity- leading to financial constraints and reduction in public spending.
- that average life expectancy in the UK (as well as the EU) rises – meaning more people will need healthcare for longer
- because health care expenditure has risen at a faster rate than economic growth.
- as healthcare service users increasingly become consumers – their involvement in health policy and practice increases as the social narrative supports legal/human rights to involvement and the move from hierarchy to participatory public management

2.4.2 Understanding and Grasping the Challenges of Integration

To lend 'integration' in healthcare services a further theoretical base, it is described in the forms of *linkage, co-ordination* and *full* integration (Leutz, 2005) while it is also approached as levels of occurrence , i.e. *vertical, horizontal* and *service* integration (Ramsayet al, 2009; Reed et al, 2005 and Glendinning, 2003)

Kodner and Spreeuwenberg (2002) approach integrated care as either *patient-centric* (aligning management and functions across multiple service providers to deliver healthcare) or as *organisational* (structural or hierarchical driven by the efficiency imperative). Britnell (2013) suggest that integration can only work if it acknowledges authentic patient involvement as a core ingredient.

Robertson (2011) in her analysis of Kodner and Spreeuwenberg's (2002) strategies for integration suggest that service integration is a continuum from co-operation between separate organisations via coordination in multi-disciplinary networks to fully integrated services with joint planning, pooled funding, joint management positions and inter-organisation multidisciplinary teams. Kodner and Spreeuwenberg's (2002) strategies and approaches to integration include (but are not limited to): the pooling of funds; decentralising

of responsibilities; co-location of services; joint training; multidisciplinary/interdisciplinary team work and jointly managed programs or services.

Successful healthcare service integration will require developing shared values, collaboration across PSOs and inter-agency service coordination (Miller and Bowers, 2003; Stuart and Weinrich, 2001) while factors such as co-location, IT, inter-professional trust and supportive policies can enable successful integration (Robertson, 2011). On the other hand, the challenges and barriers to success in integrated healthcare (Robertson, 2011; Coxon, 2005, Heenan and Birrell, 2006) include:

- being able to collaborate rather than compete when integrating
- pooled budgets and resources rather than aligned
- establishing a common vision between PSOs
- actively developing a new culture
- concern for professional status and identity
- the desire to address and resolve the more difficult issue of integration rather than bypass them
- hesitation to work in an inter-organisational environment
- addressing the terms and conditions of employment – that is, being able to make HR decisions early in the integration process which many organisations delay until later in the integration journey
- Addressing issues related to career development and training

Service integration attempts to 'provide a full continuum of services in a user-friendly, one-stop-shopping environment that eliminates costly intermediaries, promotes wellness, and improves health outcomes' (Boone, 2000:1). Given their fairly new emergence as a model for public service delivery, sceptics may question the value of integration efforts as mentioned previously. Boone (2000) suggests that the efforts in integrating services must engage particularly with identifying and resolving culture clashes.

As I previously noted, the importance of the individual manager as a unit of analysis in the change process is critical to the integration effort. Boone (2000) elaborate that in order to successfully form and operate integrated health care delivery system requires a great deal of commitment and can pose major challenges to healthcare managers. This is because in service integration, managers are asked to perform functions and tasks that are different to what they have managed before.

Britnell (2013) crucially points out that even though great faith is placed in integration, it is easy to confuse structural integration with what users really want. On this point, Britnell (2013) argues that the NHS has had quite a lot of superficial structural integration and not enough collaboration from the user's perspective.

The implications of such change for PSOs and managers are large and new forms of governance will be required as the healthcare environment becomes complex while traditional governance forms become challenged (Savage et al., 1997). As healthcare and PSOs develop into new integrated service system, challenges arise as to how they should be governed while ways of governing must be responsive to both stakeholders and the work they do (Savage et al., 1997; Alexander et al., 1995). Robertson (2011) highlights that there remains a divide between the theoretical understanding and the practical delivery when it comes to collaborative working and integrated healthcare.

2.4.3 The Case for Collaboration and Integration in the Scottish Healthcare Service

The desire and effort towards collaboration and integration in Scottish healthcare services is widely evidenced. A core healthcare strategy *The healthcare quality strategy for NHS Scotland* (2010) suggests '*effective collaboration*' between stakeholders as a means of responding to these challenges (Scottish Government, 2010, p.23). Specific to integration, it states that attaining quality in health will involve all key stakeholders to oversee the implementation strategy that ensures ensure *whole-system integration* (Scottish Government, 2010, p.31). Similarly, the *national framework for service change in NHS Scotland* (2005) refers to the Scottish health white paper (Partnership for Care, 2003) which emphasises the need to work in partnership as a central theme. In the Scottish Government strategy titled '*A force for improvement: the workforce response to better health, better care*' (2009) signifies partnership working as one of its main vision. *A force for improvement* policy document (2009) highlights five key ambitions for the NHS Scotland workforce that set out strategy, of which, 'moving towards an integrated workforce' is one.

This document suggests that workforce planning needs to be developed with key partners for public service delivery (health and social care) and at the local level NHS boards shall develop their capacities and capabilities for workforce planning. Given this, more collaboration between workforce planners and groups across Scotland is assisting learning in a bid to increase the capacity to provide local solutions to local issues (Force for Improvement, Scottish Government, p.33). The *NHSScotland leadership development*

strategy (2009, p.8) titled 'Delivering quality through leadership' talks about the need for renewed leadership and creating a 'can do' culture of service transformation. It highlights 'cross-working and complexity' and 'Partnership working and influencing' as factors of this changing context. .It points out that senior managers in the NHS will need to work in complex systems due to the need for working across public services.

From an external perspective, agencies such as Scottish Enterprise in their efforts to encourage innovation and enterprise for economic prosperity express faith in such joint working arrangements and see them as central to enabling the public sector achieving greater efficiency and value for money (Scottish Enterprise, 2012)

The Public Bodies (Joint Working) (Scotland) Bill introduced in May 2013 aims to take further the Scottish Governments commitment to integrate adult health and social care. The bill intends to achieve greater integration between Health and Social Care services in Scotland in the bid to make services efficient and improve outcomes for users. As the bill is enacted in April 2015, it must be adapted at the local level requiring Health Boards and Local Authorities to create an integration plan. The bill will necessitate an integration plan for adult services while other services are encouraged for inclusion (Robson, 2013, p.3; UNISON, 2014).

The Bill proposes two models for integration which the Health and Social Care Partnerships can be adopted as per need. These are a Lead Agency model where both agencies delegate functions as well as transfer staff terms and conditions to one another under the oversight of a joint monitoring committee while the second proposed model, a Body Corporate sees both agencies delegate functions to a jointly appointed board headed by a chief officer, typically encouraging the retaining of staff and their terms and conditions of employment with their existing agency (Robson, 2013:3; UNISON, 2014). This Public Bodies Joint Working Bill acts as a focal point for Community Health Care Partnerships in Scotland at this moment in time and is the main driver of political and legislative change that will transform the structures of both agencies as well as their services for the coming future.

As demonstrated above, the breadth and width of policy and strategy for healthcare in Scotland provides a focus on joint-working and integration as both the mode and means for service delivery. The Scottish Government with its vision and target for the integration of health and social care as a means of achieving prosperity places great faith in Community and Health Care Partnership agreements between NHS Boards and Local Authorities across the country. This is primarily done through Community Health Partnerships (CHPs) being

established across Scotland as the mechanism through which health and social care integration is planned and implemented. The *Community Care and Health (Scotland) Act 2002* paved the way for more formal joint working by enabling NHS boards and local authorities to establish joint management arrangement for community care services (NHS Confederation, 2004). Presently, the Public Bodies Joint Working Bill (2014) as described above acts as the main driver of change in Scottish Community Health Partnerships.

2.4.4 Achieving the Integration Agenda via Community Health Partnerships

CHPs bring together the public, voluntary organisations, local authorities and health services all of whom co-ordinate and plan the delivery of health and social care services locally (NHS Fife, 2012). The aim of CHPs is for citizens to access needed health and social care services, enable service providers to improve community health services by working collaboratively and to address the issues that affect people's health and wellbeing (NHS Fife, 2012). Effectively, CHPs are partnership models with a focus on service integration between health and social care and the development of closer working relations which promote co-terminosity between NHS Boards and Local Authorities for better joint planning and delivery of services (Forbes and Evans, 2008). At a later stage of this thesis, I will elaborate further on the set-up of CHPs across Scotland and comment more on their particular arrangements in relation to this study.

As partnerships that fall under the responsibility of NHS Boards, the core purpose of CHPs is to deliver local health improvement for which, the integration of health and social care services remains integral to achievement. However, CHPs remain fairly new models of joint-working and integration in healthcare service delivery. Their establishment and management arises out of devolved policy for delivering public services that are still in their early days with respect to being models of partnership working or an integrated healthcare service system. Therefore, any evaluations reported on the effectiveness of partnership working (i.e. cases of CHPs) remain very limited and inconclusive (Glendinning 2003; ODPM, 2006; Forbes and Evans, 2006). CHPs continue to evolve and have variation in structures and purposes depending upon where they are located and ongoing clarity and progress on CHPs continues (Watt et al, 2010; Robertson, 2011). Boone (2000) highlights that even in the context of the US healthcare set-up where joint-working and integration have long prevailed, there exist 850 integrated health care delivery systems with most considered to be in an evolving state of integration as they attempt to provide integrated services.

Formed as committees or sub-committees of NHS boards, these CHPs aim to link health and social care, leading to greater integration of services (Robertson, 2011). CHPs continue to undergo much policy and structural changes and are currently as a stage of progressing towards Community Health and Social Care Partnership (CHSCP) formations, something that I will come back to at a later stage.

2.4.5 The Challenges of Collaboration and Integration

With reference to CHPs being fairly new joint-working and integrative models of managing healthcare service delivery, it is important to address their conceptual and theoretical underpinnings. Some weaknesses come to the forefront in looking at research on such collaborative management arrangements (which also pose challenges in establishing a study such as this one within a collaborative and integrated service context).

Firstly, there is the conceptual weakness of how far collaboration and partnership can be stretched and what it covers. This is because conceptual boundaries are blurred among coordination, cooperation, coalitions, collaboration, network structures, collaborative public management, collaborative governance, civic engagement, alliances, mergers, and partnerships: all lacking clear definitions and not mutually agreed upon by researchers (O'Leary and Vij, 2012). Their multiple terms, meanings and implications are overlapping, elusive and unclear leading to inconsistencies in the nomenclature. For this very reason, I chose to use the term *joint-working* simultaneously as mentioned earlier to represent the use of *collaboration* and *partnership* as arrangements for managing and delivering healthcare services. However, taking on board this limitation and challenge, attempts have been made in developing a typology of collaborative contexts (Mandell and Steelman, 2003) as well as developments on network structures (Agranoff, 2003). McGuire (2006: 35) states that:

> *"a public manager may be simultaneously involved in managing across governmental boundaries, across organisational and sectoral boundaries, and through formal contractual obligations, it is often difficult to distinguish where the boundary lies between these different environments".*

There exists (at least for the moment) no best way to conceptually or theoretically describe or organise joint-working (i.e. collaborations) in the context of the public sector and public services. Caution is advised when examining collaborative public arrangement arrangements or structures (McGuire, 2006). The same remains for integration as previously discussed given the large and overwhelming diversity of terminology and meaning given to it (Armitage et al, 2009). Nevertheless, what is prominent is the large use of networks as a

means to carry out collaboration and integration in the public sector context. This is something I come onto in the coming section.

One must work with these limitations and make an attempt to gain (or create) clarity on joint-working and integration as this shall be the context of this research. It would be noteworthy to point out here that this limitation and challenge has implications for managerial work and Management Development (MD) in a public service environment where joint-working and integration create blurriness and complexity for what managers do and how they do it: an issue that I come onto in the forthcoming chapter. Increasingly, managers have to do and operate in this changing context: referred to commonly as collaborative public management which has theoretical underpinning.

Secondly, a theoretical weakness is that of collaborative public management (CPM) in itself not offering a consistent overarching theory (O'Leary and Vij, 2012). This theoretical weakness is owed to collaboration having blurred boundaries and the difficulty in distinguishing between different collaborative *environments, arrangements* and *structures*. As it stands, CPM lacks distinct identity as an area of inquiry and current research limits itself to a cross sectional analysis of collaborative management cases, which poses the need to study (and understand) how collaboration 'actually performs over time from inception to culmination' by tracking real-time collaborations and longitudinal studies'(O'Leary and Vij, 2012:516).

Thirdly, O'Leary and Vij, (2012) also derive methodological weaknesses in CPM research, that is, its 'weak empirical validation and reliance on anecdotal description which prevents the field from improving as an applied science' – which means there is no reliable means for 'analysing and comparing different collaborations or drawing conclusion on how to foster or maintain effective collaborations' (O'Leary and Vij, 2012:517). In addition to this, O Leary and Vij (2012) highlight inconsistencies in identifying the units of analysis in CPM research and advise that the unit of analysis must capture the complete collaborative network (including informal extensions) that involve interpersonal interactions or relationships which have important implications for the collaborative network and collaboration itself (Isett et al, 2011). Furthermore, this has implications for how service managers are learning and from whom: an interest of this study.

2.4.6 The Manager in the Collaboration and Integration Context

Concerning the role of individual manager, studying CPM through the individual as the unit of analysis remains worthwhile and is encouraged because collaborations occur through individuals (Frederickson, 2007; Huxham, 2000; Huxham & Vangen, 2005; O Leary and Vij, 2012). O'Leary and Vij (2012) flag concerns that the academic community is not able to impact, influence or even inform real world collaborative practice and that there is a general lack of comprehensive knowledge on CPM. But on a positive note, CPM grows in practice while research in this field in increasing to focus on generating knowledge and developing an empirical research base (McGuire, 2006). But particularly, the role of individual managers in CPM within the Scottish healthcare service has received little research attention and lacks literature in the public healthcare services context. Taking account of this challenge, it may be suggestive that CPM efforts and outcomes be researched and evaluated within given contexts because of their relatively new emergence, rather than attempting to generalise for them. Taking on board McGuire's (2006:38) suggestion that 'only by determining impact of collaborative management will we advance of general management theory', I add further by stating that only in determining the impact of collaborative management on individual service managers (and vice-versa) will we advance our understanding of the future service manager in public services and public management itself.

Having addressed joint-working and integration in Scottish healthcare services which lays out the context for this study and elaborating upon the nature of CHPs as the setting in which I base my research, I now move to discuss the present service system of joint working and integrated service which extensively utilises networks and public sector networking to deliver public services. I review concepts and ideas about what this entails and suggest alternative directions for how integrated healthcare services can be managed and delivered using a services-as-systems approach.

2.4.7 The Role of Users in Services

The role of users in public services is an increasing focus of both governments and academics on the premise that users take prime focus as a stakeholder in the public services they subject themselves to as consumers (2020 Public Services Trust, 2010). Based on democratic ideals, there is a large voice for user inclusion in public debate and the decisions made about how services should be governed and delivered. The emerging paradigm of co-production (services produced via the involvement and input of users) in public services therefore has gained increasing pace and services are increasingly not just about delivery by

professionals and managers but co-produced by users and communities (Bovaird, 2007). Without the need to go into greater discussion on the critical issues and debates surrounding co-location and user involvement in public services, two important aspects of user involvement become important for this study.

Firstly, is the argument that the ways in which users can give input to services and interact with organisations and their management and the value of their input is contested and needs to be better understood (Simmons et al, 2012). The degree to which their input is accepted and recognised remains a point of contention as highlighted by Simmons et al. (2012). This can easily be envisioned at the practice level where the involvement and input of users in co-determining public health needs for a locality (e.g. at a Public Partnership Forum meeting) may not be taken very seriously by clinicians or service managers across the table given that they would challenge the views of users on the basis of lack of knowledge on medical grounds, lack of knowledge about service arrangements and the complexities of managing them, and the perceived limitations of users having derived their understanding of the entire service based on their limited personal experience and exposure. Fledderus et. al (2015) argue this very point that although co-production may decrease uncertainty for users, it seems to increase uncertainty for organisations.

Secondly, there is the other side of the coin in terms of user involvement being an important element of public service innovation. This is because co-production carries the potential to drive service innovation (Rhodes, 2013). Since innovation can be understood as a learning process where new knowledge can be created through the interaction between users and service providers (Jaeger, 2013). This certainly is a noteworthy observation in the case of health service design and health and social care integration which are constantly transforming. User involvement and the co-production of services gains increasing importance and maturity and becomes part of the shift in public governances and new forms of service design (Brandsen et al., 2012; Brandsen and Honingh, 2013).

2.5 From Networks to Services-as-Systems

In using a SD approach to managing healthcare services, I present below ideas that demonstrate why networks as a means of managing may restrict future integrated healthcare services and why networking may not suit this evolving public service context. I reflect upon ideas that would suggest services-as-systems as a way of managing joint working and integrated healthcare services.

2.5.1 The Growth of Networks for Public Services and their Use

The trend for public sector networking as a means of service delivery has been encouraged by the NPM era where public-private partnerships and contracting were praised (and still are) for managing and delivering healthcare services. The focus on networks in public administration both in terms of conceptualising and practice has rapidly grown in recent years (Isett et al., 2013). Their conceptualising and application in the public administration (PA) context is found in the forms *of Policy networks* which involve cross-sectoral agencies (both public and private) with an interest to influence public decisions on the premise that they all share purpose (Laumann and Knoke, 1987). *Collaborative networks* have arisen where multiple agencies and their managers get together in order to deliver public services in efficient ways (Agranoff and McGuire, 2001, 2003; Mandell 2001; O'Toole 1997a). Furthermore, *Governance networks* are also arrangements that combine joint service provision and collective policy making (Klijn and Koppenjan, 2000; Rhodes, 1997; Sørensen and Torfing, 2005)

In effect, managing public services via networking aims at transferring best practices (i.e. benchmarking) to the public sector with intention to gain efficiency. Berry et al. (2004) notes that the conceptualisation and use of network forms (described above) have their roots in other disciplines outside of PA. Managing through such network forms implies that PSOs organise and coordinate amongst themselves to deliver services through NPM means and using managerialist practices. By this very purpose, they are loosely coupled agencies and/or actors with permeable boundaries; but nevertheless with boundaries that are pre-defined in terms of responsibility and purpose. The very point here is that networks in themselves imply a make-up of an entity while services in their very nature are only fluid. For instance, a network may be made up of artefacts that bear no self-awareness (e.g. IT servers) and grant recognition to agency or objects such as in the case of actor networks (Latour, 1987). In IT, networks typically involve a platform where different systems and technologies are built and run. Social networks and organisational networks comprise of interconnected people whom in a network have loosely coupled actors in porous boundaries who no doubt come together for a given reason or purpose, but precisely without the same goals because they belong to and represent separate agency. Networks therefore become an organisational form that contains agencies and actors with *a shared purpose* but not *the same purpose*. The network takes up an existence in itself constituting professionals with complementing agendas.

2.5.2 Addressing the Limitation of Networks in Public Services

Certainly, network formations would attempt to eliminate vertical hierarchies but the network would only be effective in doing so if the people in it can sufficiently get together and be tightly coupled to function like a unified system (Williamson, 1985). For the most, networks in the public sector (i.e. Alcohol & Drug Partnerships) are inter-organisational and purposive arrangements (Kinder, 2003). The very important point here is that the loose coupling of people and organisation in the network prevents (and discourages) them from collectively acting as a system. For instance, the University of Beijing and Greenpeace may come together in a networked form to address climate change or deforestation by launching a project or campaign. The former may bring research and novel approaches to the table while the latter might oversee the implementation of the project/campaign; here you get both organisations (and their people) loosely-coupling for the task at hand but with very different goals and aspirations. The University and its researcher may seek new data and research publications while Greenpeace and its project manager seek cost-effectives and timely completion of the project/campaign.

The boundaries of the organisation in networks remain porous while retaining different goals. A limitation of networks in public services can be drawn from Weick (1995) who suggests that different or diverse interpretations (i.e. in the network) reduce enactment and lengthen the time it takes for sense-making. Furthermore, the network approach to public service management and delivery privileges sub-unit goals above that are whole (Louadi, 1998). From the managerial perspective, Boone (2000) suggests that in coming together to form integrated healthcare services, many people are asked to perform functions and tasks for which they have never been previously responsible. In doing this, risks or challenges emerge that would not be present otherwise. To decrease these, they suggest that it is important that leaders begin to focus on the system as a whole rather than a conglomeration of independent organizations, reaffirming Boone's (2000), Louadi's (1998) and Weick's (1995) claims. Also, this lends support for the case that present day networks in their management and delivery of healthcare service may not remain appropriate for increasingly integrated services. Even though in their resolve to provide solutions, networks remain limited in their ability to recognise and deal with the complexities of public management (McGuire and Agranoff, 2011)

As mentioned, public service networking enables PSOs and managers to come together for the same task but with different intended organisational interests. The network in its formation and terminology disguises itself as a tightly coupled system when infact this is not

the case. The managerialist approach (instilled with a GDL) which has prevailed in public administration over the last three decades is carried forward by and prolonged by the network concept and network approach in public administration (Toonen, 1998). Toonen (1998, p.251) goes on to state that the network approach is '*obviously not a sound or solid basis for re-founding the study of public administration*' because it is fundamentally different to the underlying theoretical pluralism of Public Administration', which reaffirms the suggestion of Osborne (2010) about the pluralism of Public Administration. Toonen (1998, p.251) suggests that '*the real challenge is to integrate institutional, managerial and network concepts*' in the study of public administration', as also suggested by Osborne (2010) when proposing the NPG paradigm for public service design and delivery which can account for the pluralist nature of public management. Rethemeyer (2005) highlights here that the theoretical approach of network management has matured and is now in need for empirical examination.

2.5.3 Beyond Networks to Services-as-Systems to Suit Purpose

As previously discussed, NPG and the SD approach argues that public services should not be viewed and treated in terms of inter-related organisations or products but rather as services and systems (Osborne, 2010a; Normann, 2002). To support this point, O'Toole (1997) suggests that organisations and practitioners need to begin incorporating the network concept to the context of contemporary public administration by accounting for and without neglecting its present-day inter-connectedness and complexities. Hence the distinct difference between networks and services-as-systems is important here. Unlike in networks, people in systems know and share the goals of the system as they agree on what inputs and processes (transformations) achieve a privileged output. Hence they are tightly coupled than they are in networks. This does not mean that they are impervious or nonporous: the service system has degrees of openness and learning and change occurs that is appropriate to goals of the collective service, not individual organisations in the service system (Bertalanaff, 1981; Chesbrough, 2006). Tighter coupling of people and the service system presiding priority over organisational goals is complementary to the nature of services. That is because services are a flow of processes rather than being an artefact or stationary product. It also enhances the ability of the service system to innovate as organisations and managers are on the 'same page'. This is evident in the case of tightly coupled programmers successfully working around the same goal and end point to develop an alternative operating system (linux) to Microsoft (Toumi, 2002; Castells and Himanen, 2002).

For PSOs, engaging in networks presently remains the approach because it is perceived as 'the way to do it'. In other words, current management trends demand that networking be popular in the public sector. Essentially it is important to understand that the network is an organisational form while a service system is a value flow. Networks imply thinking and doing only as organisations which is a lazy and restrictive approach to managing. This is because it does not allow managers from separate organisations to get to the very core of it: which it to think and act collectively and beyond their agency for the service and user first. Networks are composed of actors and stakeholders that design and deliver services to users but who remain partially-engaged and partly-concerned in that overall system, while services-as-systems have service providers and users co-determining and co-producing the service in a given context that accounts for the environment. Networks, being performance-driven may treat users as passive and only consult them while services-as-systems being value-driven actively engage users in service design and delivery. Networks encourage supply-driven service and management practice while services-as-systems encourage demand-driven service and management practice.

All of this is not to say that services-as-systems are trouble free since organisational and functional interests will pose challenges and there always will be vested agency interests. New ways of working and new skills and techniques will also be needed in such as new service system. But the effort lies with the intention here: that is to think of the bigger picture and act beyond separate functions and organisations while being committed to resolving the conflicts that occurs in the process. Below in table 2, I present below a table to summarise how public service networks differ from public services-as-systems.

	Networks	Services-as-Systems
Boundaries	• Wide, porous, stable, across or between organisations	• Definite, for purpose, flows, ignores organisational boundaries
Causality between people/events	• Fluid and Loosely coupled	• Stable and Tightly coupled
Information/knowledge flows	• Multi-dyadic, often 360-degree and at time purposeless	• Purposive (often horizontal and vertical)
User roles	• Passive (includes consulted) recipients of supply-led	• Active in co-production and co-design in demand-pull
Goals	• Consequently the network always contains an elements of both co-operation and conflict	• Privileged outcomes agreed by participants (require managing conflict)
Epistemology	• Organisational form that includes intra- and inter-organisational working	• Flow of value arising from agreed coherent patterns of activity

Table 2: Contrasting Public Service Networks and Public Services-as-Systems

To summarise, networks do not suit the purpose of integrated healthcare services and neither do they cater to creating value in public services. But rather, they pursue the creating of efficiency in services and encourage psychic distances. Isett et al. (2011) suggests that networks preach what has already been practiced under the GD approach to managing public services. They limit themselves to 'scientific management' while integrated services should be about engaging in processes that bring about 'value creation'. The network, given its inflated conceptualisation as a term, disguises those within the network to be tightly-coupled when infact, this is a characteristic and quality of services-as-systems. From the service manager's perspective, conceptualising public services as service systems draws their attention to the concerns of the service and user, to the restrictions and boundaries, to the causal links and service goals and to a whole epistemology that is different from that of the networked participant. As Kavanagh and Kelly (2002, p.583) highlight in their empirical observations of the difficulties involved in managing networks for organisations:

> *There is a need to move away from rationalistic assumptions about communication processes…. Towards a richer conceptualisation of such enterprises as involving collective sense making activities within and between situated communities of actors….. contrary to much contemporary writing….space and location are of crucial importance to our understanding of network forms of organising".*

2.6 Summary

This chapter has reviewed management theory and practices in healthcare services and discussed NPM and the move towards NPG. It also discusses the move from a goods-dominant approach to a service-dominant approach and reviews joint working and integration in the context of Scottish Healthcare Services. Ideas surrounding networks and services-as-systems have also been reviewed. Below in figure 2, I illustrate the theoretical concepts and ideas of this chapter using a diagram, to provide an overview of the main arguments and comparisons distilled from the literature in this chapter.
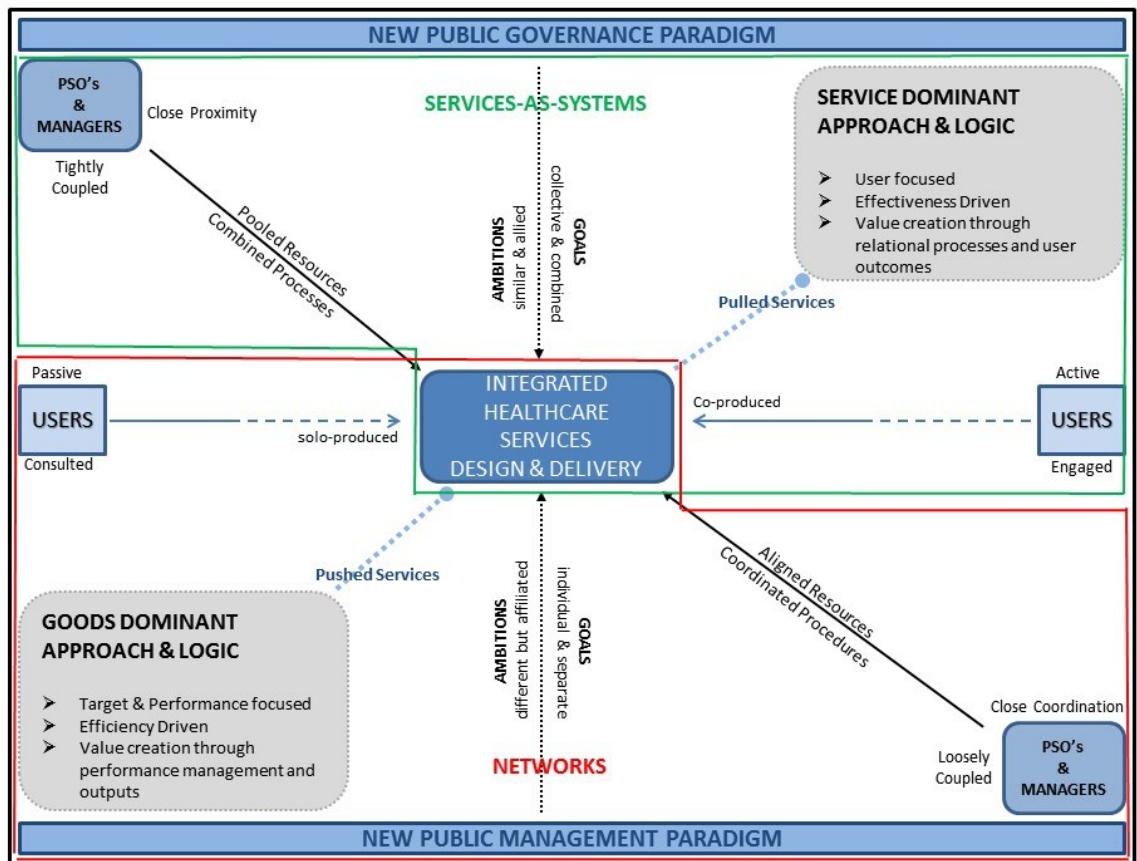
Figure 2: Public Management and Pubic Services Arena

Taking on-board the concepts, the ideas and the context presented in this chapter, I now move to consider what service managers do and how they do it in the midst of change resulting from joint working and service integration. The next chapter sees me address ideas on managing in a new service environment and how the roles, responsibilities and relationships of managers alter as a result. I conclude by considering what the implications are when a Services-as-Systems approach is adopted for the future.

3. MANAGEMENT AND MANAGERS IN TRANSITION

3.1 Managers in the Midst of Change

As service models adopt collaborative and integrated forms, how managers engage with 'management' also evolves: that is *what* service managers do and *how* they do it. As inter-organisational forms of service delivery become dominant and move to a whole systems approach, this alters the roles, skills and behaviours and the training needs of public service managers. O'Flynn (2007) suggests that this transition means a shift from managerial efficiency to outcome effectiveness with respect to creating public value.

Pointing to current flaws, Osborne et al. (2012) suggest that current management practices in public sector are derived from private sector theories and are created from the experiences of industry, focused around the enabling of managerial efficiency. The Services-as-a-System approach (Memon and Kinder, 2016: forthcoming) advocates that as inter-organisational forms of working become more dominant, local service providers will treat service delivery as a whole (holistically) to address service user needs in the austerity age and will move beyond inter-organisational managerialism. Here, the shift towards co-produced services offers novel ways to meet challenges of modern day health service delivery (Cottam and Leadbeater, 2004). This transition however is not straight forward for service managers since the change is both complex and unclear. Particularly when the collaboration and integration agenda is driven by cost efficiency and a desire of the NHS to innovate organisational structures (as a response to cost efficiency) rather than healthcare integration being driven by user outcomes (Tschirart et al, 2009; Segar et al, 2013; Mark and Scott, 1992). Added to this of course, is the previously mentioned conceptual challenge described by O'Leary and Vij (2012) and McGuire (2012) of not being able to distinguish between forms of coordination, cooperation, alliances, partnership, integration and so forth. Huxham (2000) suggests that governing such collaborative forms is difficult and invites conflict. O'Leary and Vij (2012) discuss the reasons for agencies to collaborate vary extensively as will the function of those who attempt the collaboration: therefore naturally raising complexity and conflict given the different cultures they bring, different methods of operating, different degrees of power and with networks containing different stakeholders and resource bases.

Integrated service systems create complex governances and accountabilities across the UK public sector (Hudson, 2002; Flinders, 2004) making both inter-operating PSOs and programmes of health and social care complex and messy (Segar et al, 2013; Land, 1991).

Managers increasingly are needy of being able to network, lever resources and beyond relationships beyond the organisation and learn in different ways than before (Stoker, 2006; O'Flynn 2007: 361). This ambiguity represents change where new public governances will emerge (Osborne, 2010a) and where the balance of time between leading, managing and administering will alter (Harley and Alison, 2000). Given collaboration and integration as fairly new and emerging phenomena in the public sector, McGuire (2006: 34) suggests that management principles must be re-written and theories of organising must be updated. Managing in this environment is the 'new kid on the block' (Stoker, 2006: 43) where management defines its tasks more broadly than before. Kettl (1996) argues that an increasing interdependence among PSOs has changed the job of public administrators who must now build critical linkages with other agencies. The individual manager in this context has received little attention within the NHS both in terms of conceptualising and practice since the phenomena has been researched more at the level of collaboration between organisations and little on collaboration between individuals (Huxham, 1993; O'Leary and Vij, 2012). Particularly, service change led by co-production raises a new environment and creates new challenges for what managers will do and how. In the process of delivering new collaboration forms, Agranoff and McGuire (2003) suggest that the managers' work becomes more complex and interdependent.

In the next section, I critically discuss and evaluate the literature on managers in change that can aid an understanding of how managers will fare with a future public healthcare service system that signifies collaboration and integration with users at the core.

3.2 Challenges for Managing in Integrated Public Healthcare Services

In this section I discuss the challenges and tensions associated with change for management in Scottish healthcare services and argue that NPM practices and the network model do not enable managers to address them.

Haynes (2003) addressing the weakness of NPM in the public sector, points to the over-rigid adherence to artificial market boundaries and a loss of confidence and power for professionals. This happens because work practices are imported from the private sector without taking into account their appropriateness for the public sector (Osborne, 2010a). Where integration occurs in public services based on market principles, accountabilities become unclear and fragmented. The tension for managers arises with the PSO desiring

performance standardisation as advocated by NPM while the innate managerial desire is to be creative, intuitive and to innovate.

There is also the tension here between managers and clinicians since Clarke and Newman (1997) argue that NPM bore an ideology and endeavoured methods that attempted to compromise the authority of clinical professionals by making them accountable to management and governing healthcare service performance. Haynes (2003) interestingly argues that this tension between managers and clinicians different ways of thinking is fundamentally the difference between the business and public sector environments. Added to this is a managerial need to focus on delivering services that are increasingly co-produced with users at the centre. This will demand managerial engagement with and accountability to users at the local level, which requires a different mind-set for prioritising service management when compared to traditional management of public services, which focuses on organisational performance with the organisation at the centre.

Since policy advocated the introduction of managerialism into public services, this in reality has blurred the boundaries between managerial and professional roles. The NHS saw clinical professionals (managerial professionals) such as nurses predominantly taking up managerial roles while maintaining ties with professional bodies and their prior clinical experience. What has since lacked is a clear separation of managers and professionals (Mark and Scott, 1992; Haynes, 2003). On the other hand, managers and executives from the private sector with business backgrounds and a GD approach were also recruited and enrolled into the public sector and NHS to drive NPM practices while for the 'managerial professionals' (Exworthy and Halford, 1999) management practice is informed by clinical reasoning or judgement and influenced by professional allegiances.

Alongside this, policy and performance has dictated best-practice management. Haynes (2003) identifies is that while senior managers are under direct pressure to comply with policy and be answerable to politicians about delivering on targets, front-line middle managers end up having to interpret these top-down demands and precise performance language imposed upon them by politicians and senior executives: as a result, middle managers in their everyday service management practice end up trying to make sense of business-sector models which need to be applied to their work since that is what is demanded from them.

Mark and Scott (1992) advocating Domain Theory suggest that these managers increasingly have had to manage in and across different domains, deal with antagonising relationships,

poor communication and coordinated planning between separate domains. Early proponents of Domain Theory can be located in the NHS where its application has treated the PSO as an organism (Morgan, 1986) that cannot be viewed as being independent of its external environment (Gunn, 1989) in an attempt to create health service value. But in rightly proposing this, Domain Theory does not offer anything realistic beyond as it only identifies the existence of separate domains that can be brought together. For instance, early research on Domain Theory conducted with NHS managers (Thompson, 1985; Smith, 1984) identifies that the separation between the three domains of managers, professionals and policy makers can be addressed by unifying the external environment with them as a fourth domain: so that unity and harmony can be achieved in organisational life (Morgan, 1986). The suggestion being made here is that once the fourth domain of the environment is added, collaboration suddenly becomes pretty and trouble-free. This remains almost a utopian concept because it shows a lack of acknowledgement of tensions and conflicts that occur within organisations and among managers and which influence learning and change. Conger (2004) suggests that managers remain in a dilemma of needing to be flexible to deal with multiple interests and inter-agency partners yet at the same time complying with the organisation's ambition for stability. Further to this, it ignores other stakeholders, particularly users who co-determine services. How managers perceive and experience change as a phenomena in the context of joint working and integration in healthcare services that are increasingly co-produced remains worthy of exploration.

To address such challenges of organising and managing that have long prevailed, the use of networks in the public sector has established popularity (as previously discussed in chapter 2). But Haynes (2003:23) deems networks as having limitations when used for the public sector context because they too are horizontally and vertically dependent on bodies that delegate power and authority to act in that network with performance pre-ordained and within limited cooperative stances (reiterating the concepts discussed in chapter 2). Haynes (1992) acknowledges the transition to networks seeks more involvement of stakeholders while new post-NPM language such as leadership and whole systems is given to represent change management beyond new public managerialism. The network model positions itself as being more than just a system of inputs and outputs.

Nevertheless, the limitations and difficulties for the service manager under the present network concept remains: that even though it desires for service design and delivery to be more holistic and user sensitive, it does not offer a clear direction of where service integration is headed since the management focus is still organisation-centric. Neither does

networked management allow flexibility to adapt to local circumstances. The ambiguity and blur remain because the network model still retains the NPM ideology that managers address change via pre-determined and benchmarked performance, with standardised target achievement (Rhodes, 2000; Haynes, 2003) by using pre-designed interventions that involve managing on the basis of pre-packaged competences (Holman and Hall, 1996; Currie and Procter, 2001). In accordance with this critique, Rose and Lawton (1999) argue that we are still left with the same challenges as before:

- no clear distinction regarding the location of responsibility and accountability of PSOs and the actors within the network and;
- blurriness as to how policy must be converted into operational action – where the novel network is left to rely on and make use of the same NPM advocated practices and techniques: old wine in new bottles.

Hence organisations fail to create value using network management and the managerial effort becomes frustrated because agencies take up membership in the network but operate on individual basis to achieve organisational service targets. To support this argument, Bardach (1998) argues that value-creating collaborations do not occur because the task of collaborating is a very difficult one that requires working *cooperatively*: the network model just poses itself as an arrangement where this element of *cooperation* is deemed to be pre-existing, pre-aligned and naturally occurring:

> *Working cooperatively is often much more complicated than it sounds. It involves reconciling worldviews and professional ideologies that cluster within agency boundaries but differ across them. Moreover, it is difficult to align agencies' work efforts in the face of governmental administrative systems that presuppose deliberate nonalignment. Indeed they favour specialisation and separateness down to the smallest line item*
>
> (Bardach, 1998:306)

The network system is not user-centric and ignores the need to tailor services for users at the local level. It struggles to deliver because it treats managerial tasks and service needs in standardised ways. From a management perspective, what is necessary here according to Haynes (2003) is to recognise the likelihood of any given context and the difficulty of generalising (e.g. standardised targets for all NHS Boards or a key skills and competence framework for all managers across NHS Boards). The point made here is that organisational and managerial lessons learned in one context may not be applicable in another context regardless of the type of boundary. Shacklady-Smith (2006) elaborating on the nature of the change process in healthcare services argues that rather than pre-planned and pre-determined

responses to change (e.g. policy for H&SC integration or pre-set service improvement targets) determining service context, it is about the local service context and *as-per-need* responses that should determine change and performance.   Borrowing from Ackerman's (1997) perspective on change, managers are in a constant state of flux as they try to determine the nature of the change that is transformational: it is *change* where a new state emerges that was previously unknown until it took shape out of the remains for the old state and where the time period of the change could not be controlled (Shacklady-Smith, 2006:386). The emergent change according to Burnes (1992) assumes that PSOs operate in uncertain conditions over which they have little control. The SD approach would suggest that user-focus can provide clarity and focus here for navigating emergent change.

Theorising change as being emergent and unsystematic would be realistic since the nature of change is chaotic and convoluted (involving subjective interpretation of the inter-connected social world) while the change process itself is non-linear and involves complex dynamics such as human interaction and relationships (Sweeney, 2005) which require managers to learn and innovate in new ways (Kinder, 2013). Increasingly, the learning and innovating must occur in an inter-agency environment where accountabilities are negotiated amongst managers themselves (Kinder, 2012) at the local level with a purpose to deliver value to the user.

What has been missing in the debates so far is any notion of a trajectory towards co-produced services where users are accounted for and actively engaged in service design. This is a fundamental factor in the non-linear change process that is ignored as traditionally, public service design and delivery has always treated users as passive recipients with a GD approach to managing healthcare services. As highlighted earlier in this chapter, management in service integration is based on principles where value is derived from efficient targets delivered nationally. But the NPG paradigm advocates that integration (and its management) be driven by user-focus where value is derived locally from delivering co-determined outcomes. The service-dominant (SD) approach offers us an insight and direction to deal with a further limitation I have highlighted: which is that managers in their everyday practice try to make sense of business sector models that must be applied to work. The SD approach advocates that rather than making sense of business sector models (a GD approach), managers make sense of user-focused needs and work on how the different services in the system (S-A-A-S) can best come together and align processes: this should dictate the management agenda and the managers' work.

To deal with the limitations of the network concept which is a loosely coupled system of inputs and outputs by organisations, the S-A-A-S concept can offer a clearer direction for future integrated services: towards a tightly coupled system that faces the user and engages with their service needs. A NPG paradigm advocates that value in public services will be increasingly user-centric and a fundamental shift will occur in how the healthcare service design and delivery are treated: In S-A-A-S, the focus shifts to a SD approach where managing is about user priority rather than organisational priority.

To summarise, I have identified the limitations and challenges of managing in the present healthcare service and have pointed out that the NPM approach is unable to address them given its focus on management using business principles. I have highlighted the difficulty of managing through the GD approach (prioritising policy and organisational demands) for managers who are interested and concerned with managing for users instead of being fixated with organisational performance. This conflict causes confusion and frustration. I have pointed out to the limitations of domain and complexity theories arguing that they offer very little insight to understanding the dynamics of inter-agency environments and the subsequent culture that emerges. Also, they do not pay attention to the involvement of users in the service delivery environment. I have argued that despite networks intending to address these challenges, remain limited in application because they pre-determine management approaches using standardised terms while adhering to organisational priority.

Identifying change as uncertain, emergent and transformational, the SD approach to value in services being user-centred and user-derived can help navigate the change and give managers direction. Here I have advocated S-A-A-S to make sense of change and an inter-agency user-induced environment. S-A-A-S can offer a fundamental management shift in management ideology and practice to move beyond the network model for integrated and user-engaged health service delivery. In the next section I attempt to provide arguments that can carry the S-A-A-S construct forward.

3.3 Managing Change in Public Health Services in the UK

In this section I will discuss the complexity of change and critically analyse the prevalent NPM approaches to management that are used in response to change. I will then discuss an alternative perspective (S-A-A-S) for understanding change and examine alternative approaches to management in its response.

3.3.1 Present change and complexity

To understand how managers can keep up with the changing healthcare service context and be able to advance management practice in a time where policy demands cost-effective integration while services become increasingly user-focused, Haynes (2003) advocates Complexity Theory whereby the service system is viewed as inherently complex and unpredictable and where organisations adopt. Complexity Theory advocates that change in healthcare services is better understood when treated as a non-linear complex system. It suggests synthesis of the system where public managers need a good sense of 'over-view' if they are to do well. They must avoid the peril of getting fixated with a few points of detail at the expense of the wider picture. Rather, it is about a managerial approach that shifts the focus from things to processes; from entities to interaction (Lissack and Roos, 1999:3). This view can support a NPG paradigm and a SD approach where inter-agency service processes can be aligned to achieve better user outcomes (Osborne, 2010a: 2010b). It also supports a services-as-a-system view where the focus should be on managing a holistic system of services comprising inter-agency efforts together that go beyond the network concept to deliver to the user.

Here, integrated services are about *managing in a system made up of inter-agency services for users* rather than *managing in an organisation that is networked to deliver services to users*. Essentially Complexity Theory according to Cilliers (1998) argues that change yields non-linear and unpredictable outcomes because services involve humanly interactions, and therefore it would be more realistic that service management does not give any optimal or predictable rationale state of equilibrium (as would be expected by systems theory and systems thinking) . Haynes (2003) suggests that generalisable good-practice applied from one situation to another therefore ends up becoming flimsy: a theory or practice of management applied by an organisation in one context may not necessarily work for a similar organisation in a different context. Organisations like any social change are not subject to mechanistic or manipulative manoeuvring. PSOs are complex adaptive systems (Haynes, 2005). Stacey (2000) advises that managers attempting to understand and manage interactions between people must realise that there can be no failsafe strategy. Complexity Theory lets us realise that simplified or rationalistic management practices such as organisational redesign, quality standards and performance management based on set definitions and reductionist approaches are unlikely to deal with modern day complexities of inter-agency service such as excess demand and new dynamics such as user-involvement. Instead, modern day healthcare services require varied and situated approaches to managing.

Bardach's (1998) ideas on collaboration can be aligned with this reality as he suggests the need for "working cooperatively" for PSOs to build inter-agency collaborative capacity (ICC): which he characterises to be a 'demanding sort of creative activity' requiring more than routine scientific management practice. But managing in the public sector and the NHS has classically and largely been NPM induced focusing on scientific management principles (Pollitt, 1990). These practices rooted in Taylorist and Fordist methods derived from industry techniques when applied to the public sector result in a scientific approach to organisational design and processes that enable PSOs and public services to achieve economic efficiencies (Lapsley, 2009; Osborne et al., 2012). The approach has promoted top-down management because it believes that public policy can be clearly defined and put into action using principles and objectives which can be controlled and managed via specific and measureable outcomes. Borrowing here from industry- based management practices, traditional systems theory attempts to bring together and balance the complicated division of factors such as people, organisations, resources and the environment using relational methods and boundaries to balance them.

Haynes (2003) argues that systems theory encourages a simplified and reductionist understanding of these factors where order, control and improvement can be scientifically achieved. Complexity Theory in contrast suggests that organisational systems are complex to the degree that they require managers to engage with the changing PSO and embrace the complexity of the factors involved, rather than attempting any equilibrium balance between the factors. Haynes (2003) suggests that the complex system positions the manager for inevitable periods of instability in the PSO. Fenwick (2012) suggests that Complexity Theory helps to articulate complexities of professional practice and knowledge while providing support during unpredictability. Haynes (2003:62) argues that *change* becomes increasingly viewed by managers as an 'opportunity rather than a system error'. Stacey (2000) argues that traditional systems take an approach whereby the social context and the individual are both separate but interacting entities where action encompasses the management of this separation: the complex system is one that treats their interaction combined so that individual action can be understood in the context of the social environment.

Goleman (1996), here is suggestive that an understanding of emotions (emotional intelligence) is more suited to the nature and task of managing and for a managerial career rather than traditional measures of rational cognitive measures. Bardach (1987:188) reverting to a scientific management model, argued that the tools of theorizing and scientific

investigation are useful for rules, principles and checklists only when made available to managers' own accounts of what they do and how they do it. Tsoukas (2005) suggests that discourse is important to understanding the nature of complexity of change is helpful especially where the role of agency is concerned

A crucial contrast between these two views to management is made by Stacey (2000), who comments on confusing the *complicated* with the *complex*. Systems theory sees management in PSOs as complicated, but not additionally complex: hence it advocates the use of scientific management that enables control, role clarity and task definition to eliminate that which is complicated. Complexity Theory on the other hand notes that PSOs (a human organisational system) comprising of interaction between human beings is therefore a complex one rather than complicated: where no detailed analysis or intervention can create perfect understanding or desired state. Essentially, management in PSOs (which are human organisations) is more than dealing with the complicated. It is dealing with the complex since PSOs will take up a life of their own (Haynes, 2003). Haynes (2003) argues, that change lies for the PSO in the real world. Unless the PSO and its managers can evolve through these tensions and conflicts, it cannot gain progress.

But the limitation with both domain and Complexity Theory I argue, is that they are fixated on the organisation and management 'within' it. They fail to account for 'across organisations' and disregard managing complexity beyond the organisation. They ignore that vital element of users as stakeholders that influence service change. Extensive research in the context of the public sector and the NHS is suggestive that such management approaches do not pay heed to the inter-connectedness and inter-dependency of public services (Lapsley, 2009; Osborne, 2010a) and they are disruptive to inter-agency working and compromise on service quality (Watson, 2002; Haynes, 2003) while lacking user-focus.

3.3.2 Thinking Beyond Organisational Complexity and Change

While Complexity Theory elaborates on the nature of change is in a complex system and why managers should treat it in particular ways, it however offers little in the way of how managers will operate in a future integrated service environment, which incorporates co-production and exchange with active users. It also offers little insight into how the roles, responsibilities and relationships of managers change and how their learning, training and development alter in an inter-agency service setting such as the Scottish healthcare service that has embarked upon integration. It treats users as passive recipients and does not offer insight for an inter-agency service environment. Complexity Theory fails to address the

element of user engagement in public service design and the idea advocated by the S-A-A-S approach: that services are pulled by active users and where managerial effort facilitates bottom-up interventions that treat inter-connected service delivery as holistic yet delivered locally.

As mentioned previously, given that joint working and integration are fairly new models of healthcare service delivery and that integrated set ups like Scottish CHPs are in their early years, the phenomena of managerial work and development in this context is open to exploration. But what becomes certain is that healthcare service design and delivery with users at the centre of it will drive policy reforms and innovation (Cottam and Leadbetter, 2004) and it will create the change agenda for making services more effective as advocated by NPG (Osborne and Brown, 2005; Osborne, 2010a; 2010b). Where historically, senior management and policy has dictated value and the service managers' work agenda (a NPM and GD approach), user-led and co-produced services and the SD approach will determine value and drive the service managers' work that becomes increasingly user-dominant (advocating a shift towards NPG)

Increasingly, it may be that for service managers involved with delivering integrated healthcare services, the managerial effort and commitment is concerned with delivering services locally in a system comprised of services (S-A-A-S) rather than in any PSO or network of PSOs. The future is more about *user-led change in a holistic service system* and less about *policy-led change in an organisation.*

If we consider the nature of change in *S-A-A-S* compared to a *traditional system* or *complex system*, then certain differences can be highlighted as illustrated below:

Traditional System	Complex System	Services-as-a-system
Supports generic management and standardised performance for managing services; the system has active and passive data; has symbols and rules that allow to programme a future state of services	Supports context specific management and adaptive performance for managing services; characterised by dynamic continuous exchange of active and passive data; the system has a memory that reinterprets based on the current context.	Supports improvised management that is situated in the local context. Characterised by various exchanges of activities that are user-centred. The system has a collective memory formed by multiple services coming together based on user needs which gets better at integrating via trial and error (practice).
Presupposes optimisation, predictability, rationalising in the service system based on economic principles; suggests change to be linear and predictive with cause and effect	Emphasises on individual's actors and constant feedback between the service system and individual and supposes complexity; self-organised interaction and patterns of play transform the system; suggests change to be non-linear and unpredictable for PSOs	Emphasises on constant feedback between individual actors but also between the processes of different service agencies; they address complexities by aligning outcomes of service delivery for the user; suggests change to be non-linear for a service system comprising multiple agencies and driven by user-engagement.
Rationale processes that lead to predictable results under given conditions and rules in the system	Solutions achieved via dynamic processes that are evolving and unlikely to lead to any single or final conclusion.	Solutions achieved via negotiated processes that are evolving but intend to lead to better service outcomes for users.
Operates on basis of dominant and discernible rules that enable management to calculate potential equilibrium or a stable state of the system	Does not associate with an equilibrium or stable state of the system; the system settles into a condition that satisfy external constraints for the given time period.	Does not associate with an equilibrium but desires a user-relevant and user-focused service system that can deliver personalised services locally; the system settles into a condition that satisfy local service needs
Controlled and regulated system with elements and symbols that are isolated; meanings are derived from rules and preordained outcomes	No strategic regulatory element but rather is a self-organising and evolving regulatory system; derives meanings from the complex system where the meanings are attached to the elements and symbols that change overtime as the system evolves.	User needs and inter-agency dependency regulate and direct as regulatory elements. Derives meaning from the local context and a co-produced service agenda where meanings are negotiated but change over time.
The system changes its structure in accordance with rule-based learning and lessons about what works and does not; change occurs through explicit interventions and procedures.	Change occurs spontaneously through self-organisation where learning is constant; change occurs organically rather than through planned interventions and procedures.	Change occurs spontaneously but with a clear purpose in mind of delivering value to users; learning is constant and change occurs organically and through improving processes in a tightly coupled service system.

Table 3: Comparison of Traditional System, Complex System and Services-as-a-System; Source: Developed from Haynes, 2003: 26-29

To summarise, in this section I have argued that change is complex and that its management

becomes ineffective when using standardised and reductionist management principles and approaches that promote top down managerial practice and intervention: limitations of attempting to understand and deal with change using traditional and complex systems. Rather, I have argued that modern day change will require varied and context specific approaches and managerial interventions at the local level. Even though useful for identifying the nature of change, I have highlighted the limitations and criticisms of Complexity Theory arguing that it does not provide any insight for managing inter-agency challenges and ignores the active role of users in service design and service change. As an alternative, I have proposed the potential of S-A-A-S to understand modern day change in public healthcare services. What such change implies for managerial practice in integrated healthcare services using an S-A-A-S approach is the focus of the next section where I elaborate on ideas and related issues.

3.4 Managing in the New Service Environment

Haynes (2003) argues that the bipolar representation of managing and leading needs to be overcome since in a complex adaptive system, managers need to come out of prescribed roles and take on skills requires for a specific context where they embrace professional, managerial and leadership roles at different points. An overlap of these roles must occur for the manager to deal with particular moments bringing forth the one that most suits a situation and that this undoubtedly creates tension and conflict for managers in and amongst themselves. This suggests managing beyond the 'safe way', Bardach (1998) argues that the service system and PSOs need to confide in and utilise the tacit knowledge and experiences of managers as practitioners in order to address the complexities and challenges of change: rather than prescribing generalizable and scientific rules, principles or processes upon them for the task of managing (Bardach, 1998:197):

> *Scholars can compile, clarify and explicate principles; but because principles furnish meaning rather than truth, efforts at empirical validation are generally beside the point.*

The management of change is therefore situated and context specific. Haynes (2005) suggests that it is best treated as a non-linear process with no starting or ending points rather than a project with start and end points. For the manager, change therefore is about managing conflicts and tensions arising in the continuous change process where there are different views and ideas about the future direction of the PSO and its people. Since there is no single truth about the future of the PSO, managers must evolve to keep up with change. The key position here is that the ability and behaviour of the manager (and therefore the PSO) to

change is important rather than how the change is done. Here, I suggest that it is *behaviour of individuals in the organisation* that occurs and responds to change in environment and circumstance: as opposed to any such scientific *organisational behaviour* occurring or responding. Haynes (2003) argues that there can be too much debate about the details of change and not enough of an informed overview, pointing out that it requires reconciling personal, interpersonal and organisational conflicts: this is a contextual approach to managing, which Goleman (1996) argues, emotional intelligence can facilitate.

In the public sector where inter-agency service delivery and user-engagement is the future, the complexity and conflict needs to be viewed as creative tension rather than an occurrence of negative events (Haynes, 2003). Realistic to say, this human approach to public service managerial work is not embraced to its true potential because 'government policy asks public service managers to be innovative and enterprising, while at the same time increasing regulation and imposing potentially narrow definitions of performance' (Haynes, 2003: 84). This is a major limitation of the NPM approach in public service management. The S-A-A-S approach to managing advocates that managers work bottom-up in a co-produced service system where local context and close psychic distance serve as suitable grounds for effective management and innovation (Kinder, 2012). This is a NPG paradigm where local user-needs determine effective service outcomes. By all means national policies and guidelines for good management practice should facilitate this, but should not dictate the managerial agenda. Instead it should be the needs of users that drive the managerial effort and performance. Here, services are viewed to be differential and the management effort is effective because it allows managers to utilise tacit knowledge and prior experience to adequately respond to change in the best manner possible. In S-A-A-S, services and their management become pulled: the managerial effort becomes a natural response. This is starkly different to the NPM paradigm where managers work top-down achieving pre-defined service targets and where performance is pre-determined using targets. Users are treated as passive recipients of a standardised quality service. The management effort here is a frustrated one because it is trying to apply standard solutions irrespective of user need, even when done through networks. In this network model, services and their management are pushed and the managerial effort is pre-engineered and pre-ordained.

Beyond managing in singular PSOs and organisational networks, S-A-A-S offer the opportunity to engage with the element of the user and nests inter-agency service delivery efforts towards shared but more importantly unified outcomes. Hence, the interplay of

management expands beyond just the manager and the organisation in the design and delivery of service. It transforms to include users being of equal importance.

To summarise, I have discussed how managers respond to and manage change and talked about associated behaviours and what a suitable and alternative approach might be. I argue how and why the NPM paradigm disables the managers from performing effectively in the current service environment. I suggest the S-A-A-S approach to be useful for the manager which encourages bottom-up practices in a local user-led service environment where close psychic distance enables effective management and service innovation. I advocate the NPG paradigm here and its perspective on effective service outcomes. Located in the New Public Management (NPM) and New Public Governance (NPG) debate, I have differentiated between managing in a loosely-coupled service system comprising of the network and managing in a closely-coupled service system in which a variety of actors (specially users) are considered to play a role: the former which promotes top-down mechanistic management and pre-determined solutions for organisational efficiency and the latter which supports bottom-up creative management and localised as-per-need and user-led interventions for service effectiveness.

In the next section, I discuss the implications of a changing service system for managerial roles, relationships and responsibilities and discuss implications for what service managers do and how they do it.

3.5 Roles, Responsibilities, Relationships: the altering managerial remit

From a public service manager's viewpoint, conceptualising management in local public services using the S-A-A-S approach draws attention to a whole epistemology that is quite distinct from that of management in networks. Below, I elaborate on how roles, responsibilities and relationships alter in a user-centred service context.

How managers understand and embrace increasingly complex roles is likely to facilitate the integration of services (Segar et al, 2013:1) endorsing O'Leary and Vij's (2012) idea that it is through the individual that collaboration occurs as well as Clarke's (1994) suggestion that the manager's behaviour becomes a decisive factor in creating an agenda for any organisational change. Managers will have to challenge their own assumptions because collaborating and integrating will be a frustrating experience driven by the cost-efficiency imperative (Tschirart et al, 2009) while service managers are concerned with quality for the

user. Managers will also be challenged because collaboration and integration are blur in definition and formation. In line with this, McGuire (2006:35) notes:

> …*a public manager may be simultaneously involved in managing across governmental boundaries, across organisational and sectoral boundaries, and through formal contractual obligations; it is often difficult to distinguish where the boundary lies between these different environments*.

Segar et al (2013) argue that the service manager's operating environment becomes increasingly messy and complex where the dynamics of inter-professional and inter-agency relationships are changing. Mark and Scott (1992) in the case of the NHS note that this is due to the desire for innovative organisational forms motivated by the increasing complexity of health service and pressures on it. Salamon (2002) suggests that collaboration shifts emphasis from bureaucratic managing in public services to enablement skills that bring people to work interdependently, keeping in mind McGuire's (2006) critique that collaborating may complement separate organisations rather than eradicate them. The managerial remit therefore is likely to become multi-faceted. By the use of the term 'remit' as a noun, I refer to managerial roles, responsibilities and relationships for the purpose of this study.

For the integrated service management context, Bardach (1998) highlights that besides generic and transferable management skills, the skills and styles required in a collaborative or integrated setting will differ from those of the single organisation. This is specially the case when increasingly; the manager's role becomes that of leading radical innovation (Kinder, 2010) in integrated service systems which intend to transform services. Many theoretical suggestions are offered for the collaborative and integration context. Entwistle and Martin (2005) suggest values such as trust building, information sharing and conflict-resolution that the collaborative manager will need. Broussine (2003) proposes skills such as critical reflection insofar as maintaining self-knowledge and tolerance for ambiguity and uncertainty will be required by the manager in integrated service delivery. Working in networks of organisations where authority relationships are ambiguous and contested, diverse leadership will be needed (Denis et al, 2010) while Rhodes (1997) suggests that managers with need boundary spanning and diplomacy to function in a cross-boundary and inter-agency environment. Fenwick (2008) critically adds that new service models will only be possible if and when managers become reflective practitioners that review and revise their ways of working. This is because managers carry the potential to combine the work effort of separate organisations by coming together to deliver integrated services rather than getting together just for the sake of structural integration where the work effort remains coordinated

but separate (Memon and Kinder, 2015: forthcoming). This is supported with the idea of reducing psychic distance (Kinder, 2010) between people in inter-dependent and co-determined service delivery.

It therefore seems that managers must be willing and prepared to challenge assumption and mind-sets about what managing encompasses and the skills and behaviours involved. Given that service integration contexts differ as do the skills of managers to deliver integrated services (Bardach, 1998; Agranoff and McGuire 2001a; 2001b), translating these needed skills and behaviours into practice for a service context will need fresh situational analysis (Memon and Kinder, 2015: forthcoming). Because the public value paradigm requires inter-connected healthcare service delivery with a focus on the user (i.e. co-produced services), managers must move beyond constrained or defined remits. Lauria's (1997) suggestion that building a service system from bottom up requires acceptance of differing contexts as a starting point. Below I further elaborate on the managerial remit.

3.5.1. Remit

By 'remit' I refer to a much wider collation than 'job description' since it includes roles, responsibilities and relationships to convey the knowledge base and relational activities of the service manager in a post-bureaucratic PSO. To reiterate, I use the term *remit* in this thesis as a noun meaning span of control; area of activity; power range; prescribed duties and outcomes; terms of reference; expected return from activity. In a given public service system, stakeholders, including users heavily influence the service manager's remit while their tasks will vary from one context to another. Whilst it may be possible to list and categorise managerial skills, attributes and competences (Virtanen, 2000) one is more concerned with the capabilities that managers need and which are most likely to be different as integrated healthcare service delivery makes a transition towards a SD approach: where responsibilities, roles and relationships come together but in altered ways for management practice and to deliver a user-centred service.

3.5.2 Responsibility

Where roles and relationships have traditionally characterised responsibility as being exercised face to face and among managers within organisations (Durkheim, 1964), the roles and relationships in modern day PSOs revolve around less definite *authority* based on knowledge, experience and wisdom. Increasingly, responsibility is viewed as distributed and less deterministic (Jonas, 1984; Beck, 1992). Arendt (2003) argues that collective

responsibility is at best a noble metaphor since individuals exercise moral agency. Arendt (2003) further argues that responsibility is socially situated with communities and cannot be detached from the context in which judgements are made. Responsibility is viewed as the acceptance of *obligations* and the ability to negotiate *duties* with others. Typically when a manager accepts obligations in the organisation and among members, it is on the basis that the obligations are acceptable to the manager and are allocated to the manager because he/she holds sufficient abilities and powers to affect due outcomes. Adams and Balfour (1998) argue that anything otherwise represents administrative evil where managers may be held accountable for matters beyond their control. In inter-agency collaboration and integrated service delivery, this very assigning and obligation to tasks and duties becomes contested since integration remains in-progress and scattered without set boundaries. Ricoeur (1995) importantly notes that sufficient *human time* is necessary to renegotiate responsibilities as might be the case with a SD approach to delivering integrated services since integration in practice takes time to make sense of (Bell et al, 2008). Furthermore, it requires time to develop user-orientation when designing management tasks. A criticism of NPM (Power, 2003) with regards to managerial responsibility is that it caters for only upward responsibility without taking into account personal responsibility and where focus is on administrative processes rather than social outcomes. With a SD approach to managing integrated services, managers take responsibility and share it among members both within and across PSOs while also critically negotiating their accountabilities until suitability can be achieved. What can regulate this is close psychic distance and shared user orientation.

Increasingly what will drive managerial relationships is the focus on users in NPG paradigm. Managers will increasingly engage in inter-agency relationships within a service system that allow them to deliver value to users and where they improvise on what relates best. This SD approach is a stark contrast to the GD approach where managerial relationships have been governed by pre-determined intra-organisational relationships where managers focus on relationships with others within the PSO or a network of PSOs. The span of relationships becomes wider and more complex in S-A-A-S but the purpose of engaging in those relationships overtime becomes clearer as user-orientation becomes stronger.

3.5.3 Roles

With regards to managerial roles, Biddle (1979) states that roles are those behaviours characteristic of one or more persons in a context. Context is crucial to role implying that roles will vary vastly depending on the given context: in this case, the local needs of service users where managers are involved in a role that contains within it, certain managerial *jobs*

or *tasks* which serve the need or requirement of that role (Hales, 1986). In other words, roles are enacted by the person performing to a set of expectations or responsibilities situated within the local context. Masolo *et al* (2004) note that roles are social constructions with shared meaning: and therefore entail relationships and responsibilities. From a service systems perspective, Sowa (2000) views roles as patterns of relationships while Zambonelli et al (2003) understand roles as abstract description of an entity's expected function and argue that the properties defining roles are responsibility, permission, activities and protocol. Crucial to understanding here is Pacheco and Carmo's (2003) argument that agents can act, roles cannot. Different agents can play the same role and roles alter over time and context and in combination with other roles. Managers as people form purpose and habits based on experiences from trial and error. Therefore, embedded routines are detrimental to change and transformation. Kelman (1973) argues that routinisation can create a dehumanising *instrumental rationality*: roles in which the focus is on process compliance rather than the needs of individuals: roles based on a goods-dominant logic rather than a service-dominant logic. The SD approach suggests that roles will adopt and develop to serve purpose: the needs of users. S-A-A-S advocates that managers will negotiate roles within the service system to best fit purpose and will learn to improve their roles over time, rather than fit into given titles or hierarchical positions.

3.5.4 Relationships

Taking a social constructivist view to relationships, Butler (1997) states that we are how we relate to others. The given context will therefore structure mutual responsibilities, intertwining subject formation and generate varieties and meanings of relationships. This presumes that knowledge and responsibility are not constant but are constantly changing with context. Service managers will need to increasingly manage relationships with users as co-producers. What remains critical in the process of change is knowing what the relationships are as this is what helps process information and guide sense-making during the complexity and uncertainty (Vygotsky, 1987). I argue that it is in the midst of this that the learning of a closely coupled service system develops and psychic distance narrows. In view of this changing nature of relationships, rather than placing faith in pre-tailored approaches to determine *what* managers do and *how*, there is a case to allow natural and organic transition for determining *the managerial remit*. A managerial remit defined or created using pre-set relationships and competences restrict the managerial potential to innovate.

3.5.5 Conceptualising Services-as-a-System

Removed from the recipes or lists of competences still found in some HR literature (Ulrich et al., 2008), the remit of the Services-as-a-System manager is characterised by roles, relationships and responsibilities that will be increasingly inter-agent and user orientated. This as a result changes how manager behave and perform tasks, how they gain knowledge and process information, and how they relate with other professionals in order to satisfy users and other stakeholders. I recognise that managing in S-A-A-S is not a conflict free world, for example discharging patients from hospital into social care, may still result in conflicts of interest between agencies and different agency managers in the service system. To summarise the ideas and arguments of the last two sections, I propose a conceptual diagram representing the PSO and its managers engaged in the system (healthcare services) where other coordinating organisations participate (e.g. social care and third sector). Note (thick blue arrowed lines) the learning loops from users and experiences in delivering processes, back to the service managers' remit that subsequently reshapes their roles, responsibilities and relationships.
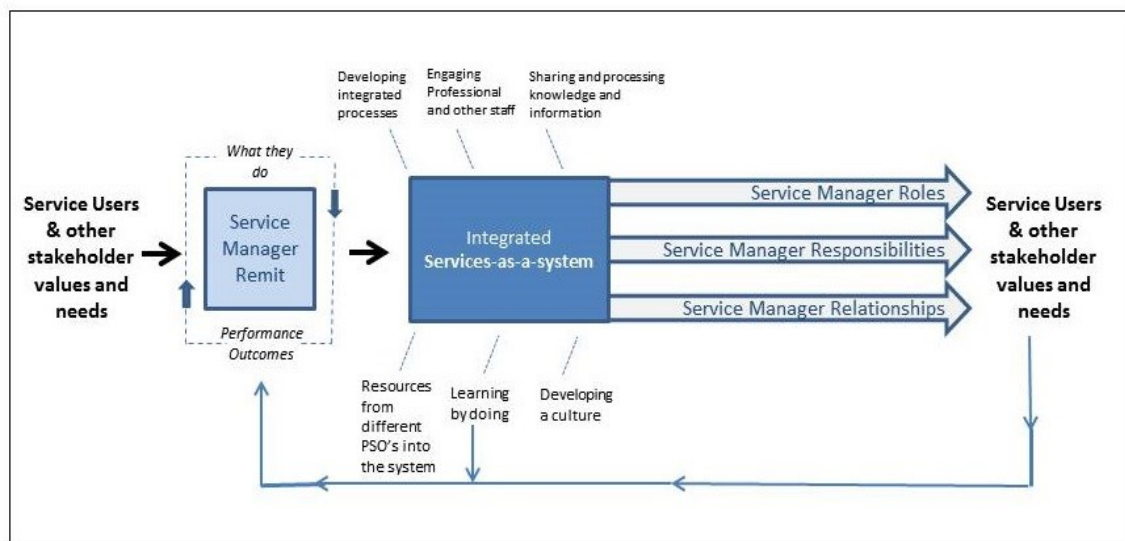
Figure 3: Public Service Organisations and Managers in Services-as-a-System; Source: Author (Adapted from Kinder, 2012)

To summarise, I have discussed ideas related to how the managerial remit changes in collaboration and integrated service delivery. I have given coverage to arguments on the changing nature of managerial skills and behaviours and have provided an argument for how

roles, responsibilities and relationships will alter in S-A-A-S where a SD approach encourages new priorities and forms that place users at centre stage. I argue that pre-fixed remits, encouraged by competence-based management fundamentally assume pre-set expectations, actions and responses to the needs of public service delivery and users. I elaborate on ideas and arguments related to this in the next section.

3.6 Challenging the Givens of What managers Do and How

In this section I argue that *what* managers do is quite distinct from what is expected of them in traditional or network setting and is increasingly influenced by users of the service to whom they become accountable in ways that were previously ignored. I discuss theoretical ideas on what managers do and how they do it in S-A-A-S.

The ideas presented so far have argued the need to go beyond traditional theories and models that attempt to define *the remit of managers* which have typically positioned the work of managers in single organisations are of little relevance for modern day management public services and do not align with the dynamics of an inter-agency environment and co-production. In contemporary public service management where boundaries of operating and scope of work are beyond the confines of the organisation and are blurred, service managers are inquisitive about the context in which they operate and question the appropriateness of their actions (Burnes, 1996). According to Burnes (1996) past experience reinforces behaviour while the ability to perceive the whole picture enables managers to successfully align with context. Managers based on the experience gained and from interpreting the environment overtime form 'definite opinions of what works and why' (Burnes, 1996: 355)

For managers to engage with an integrated service system, there needs to be an exploration of management ideology and an attempt to give some classification to how their work changes. Giving classification enables one to reveal meanings and significance of the phenomenon (Freeman and Frisina, 2010). Barley and Kunda (1992) have suggested that there has been a succession of management ideologies that have shaped managerial thought and practice. They argue that these management ideologies have not evolved in any linear manner, but rather have altered recurrently between normative and rational control as summarised in the table below:

Succession of Managerial Ideologies	
Ideology	*Tenor*
Industrial Betterment	Normative
Scientific Management	Rational
Human Relations	Normative
Systems Rationalism (NPM)	Rational
Organisational Culture	Normative

Table 4: Succession of Managerial Ideologies; Adapted from: Barley and Kunda, 1992

Beyond the mid 1990's and into the new millennium, management via networks has made a place in managerial thought and practice yet instilled in NPM ideology and organisational culture. Inter-agency collaborative management has gained momentum in an austerity era where the focus turns to delivering better quality at lower cost and with users at the centre of service design. The influence of this upon managerial thought and practice (what managers do) is subject to exploration. But just as in the past, the managerial adaptation of this new context is unlikely to occur is any aligned manner since services are to be co-determined, be disrupted by technology and burdened by rising service demand. What is further important here is that both normative and rational forms of managerial control now become challenged in the inter-agency management of integrated services: this is a new phenomenon because it disturbs the managerial remit (relationships, roles and responsibilities) that has long prevailed regardless of ideologies or tenors of the past (Barley and Kunda, 1992). This is because all past management thought and practice has focused on *managing in the organisation to deliver public services* whereas what the future now requires is *managing across organisations to deliver services to the public*. In the context of public services management, responsibility and accountability to users is a new phenomenon that has not been dealt with before.

In a NPG paradigm where the context is user-dominant services, ideas of managerial authority, control, and jurisdiction become challenged and so does the managerial practice of integrating. It is a very different playing field since what managers did in the past was largely governed by regulatory bodies (i.e. health ministry) rather than by users. In the past, managerial accountability existed as indirect responsibility to the public taxpayer: it allowed managers to distance themselves from engagement with users. However, this is no longer the case with user-engagement and co-production (e.g. Public Partnership Forums in the NHS) becoming increasingly important to service design.

Williams (2002) mentions that in working across boundaries, managers have to manage multiple accountabilities in non-hierarchical structures and with dispersed power. Fenwick (2013) in examining professional practice and learning highlights that professionals are experiencing a 'heightened state of transition' as they respond to large changes in policy, restructured work arrangements and user demand. Fenwick (2013: 352) suggests that professionals must cope with these transitions, which bring forth 'new levels of responsibilities, implementation of new practice protocols and migration to new work sites and cultures'.

Based on evidence from British healthcare services, Burgess and Currie (2013) highlight middle managers as playing a strategic knowledge-brokering role in the inter-organisational healthcare environment. They suggest that increasingly, middle managers involved in managing and delivering integrated healthcare services play a hybrid role where they cross the professional frontline and cross managerial domains and manage knowledge flows across both occupational and organisational boundaries. This role of the manager is attested by Sparrow (2000), who argues that over-burdened managers devote large time to the skill and task of information searching and little time on learning from it. He further adds that new forms on interaction combined with information overload reinforces the need for middle managers to develop new mindsets at work: this in itself Sparrow (2000) argues is a key management competency.

Bell et al (2008) suggest that practicing managers in Scottish healthcare services are attempting to grapple with integration and what it may translate to in practice. According to Bell et al (2008:47), it appears that integration as policy and concept fails to connect with integration as practice because for managers, integration is about delivering service rather than governances. Hales (1986) in an extensive review of literature and evidence on 'what managers do' highlights certain weaknesses in past research effort, which I discuss below in light of the S-A-A-S approach:

- The distinction between *actual* behaviour and activities (doing) of managers to those that are *expected* and *achieved* (what is expected). When suggestions are made about what managers do (i.e. activities), this distinction is avoided and managerial behaviour is conceived as being simplistic: this deprives factors such as contexts, intentions and complexities that are important elements in the contributions which managers make through engaging in tasks and activities. This distinction and gap between actual and expected cannot be addressed until integrated services are

planned, designed and delivered locally based on desired user outcomes in any given locality.

- In describing what managers do, the nature of the management function and the context in which they do remain missing. Hales (1986) describes this as a major weakness referring to it as the unsituated character of the manager. Services-as-a-system here suggests that user-led services delivered as per local need becomes the situated character that can serve as both context and function.

- The standards against which actual managerial practice can be compared are treated as absolute, objective and benchmarked. Hales (1986) states that given the variation of managerial jobs and tasks, it becomes difficult to sustain such standardisation. S-A-A-S alternatively suggests that the managerial focus should be on managing in tailored and improvised ways where jobs and tasks are determined as per local needs of the service.

- The distinction between *performance* and *expectation* is key to the conceptualising the managerial role, whereas past research efforts have treated both in combination despite both having different implications for what managers do (Hales, 1986). Services-as-a-system advocates that user expectations determine and define performance (outcomes) to be delivered locally.

Certainly, these weaknesses get carried forward as challenges when studying the role of managers and what they do when in a co-produced service system. The reluctance to deal with these issue leads to unsatisfactory treatment and understanding of managerial challenges. Services-as-a-system advocates that relevant and better management is improvised for the local and user-focused where processes are improved for better outcomes, rather about absolute solutions for targeted outputs. To support this view, Hales (1986: 106) states that managerial effectiveness is informed by 'actual managerial behaviours achieving desirable outcomes depending on '*how* outcomes are defined and negotiated and by *whom*' and that the 'diversity of managerial work could be better explained by examining the interaction between behaviours and outcomes if and when we accept that what managers 'do' is susceptible to continuous, even post hoc negotiation'. This is supported by Segar et al's (2013) position that roles and identities are in transition as boundaries of working and inter-professional relationships alter.

Keeping in line with this realistic view, Campbell (2012) in his empirical research on how public managers at the local collaborative level implement national policy initiatives, argues that public managers adopt a strategy whereby they treat public policy directives as a starting point for negotiation, practice discretion and risk in their performance and establish local collaborative goals as alternative arrangements of accountability while distinguishing front line service delivery from back-end accounting: in other words, they improvise by creating 'workarounds' which work effectively as a means of dealing with complexity and managing local integrated services. Currie and Procter (2001) argue that there lacks an understanding of the process of enhancing the willingness and ability of middle-level line managers in the NHS to take on people related issues: the potential solution to this lies in allowing middle managers to cross functional boundaries. This is especially so when service needs are to be met locally for users. Certainly, managers will renegotiate what practice means through their activities (Holman and Hall, 1996) in the inter-agency service delivery context. Taking on board Nooredegraaf's (2000) propositions, managers in a new public service arena are professional sense-makers who adapt within ambiguous settings that involve unstable partnerships.

To summarise, I have argued that in an emergent service systems setting, what managers do is quite distinct from what is expected of them in traditional or network setting. I have argued *what* managers do and *how* is increasingly influenced by users of the service and have argued that managers become accountable to users in ways that previously did not exist or matter. As services become user-centric and tightly coupled, managers will have to manage in new ways and in multiple directions. In the past, managerial accountability has traditionally associated with the organisation or regulator.

3.7 Beyond Pre-Packaged Competence: Managers in Services-as-a-System

In this section, I discuss ideas and present an argument as to why conventional competence-based management is increasingly irrelevant and futile because the actions and behaviours required for collaboration and integrated service delivery differ. I argue that present Competence-Based Management (CBM) approaches and Management Development (MD) efforts are ineffective and give reasons for why this is. I present an argument for how competences may change as service becomes more user-engaged and why there is a need to

reframe managerial actions and behaviours (competences) as well as management development efforts for the future healthcare services. I present ideas on what such changes may incorporate.

The arguments presented so far suggests that attempting to standardise what managers do and how they do it through pre-determined and pre-packaged competences becomes increasingly inappropriate. This research study will explore how managers involved in delivering integrated healthcare services view such Competence Based Management (CBM) approaches to managerial work and development: of which there are many such as the Knowledge and Skills Framework (NHS) and Management Charter Initiative standards (Holman and Hall, 1996). Such pre-ordained and across-the-board approaches to managerial work design become ill-suited to the nature of managing in integrated public services. Holman and Hall (1996:199) state that such standardisation in management segments the managerial effort which by nature desires and involves interpreting and adapting:

> *management as a concept becomes sanitized, pre-packaged and reduced to a book of segmented activities devoid of political or moral dimensions - a position which may be at odds with managers' everyday understanding of their own practice.*

Inter-organisational collaboration and integration in healthcare service delivery necessitate that managers improvise and adapt both action (what they do) and behaviour (how they do) in their remit. This is especially so when the austerity era demands that PSOs partner with cross-sectoral agencies (i.e. voluntary sector organisations) to deliver integrated services: which poses an environment where healthcare service managers have to partner with and rely on other professionals in other agencies they know little about (Grisham et al, 2014). What is required is a better understanding of the joint working and integrated service context so that future competency requirements can be better forecasted (Robinson et. al 2005) for this environment and which can support inter-agency managerial approaches. Managers will also need actions and behaviours that can successfully engage with service users who contribute to service design and who expect personalised (as per need) services.

Sammarra et al. (2012) suggest that boundaryless careers for managers where inter-organisational mobility increasingly occurs can have a positive impact on workers. The transformation and improvement is in the doing as Caluwe et al (2014) find that public employees who have previous experience of working cross-agency report a stronger boundaryless career mind-set. Sparrow (2000) discusses that fundamental transition in forms of managerial work organisation have come forth which create a need to develop new competences and job designs to cope with changes in work design and also that the managers

psychological contracts may alter. I further argue that the managers' psychological contract transforms over time to incorporate the user and that this may already be the case for service managers in the NHS.

Holman and Hall (1996) from their empirical research on management development in the NHS find that managers experience competences ambiguously and argue that it would be beneficial if competence based performance criteria was not treated as objective truth. They suggest that in designing competence programmes there must be a balanced approach which considers the activities of the participants (managers) themselves: that 'competences should not be central to the management development (MD) process but be regarded as a tool to use, discard and recycle, and be treated as indefinite and open for interpretation. Hence, reliance upon Competence Based Management programmes that categorise and set out set pre-determined actions as representative of managerial performance become increasingly futile.

By no means do I intend to provide a comprehensive understanding of what managers do or how they do it in a changing healthcare service system. Instead, I argue that given the complexity and variance in what managers do and the significance of locality, there should be caution towards standardised prescriptions for actions and behaviours (competences) for the manager since the managerial remit will vary depending on the situated context. Rather, what is important is to examine a given context and attempt to gain an overarching understanding of phenomena related to managerial work and management development in different integrated settings. As managerial practice will transform, there will be transitions in managerial learning and development also. Understanding these transitions is important both for policy makers and organisations in the bid to ensure quality and reliability of managerial decision-making through periods of transition (Fenwick, 2013) and to facilitate useful and effective MD interventions in a changing service system. Based on the findings of this research, I hope to be able to suggest a framework in which future service manager competences can be better conceptualised and approached in the context of Scottish healthcare services.

Such research effort remains worthwhile if seeking purposeful and effective managerial performance at a time when the HRM link with individuals and organisation performance is contested to be associated rather than causal (Guest, 2011). In relation to the NHS, Hyde et al. (2013) find that employees form their own mental models and perspectives of how HR practices in the NHS contribute to their performance suggesting that employees react in various ways (both positive and negative) to change arising from rearrangement of health

services. In an altering service system marred by different cultures coming together and user-focus, there are also implications for managerial identity that changes (Holman and Hall, 1996). The complexity and tensions experienced by the manager have implications for their identity (Causer and Exworthy, 1999). Identity that is always in-process and which reflects the complex unstructured process of change and the multi-dimensional nature of culture (Holman and Hall, 1996). Management development would therefore posit that learning is unintentional and situated within activity, culture and context (advocating situated learning theory and reflective learning theory discussed in the next chapter). In line with this, Holman and Hall (1996: 199) suggest competences and management development programmes should 'avoid claims of universality' and be assessed differently given that they form part of other wider social practices which have an 'effect on changing the discourse and identity of the manager'.

Currie and Procter (2001: 53) suggest there needs to be significant investing towards the manager's development where the HR strategies of the NHS should consist of 'broad themes rather than tight prescriptions': where the HR function operates 'alongside' middle level managers suggesting a supportive and flexible purpose rather than a directive one. This is especially so given the evidence to support that managerial learning in the NHS is a negotiated process rather than a structured or prescriptive outcome of competence-based management development (Holman and Hall, 1996; Campbell, 2012; Hyde et al. 2013). Hence, getting better at 'managing' will arise from experiential learning. Also, past and current MD efforts in the NHS to appropriately train and develop managers for a changing service context are highly disputed (see Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Alimo-Metcalfe and Alban-Metcalfe 2003a; Collins and Holton, 2004; Hamlin and Cooper, 2005). Again, this is because public sector training and development is derived from private sector theories and models which mimic industry experiences and seek organisational efficiency rather than service effectiveness for users (Osborne, 2012). Holman and Hall (1996: 197) argue that the development of managers for the time being may largely be the 'adoption of managerialist rhetoric rather than a fundamental change of practice itself'. This would suggest the need to re-think approaches to management development using a SD approach where future managers can lead integrated services.

To summarise, I have argued why I believe Competence Based Management Development to be increasingly irrelevant and explained why Management Development (MD) efforts become ineffective. Alongside, I have presented arguments for how competences may change as service becomes more user-engaged and why there is a need to reframe

competences along with training and development efforts for the future healthcare service delivery.

3.8 Conclusion

In this chapter, I have attempted to highlight and critically examine the nature of change and how management transforms in collaboration and integration and as services become more user-orientated. I have also examined issues and discussed ideas on how the managers remit (roles, responsibilities, relationships) alters as services adopt a SD approach in a NPG paradigm to promote user-focused service delivery. Along with this, I have also conceptualised how a transformation occurs in what managers do and how they do it as services adopt the S-A-A-S model. I hope to have demonstrated that the GD approach to management instilled in the NPM paradigm becomes increasingly irrelevant. As a new service system emerges, I discuss and critically examine the implications of the present Competence Based Management approach and how management competencies will alter. This can support ideas and arguments for how managerial training, learning and development will evolve in Scottish healthcare services, which is the focus of the forthcoming chapter.

4. MANAGEMENT DEVELOPMENT: THE LEARNING, TRAINING AND DEVELOPMENT OF SERVICE MANAGERS

In this chapter, I analyse Management Development (MD) in Scottish healthcare services and argue that present forms of MD ideology and practice is increasingly irrelevant for collaborative and integrated service delivery. I present a case for MD in form and content as being predominantly driven by the GD approach, supporting NPM driven practice. Within this, I critically examine Competence Based Management (CBM) and the competence approach to developing managers. For the purposes of this study, the term MD is used to represent the diverse range and forms of management learning, training and development (M-LTD) interventions (both formal and informal) that intend to enhance managerial capabilities. I take such a position because this study concerns itself with the changing nature, relevance and appropriateness of MD both as concept and practice rather than being concerned about particular MD types or classifications used in public healthcare services. Support for this is provided in the next section. The literature in this area is typically addressed as MD in the NHS and therefore I use the terms NHS and Scottish healthcare services interchangeably for this study.

As healthcare services become more user concerned (see chapter 2) and the remit of managers becomes more user engaged (see chapter 3), how do M-LTD needs of service managers alter in form and content becomes of vital importance. I argue that service managers will need different capabilities and new ways of learning in a SD setting as their remit alters from managing in an organisational or networked model (accustomed GD settings) to a co-produced S-A-A-S model. The chapter proceeds to analyse the changing M-LTD needs for managers and discusses ideas that can make MD relevant for a changing service environment. Using the S-A-A-S approach, a reframing of MD in S-A-A-S is proposed.

4.1 Management Development in concept and practice

In this section I discuss ideas and issues relating to MD as a concept and practice and provide critique towards the limitations and shortcomings in the context of changing public services.

Taking account of the diversity in managerial activity, a wide range of approaches have been adopted and aimed at making managers more effective. These approaches to learning, training and development can be loosely clustered under the term 'management development' to include both formal and self-development activities, direct and indirect training even though such traditional distinctions have become increasingly blurred (Easterby-Smith, 1994). Mumford and Gold (2004) discuss that for MD to have any purpose in an organisation, it should be linked to the organisation's strategy and be seen as a tool to improve business performance. A survey by the CIPD (2002) recognized two key purposes of MD: developing managers to sustain business by maximising their efficiency and secondly, developing managers to create future business models as they can be equipped to understand change and be involved in it. Morgan (1988) calls for MD to be treated as a key device to engineer organisational change and to manage culture change while Lippitt (1982) talks about MD as a key to organisational renewal and a process of growing leadership. Gridley and Fulmer (1986) also suggest MD as for forging common identity following mergers and acquisitions (Gridley and Fulmer, 1986). Below I present some critical debates and associated theoretical challenges for such existing MD concepts.

4.1.1 Thinking beyond distinctions and classifications of Management Development

Past Management Development (MD) research has attempted to establish a link between MD and organisational performance where MD leads to good managers that give successful performance which leads to successful organisations (Garavan et al., 1999). Ofcourse such prevalent thinking of MD and its association with organisational success can be contested since causality becomes a concern. Despite many examples of MD practice and excellence, there lacks evidence in proving the value of MD for managerial betterment in a public service context. Crucial to the MD debate is whether education, training, development and learning are the same thing or not. Garavan (1997) suggests that it might be appropriate to view the first three concepts as an integrated whole with the concept of learning as the glue which hold them together. But training, development and education are essentially concerned with learning. Development appears to be the primary process to which training and formal

education contribute for both the individual and organisation. All four may be seen as complementary components of the same process which enhance managerial potential. Distinguishing features and the extent to which distinctions should be drawn between the concepts of managerial education, training, development and learning is a matter of debate. Garavan (1997) argue that the debate about differences is primarily a semantic one. Even though in practice such distinctions may exist, trying to differentiate between education, training, development and learning may not be helpful in understanding contrasting managerial roles in a complex service environment.

Separating and distinguishing education, training, development and learning may now be outdated as the world of work no longer has tidy boundaries that were once present. There is significant increase in the overlap of education, training, development and learning due to the speed of change in organisations and sectors brought upon by integration and technological change which demand that workforce adopt change in much shorter time periods (Hammett, 1994; McCarty, 1994). Another significant factor related to the quantity, speed and complexity of information that flows through an organisation and to which an employee is exposed (Reed, 1991). Complex information systems, ICT developments and having to multitask have changed the nature of the managerial remit. To add to this, the growing nature of joint accountability and cross organisational work (Kinder, 2007) places new demands on how managers learn and negotiate in relationships.

It cannot be assumed therefore, that a pre-requisite set of principles learnt in an education or training program can facilitate continual learning needs. And so, learning becomes a process anchored in live cases, experience and examples. The distinctions are further blurred when one considers the increased pressure on employees to be more productive, innovative and change orientated. Atkinson and Meager (1986) suggest that organisations are resource driven, with an emphasis on managers than can gain competitive advantage for organisations in an age where advantage is short lived. A consequence of this is significantly more career changes as well as job changes than in the past (van Wart et al, 1993) which make traditional distinctions between training, development, education and learning further redundant.

4.1.2 Management Development Beyond Organisational Hierarchy and Boundary

Pedlar et al. (1991) argue that the learning of an organisations employees is essential basis for the learning organisation concept while Hofstede (1992) deems organisational culture to be a product of employee learning placing the focus on 'learning' per se rather than on

specialist processes carried out by a HRD function (Garavan 1997). This paradigm provides an integration and blending of adult learning and Jones (1994) crucially argues that such a paradigm allows the complexity of the learning process to emerge and puts emphasis on a qualitative understanding of how people develop within organisations. Talbot (1993) suggests that combining a disputed process (development) and a contested object of that process (management), the outcome (MD) is perhaps, less clear that it could be.

Even though efforts to evaluate management development should be directed in this manner, there still lacks attention to MD in an inter-agency environment that can enhance managerial learning and support the prioritising of service users in a collective service system service rather than the organisation (the S-A-A-S model). The underlying assumption within the PSOs view of MD is the central objective for planned progression of talented managers up a career ladder. Evans (1986) argues this leads to neglect of effective performers and is inappropriate in modern organisations with relatively flat structures and need for adaptability where mangers must be innovative and multi-faceted. Thus MD critically misses out on the objective of developing effective managers across an inter-agency service environment and setup.

Talbot (1993) states that a key dimension that separates different approaches to MD is whether it should be about a focus on the individual's development in a broad educational sense or should it be about the narrow focus on proficiency in achieving specific managerial tasks. It is any perspective organisation's hold on management and the role of its managers that informs and shapes their perspective on MD. MD is an ambiguous concept attracting multiple and often conflicting definitions, and conveying different things to different people both in literature and in organisations (Lees, 1992). Storey (1989a, 1989b) suggests that concepts about what MD is, is closely wrapped up with what it is for, because, clearly it is not an end in itself. Therefore, MD is those processes that enhance capabilities whilst leaving scope for discretion, creativity and indeterminacy. Ashton et al (1975) suggest that the organisational climate mainly influences what occurs in MD, though organisational structure and technology may significantly determine a pattern. Some patterns of MD can be effective in one situation and yet ineffective in another. MD continues to be subject of considerable debate (Garavan et al, 1999) in terms of its nature and aims and as a concept, which must extend to close involvement of the wider changing role for managers (Storey, 1989). Certainly, MD in the context of health services integration and inter-agency collaboration is under explored. Primarily, MD research and its conceptualising has been done within the organisational context in the pursuit of enabling managers to maximise performance

efficiency using set competence based T&D. The conceptualising of MD in the context of enabling managers to operate in an inter-agency environment and maximise service effectiveness geared towards service users is undermined.

It is important to take a stand that MD cannot be holistic or unified in concept and practice. Having discussed in the previous chapter, the changing nature of the managerial remit and the demands placed upon service managers in a changing service system, the merit of drawing traditional distinctions are questioned since, for example, technical specialists are often promoted to supervisory and managerial positions with little concern about their ability to relate with service managers in another agency or relate with the front-end service user. There is the tacit assumption here that these professionals can manage without prior management experience and without MD interventions. Fulmer (1992) cautions that if MD is to be of any success, then it must be adopted and implemented in ways that are congruent with the changing needs and expectations of the new organisation. Storey (1989a; 1989b) is critical of MD literature for advocating universal remedies without 'due regard for context'. Given the complexity of the managerial remit, service managers require M-LTD that allows them to adapt to suit local context and deliver user value. Because it is context that shapes and influences the way development is formulated and enacted. It becomes necessary to move away from competence induced approaches that limit managerial development. I discuss this further in the next section.

4.1.2 Management Competence As it Comes

The competency approach has sought to develop managers though workplace activities, with the focus on the manager's ability to perform and deliver predetermined outcomes. While some organisations adhere to prescribed sets of standards and competencies (i.e. the Management Charter Initiative) for developing and evaluating managers, other organisations devise their own frameworks of managerial competencies. Either way, competency based programmes attract criticism as they are too functional and behavioural in orientation (Stewart and Hamlin, 1992); too bureaucratic, over simplified, individualistic and unable to cover all types of relevant behaviour or mental activity adequately (Ashworth and Sexton, 1990). It is also argued that competency-based MD initiatives are unable to take account of the complex, contextual, contingent and ever-changing nature of the managerial role (Canning, 1990). The managerial role and MD interventions are complex in nature and therefore cannot be universal: thus a holistic framework for a MD definition, its purpose and its delivery is neither realistic nor plausible. In line with this, Mumford (1987) argues that there is an over-emphasis on the degree of deliberate planning for the development of

managers and that many developed managers have not been products of a planned process. To view the development of managers as something deliberate or planned is to be confined to planned interventions and does not let research embrace other unplanned and informal ways in which managers are made. Oliver (1994) takes this further in asserting that the workplace has lacked association with the learning of managers and seems fixated on development of their ability to perform tasks.

Margerison (1991) advocates MD approaches that can be 'process orientated' rather than 'product-centred' as well as being 'learner orientated' rather than 'instructor dominated'. In line with this, Beddowes (1994) calls for a focus on MD strategies that not only cater to the specifications of organisations, but more importantly to the development needs of individual managers. To overcome limitations, Doyle (1994) views MD as an integral part of a wider organisational system and as linked to the context and reality of managerial work. This systems perspective fosters awareness of complex interactions and causal relationships that exist both internal and external to organisations and views MD as both a system and process.

Hitt (1987) suggests that essentially as an open system, MD interacts with variables from other environments and organisational subsystems, activities and processes, ideally aiding pursuit of common goals in an integrated and supportive way. Here, Mabey and Salaman (1995) advocate a stakeholder perspective where the responsibility of MD is shared and requires involvement and participation of all parties. This advocates that the role, interests and impact of different stakeholders and their linkages will help shape the ethos and the practice of MD in the organisation. But clearly, what lacks in such theoretical propositions is that they do not pay heed to users as vital stakeholders in public services and do not account for managers in a collaborative service environment. They are on the whole, focused on the networked organisation and formal networks themselves.

To summarise, present conceptualising and practice of MD in the public sector is grounded in the organisation and inflexible to change with the changing remit of the manager in delivering integrated public services. It fails to account for inter-agency complexity and lacks accounting for users in increasingly co-produced services that managers must engage with. MD practice remains product centric and aims to enhance managerial competences that deliver organisational performance and not beyond it. Hence, coherent or universal models and theoretical frameworks and the application of scientific principles to MD is not feasible as there are varied cultures across agencies and differing public service contexts (Engeström & Kerouac, 2007; Haskins and Shaffer, 2012) which cannot be excluded from planned MD efforts. I argue that the MD concept ought to focus on the wider service system

that can enable managers to engage with and prioritise users in the management of service delivery. On the other hand, MD activities should be flexible so they can be adapted to support the changing remit of the manager, the local service context and learning needs accordingly. Garavan (1999) argues that the major responsibility for development falls on the shoulders of managers themselves. Schon (1988) suggests that managers must become reflective practitioners capable of contingent action and reflective conversation within situations so that they can learn but not be taught the skills needed to be effective. This aligns with the idea of learning while engaged in work (Irby, 1992; Raelin, 2008) as well as the idea of having the managerial capacity for learning to learn (Argyris and Schön, 1978; Kinder, 2010; 2012). I will discuss these ideas further over the course of this chapter but before doing so, I will provide an overview of MD in British healthcare in the next section and consider associated issues and challenges.

4.2 Management Development in Healthcare Services

The variety of MD strategies and programmes in the context of the British Health services are vast and MD in the NHS has largely varied from time and place and has involved a complex range of stakeholders (see Sambrook 2001, 2004, 2006; Garavan, 1995). MD in the NHS remains a complex process and occurs in professional silos (Burchill and Casey, 1996; Sambrook, 2006) while the idea of doing generic evidence based management development (just as evidenced based performance) is cautioned against (Hewison and Griffiths, 2004).

4.2.1 Management Development and its Progression

The focus on MD in an integrated NHS is of critical importance to both policy and practice (Sambrook, 2007) and has seen intensive effort at central and local levels. The establishment of the National Health Service Training Authority (NHSTA) is one classic example of the mid 1980's that saw MD being used as a tool for delivering public services and driving organisational change (Annandale, 1986). Also accounted for are the efforts of NHSTA at the Unit level for using MD to re-evaluate the role of the unit's general manager (Smith et al, 1986; Turrill, 1986). More recently, efforts in MD evaluation highlight shifts in NHS Scotland (Wimbush 2011, ESRC, 2011). At the national level, the NHS Training Directorate oversaw programs in management and organisational development in the 1980's such as MESOL (Management Education Scheme by Open Learning) MTS (Management Training Scheme) and MAP (MD Action Planning). The NHSTD (1991) also coordinated MD

activity in response to external initiatives such as MCI competences and standards, IIP (Investors in People) and NVQ's (National Vocational Qualifications).

The Griffiths inquiry into the management of the NHS (DHSS, 1983) recommended a culture change from an administrative one to a managerial one which saw the introduction of the role of general manager in health authorities throughout the UK and a growth in numbers of managers employed (Ranade, 1994). The mid 1980's arguably saw Management Development come of age with NHSTA's publication of *Better Management, Better Health* (NHSTA, 1986) which focused on the concern of both the development of individual managers and the development of management within the service. It proposed the establishing of the National Accelerated Development Programme (NADP) which provided framework on the basis of which health authorities could base the development of managers. This comprised three separate General Management Training Schemes with the aim of developing future managers with each scheme intended for participants at different levels of managerial experience.

The core features common to all these schemes was the production of carefully considered Personal Development Plans and access to necessary work experience and education (NHSTA, 1986). Essentially, these were standardised across-the-board MD opportunities. In 1991 the NHSME nationally launched 'A MD strategy for the NHS' (NHSTD, 1991) which provided a guiding framework in which MD activity would be formed. This came about due to the feeling that MD required a national framework as more than 250,000 staff exercised managerial functions and many who needed to develop managerial competence were slipping through the net. The strategy proposed the development of a national framework of competences for all levels of management and suggested improvements in the measurement of performance as it contributes to organisational objectives. The competency based management approach allured both organisations and practitioners in the public sector to the idea that consistent and measurable quality in people at any stage of the work cycle meant progress at levels and stages and represented a scientific management approach (Horton, 2000). This also suggested the introduction of performance measures to improve ROI in management training and the establishment of a national management centre. This was essentially the adaptation of private sector MD models that aspired enhancement of performance efficiency among personnel which Talbot (1998) argues against stating that private sector business models are inappropriate for assessing performance in public services. Such a strategy was underpinned by the proposition that all jobs should be charted against the competence framework developed which Horton (2000) argued predicted the

needs of the future and how to address them. Holman and Hall (1996) argue that such standardised competence based MD programs go against the nature of managing which seeks flexibility upon situation.

4.2.2 Goods Dominant Approach to MD and its Misfit

Hence, the culture of competence based MD had emerged for both identifying MD content and influencing mode of delivery with considerable variety being possible. Smith (2000) highlights that the NHMSE highlighted the use of competency-based approaches to support the assessment of managerial performance and the identification of their personal development needs. The competencies were based on the MCI national management competencies but adapted and made more relevant to the NHS context. A growth of Citizens Charters and the requirement to develop service standards and obtain charter marks for public organisations (Horton, 2000) established Competence Based Management and represented development. Dawson et al (1995) state that at the regional level, this has resulted in considerable diversity in MD provision with some regions developing links with local education institutes to provide MD support while other regions have designed assessment centres for managerial assessment and development. Dawson et al (1995: 204) argue that this has resulted in MD out of individual initiative, which has occurred in unsystematic and unplanned ways without local policies and strategies and without a self-development culture. The agenda for MD had widened with these restructurings and with trusts being enabled to develop their own staffing policies and procedures making the MD effort fragmented. Stewart (1994) asserts that the NHS has never had fully planned MD but rather has a poor history of it despite many national and local initiatives: owed to separate authorities, strong professional and bureaucratic rigidities.

Despite calls for MD to create culture change the NHS the change has sought the application of business management approaches to MD that aspire transformation into a managerial organisation (Holmes, 1995). Such a transformation is problematic (Newman and Clarke, 1994; Pollitt, 1990) because such normative MD strategies in the public sector exist largely to be symbolic and rhetorical artefacts which majority of staff treat cynically' (Currie, 1997 p.304). Currie (1997: 311) argues that 'the weakness of the competence approach and insensitivity to context reinforce the ideological conflict with managerialism. This is because implementation of a competence based approach leads to the service managers distancing themselves from the organisation instead of associating with it. Smith (2000) argues that the competence-based approach to MD had become widespread and grown, it was using

increasing amounts of staff time and resources with a growing reluctance to participate due to complexity and bureaucracy in administering the competency standards. Attempts have included *fit-for-all-circumstance* programmes to meet the challenge such as for instance: a NHS specific MBA programme at Keele University and an in-house accredited management development programme run by the Dumfries and Galloway Community Health NHS Board in association with Napier University (Edmonstone and Havergal, 1995). Even though useful in their own right, there have been issued raised about the concentration of such programs to focus primarily on structures, processes and initiatives to meet the needs of top managers in order to ensure succession for positions. Similarly, other programmes such as the NHS Chief Executive Development programme followed by the Trent Leadership Development programme and the creation of similar programs in Scotland have given importance to top management while leaving the development of middle-managers with the individual employer (Edmondstone and Havergal, 1995:34). Similarly, Neirotti and Paolucci (2013) find that training is mainly confined to senior management

Workforce planning and development arrangements which prevailed at the turn of the century did not align with the government's and NHS's desire to see the needs of users at the centre of workforce planning and development (Department of Health, 2000). Also, MD efforts were not supportive of multi-disciplinary training, education and working owed to a lack of management ownership along with training and education weaknesses (Department of Health, 2000). Winterton and Winterton (1999) highlight several cases in the context of the NHS that highlight MD programmes based on set standards (i.e. MCI standards and IiP initiatives) and functional competences that desire linkage between MD effort and organisational performance. While on the other hand, managers engaged with service delivery suggest that such standards are bureaucratic and get in the way of actual development. The competency movement and CBM has had a large influence on how management is done in the NHS (Horton, 2000) supporting performance management systems for organisational efficiency that pay little attention to the dynamics of users or their involvement in services.

Van der Wal et al (2011) argue that healthcare remains a complex territory that is subject to short-term political interference and goal contesting. In this environment Powell et al (2013) argue that MD initiatives in the NHS face issues such as unclear definitions, problematic measures and conflicting principles and lack of culture in attempts to develop NHS managers and that such interference causes a critical constraint on M-LTD. Hyde et al (2013) suggest that political winds distort the mindset of the healthcare manager.

Sambrook (2005) discusses the diversity of talk in the NHS and tries to understand how a complex range of M-LTD activities are perceived and articulated from the perspective of senior managers. He suggests that MD in the NHS largely ignores critical pedagogy and is diminished by the wrath of a dominant 'business' NHS culture. Mintzberg (2004) refers to this as the formulaic MBA approach to developing managers. The need for MD programmes to include other stakeholders involved is highlighted since user aspirations, local cultures and multi-agency relationships set out an agenda for rethinking and reframing MD: values, attitudes and behaviours change. The need to understand MD for this new context becomes crucial given that the NHS's ability to appropriately train and develop service managers is empirically questionable (Edmondstone and Western 2002; Hamlin 2002b; Smyth 2002; Alimo-Metcalfe and Alban-Metcalfe 2003a; Collins and Holton, 2004; Hamlin and Cooper, 2005). Beer (1979) suggests that the job of management is primarily considered to be of managing instability and change and concerned with T&D to improve performance.

The T&D of managers in the public sector is criticized as being formal and insufficiently relating to the practice of managers (Khurana 2007; Locke and Spender 2011; Thomas et al 2012). Certainly, the criteria by which M-LTD is evaluated remains contested (Chochard and Davoine, 2011) and continues to place emphasis on measuring outputs against inputs (i.e. ROI) for the development effort (Kirkpatrick, 1960; Bramley, 1991; Hamblin, 1974; Phillips, 1991). The problem with these approaches is their treatment and assumption of human development is straightforward and causal (Neirotti and Paolucci, 2013) while containing clear goals and objectives to deliver (competency development) in terms of the development. Hence the criteria by which MTD is evaluated remains contested (Chochard and Davoine, 2011). This is because such a goods-dominant approach to the M-LTD of service managers' desire technical rationality (Schon, 1983: 87) and scientific principles for the T&D of people. Such dominant NPM orientated T&D forms have been unable to develop managers in the NHS (Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Collins and Holton, 2004; Hamlin and Cooper, 2005) and may not be the way to go about developing managers who take up complex remits in diverse and changing system of integrated and inter-dependent services.

Doyle (1995) has suggested that MD ideology and practice has attached to it the systems metaphor and seeks organisational transformation and sophistication in response to growing complexity, arguing the need to reframe MD if it is to deal with complex influences and challenges arising from reorganisation and changing cultures. He suggests a more holistic and relational approach to contemporary MD but nevertheless, envisions the reframed MD

within the systems thinking and organisational learning frameworks without identifying and recognising service users and co-production as influences. As it remains, present MD practices in local healthcare service organisations do not reflect the challenges of collaborative inter-agency working or co-produced services.

To summarise, there exists an extensive barrage of criticism for the competency based MD model (Edmondstone and Havergal, 1998). Given the extent of NHS reform and its frequency, it becomes difficult to give a clear cut description of what MD in the NHS is from the perspective of the service manager within (Harman, 2011) and given the varied MD discourses used by managers in the NHS. But certainly what is missing is the need to pay homage to the context in which MD takes place (Cunningham, 1994): a crucial factor which the competency based MD model has ignored. It is clear however that seeking transformation and improvement for what actually works is strategically desired (Scottish Government, 2012) and which needs discourse on understanding the nature of complexity and change (Tsoukas, 2005). What becomes of MD and how it is transformed in an increasing collaborative health service delivery context is crucial since individual managerial learning will be shaped by the context in which it occurs (Antonacopoulou, 2006). The significance of this coincides with the Scottish Government placing management and leadership development at the heart of the modernisation agenda for public services, particularly the NHS (Hamlin and Cooper, 2005).

How does or should M-LTD needs of service managers alter in form and content as public service delivery models change and where will managers get these capabilities from becomes of vital importance? Memon and Kinder (2015; 2016: forthcoming) argue here that local healthcare organisations will need to take on the managerial T&D agenda into their service models and reframe MD in a NPG paradigm.

In the next section I move onto further discussing the challenges and limitations associated with CBM and the possibilities of overcoming and moving beyond.

4.3 Rethinking competency in MD

Conceptualising competence becomes a difficult task and so does drawing its width and depth both in theory and practice (Winterton et al, 2005). As noted:

> *There is such confusion and debate concerning the concept of 'competence' that it is impossible to identify or impute a coherent theory or to arrive at a definition capable of accommodating and reconciling all the different ways that the term is used*
> (Winterton et al, 2005:12)

Competence-based approaches to M-LTD attempt to fit individual managers into the organisation's needs using predetermined sets of competences and promotes the relationship between performance and endogenous resources (Boyatzis, 1982) and promote long term organisational capabilities (Prahalad and Hamel, 1990). Dawson et al (1995) note that particular attention to and desire for the competence approach to MD in the NHS had become prevalent. Using competency based management systems and competency approaches for managing human resource in British Public services has become universal and strong footed and seeks excellence in management (Horton, 2000). Similarly, CBM is identified as the novel approach and means of increasing performance in the public sector (Hondeghem and Vandermeulen, 2000). Its origins stem from the US consultancy firms seeking successful managers with Boyatzis (1982) describing it as a characteristic of individuals related to effective or superior performance. Horton (2000) identifies that commonly up to 300 models of competency to exist. Numerous previous researches identify an extensive array of managerial competencies (see Vilkinas et al, 1994; Winterton et al, 2005).

Approaches such as Holton and Lynham's (2000) six competency domains and McClelland job competence assessment (Spencer and Spencer 1993) and formalised standards such as MCI standards and the eKSF in the Scottish NHS are all based on predetermined competences, are formulaic and focus on performance skills in the organisation: rather than relational skills in a multi-profession service system. Novel models such as the AMA MD competency model (Tobin and Pettingell, 2008) for managing the self and others provides nothing in the way of capabilities to managing in an integrated inter-agency and co-produced service environment. Holman and Hall (1996) point out that such standardisation in management segments the managerial effort since managers want to do the opposite to standardise: to interpret and adapt accordingly. In other words, Memon and Kinder (2015: forthcoming) argue that they are rooted in a goods-dominant logic rather than moving towards a service-dominant logic.

Further support can be given to this argument from Noordegraaf (2000) who has argued that even though managerial functions may be generic, the context in which managers operate are infact unique: therefore managerial competencies must be derived out of what service managers actually do in a given context. Since professional 'sensemakers' (Noordegraaf, 2000) adapt, interpret, relate in ambiguous settings and structures and in unstable and fluid partnerships: competences must also follow suit. Normann (2002) suggests that with services

being co-produced, intangible and experienced across a system requires reflective practitioners across a system. Virtanen (2000) critically argues that competency based management has not been able to address aspects of value and commitment of public managers that are key to effectiveness on public services. This is because competences are understood as being technical and instrumental rather than value based (Virtanen, 2000) and modern day PSOs increasingly require value competences. Instead competences have only focused on managers being able to deliver organisational performance which Virtanen (2000) argues is owed to NPM that causes a deviation from value competences and has created transactional tensions in commitment to public service for managers. Subsequently, Hondeghem and Vandermeulen (2000) argue that reforms, modifications and improvements in CBM overtime remain influenced by NPM and end up focusing on managers being able to give better organisational performance: describing it as old wine in new bottles.

Prescribed approaches to the M-LTD of service managers ill suits the changing service context that is user focused (co-produced). Such competence approaches are insufficient to deal with the challenges of service re-design (integration) and the needs of individual managers. Memon and Kinder (2016: forthcoming) argue this is because pre-determined competences privilege pre-ordained service outcomes. This is supported by Sambrook's (2009) findings that MD in the NHS largely ignores critical pedagogy which hinders new learning and thinking because managers operate in structures that maintain fixated approaches to organisational performance. Bramley (1999) has argued that organisations may be interested more in management performance rather than what managers learn and advocates that evaluating the contribution of MD through the use of a business excellence framework with organisational effectiveness as goal rather than service effectiveness or users. Fenwick and MacMillan (2013) suggest that MD therefore has generally been sought out by PSOs through the use of external providers that has been a long standing trend where the focus has largely been on contractual MD provision and formal structures of programme design and delivery. Such MD frameworks have limited utility in the integrated and user-focused service delivery arena because only user satisfaction (based on user perception of the service) is considered and treated as secondary to the organisation. Similarly, Smith (1993) has suggested that the evaluation of MD has had limited focus given the inappropriate application of scientific principles to evaluating the training of people. She suggests that even in cases where development objectives for managers are achieved, it is for the enhancement of organisational effectiveness. Viitanen (2001) argues that instilled in MD concepts and models and their evaluation is the problem that they are directed towards

measurable productivity where pedagogic, humanistic and social evaluation are missing in the individual growth perspective that are needed.

What is required are MD frameworks that treat the user element as primary not only to the extent of accounting for user satisfaction and perception, but for user engaged and user-determined (co-produced). Henderson and McMillan (1993: 200) note that recognition of cultural change in the NHS is a complex, lengthy and convoluted process which needs to be managed in various directions and using a variety of methods. They suggest that management training and development needs to focus on (as well as achieve) cultural change in the NHS. Bingham and O'Leary (2005) provide support from this argument stating future public managers must be trained in processes involving co-determined governance and decision-making and that development curriculum must incorporate this vital user participation element. Britnell (2013) suggests that any effort to improve integration and deliver quality health services must entail authentic user involvement and collaborative cultures.

I argue that competence-based MD is inappropriate for the new setting where a user-focused service system determines the roles, responsibilities and relationships of managers and where managerial work is increasingly situated and context dependent. This can be supported by Sambrook (2006) findings which highlight tensions associated with MD in the healthcare service. These tensions are ones such as: between professional and managerial development; the use of competition or cooperation as means of service delivery; between the desire for performance and the need to learn; between local (varied) and national (standardised) approaches to HR issues. Bolton and Houlihan's (2010) suggestion that there is a lack of training and support for middle-managers when making a transition between professional to managerial roles also supports the argument. Prevailing M-LTD efforts (instilled in a GD logic) fail to prepare managers for the inter-agency environment where relationships and accountabilities are changing and the challenges of user involvement and multi-disciplinary teams in delivering services gain momentum. The SD logic encourages the empowering of managers and teams that negotiate for finding suitable ways. McCredie and Shackleton (2000) argue, that it is a duty upon middle-managers to interpret and negotiate modes of delivery and standards of service.

Future MD forms and content need to serve a changing purpose. For this, alternative perspectives for MD are needed whereby M-LTD begins with generalizable concepts and tools that are available to service managers to deliver in different contexts (Memon and Kinder, 2016: forthcoming). As it currently remains, McGurk (2009) finds that MD

interventions for middle-managers in PSOs disregard the practices and realities of managerial work as well as service outcomes and largely focusing on training middle-managers to implement top-down strategy and regulatory compliance. He suggests that MD for potential 'leadership building' in managers is neglected and that contextual research is required into the outcomes of MD across difference public service contexts. Taking on board McGurk (2009:475) argument, MD interventions are only going to be successful for middle-managers in PSOs if they 'reflect accurately the realities of the particular managerial role in its specific operating context'.

To contrast M-LTD in its present and constrained form, in the forthcoming sections I propose how M-LTD may transform in an S-A-A-S framework using the SD approach. However, from the outset, one must acknowledge that the development of human resources in the public sector remains a wicked problem (Brown et al. 2010: 4) since it involves complex issues and processes and where no final solution or resolution can ever be reached, but rather the best possible can only be done at any given time.

4.4 Conceptualising MD in Services-as-Systems

In this section I discuss alternative ideas regarding management competence and MD to make it more relevant and suited to a changing public service context. The argument put forth so far is that MD in its present form and content may be insufficiently changing to enable service managers to act effectively in an altering public service environment. This stance is supported by Ducey's (2009) case argument that a great deal of training and development in healthcare fails to improve services while Sambrook (2006) highlights that how HRD in the healthcare context is accomplished and talked about is rather neglected. Bolton and Houlihan (2010) in support of this argue that in the service context, senior management and users are often given more attention than middle-managers who are treated as *ghostlike*. Memon and Kinder (2015: forthcoming) argue that regardless of how appropriate MTD may have been for goods dominant service setting characterised by organisational performance management of the NPM paradigm, local PSOs have embraced the network model without adjusting T&D form and content.

This position represents a shift from a GD approach to a SD approach which aims to enable managers in getting *more-from-less* and enhance service effectiveness by engaging users in increasingly co-produced services. As Beddowes (1994: 41) highlights, the need of modern PSOs is to 'equip the new generation of managers with appropriate attitudes and skills to be effective' Borrowing conceptually from Fenwick and McMillan (2013) it is about the shift

from wholly organisation-defined MD to co-produced MD between PSOs. More precisely, shifting the focus from organisation focused MD to user-focused MD. MD that can facilitate moving away from managing in loosely coupled organisational networks to managing local services that are closely coupled as a system. Memon and Kinder (2015: forthcoming) argue that local services are beginning to move beyond the network model towards a more holistic system comprising of multiple services. This can be supported by Norman's (2002) view that public services are co-produced, intangible and subjectively experienced by users. Osborne et al. (2013) acknowledging these elements of changing public services highlights co-production as a vital part of future public services design and delivery as advocated by the NPG paradigm.

However, managers need to be facilitated from such a transition with appropriate M-LTD forms and content if they are to create integrated value flow: that is, being able to integrate services as necessary to meet user-needs (Memon and Kinder, 2015: forthcoming). Taking on board ideas on service-dominant logic from Vargo and Lusch (2008), the service managers remit will involve managing personalised problem solving beyond the confines of the organisation and this need require an ability to reflect on the wider service system and how it can service the individual user: co-determining and co-creating. In doing this, there will be variation in terms of individual user needs and different local contexts. Williams (2013) suggests that modern day managers in the context of collaboration are boundary spanners who must possess coordinating and communicating competences to deal with tensions and ambiguity that arise from complexity, multiple accountabilities and governances.

M-LTD in its current form and content is much influenced by the business imperative and focuses on facilitating organisational effectiveness. The argument Ducey (2009) makes is that NPM orientated M-LTD despite promoting techniques that savour employee and customer interaction, concerns itself with organisational performance and does not improve the quality of work managers engage with or the service itself. This ties in with Berg's (2006:556) findings that the 'transformation of public services towards market based and private sector models challenges service providers who generally oppose such reform since they affect the ability of professionals to do a good job'. Ducey (2009) argues that training ends up becoming a false promise and in its various formations ends up becoming contrary to what healthcare requires while causing problems for those attempting to manage.

4.4.1 Value-Commitment-Context (VLC) Based Management Competence

With reference to managerial competence, I take a position whereby if competence serves the 'purpose' of enabling managers to deliver better outcomes, then they should enable managers to do that which is user-focused in terms of task and process. Therefore it is about developing personal competences for meeting 'purpose' which context specific MD interventions can facilitate. Also, this position asserts that competence is not a permanent, uniform or static acquisition. But rather, it is a construct that is open to on-going formation and comprises of both experiential and action based learning in its improvement. I build upon the propositions of Nooredegraaf (2000) and Virtanen (2000) that advocate developing competences as being context and situation specific (based upon what managers actually do), enabling flexibility and adaptability, being value based and commitment orientated.

Furthermore, it is about competences that enable managers to become better professional sensemakers (Nooredegraaf, 2000) who can function effectively in the midst of structural and political ambiguity and in complex and fluid partnership arrangements. Furthermore, Rice (2007) being attentive to the diversity of inter-agency management and its associated complexities, suggests the need for managers and PSOs to focus on (and develop) cultural competence: to be able to relate to different groups (either provider or user) in order to effectively deliver public services. This is necessary to facilitate sense-making of the inter-agency cultural contexts in which services occur.

The S-A-A-S framework advocates that users (as active recipients) and co-produced processes at the local level determine the value and commitment based competence that managers ought to develop use.

Fenwick and McMillan (2013) argue that MD programmes primarily serve the internal objectives of organisations seeking MD and those delivering MD without any joint determination or production of mutual MD between them. Furthermore, they question whether present day PSOs and their managers get anything out of externally sourced MD. Borrowing from Fenwick and McMillan (2013), one argues that meaningful MD in an integrated service arena requires co-creation where time needs to be given and relationships of trust need to be built over time.

4.4.2 Envisioning Appropriate and Effective Management Development

To enable such a MD strategy and promote adequate forms of M-LTD, Kalleberg's (1977) ideas on *commitment-based HR* and Hodson's (1999) ideas of *management citizenship behaviour* built around trust and reciprocity lend direction. Rubin and Brody (2011) argue that theorising in these ways improve commitment and satisfaction and potentially enable managers for new service design and delivery forms. Denis et al. (2010) discuss that managers in messy arrangements of organisations (such as in health service integration) need to practice leadership that is situated, collective, dynamic and dialectic. More importantly, Denis et al. (2010: 84) suggest that leadership cannot be exercised without taking into account the multiple, dynamic and fragile coalitions that constitute them while accepting that managers can never be fully in control. The S-A-A-S approach gives weightage to the contribution of users in the service system and encourages M-LTD interventions that can address relational challenges for the manager with users and other professionals in the service system. As demonstrated in the case of multidisciplinary working in Scottish public services, managers can learn from the inter-connected and multi-agency setting in which they operate (Kinder et al., 2008; Memon and Kinder, 2016: forthcoming) to build commitment-based human relations (Brown, 2007) over time. *Over time* becomes important here because successful integration requires lengthy discourse and trial at the points of service design and delivery (Memon and Kinder, 2015: forthcoming).

I advocate that MD need not be about formal initiatives sought out from external MD providers but be about co-produced MD activity between agencies and managers themselves. This position can be supported with constraints facing novel forms of formal training such as transdisciplinary training (Bimpitsos and Petridou, 2012) which despite conceptually complementing the inter-agency service context, have little potential in practice, which Mitrany and Stokols (2005: 439) argue is due to communication constraints, discipline-specific jargon, difficulties in cooperating due to professional siloes or pride and the length of time required to jointly plan and develop training. Fenwick and McMillan (2013) crucially point out that public sector managers are highly skilled people who are likely to possess more knowledge and experience than external M-LTD providers and so, PSOs should question what is being offered by external providers that they themselves cannot provide for.

Therefore, traditional and formal MD forms may not yield anything substantial, also given the view that middle-managers do not get much opportunity for formal MD. Added to this,

Jewson et al. (2014) through an extensive study establish that funding for training, opportunities and availability of training, tightening of eligibility for training as well as the frequency of engaging with training in the public sector are being reduced in the present period of austerity. Instead training in economical and smarter ways is now encouraged: but what constitutes economical and smarter is open to exploration. Given this scenario and the integrated service delivery context, the question worth asking is whether service agencies can together produce something smarter and better in terms of MD that otherwise is difficult to produce alone or which may require formal and funded means.

Borrowing conceptually from Fenwick and McMillan (2013), I ask whether agencies can jointly produce creative MD interventions in the public services arena where service managers are acquiring the necessary learning. Such co-produced MD offers the opportunity for knowledge and culture exchange between agencies to form a collective service system that incorporates closely coupled managers and agencies seeking unified and user focused service outcomes. As Fenwick and McMillan (2013) suggest: co-produced MD offers the opportunity for 'learning to learn' where outcomes are negotiated over time: hence encouraging close psychic distance (Kinder, 2010) and the development of shared purpose among PSOs. Sambrook (2007) argues that without shared meanings, HRD agendas within the NHS may be problematic since managing learning and development in the health service is complicated. For this reason, Sambrook (2007) finds that although learning is central for the modernising of the NHS, it occurs only in professional siloes and lacks in serving common purpose while being struck with identity issues. I move on to discuss aspects of learning that must essentially be re thought if MD is to achieve effectiveness.

4.4.3 The Transformation of Managerial Learning

The manager in a cross-agency and multi-profession integrated service setting will therefore reckon with differing contexts as highlighted by Lauria (1997) if they are to build systems bottom up. Boon and Van der Klink (2002:6) argue that universally applicable management competences become less important than organisationally-specific ways-of-doing that merge and apply formal and informal learning. With regards to the MD of middle-managers, culture (Schein, 1985) and context (Engestrom and Kerouac, 2007) become crucial as services increasingly begin to engage with users and where contextual-cultural learning is required of service managers. In different terms, competence based MD privilege preordained services outcomes, whereas the SD approach to management competence as Oswick and Grant (1996) argue, emphasises individual knowledge, roles, relationships and responsibilities. Leonard-Barton (1992) note that this encourages experimentation and learning-by-doing

using the term *deutero-learning (*Bateson (1973) i.e. learning in new ways often, enhancing tacit knowledge and re-building absorptive capacity). Warhurst (2013) argues that managers creating new practices as a result of learning is a cost-effective HR strategy when HRD activity might be tightened due to austerity (supported by Jewson et al. 2014). In order to achieve this, Poell and Krogt (2007) suggest that there is the potential advantage of exploiting (co-produced) learning from the everyday interactions between staff and service users.

Hartley and Allison (2000) classically argue that at key moments the balance of time between leading, managing and administering alters which Osborne (2010a) suggests is the dawn of new public governances. Akin (1994) discusses that understanding learning processes, creating new skills, knowledge and attitudes is essential for appreciating how new service systems are created. In light of this, Kinder (2012) suggests that to transform local public services into models of service delivery models places importance on leadership roles informed by (and endorsing) learning.

Learning can therefore be viewed as both a critical process and resource that actively occurs *in* organisations. Active learning in an integrated setting means that managers become accountable for developing new service systems where *managing change* rather than *delivering stability* takes precedence. It also enables new-ways-of-working by diverse professionals. Fenwick (2008) points out that new service models are only possible if a wide range of staff acting as *reflective practitioners* review and revise their ways-of-working. Understanding, how and why particular staff learn as participants, becomes essential and especially so within interdisciplinary teams. Fenwick (2010: 79) elaborates on the nature of such learning to be acutely mistaken as singular when it is multi-dimensional:

> *The critical problem lies in mistaking learning as a single object when in fact it is enacted as multiple objects, as very different things in different logics of study and practice. Particularly in the contested arena of work…. learning needs to be appreciated as a messy object, existing in different states, or perhaps a series of different objects that are patched together ….*

Such limited treatment of learning is apparent in approaches such as Craig (1994) where learning abilities are classified into 30 types and seek stability and exclusivity. Similarly, Salaman and Butler (1994: 39) who state that 'since managers only exist within structures of power, managers will only learn when they can see that what they are learning will be valuable and legitimate within their organisational setting'. Such conceptualising becomes outdated and constraining of managerial purpose. To oppose such prescriptive treatment of learning and to support Fenwick's (2010) proposition of learning as multi-dimensional,

Heywood's (1989: 59) work on the nature of the manager-as-learner assists with developing a position which points out that the manager-as-learner is complex because he/she is variable and can have multiple motives at one time; is capable of learning new motives through work and institutional experiences; can have different motives within and across departments and organisations and can become productively involved based on motives and can respond to many different types of learning strategies depending on motives.

How learning is treated depends on what position one takes on professional transition (Fenwick, 2013: 362): as either a problem to be resolved or as inevitable and continuous. Typically when transition is treated as being disruptive and detrimental, Fenwick (2013:363) argues, that 'management education then focuses on learning to manage transitions, the complexity of challenges become narrowed and its challenges flattened'. The focus also falls upon the individual in transition ignoring the range of social forces that bring forth the transition. Dyllick (2015:18) argues that current learning from management is fundamentally questionable with serious doubts about the ability of formal management education to provide the skills needed to function in the modern organisation or to prepare future professionals for the challenges of a pluralist world. Fenwick (2013) suggests that more recently, the focus has shifted to acknowledge greater complexity and the larger collective rather than the sole individual in transition; which Colley et al. (2007) support with the view that professionals are caught in transition made up of conflicting responsibilities to various stakeholders. Therefore learning, just like professional transition, needs to be understood within broader arrangements of work. Managerial learning for the integrated public service setting therefore needs to move away from configuration, order and predictability (Fenwick, 2013) and requires wider and braver discourses and perspectives. To illustrate this point, I quote from Fenwick (2013:364):

> *how can we conceptualise transitions in ways that disrupt linearity, universality, and "development" from deficiency to proficiency, to appreciate transition as multiple, complex, non-linear pathways?....... "Becoming" might be understood more richly in terms of emerging ecologies rather than congealing subjectivities.*

4.4.4 Managerial Learning in Integrative World

Dyllick (2015) argues that learning contents are seen as reductionist and that the process of learning and pedagogies are deficient in preparing for leadership challenges. Managerial oversight that seeks success through planned means leads to insufficient variety since any deviation from plan is branded negative or failure and therefore inhibits learning (Edmondson, 1999). Fenwick (2012:141,156) argues that since professionals must collaborate through inter-agency work arrangements, this involves learning in and for

collaboration: which in itself involves articulating the changing complexities of knowing. However, little training occurs to build integrative learning and thinking (Martin, 2007). Guile (2012) suggests that managers as learners must be assisted to develop capabilities for inter-professional learning and working. Such a transformation Dyllick (2015:18) argues needs to:

- simulate the complexity of real world problems that are 'messy' and cross boundary rather than being discipline based and resting in silos
- refrain from the dominating logic of the market which dominates management education which idealise markets and the purpose of organisations of serving it through maximisation: so that education can promote learning of pluralistic values and logics of public policy, management and society.
- pay attention to learning to learn, in particular, self-managed learning and pay attention to self-knowledge and reflective exploration of meaning.

Nygaard and Bramming (2008: 404) suggest that learning centred MD programmes should develop 'competence-in-practice': that is, knowing what to do, being able to understand and address context and values and be able to react and enact in positive and justifiable ways.

Edwards and Daniels (2011: 39) suggest that 'what matters in practices within services' and 'what matters when practices intersect' are negotiated across practice boundaries. Hence, it is at these intersections where new learning is occurring and practice competency is built. This supports Fenwick and McMillan (2013) idea that outcomes are negotiated over time and via learning to learn. Warhurst (2013) in an in-depth study of managers' narratives on managerial practice and workplace activities suggest strong intentions of facilitating learning of individual managers through experience and communities of practice. He suggests that this is possible through participation and involvement and where learning is situated and where non-formal learning is facilitated. Essentially the learning is in the doing. Hence Nygaard and Bramming (2008) suggest the pedagogy is in learning through action and reflection in real life experience, which Schon (1983) suggests aids re-conceptualising.

Frost and Wallingford (2013) propose that on the job MD be designed on the basis of action learning models to develop managers with an emphasis upon their active participation in the process of self- determining and self-evaluating their learning and development. This is supportive of Gilligan's (1994) ideas on self-managed learning to the degree that a proactive approach to taking responsibility for one's own learning is beneficial and that managers

diagnose, negotiate and control their own learning in the organisation. In the context of the NHS, Gilligan and Boddington (1995) evaluate self-managed learning in MD initiatives across the health service and conclude that the use of self-managed learning in MD provides sophisticated structures for supporting learning and better development of individuals. Here, McGrath's (2001: 118) suggestion that effective adaptation requires sufficient variety is complementing: exploratory learning is critical to the capacity of creating variety and to adopt.

The case for adaptive learning is supported by McGrath (2001: 127) who, reflecting on the work of Cheng and Van de Ven (1996), suggests that when groups were engaged in trying to innovate, learning stemmed from chaotic interaction and where outcomes and consequences were not tightly coupled. This supports Kinder's (2008; 2012) ideas on learning and innovating through inter-connected multi-agency settings to develop shared purpose and close psychic distance in the attempt to transform local public services. Furthermore, McGrath (2001: 128) finds that high levels of exploration lead to learning effectiveness associated with variety rather than pattern in managerial oversight, arguing that this questions the assumptions and norms of learning being more effective when work goals, tasks and targets are specified. Rather, this supports the case for learning via action and adaptation in uncertain environments.

4.4.5 Action learning to suit purpose

The ideas put forth so far can be supported by action learning theory. Action learning (AL) can have variety as to what it means (Weinstein, 1995) and variations occur in how action learning in implemented and encouraged in organisations (Raelin 2000). But nevertheless it is about intentional strategies to help people to learn from their work (Marsick and O'Neil, 1999) where participants work on real problems at individual, team and organisational levels that are complex, overarching and cross functional and have no clear solutions (Gray, 1999). Raelin (2006: 153) suggests the essential principle to AL is that learning is acquired in the midst of action where learning-to-learn aptitude enables the practitioner to critically examine and question practice: learning is treated therefore as a 'concurrent by-product of practice' (Raelin, 2006: 153)

Marsick and O'Neil (1999) argue that even though it is a challenge to learn from experience and from real messy situations, AL offers greater insight and capacity to learn and develop more political and cultural awareness once participants take on board their own learning. This happens as individuals direct their own learning and achieve more control upon it.

Learning therefore is an inductive (Gray, 1999) and social process (Revans, 1982) with emphasis on learning from processes rather than from solutions to real problems. Advocating AL, Raelin (2000) suggests that learning occurs via reflection on work practices and knowledge is generated as a shared activity (learning becomes everyone's job), which Schon (1983) supports with the *reflective practitioner* that develops effectiveness over time by learning from action in situations.

With respect to AL in the collaborative and integrated environment, Eraut et al (1998) find that individuals learn through others beyond the PSO and from a range of stakeholders such as cross-agency professionals and users, while also recognising that the workplace itself is as a highly effective learning environment where collaborating with other people generates learning. I borrow from the theoretical propositions of Raelin (2006) who makes a case for action learning as having a profound effect on building collaborative leadership ability and capacity. This is because reflecting on practice in unfamiliar conditions (i.e. health and social care integration) but in the midst of action provides a better chance of creating new and suitable leadership styles compared to traditional and hierarchical MD methods. It also provides the opportunity to learn collectively and upholds the potential that professional communities possess for leadership rather than belief in the charismatic individual leader.

Raelin (2006) argues that such is the importance of learning embedded in real life practice that formal management education and development are making transitions to using approaches that are based on actual problems. Furthermore, AL is strongly positioned since managers are increasingly being encouraged to 'co-construct' their practice environment which also encourages co-constructed learning environments at the local level and as per local needs. Raelin (2006: 165) proposes that such learning becomes spontaneous, interactive and people dependent where managers help each other to 'learn their way out of trouble'. Hence, leadership becomes dispersed and is a collective matter supporting Lauria (1997) argument for building service regimes bottom up. This supports the S-A-A-S approach where MD moves beyond pre-conceived approaches of the past that gave us the 'pre-loaded' manager as a leader, who has now become far-removed from the realities of present day management practice in inter-agency service environments:

Such a socio-cultural learning perspective makes a case for AL as key to operating in a public healthcare service system, what Eisenhardt (1989a) would describe as a high velocity environment which needs improvisation and what Argyris and Schon's (1978) term as needing double-loop learning. Kinder (2010; 2012) suggests that such double-loop learning (ability for learning-to-learn) requires both absorptive capacity created by formal knowledge

and wisdom from experience. Raelin (2006: 165) notes that AL enables managers to 'learn and become competent practitioners as they work'. This is a point which encourages the case for actively learning through means such as co-location.

Further to this, Engestrom and Kerouac (2007) suggestion that context matters most and Schein (1985) argument for culture defining logic would support the view that culture and context promote contextual learning with MD interventions that are work-based become increasingly relevant. In the case of managers in integrated healthcare services, learning is only made relevant and meaningful when it is created and deciphered in a particular culture and context of a public service set-up and its users. With a SD approach to delivering services, the manager must learn and develop in a fluid, overlapping and complex system of services rather than in any dogmatic organisational or networked structure. Varied cultures and differing public service contexts therefore cannot be ignored in planning MD interventions and the manager must engage in continuous co-produced learning (Haskins and Shaffer, 2012). Service managers in delivering integrated and co-produced healthcare services will be open to learning and experimenting (Chesbrough, 2010) and will embrace change rather than stability (D'Netto et al., 2008)

Co-location as strategy serves M-LTD in the integrated health services context as Raelin (2006: 165) notes AL to be 'bound up with the participation and activity of others, that sees practice as a process of experimentation and reflection' with profound effect on the ability to lead in collaboration. Co-location conceived as both a strategy and intervention offers the very opportunity to do this: managers learning from each other and from practice in uncertain but a real world environment.

4.4.6 Co-location as Opportunity

Analysing co-location as an action learning environment for the integrated service context has been little conceived especially when the case is that co-located services create opportunity in the everyday work of managers to co-construct learning from participation, experimentation and reflection with other managers in and across agencies. There is evidence to suggest that co-located professionals physically working together enhances trust and performance (Sliger, 2001), reduces error (Ebert and De Neve, 2001) and encourages tacit knowledge sharing (O'Connor and Coleman, 2009; Baskerville and Pries-Heje, 1999). Co-located services and the co-location of service managers offers a rich opportunity to develop collaborative leadership amongst service managers as Kinder (2010; 2002 and 2003)

highlights that co-location in public services enables better user-focused service delivery and enables inter-operability.

Despite increasing endorsement of service co-location in the public sector (Stein et al., 2011; Kearney, 2005; Colman, 2006; Christie Commission, 2011) and its adaptation as a means of modernising public services, its objective is restricted to cost reduction, better resource utilisation and service efficiency (Seddon, 2009; Cowan and Jacobs, 2009; Cornwall Infrastructure Delivery Plan, 2011; Whitfield, 2007; Allaby, 2011; Audit Office, 2012). Co-location offers the chance to develop collaborative managerial capacity, which nevertheless requires time since learning from being co-located is associated with the context and culture of the agencies that come together (Bardach, 1998). The move towards integrated service systems (like any change) requires learning using absorptive capacity (Kinder 2010; 2012), requires co-constructed learning involving participation and experimentation (Raelin, 2006) and discourse with colleagues (Nonaka and Takeuchi, 1995) across-agency and profession (Eraut et al. (1998) that are built bottom up (Lauria, 1997): here co-location enhances the managers capability and chances to deliver user-attentive services that are truly integrated overtime: it aspires co-located people that do co-constructed learning and engage with joint practice to not only collaborate, but more importantly to unify purpose and outcome. Co-location as opportunity for MD can support managers to deliver user led services as advocated by the NPG paradigm and S-A-A-S approach.

4.5 Theoretical Propositions and Framework

From the ideas and argument put forward in this chapter, I synthesise below the theoretical propositions and framework that characterise MD in an S-A-A-S framework and which make MD both suitable and effective for managers in a future healthcare service system.

Idea	Author	Implications for MD
Co-production and co-design	• Normann (2002) • Schön (1983) • Osborne *et al* (2013) • Vargo *and Lusch* (2008) • Memon & Kinder (2015: forthcoming)	• Value and the reflective practitioner in a service system • User-influenced design and delivery • Changing nature of managerial work in Services-as-Systems
Context and Culture	• Schein (1985) • Engeström & Kerouac (2007) • Haskins and Shaffer (2012)	• Context (knowledge, wisdom, work-based learning) • Varied cultures
Reframing MD	• Fenwick and McMillan (2013) • Bingham et al. (2005) • McGurk (2009) • Memon and Kinder (2016:forthcoming)	• Co-produced MD • User-led/User-focused and co-determined MD • Role specific and Context specific MD interventions • Changing nature of M-LTD in Services-as-Systems
Redefining Competency	• Noordegraaf (2000) • Virtanen (2000) • Nygaard and Bramming (2008)	• Context specific and context defined competences • Value based and commitment based competence • Competence-in-practice
Open learning	• Chesbrough (2010) • D'Netto et al. (2008) • Dyllick (2013) • Edwards and Daniels (2011) • Warhurst (2013)	• Open Learning • Life-long learning • Changing and multiple motives • Dynamic inter-agent learning • Learning via negotiating at intersecting practice boundaries. • Learning via experimentation in communities of practice
Action Learning	• Raelin (2008) • Kinder (2010: 2012) • Eraut et al (1998) • Raelin (2000; 2006) • Gilligan and Boddington (1995) • Fenwick (2008; 2010; 2013) • Raelin (2006) • McGrath (2001)	• Knowledge-wisdom-learning (absorptive capacity) • Learning cross agency and cross-profession • Co-constructed learning • Self-managed learning • Practice based and workplace learning • Learning for collaborative leadership • Learning from exploring and adapting to uncertain conditions
Co-location	• Bardach (1998) • Kinder (2010:2012) • Raelin (2006)	• Developing new ways of working overtime in agency collaboration • Learning and Innovating for user led services • Learning via experimentation and participation opportunities

Table 5: Theoretical Propositions constituting Management Development in Services-as-a-System: Source, Author

4.6 Summary

This chapter has reviewed MD both as a concept and practice in the context of public services and discussed propositions of thinking beyond distinctions and classifications of MD in a changing healthcare service context. The chapter has highlighted the misfit of MD that prevails with a goods-dominant logic and which is fixated on competency based management. The chapter discusses ideas for rethinking and reconceptualising MD in Services-as-Systems and discusses the transformation of managerial learning where Action Learning suits purpose.

The chapters so far have reviewed a wealth of ideas and theories that develop a sound theoretical base upon which to progress with the empirical investigation of this research study. I now proceed to the next chapter to discuss the methods of this research study and provide the reader an insight to the research methodology of this study.

5. METHODS

5.1 Introduction

This chapter discusses methodological issues and decisions made in light of the research questions and the conceptual framework proposed. It discusses the research methodology pertaining to epistemology, approach and method (Section 5.1) and research design pertaining to sampling, study phases, data collection and case profiles (Section 5.2). It then moves onto discussing possible limitations (Section 5.3).

5.2 Research Methodology

5.2.1 Research Philosophy

This section addresses the epistemological and ontological stance which I adopt in this research study, which concerns itself with Management Development in changing public service systems.

5.2.1.1 Epistemological Stance

With regards to what can be considered as acceptable knowledge (Bryman and Bell, 2011) or what it means to know (Gray, 2004), the study takes a Constructivist position whereby meaning is constructed (rather than discovered) in the social world by subjects in their different ways in relation to the same phenomena (Gray, 2004). This theoretical perspective ties in with Interpretivism, whereby service integration as a phenomena is explored and how managerial learning, training and development are altered in the process of health services integration, managers interpret in their individual ways and construct meaning from context.

As Gray (2004) suggests, Interpretivism is closely tied in as a theoretical perspective with Constructivism. Blumberg et al (2014) argue that interpretivists hold the principles that the social world is constructed and given meaning subjectively by people. Such a position is appropriate for this study since it explores service integration which involves processes and the need to understand them. In other words, health services integration is about phenomena as experienced.

Furthermore, the position is deemed suitable as the study explores managerial work and the development of managers, both which are experienced subjectively by managers as individuals. In other words, the study addresses phenomena that are ill-defined, complex,

intangible, viewed in multiple ways and not suited to any quantifying or measuring. This therefore positions the study at odds with Positivism as an epistemology which would hold that such phenomena and the social world are objective, measurable, can be reduced to simple elements and are subject to logical and methodological principles (Bryman and Bell 2011; Gray, 2004; Miles and Huberman, 1994).

As highlighted by Crotty (1998), a Positivist stance would imply that the results of this research present objective facts and establish "truth", which is certainly not intended. Neither is my position that of an Objectivist: Objectivism as an ontology (understanding what is) suggests that an objective reality exists independently of individual consciousness and that research should be about discovering such truth, closely linking itself to a Positivist epistemology Gray, 2004;. According to this, there must remain an understandable truth as to what health services integration and the development of managers as phenomena involve and that particular fact and order exists to them needing to be discovered (Bryman and Bell, 2011).

However, I hold that these phenomena are interpreted by subjects in order to derive meaning while also constructed over time. Hence, social phenomena are subject to constant meaning and constructing. This research therefore proceeds from an ontological view that the world is socially constructed and given meaning by people (Easterby-Smith *et al.,* 1991). In context, the task of managing and improving service delivery involve notions of trying out; experimenting; trial and error; learning over time. Ontologically, true to the nature of service integration is that it contains inter-twined processes that shape out yet alter over time (Pettigrew 1997). Another principle also asserted by taking this epistemological stance is that the research is part of what is observed (Blumberg et al, 2014) which lends support to the use to Constructivist Grounded Theory which I discuss in the next section.

5.2.1.2 Sociocultural Theory Perspective

With regard to learning and knowledge construction, a Constructivist epistemology is promoted by Vygotsky (1978) who, interested in knowledge and interaction, advocated Sociocultural theory. Sociocultural theory suggests that learning and development cannot occur in isolation from cultural context in which individuals operate. It also holds a position that social interaction (and therefore learning) precede development and that development is a consequence of interaction between people and the Sociocultural context in which they interact via shared experiences (Crawford, 1996).

Sociocultural theory stresses learning as arising from the interaction developing between people and the culture in which they operate (Cherry, 2015). From this Constructivist perspective, as the learner participates in a broad range of joint activities internalises the effects of shared working (creating experiences), they acquire new strategies and knowledge of the world and culture (Scott, 2015). Crucial to Vygotsky's (1978) theorising and important to epistemology here is that learning and development are treated as internal processes that are interdependent of one another rather than being a consequence of one another (Scott, 2013). Vygotsky (1978) suggests that individuals learn through interaction with others at one level while at another level, they expand their potential for development (zone of proximal development) and fulfil their development potential through problem solving by collaborating with capable peers (UNESCO, 2003).

5.2.1.3 Constructivist Position

It is also important here to clarify and justify ones position with regards to Constructivism as an epistemology as opposed to Constructionism given that both are sometimes used interchangeably (Crotty, 1998). It can be a challenge to differentiate between them since research methodology literature (Bryman & Bell 2011; Gray 2004, Blumberg et al 2014, Miles and Huberman, 1994) lacks clarification between them. Yet, for the purposes of clarifying my position in this research and supporting Vygotsky's (1978) socio-cultural theory as a lens through which to explore learning and development, it is useful to reflect on the differences between Social Constructivism and Social Constructionism as epistemologies. This also enables one to appreciate the distinctiveness of both in understanding meaning. Both stances take the position that knowledge is constructed by people either individually or socially, however both are distinct.

While Social Constructivism refers to the individual's meaning-making of knowledge within a social context (Vygotsky, 1978), Social Constructionism points to individual experiences and maintains that sense-making as done by one individual holds as much importance and validity as that done by the next individual. Social Constructionism points to the influence culture has upon individuals shaping the way in which individuals do sense-making (Crotty, 1998, p.58).

Social Constructivism thus places emphasis on the meaning making of individuals in relation to experiences in their environment while Social Constructionism emphasises on the purposeful production of knowledge. Social Constructivism places individuals at the centre of meaning-making within a social context while Social Constructionism places the social context itself at the centre of meaning making. Therefore, Social Constructivism focuses on

the individual's learning that takes place because of their interactions and therefore people construct new knowledge as they interact with their environment (Coutas, 2009). Knowledge therefore becomes a human product that is socially and culturally constructed (Ernest, 1999; Gredler, 1997) while Social Constructionism focuses attention on the artefacts created through shared production.

From the Constructivist viewpoint, while Constructionism uncovers the ways in which individuals or groups participate in creating social reality (as perceived), Constructivism takes up the importance of culture and context in people's understanding of what occurs in society based on constructed knowledge (Derry, 1999; McMahon, 1997; Coutas, 2009) lending support to Vygotsky's theory. Social Constructivism would maintain that learning is a social process and that meaningful learning occurs when engaging with social activity (Ernest, 2010).

With respect to exploring how Management Development (the learning, training and development of managers) alters as new integrated health service systems emerge (context), it becomes more suitable to adopt a Social Constructivist epistemology as opposed to a Social Constructionist one. To put it differently, this research concerns itself with the individuals' (managers') meaning-making of Management Development within a social context (health services integration) and therefore, hoping that my epistemological position is clarified.

Fenwick's (2012: 364) suggestion that 'becoming' with respect to professional transition 'might be understood more richly in terms of emerging ecologies rather than congealing subjectivities' supports the case for a constructivist epistemology. Particularly, the case for Sociocultural Theory and Social Constructivism is strengthened given the nonlinearity, complexity and multiplicity that managers encounter and experience as 'practitioners in transition' (Fenwick, 2012) and which they use to construct understanding and meaning of social reality and by means of which they learn.

With respect to ontological considerations, the stance is that 'organisations' and 'management development' are social constructions not independent of the actors that function within them. A Social Constructivist view is adopted which proposes that knowledge is constructed through social groups and not just through individuals, implying that knowledge is an inter-collaborative construction where meanings are based in specific social contexts (Wittgenstein, 2001 cited in Lupson 2007, p.76). The research considers organisations and managerial learning and development primarily as social constructions

created out of continuous discourse and more importantly, as constantly changing. This also implies that knowledge in any case is viewed as only intermediate.

5.2.2 Using a Phenomenological Approach

This research initially started out with the use of phenomenography as an approach in the pilot study phase as the research was concerned with understanding the different ways in which managers experienced Management Development and was interested in establishing a firm context for the study going forward. Initially, using phenomenography as an empirical approach suited purpose as it aims to identify the "qualitatively different ways in which different people experience, perceive, conceptualise and understand various kinds of phenomena in the world around them'' (Marton 1986, p.31). Beyond the Pilot study phase, the research then further adopted phenomenology as an approach on the basis of methodological and philosophical reflection over time. This decision was underpinned on the fundamental distinctions between phenomenography and phenomenology as approaches to research. While phenomenography focuses on the different ways in which people experience phenomenon, phenomenology focuses on establishing the essence of the phenomena (Martin and Booth, 1997). Furthermore, phenomenography does not distinguish between conceptual thought and pre-reflective experience while phenomenology does (Barnard et al, 1999; Lupson, 2007).

Phenomenology concerns itself with how individuals make sense of the world and is embedded in an anti-positivist position (Bryman and Bell, 2011). It also asserts that any attempt to understand social realities must be grounded in peoples experiences of those social realities and becomes an exploration of prevailing cultural experiences (Gray, 2004) supporting Vygotsky (1978) Sociocultural theory reasoning of learning and development. The phenomenological paradigm focuses on meanings and attempts to understand what is happening and attempts to construct theory and model from the data rather than focusing on deductible facts, measuring variables or locating causality in a positivist paradigm (Gray, 2011). As this research encourages one to think about phenomena as experienced by managers with reference to learning, training and development in a changing service system, the outcomes and propositions are exploratory and indicative rather than definitive, as suggested by Fenwick (2012) in the attempt to understand transitions in professional practice and learning.

Keeping these distinctions in mind and having adopted CGT methodology for data analyses and development of theory, I intend to theorise my research on the basis of studying the

phenomena of MD in changing healthcare service systems (advocating phenomenology) rather than 'studying the different ways in which people experience a phenomena' (advocating phenomenography). While phenomenography was the intention at the Pilot study phase of this research, having established how managers experience the phenomena in different ways and establishing the research context itself, Phenomenology then became of relevance and concern to this research. Since the research hopes that theory will emerge from data to support and theorise Management Development in Services-as-Systems', the use of 'Phenomenology' as the dominant approach to research is justifiable.

5.2.3. Abductive Approach

Using an abductive approach enables one to take up methods that permit theory to developed in light of insights from data, (Dubois and Gadde, 2002). An abductive research approach intends to produce scientific accounts of social life by drawing on the concepts and meanings used by social actors (managers) and the activities (MD and integrated service delivery) in which they engage (Atkinson, n.d.). Abduction (similar to induction) "acknowledges that human behaviour depends on how individuals interpret the conditions in which they find themselves and accepts that it is essential to have a description of the social world on its own terms" (Atkinson, n.d.).

Initially adopting an inductive approach at the pilot phase of the study because an inductive approach enabled me to induce and conclude from data (Blumberg et al, 2014) and to understand phenomena (Miles and Huberman, 1994): particularly, it enabled me to draw out and develop an understanding of the context and issues faced by healthcare managers with regards to MD. The research study thereafter takes up an abductive approach in the realisation that the inductive process is 'likely to entail a modicum of deduction' (Bryman and Bell, 2011, p.13). In other words, as one explores the literature and collect the initial data, one develops conceptions and a conceptual framework (Miles and Huberman, 1994), on the basis of which further data is collected and thought about. The data enables the researcher to reflect and infer from its outcomes and then analyse the conceptual framework proposed. The research task, given its nature must draw a conclusion – an inductive inference (Platt, 1964; Blumberg et al, 2014). Of course, the process respects the genuine theory that emerges 'as is' from the data but this does not eliminate the process of reflecting on and engaging in induction from the conceptual framework.

The use of an abductive approach is further justified by Dubios and Gadee (2002), who suggest that research based on case studies that aim for theory development may be better

when the approach is grounded in an abductive logic based on the systematic and realistic combining of inductive and deductive reasoning. Subjects in the social world engage in abductive reasoning combine both induction and deduction in relation to their surroundings, which Dewey (1971) theorises as a double movement of reflective thought. This research establishes objectives, and questions prior to a pilot study, and then derives from these a main study which, upon its implementation and completion, informs the responses to the objectives and questions, at the same time allowing reflection on these, therefore engaging in an abductive approach. Blumberg et al (2014) reiterates this position that an abductive approach would be appropriate for research whose conclusions (either specific or generic) depend on empirical data. In line with the use of CGT as a method for this research, further support for using the abductive approach comes from Goulding (1999: 18) who asserts the risk of confusing inductive research with grounded theory since the 'very nature of induction as a pure process in itself has been challenged'.

This study therefore adopts the abductive approach, with mainly inductive and partially deductive approaches applied. This is because the research process pragmatically involves using existing theory and a conceptual framework to guide the data collection process and them using the data (and whatever emerges from it as theory) to either inform, explain, support, and contradict existing theory and the conceptual framework (Powell, 2003). Hence, the theory building and theory contribution process or exercise of this research study becomes an abductive process.

5.2.4 Using Constructivist Grounded Theory Method

From the grounded theory perspective, I plan for the investigation to construct what interactants see as their social reality and how their experiences contribute to constructing that reality (Baker et al, 1992; Goulding, 1999). It concerns itself with the 'actual production of meanings and concepts used by social actors in real settings' (Gephart, 2004: 457). Grounded theory as a method is suited to efforts to 'understand the process by which actors construct meanings out of intersubjective experience' and supports making knowledge claims about how individuals interpret reality (Suddaby, 2006: 634). The case for using GT as method for conducting research in management is suited given that management is a social science concerned with how humans generate new ways of interacting and organising:

> *Researchers can best understand new models of interacting and organising by using a methodology that is attentive to issues of interpretation and process and that does not bind one too closely to long standing assumptions. Fortunately, that's precisely what grounded theory is.*
>
> (Suddaby, 2006: 641)

Constructivist Grounded Theory (CGT) seeks to generate theory in areas and provide new insights to existing knowledge about particular social phenomenon (Goulding, 1999) through creating abstract understandings from the data (Charmaz, 2006). What is distinct about constructive grounded theory as method opposed to traditional or classic Grounded Theory (GT) is that grounded theory is constructed through involvement and interaction with the data and participants and the process itself, rather than discovering theory as emerging from data that is separate from the scientific observer (Charmaz, 2014). Traditional GT methods such as Strauss (1987) and Strauss and Corbin (1990) advocate the GT methods towards verification by applying procedures that force data into preconceived categories but also give it positivistic rigor, use GT as qualitative research that enables the quantifying of findings and give outcomes the tendency to be explicit (Goulding, 1999; Breckenridge, 2012 Charmaz, 2014). The use of CGT enables the researcher to obtain fresh perspective and insight on existing knowledge about social phenomenon. One takes a deliberate decision therefore to utilise particularly the CGT approach as opposed to the Strauss and Corbin (1990) approach to GT which is criticised on the basis of purpose, use of prearranged coding, using qualitative data to quantify findings and creating forces conceptualising therefore distorting what may have organically emerged (Stern, 1994; Glaser, 1992; Goulding, 1999). Breckenridge (2012) reaffirms this position by arguing that class GT approach intends to conceptualising into main concern and achieve resolution , is iterative and intends to deduce through specific codes while CGT enables one to present a more diffused theoretical product which does not centre upon a core category (Breckenridge, 2012; Martin, 2006)

Based on the adopted constructivist grounded theory approach, theory generation occurs as the result of researcher and participant exploring phenomena together, where data is created by both the respondent and the researcher being involved and taking into account both the participant's and researcher's understanding of the phenomena (Charmaz, 2006; Mills et al., 2006; Glaser 2002). The approach relies on using qualitative data analysis techniques of grounded theory coding, memo writing and theoretical sampling for grounded theory to emerge (Charmaz, 2006) which I will elaborate on later in the chapter. Rowlands (2005) defends the validity and utility of using the GT as an approach for data analysis where there is uncertainty and lack of clarity surrounding a given problem and a difficulty in explaining it due to its nature. This is empirically demonstrated for example in the use of GT to study how managers interpret the unfolding of organisational change processes (Isabella, 1990)

The decision to adopt CGT as method was made in reflection to comparisons drawn with Interpretive Phenomenological Analysis (IPA) as a method which was considered and explored at early stages of the research. IPA method focuses more on individual experiences of participants and the process of how they make sense of their experiences rather than developing theory that may (or not) support certain concepts arising from a social problem (Smith, 2004; Brocki and Wearden, 2006). Hence there is evidence from studies to suggest diverse applicability of using GT compared to IPA as a method which has largely been limited as a methodology in the Psychology discipline inclined towards deriving themes (Brocki and Wearden, 2006). In line with Smith and Osborn's (2003) and Smith's (2004) arguments, even though IPA methodology is useful when concerned with complexity, it is only useful upto the level of individual experiences and the study of cases but is of little use beyond this for levels of agency and professional organising: the very phenomena managers deal with. Brocki and Wearden (2006: 95) distinguish and compare IPA with GT method to claim that 'while IPA tends to be concerned with divergence and convergence in smaller samples,' GT seeks to 'establish claims for a broader population'. Based on these distinctions, one can take the position that this research concerns itself with the changing nature of what managers practice and how, the organising of their work (i.e. service integration) and their management development of managers, rather than just concerning itself solely with an inquiry about the individual manager being the subject of inquiry. The case for using CGT as a method can therefore be supported.

To conclude this section on a cautionary note, while interconnection has been drawn and the position clarified between the epistemological issues and approaches adopted in this study, Bryman and Bell (2011: 20) suggest that it is important not to exaggerate upon them since 'they represent tendencies rather than definitive points of correspondence. Thus, particular epistemological principles and research practice do not necessarily go hand-in-hand in neat unambiguous manners'.

5.3 Research Design

5.3.1 Research Sample and Unit of Analysis

For this research study, Community Health Partnerships were selected using the criteria of *Population Density* and *Co-terminosity*. This is because population density is important to the manner in which services are delivered by an NHS Board and other service providers

(i.e. Councils) in a given locality, while co-terminosity is an enabler of integration between service providers (i.e. the sharing of resources and/or pooling of budgets between health and social services will be dependent on the degree of co-terminosity between the NHS Board and Local Authority). Commonly in practice, the terms 'Council' and 'Local Authority' are both used to refer to the same organisation. A Community Health Partnership (CHP) typology by Watt et al. (2010) is adopted for this study which classifies all existing Scottish CHPs to fit into one of the following types:

TYPE A	Each NHS Board co-terminous with 1 Local Authority – Having 1 Single CHP
TYPE B	1 NHS Board co-terminous with 1 Local Authority – Geographical area contains 3 CHPs co-terminous with the 1 local authority.
TYPE C	Each NHS Board – covers more than 1 Local Authority – Having multiple CHPs
TYPE D	Each NHS Board - covers more than 1 Local authority – With each Local Authority having atleast 1 CHP that is co-terminous

5.3.2 Using Cases

I adopt a case study approach as it allows for investigating the phenomena in a real life context (Yin, 1994. p.13). A four stage research process (described further on) has allowed me to verify and validate findings in an attempt to generate sound theory. Nevertheless, this research takes the position that case study method is more an 'approach' for organising and presenting data in terms of some chosen unit (i.e. the CHP) rather than case study being a specific data collection technique (Goode and Hatt, 1952). Four cases representing CHPs are presented as part of this research.

5.3.3 Selection of Cases for Study

Based on the Watt et al.'s (2010) classification and typology of CHPs across Scotland, the research selects the four cases ensuring that one of each CHP classification and type is represented. A further two criterias of *Population Density* and *Co-terminosity* are also used ensuring that all cases are representative of these two criteria. These are further explained in the diagrammatic representations below:

Diagram 5.1 below elaborates on the CHP classification and typology (based on Watt et al. 2010) with details of their respective NHS Board and Local Authorities:

CHP CLASSIFICATION AND TYPOLOGY

TYPE A	Each NHS Boards co-terminous with 1 Local Authority – Having 1 Single CHP
TYPE B	1 NHS Board co-terminous with 1 Council – Geographical area contains 3 CHP's co-terminous with the 1 local authority.
TYPE C	Each NHS Board – covers more than 1 Local Authority – Having multiple CHP's
TYPE D	Each NHS Board - covers more than 1 local authority – With each Local Authority having atleast 1 CHP that is co-terminous

TYPE	1 NHS Board that represents	No. of Local Authorities	No. of CHP's	Co-terminosity
A	Case D	1	1	Exclusively
B	Case A	1	3	Exclusively
C	Case B	6	10	Not Exclusively
D	Case C	3	3	Not Exclusively

Diagram 5.2 below elaborated on how each case fits in to the four different case classifications and typology using the criteria's of Population Density and Co-terminosity.

Case Selection Criteria

		CO-TERMINOSITY	
	POPULATION DENSITY	*Exclusively Co-terminous*	*Not Exclusively Co-terminous*
POPULATION DENSITY important to the manner in which services are delivered by an NHS Board and other service providers in a given locality	*Semi Rural*	(Type A) **Case D**	(Type D) **Case C**
CO-TERMINOSITY an enabler of integration between service providers (i.e. the sharing of resources and/or pooling of budgets between agencies may depend on the degree of co-terminosity).	*Urban*	(Type B) **Case A**	(Type C) **Case B**

5.3.4 Case Profiles

As previously mentioned, Community Health Partnerships (CHPs) were established by NHS Boards as a mechanism through which community health services are planned and delivered (Watt et al., 2010; Scottish Government, 2010). The history and purpose of these CHPs was discussed previously in chapter two and as these CHPs exist in various arrangements, the typology by Watt et al. (2010) is used to classify each one which has been done earlier in this chapter.

The intention of this section is to provide background information to each CHP Case so as to give the reader an overview of the CHPs arrangement and direction. For convenience, the cases are referred to as CHPs where they are a health only structure and as CHCPs where they are in a health and social care structure. Irrespective of this different types, all CHPs are statutory committees or subcommittees of the NHS Board and therefore accountable to the NHS Board (Audit Scotland, 2011). Going into the future, once these CHPs and CHCPs integrate into legal entities upon the enactment of the Public Bodies Joint working bill, they are then referred to as CHSCP. It is unknown at the time of writing this chapter as to what these different CHSCP's will be actually be named by the actual organisations.

Case A

Case-A CHP is one of three CHPs serving a region, all which fall under the accountability of an NHS Board that serves Scotland's largest region. The Case-A CHP comprises a CHP Committee to ensure that the NHS Boards strategic and operational objectives can be met by engaging with local communities to improve health and deliver more integrated health and social care. The committee comprises of non-executive NHS Board members as well as elected members of the Local Authority and members of the Public Partnership forum (Case-A NHS, 2013).

Partnership arrangements between health and social care are complex in Case-A CHP and this CHP has more an operational role rather than a strategic role (Audit Scotland, 2011). Both the NHS Board and Local Authority have established Local Management Units which are responsible for joint working between both organisations at the operational level to manage and deliver integrated services in localities. The CHP manages selected primary and community care services for their given geographical coverage but also coordinates particular region-wide services that overlap with other CHPs (Audit Scotland, 2011). Therefore, the structure for management and coordination responsibilities remains quite complex.

Changes with respect to future integration between health and social care and the implementation of the Public Bodies Joint Working Bill in April 2015 is expected to simplify structural arrangements for the region as the three separate regional CHPs will merge into a single CHSCP, which along with the NHS Board, will be exclusively co-terminous with the one Local Authority serving the region. Currently, a Joint Shadow Integrated H&SC Board is in place that actively plans for future partnership arrangements and an Interim Director for H&SC integration has also been appointed responsible for overseeing planning and reporting by the Joint Shadow Board. The focus of this is largely around multi-agency working for children's services (i.e. the Early Years Collaborative) and around adult health services (Case-A NHS, 2013). Input from the Joint Improvement Team (an integrated T&D provision agency set up between Scottish Government and various public service sectors) is utilised by the Joint Shadow Board for supporting shadow board members in the planning for integration (Case-A NHS, 2013). Case-A CHP remains largely active and involved in the planning and implementation of H&SC integration.

Case B

Case B CHP serves a large urban population and previously existed as part of a CHCP arrangement which was dissolved in 2010. This was owed to the lack of approval and implementation of a shared vision for a CHCP but did not provide clear details of services and budgets that were to be devolved by partners (Audit Scotland, 2011). Further to this, there were tensions between the desired strategies of both Health and Council organisations. Following the dissolution of the CHCP arrangement, a single CHP model was implemented in 2010 and which presently exists (Audit Scotland, 2011)

It can be ascertained from observation that Case B has reverted to a "commission" model between itself, the Council and other voluntary organisations and continues to build upon a long history of successful networked service delivery and successful joint working through separate organisation arrangements that come together within the existing CHP structure. Senior management however believe that past service integration was unsuccessful and that the network collaboration model better serves local interests. Good working relationships between Health and Council service managers have prevailed as a result of past joint working in a CHCP structure. Managers see no intrinsic benefit in multi-agency teams or integrated service structures, though the Public Bodies Joint Working Act (Scottish Government, 2014) will encourage closer planning and implementation in the future. Case B remains fairly active through Public Partnership Forum executive groups that try to encourage public participation and intend for user involvement (Case-B NHS, 2014). The

CHP has a centralised management model and a wide range of technical and organisational management arrangements. It seeks to utilise its existing organisational structures for delivering successful joint services.

Case C

In Case C, both the NHS Board and Local Authority partners in the Community Health Partnership which jointly delivers primary health and social care using an integrated service model that encourages service user participation in the design and delivery of their services. The creation of this CHCP builds upon a long history of effective joint working between health and social care. A Joint Board composed by Health Board and Local Authority nominees establishes strategy, which is implemented by an integrated management team. The CHCP is a well-established partnership for the delivery of health and social care services and manages a substantial range of services including community care, children services, criminal justice and mental health among other services (Case-C CHCP, 2015). The CHCP coordinates the planning, development and implementation of efficient health and social care services with a particular focus on local communities as part of a plan to modernise public services (Case-C NHS, 2015). Given a strong history of joint working and an ability to cross boundaries, this CHCP represents an advanced model of a CHP and has a voluntary CHCP partnership agreement in place that specifies joint governance and accountability arrangements of deliver jointly managed services. Budgets are delegated to the joint board and effective aligned budgetary arrangements are in place (Case-C NHS, 2007). A CHCP Partnership Board is in place with equal board representation from both Health and Council that governs the work of the CHCP. A joint CHCP management team is also established ensuring the effective management and involvement of frontline staff takes place. This joint CHCP management team is headed by a Joint Director who reports and is accountable to the joint CHCP Board also comprises a Head of Health Service and Head of Council Service. Service users and third-sector partners are members of the numerous inter-agency advisory groups. With commitment to service integration, Case C encourages inter-agency team working, devolved responsibilities and co-location of services, managers and staff.

Case D

Case D defines its existing corporate objectives as 'continuing to face the challenges of changing demand and significant financial pressure' while ensuring that it 'remains at the forefront of implementing innovation and new ways of working so that health service remain as local and responsive as possible' (Case-D NHS, 2015). Its service objectives are to deliver

safe effective and high quality services while promote excellence in organisational behaviour (Case-D NHS, 2015). The Case D CHCP was established as a partnership board in 2005. It was set-up as a subcommittee of both the NHS Board as well as the Council Executive. The partnership board has been accountable to both the NHS and Local Authority and has the role of setting a strategic vision, agree to a strategic plan for community health partnership working, to monitor performance against national targets and ensure that structural and cultural barriers to joint working are minimised (NHS, 2015). The functions allocated to the CHCP include governance arrangements of services delivered by organisations and stakeholders for adult and older people, mental health, learning disability and children's services (Case-D NHS, 2015). A Joint Planning and Delivery group is also in place to ensure that the CHCP is supported in the development of strategic plans for these functions. In 2013, both the respective NHS Board and Council have agreed to the establishment of a Pathfinder Board and an appointment of a Programme Director to lead the arrangements for integration of health and social care in line with forthcoming legislative requirements. This Pathfinder Board becomes responsible for assessing the detailed arrangements required for integration in the given area. For the future, to progress further with the planning for integration, a Shadow Board is envisioned to replace the existing Pathfinder Board by 2014 followed by the start of an Integration Board in 2015 once legislation in implemented (Case-D NHS, 2014). It is intended that March of 2015 onwards, once statutory requirements come into effect, the CHCP board will be adopting a new formation. It is currently expected that consultations on a strategic commissioning plan and agreement to this strategic plan by the integrated joint board of the forthcoming CHSCP will occur by October of 2015 (Case-D NHS, 2015).

5.3.5 Sample

I sought to obtain a sample from a population of middle to senior level service managers engaged with working in CHPs across the four selected cases. Participants were identified and recruited via a process of contacting the respective NHS Boards and CHP committees with information about the study. This was done via formal written requests through the post where participation was invited from managers involved with managing and delivering health and social care services in CHPs. In the formal written request, I developed a criteria on basis of which the NHS Board could make suggestions for participants. These suggested criteria were:

1. Managers with three or more years of work experience involved in managing

processes, work, tasks, and/or people as part of their role *AND*

2. Who are engaged in working with a Community Health Partnership.

This ensured a relevant sample could be obtained and (hopefully) eliminates opportunistic recruitment of participants (i.e. taking whoever you can get).

Responses to this formal request were received back from respective NHS Board administration and CHP Committees who recommended names of potential participants that could take part in the study. I then looked into the job titles of these potential participants to further ensure that their work related to the delivery of healthcare services in CHPs. In some instances, managers were pre-selected by the NHS Board to take part. In other instances, contact details of suitable participants were provided along with permission to approach them to seek participation. In both cases, I corresponded with participants to try and ensure their work was related to what I was attempting to investigate and in order to eliminate any opportunistic recruitment and bias in terms of suggested participants. These participants were then directly contacted and liaised with over time. Partially, snowball sampling (Bryman and Bell, 2011) was also done where these participants who were relevant to the research topic were used to establish further leads, make contact and gain access to additional suitable participants within each NHS Board (keeping to the same selection criteria as before). Using this method helped eliminate bias and ensured the sample further recruited was relevant to the study.

In total, 60 respondents were interviewed as part of this study. Of these 60 respondents:
- 3 were interviewed in Phase 1 as part of the pilot study
- 37 were interviewed for Phase 2 in the form of individual interviews
- 19 were interviewed for Phase 3 as part of the focus groups.
- 1 was interviewed for Phase 4 as part of an open discussion interview

For Phase 3, managers who had participated earlier in Phase 2 became the participants of the focus groups while two new participants were inducted. In Phase 4, a senior executive (field expert) engaged with the Management Development of public service managers in healthcare was interviewed.

Having collected data using 60 respondents across four phases, the study develops a reasonable and manageable sample size which is essentially exploratory and intends for a rigorous and somewhat longitudinal data collection process that can support the emergence

of reliable findings and new theoretical insights. I argue that the study comprises a longitudinal element because managers who participated as respondents for Phase 2, were also inducted as participants into Phase 3, with both phases occurring over a period of 1 year. The two stage process enabled ideas to be built and developed with respondents over the course of two study phases.

For phase 2 in which 37 respondents were interviewed, 22 respondents are used and reported as part of the study while 15 interviews were eliminated. This was done for the following reasons:

- Certain interviews revealed nothing useful or new in relation to the inquiry being made.

- Certain interviews deviated from the interview objectives and questions (e.g. ended up in conversations about clinical care and hospital wards) and therefore become irrelevant.

- In some other instances, respondents were discovered not be working with health services in CHPs, which made the interviews irrelevant (e.g. a respondent interviewed was associated with work in housing services rather than health or social care services).

Below, I provide the details of respondent sample used and reported for the main study (Phases 2, 3 and 4). Details of the respondents for Phase 1 are provided in Section 6.2 where the Pilot Study is explained exclusively.

PHASE 2 COGNITIVE INTERVIEWS		
CASE	**RESPONDENT**	**POSITION**
Case A	R1	Director of Organisational Development
	R2	CHP Manager
	R3	Head of Physio Services
	R4	CHP Localities Manager
Case B	R5	Head of Special Children Services
	R6	Head of Primary Care and Community Services
	R7	Head of Organisational Development
	R8	Head of HR
	R9	Localities Service Manager
	R10	HR Director
Case C	R11	Social Care Service Manager
	R12	Primary Care Manager
	R13	Business Manager
	R14	Head of Health Services
	R15	Head of Council Services
Case D	R16	Clinical Director
	R17	Associate Medical Services Director
	R18	Alcohol & Drugs Partnership (ADP) Manager
	R19	Head of Service Improvement
	R20	Head of Children's Services
	R21	Joint Manager Learning Disability Service
	R22	NHS Head of Planning and Performance

PHASE 3 FOCUS GROUPS		
CASE	**RESPONDENT**	**POSITION**
Case C	R23	Head of Council Services
	R24	Head of Health Services
	R25	Social Care Services Manager
Case B	R26	Head of Primary Care & Community Services
	R27	HR Director
	R28	Head of Organisational Development
Case D	R29	Head of Children's Services
	R30	ADP Strategic Coordinator
	R31	Associate Director AHP's
	R32	Associate Medical Director
	R33	Associate Medical Director
Case A	R34	Head of Physio Services
	R35	Ex Deputy General Manager
	R36	CHP Localities Manager
	R37	Head of Health Improvement
	R38	Associate Nurse Director
	R39	Director of Organisational Development
	R40	Head of Learning & Development
	R41	CHP General Manager

PHASE 4 OPEN-ENDED INTERVIEW DISCUSSION	
RESPONDENT	**POSITION**
X1	Head of Management Development

5.3.6 Phases of Study and Data Collection Process

Phase 1 of the study (a pilot study) involved interviews with three participants across two NHS Boards. The purpose of this was to gain early ideas, explore issues related to management in the NHS and to identify a suitable context for this research study. The pilot also enabled me to revisit the research questions of this research study, improve and refine them. The details of the Pilot Study are discussed in the next section.

Phase 2 of the study involved conducting interviews with participants across the 4 cases. As part of the main study, the purpose of these interviews was to explore issues and gain insight based on the research questions established for this research. This phase of the study uses and reports responses from 22 participants. A sample of the interview transcript used for this phase is provided in Annex C

Phase 3 of the study involved conducting focus groups with participants across the 4 cases. As part of the main study, the purpose of these focus groups was to further explore ideas, gain depth and clarity, and build further on ideas which emerged from Phase 2. When conducting the focus groups, participants were given an overview of the case related outcomes from Phase 2 so that further discussion on emerging issues could be encouraged. This phase of the study uses and reports responses from 19 participants that comprised five focus groups. One focus group in Case B, one in Case C and one in Case D were conducted. For Case A, two focus groups were conducted. This was due to the large number of participants in Case A and due to difficulties in coordinating the availability of participants. A sample of the interview transcript used for this Phase is provided in Annex D

Phase 4 of the study involved conducting an open-ended interview with 1 participant who was a senior executive leading the Management Development function at a leading national T&D providing institute which offers services to the NHS. This interview was treated as an open discussion where the participant, treated as a field and subject expert, was asked questions based on an interview transcript used on Phase 3. Alongside this, the participant was provided the emerging outcomes from Phase 2 and 3 of the study and asked to reflect on these alongside answering the discussion questions. The purpose of this study phase was to gain reflection on the findings from Phases 2 and 3 and explore an external and detached perspective on issues and ideas that was different to that of managers. This also intended to generate alternative and conflicting ideas. The participant was treated as a subject and field expert because over a long and diverse career, he/she had been involved with the NHS in various capacities which included working as an allied health professional, a senior service

manager and a T&D provider. A sample of the open-ended interview transcript and the emerging outcomes shared with the field expert are provided in Annex E

The following table provides an overview of each phase of the study and the data collection process.

Stage	Process	Sample Used	Rationale
PHASE 1	Conduct a Pilot study with healthcare service managers	3 Participants across 2 NHS Boards	To gain early ideas, explore issues and identify context.
PHASE 2	Conduct in-depth cognitive interviews with Service Managers across the 4 Cases	22 Participants working across 4 CHPs	To explore issues and gain insight.
PHASE 3	With the same service managers from Phase 2, conduct focus group sessions	19 Participants in 5 Focus Groups conducted across 4 CHPs	To gain further insights, explore further issues and build on the outcomes from Phase 2
PHASE 4	Open-ended interview discussion with a field expert	1 Senior Executive, based at a national T&D providing institute which offers services to the NHS	To gain reflection on findings from Phase 2 & 3; explore an external expert perspective; generate alternative and conflicting ideas

5.3.7 Data Collection Tools

5.3.7.1 Cognitive Interviews

Cognitive interviews were conducted in both Phase 1 and Phase 2 to develop conceptions. This involved getting detailed accounts of managers experiences making it a data collection method best suited to the phenomenography approach (Willis et al, 1999). Tourangeau (1984) argues that cognitive interviews enable a process whereby comprehension of the question and retrieval of relevant information from memory are aided. I intend to treat interviews as open discussion sessions where by the participant and I can discuss relevant themes in depth and where I can gather detailed accounts and stories of managing in their respective organisational settings. Within the cognitive interviewing method, probing as a technique was adopted to gain the advantages of maintaining control and order of the interview and train the interviewee to offer spontaneous thoughts, critique and insights (Willis et al, 1999) Certainly, recognising the limitation that one cannot know absolutely about what transpires in a respondent's mind as he or she answers an interview question, therefore the tool encourages the interviewer to give prompts and cues to the individual to reveal information and insights.

5.3.7.2 Focus Groups

Focus Groups were conducted in Phase 3. These were held to generate discussion and gain in-depth understanding of the experience gained by managers through the change process in their respective organisational setting. Bryman and Bell (2011) highlight the focus group as a tool that allows experiences to be captured in a group interview in relatively unstructured ways and with the use of the researcher as a facilitator to guide and moderate the sessions.

5.3.7.3 Open-ended Interview Discussion

An Open-Ended Interview discussion was conducted in Phase 4. A subject and field expert's insights were explored and reflections on Phase 2 and 3 outcomes were gathered. This was essentially a cognitive interview method applied, however the interview was treated as an open discussion through which new ideas and in-depth reflections could emerge.

5.4 The Pilot Study

5.4.1 Pilot Study

The initial literature reviewed created an interest in understanding the nature of management and the evolution of approaches to 'management development' in the UK health services sector. It is of interest to me how NHS managers working in health services delivery perceive the influences that management development has had on them. Particularly I am interested to explore 'managerial learning' as a phenomenon that managers experience and understand in their different ways.

5.4.2 Purpose

The intention was to conduct a small scale pilot study in which middle managers for themselves can explain the issues and challenges they faced in healthcare service delivery and to be able to identify a suitable and most relevant context for the study so as to make it a situated one. The pilot study also aimed to gain some early insight about how management development (both formal and informal) as managers have undertaken impacts on their work and attitudes towards issued in delivering healthcare services. Hence, managerial learning and development at the individual manager level became central at this point and the semi-structured interviews were aimed at capturing managers own accounts and experiences of what they do, how they do it and their learning development. It was through this process that context could be derived from this study based on the narratives of their own work life experience. The intended purpose for conducting this pilot study therefore was to explore

more specifically what management in the NHS was about; how service managers did their job and how they perceived their roles during the change context identified as part of the pilot.

The pilot study concentrated at the level of the individual service manager in the NHS. At this early stage and based on limited knowledge available through secondary research about the role of these service managers, the mid-career managers that were interviewed served in different localities across Scotland. There remained a lack of clarity as to the context in which these service managers operated. The Pilot Study in light of broader issues generated from the literature review intended to establish the present management context in which service managers operated and gain some insight into the work of managers and their learning, training and development. The pilot study intended to gain an insight into important ideas and issues that could serve as the bases of designing a sound main study inquiry that was grounded in real world contexts and the actual pertaining issues of service managers and health care service delivery.

5.4.3 Approach

This early stage pilot study involved conducting interviews with three middle managers based within the NHS Scotland who were selected using the following criteria developed to provide respondents that aligned with the interests of this research topic.

1. Engaged in public/community health service delivery.
2. Have experienced or undergone MD in the NHS.
3. Responsible for engaging with processes and people in their managerial role.
4. Engaged in and/or have experienced L&D evaluation in the workplace

5.4.4 Method

This pilot study engaged with an Ocular Scan method (Bernard, 2000) as a method which involved reading carefully through texts and analysing them by highlighting and marking key phrases in texts using different coloured coding. The basis for doing so as supported by Sandelowski (1995a) was to analyse texts and underlining important phrases that made sense after being reviewed multiple times. This generated a feel for the text and handling the text multiple times, until eventually patterns began to emerge between the data by constant comparing and contrasting (constant comparison method) across the data (Glaser and Strauss, 1967; Strauss and Corbin, 1990) until common categories or themes emerged as an outcome. In the process, constant comparison method (Glaser and Strauss, 1967:101) was

applied and the emerging of these common themes involved initial coding followed by careful paragraph-by-paragraph coding and analysis as a grounded theory method (Strauss and Corbin, 1990: Charmaz, 2006) keeping in mind throughout the process the question of 'What is this About' which helped to keep the task focused (Charmaz, 2006). To summarise the methodology for the pilot study, one can admit in practice that a thematic analysis has been carried out using grounded theory technique.

5.4.5 Sample and Exploratory Questions

The pilot study using cognitive interview method (described above) interviewed three healthcare service managers across mainland Scotland NHS Boards using four broad exploratory discussion questions derived from the literature review.

PHASE 1 PILOT STUDY	
Participants	**Exploratory Pilot Questions**
Surgical Trainee (R1) NHS Board A Public Health (R2) Consultant, NHS Board A Single Point Access Service Manager (R3), NHS Board B	1. As a manager working within the NHS, can you highlight the work activities you typically engage in? 2. What do you deem to be the most significant influences on your learning as a manager? 3. How do you see these influences as having worked or working, to what effect and how? 4. How do you view and understand the evaluation of your learning and development?

A fourth participant (a joint service manager) was also interviewed for this pilot study but could not be included due to the decision by the concerned NHS Board to opt out of participating in this research study.

It was intended that this Pilot Study phase would inform the design of the main study by lending it both content and methodological validity as well as enabling a research study design that was relevant to real world problems. More details about the pilot study and its findings are reported in Chapter 6.

5.5 Data Analysis

I have argued that adopting Grounded Theory as a method to data analysis is embedded in the Abductive approach described earlier since the goal of CGT is to describe and understand how subjects experience phenomena and understand the phenomena itself within a particular context relative to a specific research question. Even though theory is emergent

from the data, the research process and the researcher possess expectations as set out through objectives and research questions: hence an inquiry. Furthermore, Gregory et al. (2012) suggest that Grounded Theory enables one to support interpretation with evidence from data and is applicable to study topics other than individual experiences such as social processes and relationships.

This section discusses the procedures used to analyse the data for the main study in Phases 2, 3 and 4 and describes the process by which the findings were reached. Procedures to analyse the data are adopted (rather than strictly applied) from CGT as a method based on suggestions for data analysis by Charmaz (2006: 2014) and Burnard et al. (2008) which involve steps of initial coding of data, developing a focused coding framework, making sense of the data and generating categories. These multiple categories are used in the way of theoretical coding of the data again until they can be consolidated depending on what theory emerges from the data. These then enable one integrate the final categories into broad themes that are used as a way of sorting and presenting the findings. I discuss each of these data analysis steps further.

5.5.1 Initial Coding of Data

The coding process is critical to move from the stage of having data in hand to developing emerging findings and theory. Grounded Theory coding which involves the first stage of initial coding means that data segments can be categorised with short names or sentences (the initial codes) that summarise segments or pieces of data (i.e. the interview). When doing this I have looked for important issues, interactions, evidence, examples, opinions and behaviours: all which can provide some insight to the questions being asked in the interview (either individual or focus group).

At every instance where data is seen to be relevant and important, I have generated an appropriate initial code. An initial challenge faced when doing initial coding was the decision to do coding on a line-to-line basis, on sentence-to-sentence basis, on the basis of paragraph-to-paragraph or incident-to-incident. In engaging with the process, one realistically coded on a sentence-to-sentence and paragraph-to-paragraph basis while also using constant comparative method (Glaser and Strauss, 1967) to make distinctions and comparisons in my analysis. The purpose of going through this stage of initial coding of data is that one can begin crystallising participant's opinions and experiences (Charmaz, 2014).

As an extensive number of initial codes were generated in the first round of data analysis, many of these codes were repetitive and duplicated and therefore, any such codes were either eliminated or combined into one to reduce the extensive number of codes. This then enabled us to develop a comprehensive initial coding framework with initial codes that could be most purposeful (see Annex F for the initial coding framework). The data was analysed further with a second round using the initial coding framework.

The process of memo-writing (Charmaz, 2014) alongside doing the initial coding was also adopted as this enables the researcher to make a note and record of important issues along the way as the coding process can become cumbersome and repetitive.

As a researcher, I was challenged by the question of when or at what stage to stop the initial coding process. Suggestions to address this question were taken from Barbour (2008) and Charmaz (2014) who advise that at the point where no new insights or issues are being revealed and when no significantly new and different initial codes are being produced, is the point at which the researcher may consider ending the initial coding process. It is at this stage that the analysis of the data has been exhausted. The process of doing this initial coding was done manually rather than through the use of coding software as this enabled one to exercise judgement with reason and openness. It also enabled one to be flexible in terms of how the coding could mapped onto the data using different colour pens and markers enabling one to differentiate between ideas and sets of data.

5.5.2 Focused Coding

At a next stage of the data analysis procedure, I engaged with focused coding which meant using the most significant (and frequent) codes from the initial coding framework to scan and code through the data. In doing so, the intention here was to make sense of what codes would seem to make most analytical sense to categorise the data completely. Further to this, key here at this second stage is to collect these initial codes and the data that has been separated into a fresh set of papers and go a stage further (conducting a third round of coding) to look for overlapping and similar categories, which Burnard (2008) refers to as a final coding framework but which Charmaz (2014) refers to as a second stage of analysis through focused coding. Through comparing the data these codes are generated and the initial coding framework guides this. Then the data is compared against these focused codes enabling one to refine them further. This is a back and forth process which results in a set of new and refined 'focused' codes informed by (and a result of) insights from the data. These are then organised into a focused coding framework (see Annex F).

Data was then further analysed for a fourth round using the focused coding framework, however at this stage one begins to connect the ideas and comparisons from the data and this enable theoretical categories to emerge.

By this stage, important issues and theoretical ideas from the data have enabled one to generate categories. What becomes important here is to distinguish that in the process of using focused coding to extract theoretical ideas and comparisons in the data, the categories and subcategories which result are emergent. They arise naturally from making sense of the data and from understanding the connections between ideas from cases and participants). This emergent process as per CGT method is the differentiating point from classic GT method application where axial coding is used instead (Strauss and Corbin, 1998) that uses a strict procedural application to attain *derived* categories rather than *emergent* ones (Charmaz, 2014). The axial coding process relies on a set procedure of using conditions; actions; consequences to answer questions such as why, where, how come and when before categories can be generated. In my view, such strict procedure to generating categories (which otherwise naturally emerge from the collective responses of individuals) restricts vision and organic findings. The procedure purposefully tries to eliminate tolerance for ambiguity that comes naturally to a qualitative exploratory study. This is particularly the case when one is exploring phenomena such as management and management development that involve subjectivity, intuition and contested processes.

5.5.3 Categories and Theoretical Coding

Categories that emerge from data as a result of focused coding and ideas generated have been used further to revisit the data and derive and integrate further meaning and perceptions. In other words, these categories when used to code and filter through the data enable one to tell a coherent story that is analytical (Charmaz, 2014). I use these categories as a means of coding the data on the basis that the substantive analysis upto this point where categories have naturally emerged. In other words, these categories as codes have earned their way to the analysis and the grounded theory (Charmaz, 2014). On the basis of the analytical and theoretical ideas that develop through this theoretical coding, the categories are further refined and reduced in number by being grouped together (see Annex G for the framework of categories used for theoretical coding).

These categories are reliable as a means of drawing insights and generalisations from the cases and the participants. In applying this procedure, I have used the categories both for coding data and have used them to also divide up all the data transcripts and allocate each of

the categories its own coloured marking pen working through the data (transcripts) that fits into each category and colour coding accordingly. The filtered data which is relevant to the theory that has emerged from the multiple stages of coding, is then cut out and arranged under themes. I describe this next step further below.

5.5.4 Collating Categories into Themes

Using the categories as a tool to do theoretical coding, followed by the dividing up of data and colour coding them under each category, results in achieving an organised dataset which can then be used to report the findings (Burnard et al., 2008). However, it is at this stage that the categories are conceptually grouped into five main themes. This becomes a requirement in order to be able to group findings and the emerging theory in a manner that can be manageable and presentable. Presenting the findings and emerging theory otherwise under each of the categories would mean extensive sections of findings being presented as well as having to deal with an overlap of categories and findings being presented. Consolidating the categories into appropriate conceptual themes (and sub-themes) allows for clarity of the ideas presented and provides a concise structure in which to present the findings, analysis and discussion of the research study. See Annex H for consolidating of categories into themes.

In the data analysis process, going from the stage of '*categories for theoretical coding*' to the stage of '*collating categories into themes*' is a variation to the traditional CGT method approach. The CGT approach instead makes suggestions for moving from the stage of theoretical coding to the stage of theoretical sorting and diagramming. Essentially, my data analysis process has moved from theoretical coding to theoretical sorting. However, the only difference is that of terminology and tool. I instead use themes as a means of moving from the stage of theoretical coding to theoretical sorting, rather than using diagramming as a way of doing this. The themes allow me to do exactly that what theoretical sorting intends for: 'a means and way that provides logic to organising the analysis and a way which creates theoretical links which prompt the researcher to make comparisons between categories' (Charmaz, 2014: 216). Using themes to structure our findings while applying grounded theory analysis can be further supported based on Boyatzis's (1998:4) argument that thematic analysis is "not another qualitative method but a process that can be used with most, if not all, qualitative methods" and is an approach that caters to flexible approaches in the doing (Gregory et al., 2012). Constructivist Grounded theory being iterative sits well with thematic analysis because grounded theory as a set of methods consist of systematic yet

flexible guidelines for collecting and analysing data to construct theories grounded in the data themselves (Charmaz, 2006:2).

Rather than using narrative account or diagram as a way to sort my findings and theoretical propositions, I use themes as a way to do it. For this study, themes provide a sensible means through which categories can be collated and provides the adequate structure through which to present the findings of each phase of the study that were subjected to the data analysis process. These emergent theoretical themes are used to organise and present the findings, analysis and discussion chapters of this study.

5.5.5 Review of the Data Analysis Approach

A criticism that may be levelled at the data analysis approach used can be that it is ambiguous as to how the researcher assesses which categories (or theoretical codes) best fit: both within the framework of categories and then into a theme. In other words, the ambiguity lies precisely between application and emergence (Charmaz, 2014:151). Bryman and Bell (2011) suggest this as a potential problem of coding where loosing context or meaning may occur.

However, I take the view that when one assesses analytical styles and toolkits for how data analysis can be done, one discovers 'fads and trends' among them: prescriptions for how to do that are simply 'black and white' or 'the right way to do' do not match how data analysis is actually done by the researcher. The actual doing of data analysis is complex, at times unclear and contradicting because the researcher attempts to apply methods that can best suit interpretation while trying to adopt prescribed data analysis methods that get treated as simplistic yet complete. Charmaz (2014:153) supports this position arguing that 'fads and trends' limit the way of seeing what is emergent and perhaps force data into boxes. They limit one's ability to describe and explain data analysis as it has actually been done. As a researcher engaged in the process of analysing the data and being close to it, one can only use data analysis methods as sound guideline as to how one can or should go about analysing data. Therefore, I have described the data analysis process and procedures exactly as I have done them with guidance and adaptation from suggested methods of CGT. Below I present a flow diagram of the data analysis process discussed in this section.

5.6 Use of Data in Thesis

As described in the previous section, through the process of coding at different stages and then utilising categories as a tool to theoretically code followed by the dividing of data via

colour coding using the categories, one results in a distilled set of relevant data worthy of reporting and supporting the findings (and its narrative account). This process is further refined and data re-organised when the categories are consolidated into main themes and subthemes that are used both in the way of structuring the findings, the in-case and cross-case analysis. The process of distilling the data as described previously has enabled me to concentrate the analysis contained around themes that have emerged from the distillation. This process is presented in Annex G and H, as highlighted in the previous section.

In addition to this, I have also set out in annex I, samples of the data from the Phase 2 interviews, Phase 3 focus groups, and Phase 4 open-ended interview discussion. These show samples of how the data was processed at each of these stages.

5.7 Research Considerations

5.7.1 Reliability

Reliability is concerned with whether the results of the study are repeatable and whether measures that are devised in the research are consistent (Bryman and Bell, 2011). The research draws upon issues and questions derived out of a particular context as a result of the pilot study. This gives the measures (areas of exploration, research questions and interview questions in this case) consistency on the basis that what was being enquired was relevant to the context at the time. The research study relies on 4 cases (even though explored and examined in depth), but intends to represent other CHP cases and service managers across Scotland at the time of its implementation. It can therefore be considered as being representative of the population and the results of the study may be repeatable when implemented across other CHP cases in the Scottish healthcare service.

5.7.2 Validity

Bryman and Bell (2011) describe validity as being concerned with the integrity of the conclusions of the study. Particular to this research, *internal validity* relating to the issue of causality is achieved in this study since the findings and analysis highlight causal relationships on various fronts. Examples of this are where the past experiences of managers in joint working influence their perceptions about future service integration and affects their ability to plan for it. Or that the managerial remit begins to transform as a result of managers beginning to take on tasks and responsibilities and teams from other agencies when in a formal partnership. Regarding the *external validity* of this study, which is the concern

whether the results of the study can be generalised beyond the specific research context, this research study explores the changing nature of management in a public healthcare service that is moving towards integration and assesses how the remit of the manager and their development are altered as a result. The findings provide insights and outcomes that are useful, relative and therefore generalisable to other public services contexts across countries where there are universal health service organisations attempting integration models in response to austerity and rising service demand. The generalisation of this research study is discussed in more detail in Chapter 8 of this thesis.

5.7.3 Limitations

As with any research, there are bound to be limitations, many of which are discussed in the last chapter of this thesis. Limitations with respect to the research design and implementations are as follows:

- The cases studied in this research are specific to the healthcare service and the public sector. It therefore may not be generalizable to other contexts outside the public sector since other sectors were not included in the study.

- As the study intended to research NHS organisations and gain the participation of health service managers, the process of attaining permission to conduct the study in each case setting required a series of communication, permissions and approvals from ethics committees of each respective NHS Board. This was necessitated even where the study did not involve any patient participation or the revealing of any sensitive, restricted or confidential NHS data. Getting permission for access to conduct this study was therefore a laborious and time consuming process.

- Even though all participants signed consent forms with confidentiality agreements enclosed that could ensure anonymity, there were limits to how much detail they wanted to reveal with reference to specifics about programs, performance and future planning.

- The qualitative research study is one that is descriptive, exploratory, and conducted within a particular setting. This leads to theoretical insights that are context dependent and based on the data that was collected. Such research would need to be adapted for other settings in order to gain more insight and perspective into the issues that emerge and to further validate its theoretical propositions.

5.7.4 Ethical Considerations

In conducting a research study of this scale, one ensured that particular ethical considerations based on Blumberg et al. (2014) and Barbour (2008) are taken into account and complied with. These are as follows:

- The desire for confidentiality of CHP Cases, the NHS Board and participants were respected and treated with professionalism ensuring that anonymity was maintained

- It was ensured that nothing personal or sensitive was communicated at any point of the thesis that may have negative impact upon the organisations, managers and the research community.

- Approvals for access to cases and participants were respected and complied with.
  It was intended at all times that the research participants be treated with respect and their time valued while ensuring that they were approached and engaged through the proper channels. It was also ensured that communication with participants was appropriate and prompt whenever they required clarity or information.

5.8 Summary

This chapter has outlined and discussed the research methodology of this study, covering aspects of its research philosophy, methods and the overall research design. The approach to data analysis has been discussed and research considerations have been addressed. Table 8, below presents an overview of different aspects discussed in this chapter and summarises the research methods of this study. In the next chapter, I present and analyse research findings.

SUMMARY OF RESEARCH METHODS		
EPISTEMOLOGICAL STANCE	Constructivism	Meaning in the social world constructed (rather than discovered) by subjects in their different ways in relation to the same phenomena. Ties closely with Interpretivism (Gray, 2004; Blumberg et al, 2014)
RESEARCH PERSPECTIVE	Sociocultural	Learning arises from interaction developing between people and the culture in which they operate (Vygotsky, 1978; Cherry, 2015)
RESEARCH POSITION AND ONTOLOGICAL CONSIDERATION	Social Constructivist	Knowledge constructed through social groups and not just by individuals. Therefore, Organisations and Management Development are social constructions not independent of actors that function in them (Lupson, 2007)
RESEARCH APPROACH	Phenomenology Abductive	How individuals make sense of the world. Embedded in a anti-positivist position. Attempts to under social reality and phenomena grounded in the experience of individuals (Gray, 2011) Research outcomes/conclusions result from the data (inducing). But are also being viewed and judged against some research expectation/objective (deducing from the inquiry)
METHOD	Constructivist Grounded Theory	Generation theory and providing new insights to existing knowledge about social phenomenon. Exploring the nature of different phenomena based on established claims from a population of managers. Outcomes become grounded in the data. (Charmaz, 2014; Brocki and Wearden; 2006)
RESEARCH SAMPLE AND UNIT OF ANALYSIS	CHP Cases and Service Managers	Selection of cases based on a criteria with Population Density and Co-terminosity. Participants recruited through formal outreach to NHS Boards. Interviews with middle to senior level managers across 3 study phases followed by an interview with a subject and field expert.
DATA COLLECTION TOOLS	Cognitive Interviews; Focus Groups; Open-ended Interview Discussion	Treating interviews as open discussions using open ended questions to gain depth. Encouraging the interviewees by giving prompts and cues to reveal information and insights (Tourangeau, 1984; Willis et al, 1999; Bryman and Bell, 2011)
ANALYSIS	Application of CGT methods	Initial Coding; Focused Coding; Generating Categories and theoretical coding; Collating categories into themes. Organising findings via themes (Charmaz, 2006; 2014; Burnard et al, 2008; Bryman and Bell, 2011; Strauss and Corbin, 1998)
RESEARCH CONSIDERATIONS	Reliability; Validity; Limitations	Concern for results of study being repeatable (not necessarily replicable) and whether devised research measures hold consistency. Internal validity to address causality of research and External Validity to address the generalisability of research results beyond its specific context.

6. PRESENTATION and ANALYSIS of FINDINGS

This chapter engages with the presentation of the findings of this research study, followed by an in-case and cross-case analysis of the findings.

It begins with a presentation of findings and the analysis for the Pilot Study (Phase 1). The chapter then proceeds to the presentation of findings and their in-case and cross-case analysis for the Main Study (Phases 2, 3 and 4).

For both the Pilot Study (Phase 1) and the Main Study (Phases 2, 3, and 4), the data on which the analysis are based is occasionally presented with the findings in this chapter and further to this, is presented in summary form with an accompanying commentary as Annexes. The data with accompanying commentary for Phase 1 can be found in Annex J. The data with accompanying commentary for Phases 2, 3 and 4 can be found in Annex K.

6.1 The Pilot Study

6.1.1 Overview

A small-scale pilot study completed in the 1st Year of this doctoral research was a necessary formative element in my research and the basis of which I was able to define the methodology and design the main study. The Pilot explored the different ways in which 'learning' and 'development' as phenomena are understood and experienced by service managers in the NHS and helped to identify what constituted 'change'. This initial pilot study helped me to establish 'context' when exploring Management Development in the NHS, both in terms of getting an understanding of what management in the NHS was about, how managers perceived their role and development and what the operating environment was that gave a 'face' to the change phenomena in the case of healthcare services.

I felt that a pilot study was necessary partly because of the sheer size of the NHS, the extent of reform that has taken place in the NHS and the number of initiatives that have been introduced over decades in the NHS: all which made it a challenge to draw clear distinctions between policy and practice developments in healthcare and which depicted multiple realities and versions of what constituted change.

At the early stages of this research, I felt overwhelmed by the extent of variation that existed across organisations (i.e. NHS Boards) in trying to understand both commonalities and

differences in structures and management issues. In the process of engaging with interviewees during the Pilot Study, I realised that the experience of learning and developing for any two managers within the NHS could never be the same given that all managers were exposed to constant yet different and diverse change at local and national levels (something which they themselves acknowledge). This was crucial in identifying the nature of change that managers faced and this helped shape a main study that was informed about the dynamics of the NHS, its complexities and the issues that most relate to managers. A result of the pilot study therefore was a more informed and real world research inquiry.

6.1.2 Pilot Study Findings

In this section, I present in this section the findings from the Pilot Study and highlight the implications that arose, which informed the design of the main study. In column 2, a reference is provided to illustrative data presented in Annex J.

As explained in Chapter 5, the approach taken to the Pilot Study which involved conducting interviews with three middle managers based within NHS Scotland who were selected on the basis that they were engaged with delivering healthcare services and has undergone MD in the NHS.

	Question 1: When exploring the **typical work activities that managers engaged in**, it was found that:		
	Findings	*See Annex J*	*Implications*
1	The work activities engaged in were diverse and it remains difficult to identify any consistent similarities in the nature of work managers do. However, joint working and the integration of healthcare services is perceived to have impact on how work is done and service is delivered. Furthermore, the role of the managing was changing and shifting from traditional forms to accommodate the requirements of joint working and integration	*See Quote 1, R3; Quote 2, R2*	Variety and non-uniformity in scope of the managerial roles, relationships, responsibilities. Joint working and integration to have implications for what managers do and how Managers engaging in collaborative forms of working in Community Health Partnerships.

	Question 2: When exploring **significant influences on learning and development as a manager**, it was found that:		
	Findings	*See Annex J*	*Implications*
2	The influence of other managers and supervisors has been crucial to one's own learning and development	*See Quote 3, R1 and Quote 4, R3*	The importance of learning through people
3	Learning on the job had a significant influence and entailed learning by observing others and informal exchanges of conversation	*see Quote 5, R3 and Quote 6, R2*	Learning through action and through informal means.
4	Where lack of training opportunities for generic management was identified, learning and development was owed to making mistakes and learning through experience	*see Quote 10, R1*	Lack of training opportunities in management roles and reliance upon experiential learning
5	Role Models and Mentoring had been important to learning on the job while senior colleagues were identified to play a role in learning and development	*see Quote 7 and 8, R2; Quote 9, R1*	Managerial Learning and Development facilitated through people

	Question 3: On **exploring the influences on managerial learning and development**, it was found that:		
	Findings	*See Annex J*	*Implications*
6	Managerial knowledge was acquired on the job through continuous learning and experience, particularly through the influence of people and moving into new roles.	See Quote 11, R1; Quote 12 and 13, R3; Quote 14 and 15, R2	Knowledge acquired on the job and in transition.
7	Managerial knowledge was difficult to define, its acquisition was unstructured and constant change led to never knowing everything and having to accept change as part of career. Therefore, learning was a never ending process due to the size of the NHS and constant change within it	See Quote 16, R2; Quote 17 and 18, R3	Knowledge acquired in unstructured non formal means. Change and complexity a constant state and narrative
8	Potential for excelling in strategic management roles was	See Quote 19,	Influence of

	identified if dual trained with both formal clinical and management education	R1	Professional identity and background in Management roles.
9	Consensus that no clear career progression paths exist in a constant changing NHS however, joint working and integration identified as being the determinants for future change in management tasks, management roles and their availability	See Quote 20, R2; Quote 21, R3	Unstructured managerial roles, responsibilities and relationships. Unclear managerial progression and development.
10	Joint working and Integration on health services was unanimously reported as imminent for the future and its impact on managerial roles considered significant in the following ways:	See Quote 22, R1	
	a. Increasingly clinicians will need to think, act like managers and accept the increasing need to operate as managers of integrated service delivery	see Quote 23, R2; Quote 24, R3	Professional Silo's. Changing accountabilities
	b. Managers in the NHS will have to face increasing emphasis placed on value for money (improving quality of service with lesser money) while the overall customer expectation of service delivery continues to grow. This is identified as having an impact on managerial effectiveness, communication, trust and resource sharing	see Quote 25, R2	Changing Service and User Expectations
	c. Apart from existing knowledge, skills and qualifications, managers will need to become resilient and absorptive because of the need to work d. with new groups of people, managing joint teams and inter-organisational role	see Quote 26, R2; Quote 27, R3	Changing managerial roles, responsibilities and relationships
	e. Despite joint working and service integration being the way forward, it becomes a challenge to bring together workforces from different organisations with different interests and different ways of working.	see Quote 28, R2	Altering managerial behaviours and attitudes Changing service focus to more integrated service delivery

	Question 4: On exploring **how the evaluation of learning and development is viewed and understood,** it was found that:		
	Findings	*See Annex J*	*Implications*
11	Evaluation of one's L&D as a manager is not distinguished from performance appraisal even though it is desired for both purposes	see Quote 29, R1; Quote 30, R2; Quote 31, R3	The importance of Management Development at personal and organisational levels
12	360 degree feedback and appraisal even though seen as useful is not practiced for either purposes of performance appraisal and/or management development purposes due to time, cost and governance issues	see Quote 32, R3	Future design of Management Development in integrated (inter-agency) service delivery

6.1.3 Implications from the Pilot Study

The implications of the pilot study findings were used for the main study (Phase 2 and 3), both in terms of *what* should be explored, *why* and *how.* The diagram below highlights how the implications of the Pilot specifically informed the content of the semi structured cognitive interviews and focus group discussions of the main study (Phase 2 and 3):

Implications of Pilot Study Findings	How they informed Main Study Enquiry
Variety and non-uniformity in scope of the managerial roles, relationships, responsibilities.	**CHPs recognised as representing the bulk of joint working and integrated service delivery.**
Joint working and integration to have implications for what managers do and how	
Managers engaging in collaborative forms of working in CHPs.	**CHPs recognised as subject of change as affected by legislation.**
The importance of learning through people	
Learning through action and through informal means.	**Middle Level Service Managers across health and social care services recognised as responsible for managing integrated service delivery.**
Lack of training opportunities in management roles and reliance upon experiential learning	
	Geographical setting of NHS Boards and

Managerial Learning and Development facilitated through people	**Local Authorities recognised as determinants of Service design and delivery**
Knowledge acquired on the job and in transition.	**The importance of planning and implementation at the locality level recognised**
Knowledge acquired in unstructured non formal means.	**Cultural issues and challenges for joint working recognised**
Change and complexity a constant state and narrative	
Influence of Professional identity and background in Management roles.	**The dominancy of national targets as means and measure of public service performance recognised.**
Unstructured managerial roles, responsibilities and relationships.	
Unclear managerial progression and development.	**Complexity and uncertainty recognised as a constant part of change in health services management.**
Professional Silo's	
Changing accountabilities	**What managers do and how open to interpretation and subject to alteration this is recognised**
Changing Service and User Expectations	
Changing managerial roles, responsibilities and relationships	**Changing service focus and service delivery models recognised**
Altering managerial behaviours and attitudes	
Changing service focus to more integrated service delivery	
The importance of Management Development at personal and organisational levels	
Future design of Management Development in integrated (inter-agency) service delivery	

Taking into account the ways in which the pilot study implications informed the main study (Phase 2 and onwards), I then revisited literature and secondary sources to develop overarching ideas and points for discussion in the cognitive interviews due to be implemented across the 4 CHPs with service managers associated with joint healthcare service delivery.

6.1.4 Concluding Observations on the Pilot Study (Phase 1)

- The pilot study provided an opportunity to explore how managers perceived their learning and development in the Scottish healthcare service.

- By going through this Pilot Study process, I could make an informed choice as to what issues I should aim to address, what questions my research should really be asking and the methodology that should be adopted.

- The Pilot study provided the researcher with real world knowledge and an empirically generated platform of relevant concerns and context upon which to base the main study.

- It provided an opportunity whereby issues and challenges could be better understood, so as to develop relevant Phase 2 interview using the findings and implication from the Pilot.

- It also provided a guideline for refining the use of the most relevant literature which in itself was a major task, given the plethora of multi-disciplinary literature, mass of evidence and secondary information available in connection with management in the NHS.

- Furthermore, the Pilot also provided a firm basis for making a real world enquiry and helped to ensure that my research objectives (and overall research questions) can be approached on the basis of early empirical evidence and an informed research design.

6.2 The Main Study

In this section, findings from the Main Study (Phases 2, 3 and 4) are presented in the form of both in-case and cross-case analyses. The data on which this analysis is based is occasionally presented with the findings and further to this, is presented in summary form in summary form with an accompanying commentary as highlighted previously in Annex K. In both this section and the annex, five emergent themes are used to provide focus. These themes (and the respective subthemes used in the cross-case analysis) resulted from the collating of categories as part of the data analysis (details of this were discussed in chapter 5, section 5).

6.2.1 In-Case Analysis

In this section, an analysis is presented of findings from both Phases 2 and 3 to provide insight using the five themes that emerged as a result of the data analysis process. Case profiles for all case have already been presented in chapter 5, section 3

The intention in this section is to draw out the important emerging issues and ideas particular to each case. Cross reference is provided to the evidence presented in Annex K using a key that identifies as follows: *Case*, followed by *Phase* followed by *Illustration number*. E.g. *Case A, Phase 2, Illustration 1* uses the key '*AII-1*'.

6.2.1.1 Case A

Theme 1: Perceptions of collaborative working, integration and change
Collaborative working remains constructive in Case A across health and social care agencies and delivering joint services at the locality level is given importance. Even though it remains unclear what an integrated H&SC set-up may look like, integration in itself is being treated as a cultural agenda rather than a structural one (See AII-1 and 2). This distinction is referred to as formal governance (arising from legislation) and informal governance (the actual practice of managing at the local level) (see AII-3). Legislative changes as forthcoming through the Public Bodies Joint working Bill (2014) is seen to provide a legal framework that enables H&SC agencies to move further towards a binding partnership framework come April 2015: hence enabling formal working together (see AII-5). A pro-active approach has been adopted, with a shadow board being appointed and an interim joint director appointment leading up to for April of 2014 when the bill is enacted early 2014. This step further towards a legislative framework for Health Boards and Local Authorities received a

mixed response by managers. In the case of the CHP General Manager, it is welcomed on the basis that it encourages commitment from agencies and makes the process robust and consistent (see AII-8). The Head of OD reports the organisation as being well-prepared to implement a new legislative framework (see AII-6). While in the case of a CHP Localities manager it brings uncertainty about what is going to happen or what kind of structure will be put in place which cannot be worked out until legislation is enacted:

> *I guess that (integration) is a personal opinion at this point because we don't really know how that is going to happen. I guess to some extent that depends on the structures that are put in place to support that integration agenda. But I think it's clear to me that things will change and I think there needs to be* (AII-9: R4, CHP Localities Manager)

Despite the H&SC agenda being embraced under a legislative framework and being in a state of preparedness for it, there is criticism on the basis that evidence for integration conceptually and in practice is weak while legislation and guideline are vague when organisations and management attempt to put things into practice or how to do it (see, AII-10 and 11). Integration is also viewed as providing cost efficiencies and ''more for less'' (see AII-10) and this would be congruent with perspectives of integration enabling the public sector achieving greater efficient and value for money (Scottish Enterprise, 2012)

Further insight into these issues (Phase 3) reveal a continuous and growing confidence about joint working and positivity about integration with emphasis on driving the change bottom-up. The results suggest evidence for this with managers at the ground level feeling more empowered to build structures at the ground level (see AIII-1). Planning for upcoming legislative change through a joint shadow board remains active and constructive with progress made 8 months on from previous discussions (Phase 2): this progress includes equal joint representation of health and local authority members on the joint board; planning future agenda's for the shadow board; discussion on an appropriate mix of senior managers for managing the change (treated as project management) to support an interim joint director in the process. (see AIII-5). Issues surrounding financial governance, seen as a challenge are also being addressed (see AIII-2 and 3).

Exclusive Co-terminosity which results in the future for Case A with 3 existing CHPs merging into a single CHSCP that will be co-terminus with one Local Authority. This is seen as an advantage compared to other Cases that may be co-terminus with more than one exclusive Local Authority (see AIII-4).

Theme 2: Managing with complexity and ambiguity

As services proceed towards integrated management teams, different T&Cs of staff are seen to create complexity: particularly for reasons of different pay scales, working hours and holidays of staff operating within teams (see AII-13 and AII-14). This complexity is viewed as a limitation of integration. Nevertheless, this complexity is preferred over transferring staff across agencies that is seen as troublesome. For this reason, a corporate body model for integration is preferred over lead agency model (see AII-12 and AII-14).

Because change is driven at the larger political level, there is complexity and ambiguity around how this can be translated into practice at the local level. There is the difficulty such change periods hinder joined up services for users (see AII-16 and AII-17). Further insight into these complexities reveals that during such change periods, services slow down due to lack of capacity and breakdown in coordination as organisation are left to deal with a 'huge beat at the local level' (see AIII-6). Also as senior more experienced managers at the strategic level get replaced over time, staff at the ground level are left to deal with complexities who are unfamiliar with new processes or agreed changes and lack power:

> *A lot depend on power dynamics and it comes back to the idea that if we are losing potentially strong experienced leaders at the more strategic level. Staff at the ground level can be potentially naïve and before they know there's a new process in place and agreed to and it's maybe not what it could have been. I think that's a real issue at the moment. (R37,* Head of Health Improvement)

Cultural and operational differences (ways of working) between H&SC organisations create a lack of trust and cooperation between managers (AII-21). For this reason, managers feel weary of integration, resist engaging with their counterparts in the Local Authority and revert to professional groupings, and resist change because they may not understand how the partner agency works: what they do; who sets the rules and procedures; and who they report to (see AII-22 and 23). Exploring these differences further, NHS managers' report to a great degree of political influence and hierarchy in Local Authorities that is quite distinct from the NHS which make it difficult to work jointly (see AIII-8 and 9). The need to have dialogue about these complexities is lacking (see AIII- 10).

Working with two different sets of policies and reporting streams and funding pressures are also identified as problematic and require resolution over time: how this achieved is unclear (see AII-18, 19 and 20).

A sense of what needs to be done prevails at the management level to address agency differences and complexities. This entails setting up inter-agency management arrangements in a way that is supportive and making the executive level realise not to expect too much too quick (see AIII-11). The need to resolve overlaps and bring together service guidelines in a complex sets of arrangements is required (AIII-12).

The OD functions is seen to facilitate and support managers to deal with these complexities and ambiguities (see AII-24). However, the OD functions of both organisations fall outside H&SC partnership and bringing them together as a resource is considered a possibility (see AII-25).

Theme 3: Service Logic and Value Creation

Existing management paradigms, with particular reference given to NPM, are seen as rationalistic, focused on ignoring complex problems while desiring simplicity, lacking the will to do things differently and influenced by executive management mentality rather than user needs (See AII-26 and 27). An audit culture and rational management practices that seek measurement in systems and processes rather than paying attention to cultures and people prevails (See AII-28). A lack of regard for values, culture and contexts prevails while market driven models and NPM practices continue to dominate because they offer simplicity and efficiency (see AII-29).

Having shifted away from managerialism is reported as benefitting users who would like to see H&SC coming together for integrated service delivery (AII-30 and 31). Service innovation is embedded with users rather than structural change (AII-32) User focused service delivery that is accessible in a combined manner and centred around their needs at the local level is the increasing is the logic reported (AII-33). There is scepticism about structural change that is politically driven as it diverts services from quality care provision. That is unless structural changes are driven from the ground level up where needed: form following function:

> *We should change structures where it makes sense and form should follow function by and large….I think people confuse structural change with progress...it's highly debilitating, takes your eye of the ball of delivery and providing good quality services….In health people are very sceptical about structural change now…They don't believe structural change will provide any real benefit….* (R1, Head of OD)

Further insight reveals the desire to focus on users as the product and that user-focus enables agencies to move closer into localities and work together to make things happen (see AIII-

13 and 14). The contrast to this would be a move away from user focus is likely to direct agencies towards issues of structure and budgets. H&SC integration at the local level is seen an opportunity for innovating user-led services and creating something new from different existing systems (see AIII-15, 16 and 17).

Managers' associate with a holistic view of services and the importance of joint working at the ground level. Value creation arising through user-focused and user-led services rather than by top management or structural arrangements is sponsored.

Theme 4: The managerial remit: roles, responsibilities and relationships

Managers in their remit have not had to engage in cross agency work in the past and are unfamiliar with it (see AII-35). The need to understand changing accountabilities, gain role clarity and understand the remit of managers in LAs will be needed and a common understanding of remits will be required from both sides (see AII-36 and 37). A holistic perspective, interconnected service pathways across the system and having political intelligence are all aspects the managerial remit must address (see AII-38). The scope of the manager's remit is expected to expand beyond the single agency and become more complex as they engage with a wider circle of stakeholders for democratic decision making and as resource become constrained (see AII-39 and 40). Managers will need to go beyond traditional pathways that provide for clear career pathways and move to a user-led service system (see AII-40 and 42).

> *You have to keep focus on the patient all the time and not just on what you want for your career pathway…This is not about your personal goals, it's about the care group that you manage and how are you going to get the best for that service delivery* (R3, Head of Physio Services)

> *Integration needs managers who are willing to listen and to understand the whole picture as opposed to the picture they are familiar with* (R4, CHP Localities Manager)

Exploring this theme further via findings from the focus groups, the managerial remit is seen as shifting from uni-profession to multi-disciplinary and multi-agency and creating new ways of working and new processes (see AII-18 and 19).… Parts of integrated services that can most facilitate new ways of integrated working and strengthen it can be experimented with rather than attempting large change (see AII-20 and 21).

Managing the performance of staff on integrated teams in one's role will bring the challenge of dealing with separate performance management systems since staff will retain existing T&Cs of employment and be subject to statutory performance management frameworks (see AII-22 and 23).

Theme 5: The learning, training and development of service managers

Managers highlight the need to be trained and developed to work beyond existing accountabilities and to influence change in complex environments (see AII-43). Particularly, they must be able to understand their roles, lead, gain respect in multi-disciplinary teams, develop relationships and be resilient rather than needing to know details of all service elements (see AII-44 and 45). Further findings reveal that managers are encouraged to attend and engage in cross-agency integration planning meetings so they can understand and develop knowledge of different cultures and contexts: which currently they are struggling with (see AIII-24). Findings further reveal that support from top level executives of both organisations to initiate such engagement at the ground level is something which has not happened to date (see AIII-25 and 26). Further to this, given that the T&D functions of both agencies currently operate separately, joint T&D programs are necessitated by managers (see AII-50 and 51).

Training clinicians who make the transition into middle management roles is deemed necessary for succession planning of service managers. T&D that can incorporate skills of collaboration and integration is also called for, nevertheless what these skills may be cannot be grasped by managers. However, leadership ability is emphasised upon (see AII-47 and 48). The manager in the integrated service context is recognised as one different from the past who needs faster development (see AII-49). Supporting the development of collaborative leadership is seen a means of enabling managers for complex service environments. Leadership ability is deemed a necessary transition beyond management models.

Exploring leadership further, managers place emphasis on rethinking leadership for the integrated service context (see AIII-35). Context based leadership and leading in localities stands out beyond leadership competency frameworks (see AIII-36) Leadership ability playing a pivotal role in the process of delivering integrated H&SC and the shift from traditional leadership models and command and control management to contextual adaptive leadership development in localities is strongly desired (see AIII-34 and 37)

Managers take ownership for MD at the local level and call for learning from localities to be transferred across to other parts of the service (see AIII-31, 32 and 33). Coaching comprises part of the formal MD programme as well as Action Learning sets in Case A (see AIII-30): these Action Learning Sets in principal are considered useful as an intervention but have been underutilised and unsuccessful for the H&SC agenda in Case A (see AIII-27, 28 and 29)

Managers support MD interventions that are organic, context based and tailored to individual managers. This shift in MD thinking and practice is asserted having now moved beyond programmed and generic MD programs that were a thing of the past: as advocated by rational leaders in the organisation:

> *In 2 or 3 months we could easily knock up an integrated MD programme….However we have discussed that over a number of years but fell foul of the fact there that we are creating an approach that tries to address needs that are really individual. At the time we looked at it because we were under pressure by particular rationalist structural leaders as it were. That's what they wanted to see because that fitted their mind-set. (R40, Head of L&D)*

Support from, and coordination with national T&D providers for the H&SC integration agenda is evident (see AIII-38, 39 and 40). Planned support from the OD function in supporting the L&D of managers and teams in localities and for the change process is successfully observed in Case A (see AIII-32 and 41)

Summary

Case A maintains a positive outlook towards future H&SC integration and sees opportunity in it to innovate and improve service pathways for users in localities. Even though complexities such as cultural differences between agencies and managing staff with different employment conditions are highlighted and challenges of learning new ways and leading are identified, managers demonstrate a confidence in dealing with thesis issues and take on the responsibility for MD at the local level with adequate planning and support in place by the OD function to support managers through change. A paradigm shift of moving from organisational performance towards holistic user led services is clearly evident as well as the move from traditional models to more supportive and enabling forms of managerial learning, training and development.

6.2.1.2 Case B

Theme 1: Perceptions of collaborative working, integration and change

Case B management refrains from and is cautious of structural change. Successful joint working is disassociated from service integration (see BII-1). The re-structuring that comes about due to change (i.e. integration agenda) creates ambiguity: a state of uncertainty that streamlines efforts into planning rather than doing (see BII-2).The service integration agenda is seen solely as a structural change that is politically driven and seen to cause complication and get in the way of effective and existing joint working arrangements within the area. Rather, working collaboratively but as separate organisations is advocated to be better for service effectiveness. This position is asserted on the basis of past attempts and experience of being in an integrated H&SC structure (see BII-2).

Further insight into perceptions of change associated with integration asset and emphasise on this viewpoint: that successful cross-agency partnership working is not dependent upon integrating of services: working in an integrated way is distinguished from managing integrated services (see BIII-1 and 2). Nevertheless, managers consider themselves prepared for upcoming integration seeing it as more planned compared to past attempts that were rushed:

> *But after finishing with the integration we have held onto working as partners and keep those relations going…...we have done more since we divorced (referring to the separation from partnership), we've managed to progress more and we are more clear as to what our boundaries are. So we still work together really well, but we can actually proceed and pus tings through our separate systems quicker.* (R6, Head of Primary Care and Community Services)

Planning for H&SC is at initial stages with discussions being initiated as to which services from both agencies will be included in the integrated partnership framework. A project group is set up to think about what integration will mean for localities while the appointment of a joint officer and a shadow board are not identifiable (see BIII-3). No indication or preferences for the type of integration model that will prevail is found in Case B.

Differences in levels of political accountability and risk between agencies pose a challenge to integrating both the services: with LA's being more hierarchical and managers not being empowered to take decisions as compared to the NHS which is more experimental and empowers managers to take decisions (see BII-4 and 5). Further to this different T&Cs of staff and the governing of finances are cited as areas of concern when it comes to the

integration of H&SC services: managers are found to passively cite these concerns rather than taking any ownership or responsibility towards them since integration is seemingly enforced (BIII-4 and 5).

Theme 2: Managing with complexity and ambiguity

The ambiguity of roles, structures and different T&Cs of employment in an integrated set up and the complexity of working with two separate sets of policies are confirmed based on past attempts of operating in an integrated structure and integrated teams.

Loss of influence in management roles arises as a complication of operating in multi-disciplinary teams and dealing with two different sets of policies. This is combined with a lack of clarity for the new integrated management role which causes uncertainty (see AII-6 and 7). Analysing this further: it is particularly issues of having to work with two sets of policies and processes (i.e. disciplinary procedures and absence management) which creates disempowerment which managers seem helpless about (see BIII-8). Different degrees of authority with NHS having higher levels of devolved authority compared to Local Authorities means the latter is prone to more individual decision making and rigid processes (see BIII-9). This is further confirmed with Local Authorities viewed as having more centralised uniform policies compared with health that cater de-centralised and varied policies (see BIII-10)

Re-structuring towards integrated service delivery models is seen to be a politically driven change that frustrates, causes fear and creates disparity (See BII-8). Added to this, job insecurity also arises in the fear of roles being integrated or in the transfer of staff across agencies (see BII-10): specially so when there is no clarity of the type of integration model that will be adopted which causes negativity based on past experience (see BII-6 and 9). Complexity surrounding financial governance is related to the disproportionate distribution of budgets in between agencies even within an integrated governing body: because tackling health inequalities means distributing finance and resources as per geographical needs leading to unequal distribution within services and agencies of the integrated body:

> *That's one of the biggest challenges for CASE B as a board is because if you give everyone the same you increase in inequalities in health. So if you want to target inequalities, then you can't give everyone the same…Such tensions will come to the fore and will be difficult* (R26, Head of Primary Care and Community Services)

Further findings reveal that addressing such complexities and particularly the ambiguities is challenging when there is a lack of planning and there is the inability to foresee upcoming changes (see AIII-6). The better the planning and defining of change for integration, the greater the chances of being successful in addressing complexity and ambiguity (see BIII-7). A sense of insecurity and lack of information about the future integration agenda is observed.

Theme 3: Service Logic and Value Creation

A strong association with user focused outcomes that can influence service design comes to the fore: where 'form follows function'. Decisions about structures and processes be based on user focused outcomes: something that requires culture change rather than structure change (see BII-11 and 12).

The need to involve users in the design of services is advocated since professionals are more probable to focus on process management and design services accordingly compared to user outcomes. Therefore, user participation in determining functional outcomes is promoted:

> *Put 10 clinicians in a room and ask them for an outcome and you will get 9 processes and maybe 1 outcome. And that 1 outcome may not be described in a way that a child would understand it. So I am talking about functional outcomes in mental health services. It is to define these outcomes with parents, children, families and take them and work backwards* (R5, Head of Specialist Children Services)

> *… we certainly involve all the trade unions. So why wouldn't you do it with service users. You either see them as a partner or you don't see them as a partner. If they are a partner, then they should be involved in the services.* (R10, HR Director)

This is an essential factor raised which indicates shifts towards and value in new forms of public governances (Osborne, 2010) and co-produced services (Cottam and Leadbetter, 2004; 2006)

Further exploration of findings reveal the above priorities of meeting user-defined outcomes taking supremacy over structures. User involvement in determining service outcomes and design is continually promoted. What is analysed further is that becoming entangled with integrated service structures compromises performance because it hinders user orientated decision making (see BIII-12). The challenge of integration will be to remain critically cooperative and function in ways that are user focused (See BIII-13). Managing in new and different ways for this purpose will mean that agency professionals and managers will have to ignore structures and work together (see BIII-14).

Theme 4: The managerial remit: roles, responsibilities and relationships

There are a host of suggestions that arise as to what managers will need to do and how in the management of integrated services. Managers in their roles will require to be tenacious in enquiring and getting to the core of issues; learning and accepting different cultures; being patient and learning different ways of doing and learning different governance structures (see BII-15, 16 and 17). The manager's remit will require being able to influence inter-agency partners through relationship building and motivating different staff groups and doing informed decision making (see BII-18). In the context of operating in an integrated structure, having to use multiple systems is a challenge (two sets of agency accounting standards) and requires flexibility on the part of managers (see BII-19).

The remit of the manager is viewed as one needing behavioural transition (change in thinking and attitude) and one that needs to be developed with intentional learning of the new: that new may be structures, governances: cultures; relationships and staff needs and beyond. An emphasis is placed on being able to influence cross-agency.

Upon further examination, demonstrating new values and engaging with a wider range of stakeholders will necessitate building relationships (see BIII-15). The political agenda at locality level and political changes nationally will need to be grasped by managers (see BIII-16). How they do all this in joint posts will depend on what structures come into place and nothing further can be envisioned at present:

> *Anybody as a service manager in a joint role will be doing something different than they are today. We don't know what structure will be….you have to engage with a wider range of stakeholders probably and depending on what work your involved in it will be different from sector to sector. But it's difficult to make it more prescriptive than that* (R26, Head of Primary Care and Community Services)

Influence exercised by managers in multi-disciplinary teams is enhanced as a result of budgets being pooled in formal CHSCP agreements since employees becoming directly subjected (see BIII-18)

The managerial remit is expected to go beyond just coordinating with counterpart agencies in networks towards being responsible for processes and pieces or work in and across other agencies (see BIII-19).

Theme 5: The learning, training and development of service managers

Existing skill sets and management tools are transferable to the integrated context and the development of managers is more about behaviours and attitudes; being willing and motivated to engage in joint structures and with change; and being adaptable to different situations (see BII-20 and 21).

Leading on the basis of relationships rather than supervision is endorsed. Conceptualising leadership in new ways begins to occur here since it is seen as a 'way of operating' rather than as a prescribed role. Leadership across all levels and service components is advocated as a behaviour for integrated partnerships to function rather than leadership being traditionally exercised at the top: multi-layered leadership as opposed to single-layered (see BII-22 and 23).

A lack of T&D opportunities for middle-managers is identified: lack of time and opportunity are cited as reasons (see BII-24). The use of formal and generic programmes of T&D in the NHS have not been useful (see BII-26). A useful model that identifies service structures and change processes that can be connected with development needs of managers is invited and could attract managers to engage with learning that is context based (see BII-25). Action learning sets are considered a possibility with the aim to support the integration agenda (see BII-26).

Upon exploring these issues further, there is consensus for T&D not addressing the people development challenges of integration and its opportunity is lacking for middle managers since it is offered repeatedly at levels above (see BIII-20, 21 and 22). Addressing these issues via the OD function is placed on hold due to uncertainty about what integration and management structures will prevail:

> *So taking an OD approach and developing the values and behaviours that people recognise as useful….And that's all part of the uncertainty at the moment because we don't know what that management team will look like (R28, Head of OD)*

Further analysis of MD interventions in Case B identifies a desire for flexible and intuitive learning where managers are able to select and tailor based on their needs (see BIII-25). An in-house leadership group that explores 'leadership for integration'. An internal ready to lead initiative is also in place for front line managers who can lead of pieces of change while mentoring, coaching, shadowing are all identified as being practiced (see BIII-24 and 26). A jointly funded inter-agency leadership programme is existent between the NHS, Local Authority and private-sector (see BIII-27). Even though a range of these initiatives are

identified and existing with a great degree fragmentation across the organisation, their effectiveness for supporting the L&D of managers for challenges of integrated services cannot be ascertained in case B.

Summary

The NHS and the LA are considered separate organisations delivering separate services that are nevertheless effective at partnering and delivering joint services. Joint working across agencies in separate structures is promoted while engaging with integration on structural and politically driven basis is seen as non-constructive and as a disturbance in delivering user-led services. Embracing and preparing for changes post the future Public Bodies Joint Working Bill is not evident. Largely, past experiences of integration shape how managers envision future change. A networked service delivery model prevails in Case B which nevertheless is very connected to delivering quality care at the locality level and which recognises a changing service paradigm towards new service environments that carry a logic and appetite for co-produced (user engaged) service design and delivery. In terms of MD in Case B, existing T&D and MD interventions are analysed not to be related with future integration of H&SC. There is planning to address change and support managers for the H&SC integration agenda and recognition of what needs to be done about it: engaging with this however is not found to be the case. Detachment with the integration agenda but commitment to quality partnered service delivery in localities prevails.

6.2.1.3 Case C

Theme 1: Perceptions of collaborative working, integration and change

Already engaged with integration, Case C pro-actively operates as an integrated CHCP and has out of choice, morphed over time in terms of integrated management structures. Integration is structurally visible at the executive and planning levels and managers on the CHCP management team demonstrate supremacy yet at the same time, a continued need to improve managerial knowledge and ability to understand different agency cultures, operations and politics (see CII-1 and 2).

Developing prior shared understanding, shared strategic goals and maturity as a partnership is declared a perquisite for creating a shared vision for the future and to innovate.

> *I think that [integration] very much depends on the stage of maturity of the current partnership. …. So I think we have got much greater understanding of the separate histories of the two main agencies and perhaps many other areas and that allows us to think forward with a shared view of where we need to be going in the future. You need to invest in that …I think that [innovation] does occur but I think what's particularly positive about Case C is that it occurs within an environment of shared strategic goal…for example re-shaping care for older people…. there was a contribution to a shared vision that was important* (R11, Social Care Services Manager)

Further analyses reveals a great degree of preparedness for upcoming legislative changes with the integration of strategy, processes and workforce planning already occurring via an existing integrated CHCP management team. The CHCP has already started integrating processes in terms of single assessments for clients and performance management processes (see CIII-4). A corporate body model is confidently envisioned because it is already existing and because it further facilitates the integration success already achieved over some years (see CIII-1 and 2). Establishment of a corporate body as legal entity legislated by the Public Bodies Bill provides the drive to integrate all services across the partnership as opposed to the limited coverage and pockets of integrated practices at present (see CIII-3). Efforts to streamline the existing H&SC partnership both strategically and in processes to meet future legislative changes is evident, even though the timeframe for its enforcement remains unclear.

Future legislation brings consistency to integrated services across all functions of both agencies and becomes an enabler for better governance for Case C: pooled budgets that go beyond existing aligned budgets (see CIII-5 and 1).

Case A and its managers demonstrate positivity and drive for further integration and embrace the challenges it sets forth.

Theme 2: Managing with complexity and ambiguity

Case A demonstrates a formal partnership with agreed goals and policies working towards an integrated interdisciplinary management practice. An early appointment of a joint accountable officer has been made who acts as a single point of contact with an existing joint CHCP director (see CII-5).

The challenge identified is that of integrating cultures and experiences of people. For Case C, this is aided by being co-located as agencies, developed relationships and developing a shared understanding of differences and similarities over time (see CII-6 and 7). Time, commitment and relationships built over time are required to cultivate such maturity and the ability to navigate change as an integrated partnership.

Separate T&Cs of staff in joint multi-disciplinary teams is an active decision made over time which the CHCP intends to maintain (see CII-8). Exploring Case C further, clarity is demonstrated over the T&Cs of staff being maintained separately (see CIII-6 and 7). The challenge associated with this for managers in joint posts is to manage staff performance under separate performance management systems (see CIII-8): which for statutory reasons must be conformed to and complied with based on national targets, even if a combined performance management system at the local level was desired for consistency (see CIII-9). A possible avenue to strive towards an integrated performance management system would be an investors in people award status which the Local Authority has got but to which Health aspires:

> *I suppose the other thing is that the council has been awarded the investors in people status, and the NHS are currently looking at that or that I suppose they are newer to that process, so I think that is possibly an avenue that would help us to join up although I hear what you are saying* (R23, Head of Council Services)

Nevertheless, what is essential here is that these issues are seen as manageable challenges that Case A intends to successfully navigate and work around and do not view them as complexities and neither report them as being ambiguous.

Theme 3: Service Logic and Value Creation

Being in an integrated CHCP structure has enabled staff to develop shared understanding and relationships to manage. This enables a more conducive environment and a stronger sense of delivering user-centred service with user defined outcomes. Understanding user needs is identified as the focal point from which joint planning and integrated service delivery follow: jointly derived user-defined outcomes precede structures Success with integration means an integrated single point accessibility for multiple service to users and an enhanced ability to see the wider picture:

> *At the end of the day, what we are interested in is outcomes for our customers .., our clients, our patients. If they get better service where in one visit they can get multiple services through one of these resources then that's key success really* (R15, Head of Council Services)
>
> *…. its not just about working in partnership with our immediate agencies but actually looking at the wider picture of things…*(R12, Primary Care Manager)

The service logic aspired is to be able to think of services holistically and combined. Going beyond thinking and doing as separate agencies and operating beyond organisational divisions. Deploying people and availing resources at the level of the partnership as a whole. Achieving such a holistic service system would require major culture and organisational changes, nevertheless, such a service construct is what integration should aspire to if it is going to be successful (see CIII-11)

Even though higher degrees of integration between management is aspired and a strong user focus element exists , co-production in service design and delivery is not discovered and neither is locality level planning and management emphasised.

Theme 4: The managerial remit: roles, responsibilities and relationships

The managerial remit is seen to deal with multi-profession teams where managers are unlikely to have expertise across all disciplines or in any one single discipline. Managers in their roles will be challenged for their authority and responsibilities on the basis of professional knowledge. Nevertheless their authority and responsibility in terms of the role, responsibilities and relationships will extend beyond the profession and organisation to an entire agency service model (see CII-11)

In their roles, managers will have to work with two separate performance systems since they manage staff from multiple agencies in their teams (see CIII-12). In the long run however, there are strong aspirations for integrating performance management systems towards

combined work processes for what managers do and how. A joint workforce plan and workforce development plan in their initial stages are attempting towards a combined system and sets of processes: which will require both organisations to agree to changes:

> *I think we are a long way off that on an integrated basis at the moment….. At the moment we work separately, but as the HC managers says, we have an action plan around the development of a workforce plan and a workforce development plan.* (R23, Head of Council Services)

Theme 5: The learning, training and development of service managers

The T&D effort must improve the willingness and ability of managers to go beyond existing intra-agency service management and relationships and move towards multi-agency service management and relationships. This is challenged by the traditional professional orientated development of people which reinforces professional identity and grouping and creates siloes (see CII-12). Effective service managers in the integrated context will need to be detached from such professional grouping and siloed outlook: this is particularly where leadership ability in managers becomes critical and comes to play (see CII-13 and 14). The lack of T&D in generic management and leadership for clinicians coming into management roles reaffirms these challenges (see CII-15). Further analysis reveals this to be the case with existing T&D interventions being organisation specific and focused around the development of individual manager performance rather than multi-agency team performance in integrated service context. The CHCP has not to date gone beyond their own organisational T&D function to look at the development of managers on a joint basis (see CIII-15 and 16). Reasons cited for this are the state of 'limbo' as to what the integrated model will shape out to be post legislation (see CIII-16).

Joint planning for MD has not been given consideration and working through a workforce development plan as part of the changes will seek to identify MD, particularly so when the Scottish Government is expected to provide resources (i.e. monetary) for integration that can be used towards MD (see CIII-17). The role of national T&D providers in supporting T&D for the H&SC agenda is considered irrelevant as their offerings are considered generic and strategic (even if around the integration agenda) and not related to what service managers do at the practice level (see CIII-18 and 19).

No comprehensive skill sets or competences for the integrated service context are discovered. Skills and competence are largely transferable. Rather, new ways of working,

being flexible and improvising are backed. Pre-defined constructs such as 'management of change as a key competence' is opposed and instead ranges of competences and skills that enable managers are supported (see CII-16 and 17). Pre-ordained MD needs and interventions cause a de-tracking from developing the competence needed to deliver user-led service outcomes (See CII-18): MD in form and content needs to be context dependent based on user focused service rather than generic and based on pre-determined development outcomes.

Further analysis into the L&D needs reveals that the ability to manage change cannot be developed via pre-determined and pre-designed MD interventions (see CIII-22). Ways that can support small pieces of doing and learning (action learning) are supported: Action Learning Sets are deemed useful (see CIII-23). Further analysis into potential MD interventions for the future signifies the need to consider two important elements: the nature and composition of multi-disciplinary teams and the basis on which they are organised which may be locality based (geographic) and client group (service type) based: rather than being organised and based profession or organisation. This would be a shift away from historical approaches to MD that serve managers organised on the basis of profession or organisation:

> *I think as we go onto this integration journey…. maybe that how we have structured ourselves historically isn't the way we want to be structuring ourselves in the future. So I don't know what that might look like, but it might for example look like multi-disciplinary teams that involve a range of professionals that are sitting in 2 separate agencies that you bring them together. Some multidisciplinary teams might be based on a geographical patch, might be based on a certain client group that our view is that we can address the needs of that client group better rather than having them organised on a professional basis…. Those types of models will produce quite different demands in terms of how you would choose to develop that team of individuals… (R25, Social Care Services Manager)*

Interventions that can support experiential learning where managers can share and get advice, are welcomed with support via mentoring and coaching tailored to individual needs are advised (see CII-19). Further analysis reveals that currently supporting informal interventions occurs at separate agency levels (see CIII-20). However, the advantage of co-located services plays an enormous role in facilitating the shift towards integrated service delivery since shared experiences and shared learning enable managers to establish trust and relationships (see CIII-24). The kind of L&D support managers will need for the future integration will entail supporting them to develop knowledge and skills around technical policy aspects, grievances and recruiting (referred to as the 'hard learning' part). This is followed by supporting the development of inter-personal skills and how they take on teams

in a new infrastructure (referred to as the 'softer stuff' part): for this, shadowing is deemed a useful intervention as it allows the learning to be both transitional and experiential (see CIII-21).

Summary

Case A and its managers reveal a positivity and energy for further integration and embrace the challenges it sets forth. They demonstrate commitment to integrating structures and processes further. Developing prior shared understanding, shared strategic goals and future vision as a partnership is an outcome of pro-activeness and maturity over time. Service managers show clarity about the change they are engaging with and familiar with the challenges that lie out with. These challenges of joint working such as managing staff with separate T&Cs and managing separate processes are embraced and the desire to address these challenges and plan for them is evident. Overtime, the CHCP management team has developed a holistic perspective of integrated services that looks beyond agency boundaries and professional siloes. What emerges is a vision and appetite for a holistic service system comprising of multi-agency multi-disciplinary teams and combined processes that integrate the management effort and not only structures. The challenge of developing such an outlook and attitude among staff and teams requires major cultural transition: a task that Case C takes on board.

Case C also exhibits an understanding and clarity for what MD for the future will be about: enabling managers and teams to shift focus and effort from profession and organisation siloes towards user led services in localities and interdisciplinary inter-agency work.

6.2.1.4 Case D

Having profiled Case D in Chapter 5, I proceed to an in-case discussion using the five structured themes below:

Theme 1: Perceptions of collaborative working, integration and change

Case D reveals that service managers relate financial governance as a focal point of future change related to integration. Even though already in a CH&CP set up, budgetary matters and lack of planning are seen to specifically hinder the service integration efforts. Furthermore, a strong concern for the services that are to be subjected to the future integration agenda is also revealed (see DII-1).

The Public Bodies Joint working bill is seen to provide legislative guideline to deal with issues of structures and processes for financial governance (see DII-2 and 3). A good history of joint working in localities is highlighted in the case of one particular service function (Learning Disability Services): which also is perceived as under threat when it comes to issues of financial governance for future integration as per legislative change. Pockets of integrated practices in terms of joint performance, policies and guidelines are evident in selective services (see DII-3)

Further analysis reveals integration and joint working across agencies to be problematic for Case D owed to a lack of understanding about how things will proceed and lack of planning around financial governance, especially as an interim appointed joint director for H&SC (seen as a solution around financial governance issues) having withdrawn from the post due to lobbying (see DIII-5). Concern for which services are to be included in the formal partnership framework going forward continues to linger (see DIII-1,3 and 4) while a lack of capacity to deliver health services beyond the organisation in an integrated arrangement:

> *Our big challenge will be trying to deliver skills outside these walls. And at the moment we don't have that that managerial structure that would allow us to deliver services to patients in their own homes....All of our strategic thinking realises that will happen but until and unless the structure is in place we probably wouldn't be able to deliver an integrated services between secondary care and council services.* (R32, Associate Medical Director)

Displeasure with the integration agenda and frustration with the lack of planning and moving forward are assessed. Negativity is portrayed exemplifying the Euro Zone and its attempts to integrate a common currency to reflect the difficulty of integration between H&SC (see DIII-5 and 6).

Planning for service integration at the executive level of the organisation is needed and is at early stages and forthcoming legislative changes are seen to push this further (see DII-4 and 5). It is envisioned that variation will occur as to how much progress different services within health and social care can make. A lack of trust, incentive and trust has remained between agencies which the legislation will tackle while issues around financial governance will remain an issue (see DII-6)

A corporate body model is envisioned for future integration solely on the basis that different T&Cs of staff employment (i.e. remuneration differences) cannot be overcome or addressed in any manner. A shadow pathfinder H&SC board is in planning phases alongside the existing CH&CP set up with a view to looking into the issue of different T&Cs and what integration model will prevail (see CII-7 and 8) There are perceptions of Local Authorities not wanting to engage fully with integration because it causes fragmentation for them (see CII-9). A degree of threat is taken in terms of employment security with regards to what integration model prevails (see CII-10).

Theme 2: Managing with complexity and ambiguity

As the nature of responsibility shifts to become multi-agent, difficulty will occur for managers in terms of boundary crossing (see DII-11). Managers are predicted to face anxiousness and become protective of resources and revert to professional grouping: tensions and fallouts are predicted (see DII-12 and 13). Having to work with other agencies and understand different NHS and Local Authority cultures are deemed 'huge differences' (see DII-14). Another complexity arising is that of hesitation among managers to make decisions in an integrated environment (see DII-15): this can be owed to ambiguity about jurisdiction and responsibility to make decisions related to other agency work and staff. A great degree of consciousness is revealed for these complexities.

Further analysis into the complexities and ambiguities associated with H&SC integration reveal the lack of trust between agencies and issues around budgetary planning being an obstacle: which if not resolved will not allow both agencies to progress further with the integration effort. Here, because both agencies eventually rely on government funding, until budgets are not pooled, any integration effort is viewed as commissioning of finances and therefore competition (see DIII-7). This very factor is seen to compromise on the service needs of patients since agencies are not willing to go beyond the confines of prescribed responsibility on budgetary terms (see DIII-8)

Even though in an existing HS & SC partnership, managers struggle to understand the roles and responsibilities of their counterparts across both agencies and work efforts become duplicated. The need to go back to basics of integration and clarifying expectations and accountabilities is advised:

> *…people don't understand the roles and responsibilities of specific agencies, so we have come together and are trying to deliver but actually we are duplicating and there are at time gaps that we are not aware of. So there is something very fundamental about almost going back to basics in terms of integrated working and to clarify what are the accountabilities and expectation as we work in a more integrated way* (R29, Head of Children's Services)

Pooled budgets are seen as a way to address complexities but there is recognition that moving towards aligned budgets as the first step has not yet been achieved (see DIII-10). Even in the case where a manager is operating in a two year joint post for a selective service that is integrated, there is no support, cooperation for or delegation of operational and budgetary responsibility due to agency differences (see DIII-11). Even where there is executive support from joint placement of ADP staff for a joint ADP program across H&SC, operational differences between agencies obstruct the establishing of work space and work processes and hinder the effort (see DIII-12)

Agency differences are apparent at all levels and hamper any efforts to integrate management processes and practices (see DIII-14): the analogy of 'them and us' and 'venus and mars' is drawn by the respondent to signify the severity of differences between agencies. Resolution to these complexities and agency differences require commitment and action from the executive levels of both agencies and via a joint accountable officer if integration is to occur (see DIII-13). The appointment of a joint accountable officer post is troubled with politics as organisations may fear resources becoming committed to service decisions they are not comfortable with: aspects of power and control seep in (see DIII-15).

Theme 3: Service Logic and Value Creation

Managing services at the locality level is the focus where the size of geographical coverage and co-terminosity are seen as an advantage in 'matching' localities, working together and attempting to integrate services (see DII-16, 17 and 18). Financial accountability and tightening of resources are associated with being able to do good work locally (see DII-19). Planning and delivering services locally is found to be important and the local context is given importance over national agenda's since 'the same in every area' cannot work. Context based service design and delivery trumps national programs that are difficult to adopt to the

locality (see DII-20 and 21). The need to look beyond management trends and models and focus on effective service delivery is recognised. The adopted management models by the organisation are seen to transform with changing leadership at the executive level:

> *I've been around long enough now to see the trends and models as they come and go. I was around when self-managed teams was the vogue, but never got off the ground. We have been through several years of lean methodology in Case D, we haven't given up on that yet I would have to say....but the big anxiety is that our leadership teams, the chief execs and the executive directors. When they change over the model changes with them. A few years ago lean was the way we do business...And we are very programme orientated at the minute with project implementation documents and diagrams and all that. I think there are plenty of ways of skinning a cat, the question is does it get things done* (R17, Associate Medical Services Director)

The nature of health services and its management are highlighted and recognised to be of a different nature to private sector logic: user outcome driven as opposed to rational efficiency (see DIII-16). Agency differences and professional siloes are also reported as compromising user focused service delivery (see DIII-17). Managers recognise the need to work in a holistic way but acknowledge that such progress has not been made. There are suggestions that existing services cannot be put together in a successful manner for integrated service delivery as they currently exist. Radical change for creating something new is advocated rather than combining two existing systems (DIII-18 and 19).

Theme 4: The managerial remit: roles, responsibilities and relationships
The ability of managers to deal with future integration is contested (see DII-24). Building trust and credibility as part of roles and responsibilities; understanding both organisations and understanding wider non-traditional teams will be needed (DII-24 and 25). Forthcoming integration is seen to cause tensions and dissatisfaction and there is concern that managers will revert to authoritarianism as a response where engagement is what will be required (DII-26). Further exploration into how the managerial remit is affected reveals that as boundaries become increasingly blurred, managers will need to make sense of what they contribute to integration (DIII-20). There will also be the need to deal with complexities of different policies, procedures, budgets and loyalties:

> *The key thing for managers is how they handle that: being torn apart by policies and procedures, by funding, by budgetary and loyalties and by people above them who's loyalty*

might be to their own organisation rather than to the integrated working endeavour. (R33, Associate Medical Director)

Managers will also in their roles need to address issues of trust and different employment terms of staff on joint teams that affect matter such as different remuneration and leave entitlements (DIII-22).

In managing integrated teams of staff from health and social care when in a joint post, having to deal with two separate systems and the need to comply with national performance frameworks (e.g. the eKSF performance management framework) becomes a restriction to managing performance differently or as per need locally (see BIII-23, 24, 25, 26 and 27).

Theme 5: The learning, training and development of service managers

Leadership T&D is necessitated as opposed to management T&D (see DII 27 and 28) while competence based management is reflected upon as unsubstantiated (DII-29). A severe lack of management T&D is found where managers are unprepared for the multi-agency and multi profession environment (see DII-30) and integration related training is advocated (see DII-31). Further insight reveals that Case D is newly grappling issues of T&D while the Local Authority is ahead in terms of leadership and management training across its different levels. The T&D of managers for basic management tasks, performance management and service management is lacking and is undervalued with lack of respect for the management role (see DIII-31, 32, 33). Neither are they provided the encouragement or support for development (See DIII-34 and 35). The role of national T&D providers is remains irrelevant to the development of service managers in Case D as they mainly focus on policy and clinical T&D and no coordination with them is evident with regards to the development of managers for integrated services (DIII-41, 42 and 43).

With reference to MD, the need to create capacity to learn and allowing space to make mistakes with the passage of experience are found to be key.

> *People do work in siloes managing one service and you've never had to interact with another agency that could be worlds apart. So it's getting an understanding and giving people the support to allow people to learn…So it's about how do we create capacity to learn and develop* (R22, NHS Head of Planning and Performance)

While generic leadership development programs are available, nothing that caters to the specifics of managing services in an integrated environment is provided (see DIII-28, 29 and 30). Coaching as an informal MD intervention is identified with the need to create more coaching roles in the workplace (see DII-33).

Further insight reveals Case D lacking an OD function due to a cost cutting exercise (see DIII-36 to 41). This is a lost opportunity to plan for upcoming change and to deal with the challenges of trust building, remits and joint learning (see DIII-42). An action learning set in Case D is identified however its success cannot be ascertained while it is viewed as a lost opportunity for learning around the integration agenda (see DIII-43).

Summary

Case D even though in an HC&SC partnership is marred by issues surrounding financial governance and lack of planning for the future integration agenda. The outlook on managing change for the future is met with a great degree of caution and disappointment while ideas on how the managerial remit will evolve seem fragmented while a lack of trust and understanding between the managers of both agencies prevails. Pockets of joint working within particular services are evident and budgetary issues and the tightening of resources seems to affect user focused service delivery at the local level. Addressing the range of challenges will require initiative and drive from the executive level and managers demonstrate disappointment with the lack of initiative and direction. Managers seem to lack positivity for dealing with changes since a lack of support and decision making at the top level is missing. Nothing significant in the way of training and MD for the integration agenda is planned or engaged with.

6.2.1.5 Conclusion of the In-Case Analysis

This section has engaged with an in-case analysis of each individual case bringing to the fore, key findings and features that emerge as a result of the interviews and focus groups of Phase 2 and 3 of the research study. The in-case analysis has enabled me to extract issues that are used to develop a cross-case analysis, as set out below in table form, where the main features from the in-case analysis and a summary of key findings from each case are presented.

	Case A Key Features
T1: **Perceptions of** **collaborative** **working,** **integration** **and change**	• Healthy collaborative working exists and localities given importance. • Integration as a model for improving services is conceptually reflected upon and constructively questioned • A continued and growing confidence about joint working and positivity about future integration agenda • Shadow Integration Board is active with planning for integration with equal representation from H&SC • Exclusive co-terminosity resulting from legislative changes (CHPs merging into one CHCP and coterminous with one Local Authority) seen as an advantage • A Corporate Body model preferred for the future integrated partnership.
T2: Managing **with** **complexity and** **ambiguity**	• Different T&Cs of agency staff cause complexity: different pay scales; working hours; holidays etc. This complexity preferred over having to transfer staff T&Cs across agencies under a Lead Agency model • Change driven at political level seen to slow down services and hinder joint working at locality level • Cultural and operation differences between agencies create a trust and cooperation deficit and resistance to change. The need to have dialogue in resolving such differences lacking • A sense of 'what needs to be done' to resolve complexities exists. Motivation to address complexities evident at the management level.
T3: **Service** **Logic** **and** **Value Creation**	• Existing management paradigm seen as rationalistic: tendency to measure performance and processes with disregard to culture and people • At practice level, a shift away from rationale management occurring with service improvement embedded in users rather than structures • User-centred service design and delivery given priority. User-focus enables moving closer to localities. Structural changes a diversion and distraction from quality care service delivery. • Driven by a holistic view of services and importance of joint working at ground level; rather than by top management mind-set or structural change • Future H&SC integration agenda treated as an opportunity to innovate user-led services and create a new service system
T4: **The** **managerial** **remit:** **roles,** **responsibilities** **and** **relationships**	• Managerial remit not accustomed to inter-agency working: a need to understand changing accountabilities and role of other agency staff • Remit expected to expand beyond single agency; become complex; deal with a wider circle of stakeholders when making decisions and utilising resources. • Need to go beyond traditional pathways (that give comfort of clarity) and move towards a user-led service system • Need to deal with challenge of managing via two separate performance management systems due to different T&Cs • Shifting from uni-profession to multi-profession management: meaning new ways of working and new processes • Attempting integration with parts of integrated services, learning and them moving beyond: incremental progress
T5: **The** **learning,** **training** **and** **development of** **service** **managers**	• Training needed for working beyond existing accountability; influencing change in complex environments; understanding changing roles • Training needed for being able to lead, gain respect and develop relationships in multi-disciplinary teams • Training for middle management roles for integrated context important for succession planning • Support and drive from executive level for necessary T&D not happening. • Managers needing faster development of leadership ability in order to deal with a changing remit • Collaborative leadership encouraged in order to manage in complex

	environments
	• Rethinking of leadership as adaptive and contextual beyond traditional models of command and control: context based leadership and leading in localities given priority over leadership competency frameworks
	• Ownership and responsibility for MD at local level taken: learning from localities and transferring to levels above. Coaching and ALSs are part of formal MD programme
	• ALSs deemed useful intervention but underutilised and unsuccessful for MD in Case A for the H&SC agenda
	• Support for organic, tailored and context based MD interventions over generic and programmed MD
	• Support from national T&D providers identified and utilised via coordination by the OD function
	• Planned activity and support from the OD function for L&D of managers; for teams in localities; for organisational change.

	Case B
	Key Features
T1: Perceptions of collaborative working, integration and change	• Management take caution of and refrain from structural change – seen largely to be the very future H&SC integration agenda
	• Change as led by the integration agenda seen to create ambiguity; uncertainty; overplanning
	• The integration agenda (solely structural change) gets in the way of existing joint working arrangements. Joint working but via separate agency entity considered better for effective service planning and delivery.
	• Planning for integration at initial stages with discussion across agencies as to the services that are to be subjected to formal integration
	• Social Care (LA's) seen as more hierarchical and less empowered than Health (NHS) which creates difficulties in operating in integration.
	• No preference or predictions made for either Corporate Body or Lead Agency models for integration
	• Pessimism and weariness about change associated with the integration agenda due to past experience of attempting to integrate H&SC
	• Passive about the concerns of H&SC integration rather than taking ownership since integration is seemingly enforced upon existing joint local service arrangements.
T2: Managing with complexity and ambiguity	• Based on past experience: ambiguity and uncertainty in roles, different T&Cs of employment, managing two separate performance systems (processes and policies) seen as complexities
	• Loss of influence and managerial clout when operating in joint posts and managing different staff sets
	• Disempowerment caused due to individual decision making and rigidness (centralised) in LA's: compared to empowered roles and devolved authority and decentralisation in NHS
	• Restructuring is political and causes frustration; fear; disparity; job insecurity
	• Disproportionate distribution of budgets as a need for the NHS (to address health inequalities based on localities) becomes a problem when in an integrated structure due to expectation of fair or equal resource distributions
	• Insecurity and lack of information at middle management level prevails regarding change and the integration agenda
T3: Service Logic and Value Creation	• A strong association with user focused outcomes. Service design and delivery based on user needs advocated: form follows function at locality level
	• Co-production of services acknowledged and valued: user involvement enables

	better service design and better outcomes
	• Meeting user needs and achieving user-defined outcomes trumps structures and top down change
	• Entanglement with integrated service structures compromises management performance because it hinders user orientated decision making for services
	• Remaining critical partners and managing in new and different ways will need ignoring structures and doing joint work
	• Detachment to integration agenda but established commitment to quality joint service delivery in localities.
T4: The managerial remit: roles, responsibilities and relationships	• Need to exercise tenaciousness; learn and accept new cultures and governances; patience
	• Being able to influence and motivate inter-agency partners and staff groups for decision making
	• Exercising flexibility in order to use multiple systems
	• Need for behavioural transitions and intent for doing new learning
	• Demonstrating new values and relationship building in order to engage with a wider set of stakeholders
	• Grasping the political agenda at both national and locality level as part of role and responsibility
	• Moving from aligned budgets to pooled budgets in a future CHCP arrangement enhances managerial influence on multi-disciplinary staff teams.
	• Remit to go beyond coordinating with agencies in a network towards more responsibility for work and processes in and across other agencies: so an expansion of the remit
T5: The learning, training and development of service managers	• Existing skill sets transferable to integration context
	• Development of managers more about behaviours and attitudes: willingness and motivation to engage with change and becoming adaptable
	• Beginning to reconceptualise leadership: relationship based rather than supervision based
	• Leadership as a behaviour at all levels and across all service components rather than traditionally exercised by the top: multi-layered leadership rather than single-layered leadership
	• Lack of T&D opportunity for middle managers
	• Formal and generic T&D programs as existing not useful or addressing integration challenges
	• A T&D model that can identify structural and change processes of integration may attract managers to engage with context based learning
	• Lack of initiative from the OD function due to uncertainty about what structure will prevail with forthcoming changes of H&SC integration

	Case C Key Features
T1: Perceptions of collaborative working, integration and change	• Engages with integration and pro-actively operating in an integrated CHCP structure
	• Integration at the executive and senior management planning levels via an integrated CHCP Management Team
	• Pride in developing shared understanding, goals, vision, processes and maturity as an integrated partnership; yet acknowledging of the need to improve knowledge and understand different agency cultures, operations and politics.
	• Great degree of preparedness; planning and activity for future change associated with H&SC integration
	• A corporate body model confidently predicted on formal basis since already being practiced over time

	• Legislative change (i.e. Public Bodies Joint working Bill, 2014) treated as providing the drive for taking integration of services to a new and better level; • Legislative change seen to provide consistency to integrating services across all functions and enable improved governance (i.e. moving from aligned budgets to pooled budgets) • Positivity and drive for further integration and embracement of associated challenges
T2: Managing with complexity and ambiguity	• Working towards integrated and interdisciplinary management practices in a formal partnership • Early appointment of a joint accountability officer already providing a single point of contact for integration along with a pre-existing joint CHCP director • Taking on the challenge of integrating cultures and experiences of people • Co-location of agencies has helped develop shared understanding, relationships and similarities over time • Clarity regarding the maintaining of existing T&Cs of staff as separate due to statutory performance requirements with a desire to move towards an integrated performance management system in future • The complexities are treated as manageable challenges that managers intend to successfully and willingly address
T3: Service Logic and Value Creation	• An integrated structure provides a conducive environment in which to develop sense for user-centred service with user defined outcomes. • User needs are a focal point from which joint planning and service delivery follow: jointly derived user outcomes precede service design • Effective service integration translates to integrated single point accessibility for service users and as the ability to see the 'wider picture': • Thinking of different services as combined and as holistic: being one rather than divisions or 'a branch of' • Achieving a holistic service system (as ideology and practice) will require major cultural and organisational changes. • Co-production of services and locality level service design and management not an emphasis
T4: The managerial remit: roles, responsibilities and relationships	• About managing multi-profession teams • Authority and responsibility being challenged on basis of expertise and knowledge by professionals in multi-agency teams • Need to work with two separate PM systems: taken as a challenge and aspirations to for integrating PM systems for combined management processes • Remit will extend beyond profession and organisation to an ''entire agency model'' • A joint workforce plan in initial stages that will attempt combined system and sets of processes.
T5: The learning, training and development of service managers	• Developing the willingness and ability to go beyond existing intra agency management towards inter-agency management • Going beyond single-agency relationship building to multi-agency relationship building • Need to detach from professional grouping and siloes • Existing T7D interventions deemed organisation specific and focused on individual performance. T&D interventions must become service orientated and focus on team performance for integrated context • Separate T&D functions in both organisations exist with no joint T&D planning or delivery for future integration • Role of national T&D providers considered irrelevant to the integration agenda in terms of what service managers do at practice level. • Joint planning for MD not given consideration to date, however a joint

	workforce development plan seeks to identify joint MD
	• No comprehensive skill set or competences for the integration context identified. Skills largely transferable
	• New ways of working, being flexible and improvising useful
	• Pre-defined constructs of competence are opposed in favour of range of competences and skills that can enable
	• Pre-ordained MD interventions opposed as they de-track from developing managers for achieving user-led service outcomes.
	• Context dependent MD advocated as opposed to pre-determined or pre-designed MD in order to develop ability to manage change.
	• Context derived MD to take account of a) nature and composition of integrated teams and b) basis on which they are organised such as locality or client group.
	• Interventions that can support experiential learning, sharing and advice are welcomed
	• ALSs, tailored coaching, mentoring and shadowing deemed useful interventions as they support transitional and experiential learning
	• Informal L&D supported at the separate agency level and no combined effort evident but clarity for what MD in the future will be about

	Case D Key Features
T1: **Perceptions of collaborative working, integration and change**	• Financial governance a focal point of future change in relation to integration
	• Budgetary concerns and lack of planning as an existing CH&CP partnership hinder the service integration effort
	• A good history of joint working in pockets and varying degrees of collaboration depending on service type
	• Future legislation viewed as guideline to resolve issues of structuring and financial governance
	• Integration and joint working with Local Authority problematic owed to lack of understanding and planning around financial governance
	• An interim joint accountable officer appointed as a potential solution to financial governance issues, but then withdrawn due to lobbying
	• Constant concern about what services within health will be subjected to the integration agenda
	• Displeasure and frustration with the lack of planning and lack of executive level decision making in moving forward
	• A corporate body model envisioned exclusively for the reason that different T&Cs of staff and the grievances they create cannot be addressed or overcome.
	• Lack of trust and incentive for integration as Local Authority seen to resist engaging fully with integration due to fragmentation
	• A shadow pathfinder board in planning phases to look into issues of different T&Cs and potential integration model.
	• Threat to employment security observed in relation to the integration model that prevails
T2: Managing with complexity and ambiguity	• Difficulty of boundary spanning as nature of responsibility becomes multi-agent
	• Anxiousness, defensiveness of resources, reverting to professional grouping, tensions and fallouts perceived
	• Hesitation to make decisions in an integrated environment owed to ambiguity
	• The pooling of budgets seen as a need to eliminate a competition culture: aligned budgets seen as challenge before pooled

	• Lack of cooperation and support operationally for management even when in a joint post for selected services • Agency differences are strife and hamper any efforts to plan for integrating management processes and practices • The appointment to a joint accountable officer position is politicised with issues of power, control
T3: Service Logic and Value Creation	• Patient service needs compromised since agencies not willing to go beyond confines of prescribed responsibilities regarding budgets • Focus on locality level management. • Nature of delivering public service management recognised as different to private sector models. User outcome driven as opposed to rational efficiency • Size of geographical coverage and co-terminosity (exclusively) seen as advantage in matching localities • Doing good work locally associated with financial accountability and resources. • Local context important in the planning and delivery of service and given more important over national agenda's which are difficult to adopt • Need to look beyond management trends and models towards what is most effective for service delivery • Management models seen to transform with a change of leadership at the top executive level • Currently both services (H&SC) cannot be integrated in their existing forms and need something radically new.
T4: The managerial remit: roles, responsibilities and relationships	• Ability of managers to deal with future integration is contested • Need to build trust and credibility in the managerial remit • Managers may revert to authoritarianism as integration is seen to cause tensions and dissatisfaction for the managers remit • Need to do sense making as boundaries become blurred in terms of the role and level of responsibilities • Issues of loyalties and trust will need to be handled as part of the role since different staff will have different employment terms within the same joint teams • Managers will have to manage two separate systems and different PM frameworks which becomes a restriction in managing performance as per local need.
T5: The learning, training and development of service managers	• T&D for leadership as oppose to management necessitated • Competence Based Management challenged • A severe lack of T&D established and Case D newly grappling the issue of T&D. The Local Authority seen as more progressive with T&D • A lack T&D of service managers on several accounts; lack of encouragement and support; lack of respect for management role are highlighted • Managers deemed unprepared for a multi-agency multi-profession environment • Role of national T&D providers seen as irrelevant and no coordination or planning exists with them for the development of managers for integration • The need to create a capacity for learning and allowing space for mistakes is established • Coaching identified as a useful intervention while the use of ALSs cannot be ascertained in terms of their impact. • The lack of an OD function in Case D observed as a lost opportunity to deal with the challenges of change.

6.2.2 Cross-Case Analysis

In this section, I present a cross-case analysis of the four cases to develop deeper insight into the findings. I make use of the evidence from Phase 2 and 3 findings and the in-case analysis, but also synthesize and blend in the findings from Phase 4. This provides alternative and contrasting perspectives from the viewpoint of a field expert who is acquainted with the integration of H&SC and MD in the healthcare sector. The analysis set out here is the result of multiple rounds of data analysis using theoretical coding as per CGT method. The outcomes of the cross-case analysis are theoretically organised using themes and subthemes that have resulted from the data analysis process. The process has also required deliberate selection and exercise of judgement in selecting the most critical issues for analysis. These issues therefore are also emerging from repeated insight of the findings and distilling from the in-case analysis. The cross-case analysis is presented using the five structured themes. Identical to the in-case analysis, cross reference is provided to the evidence presented in Annex K using a key that identifies as follows: *Case*, followed by *Phase* followed by *Illustration number*. E.g. *Case A, Phase 3, Illustration 1* uses the key '*AIII-1*'. Cross reference to evidence from Phase 4 uses a key that identifies the single *Respondent* followed by *Illustration number. E.g. 'X-1'*

6.2.2.1 Theme 1: Perceptions of collaborative working, integration and change

A great degree of variation is found in terms of how H&SC integration and the change associated are perceived and associated with. Based on the emerging outcomes of the analysis, these variations are nested under the following issues/categories: *Attitude towards integration and change*; *Purpose of Integration; Preparedness for integration and change*

Attitude towards integration and change

Case A is positive about integration with a continual and growing confidence about joint working. It is treated as a cultural rather than structural change. Politically driven change is accepted and therefore legislative changes are embraced. Managing upcoming change is given a project treatment (see AIII-5). Future integration is also seen to support autonomous locality working since legislative change is considered to provide guidance.

Case B treats integration as entirely about structural change with caution and refrains from it. Ambiguity and uncertainty is common with regards to integration related change which is seen to get in the way of existing joint working arrangements. There is discomfort with politically driven change and pessimism about engaging with integration based on past

experiences that largely shape the attitude of managers. A successful network formation is observed in terms of joint working.

Case C has a pro-active and engaged attitude based on acquired experience with a lead over other CHPs around the country. Integration is treated as a journey towards further integrated work processes and management practice and a step further with service improvement. Politically driven change and legislation is embraced and so are the challenges associated with it.

Case D treat integration between H&SC and doing joint work in an upcoming integrated model as problematic. There is negativity towards change caused by the displeasure and frustration with the lack of planning and inability to plan for it. A lack of trust and cooperation at senior management level between agencies is identified and a lack of engagement with the Local Authority therefore, which may explain the lack of planning for integration. Loss of power, control and fragmentation are perceived if agencies integrating because it subjects their respective services to decision making by the other agency. Due to this, there remains significant concern among service managers about the services that are to be subjected to future integration. Legislation is seen to provide the necessary push and guideline to address the lack of initiative and planning.

Purpose of Integration

For Case A, integration serves the purpose of better service provision for users as it enables exclusive co-terminosity and promotes commitment. This is achieved as a result of the Public Bodies Joint Working bill being enacted which will see 3 separate CHPs merge into a single CHSCP structure that is then exclusively co-terminus with one Local Authority. The integration agenda serves as the opportunity for innovating services locally and enables the achieving of cost efficiencies: doing more for less. It is seen to enable service managers and their teams to facilitate bottom up change via localities because the legislative changes offer more clarity, structure and statutory framework to work under a formal agreement yet offers enough flexibility and devolution to shape things locally. Integration as a model is critically questioned and deemed as the only existing model 'out there' for meeting the pressures of service demand and austerity in the present age.

Case B does not relate successful joint working in a networked arrangement with other agencies to be dependent on future integration. Related change therefore is seemingly is treated as something to be dealt with. Rather the integration agenda and legislation is seemingly enforced upon management and the existing joined-up local service arrangements.

Case C sees the purpose of integration as another step further to the 'journey' of integrating all services. This is clearly evident in the evolution and transformation that Case C has achieved over time. The purpose is to achieve consistency across all service functions for joint planning and delivery under a legislative framework and make existing inter-agency processes stronger. Move towards integrated performance management and workforce development. Integration also serves the purpose merging cultures and building a unified system of integrated inter-agency services while also improving financial governance: to move beyond aligned budgets towards pooled budgets.

In stark contrast, Case D views integration and its purpose as solution to issues of financial governance, lack of planning and coordination. It also serves as a drive for addressing cultural and operational differences between agencies and providing the legislative impetus to improve the ability and capacity to work with partner agency.

Preparedness for Integration and Change

Case A treating the change process as a project activity and placed in a stable state of preparedness with a Shadow Integration Board created and active with equal representation from the NHS and the LA and ample planning between the senior management and executive level to opt for a Body Corporate model for integration. The appointment of a joint accountable officer is also in place with work streams progressing towards the requirements of H&SC legislative changes (NHS Case A, 2013). The Case stands well prepared to implement a new legislative framework (see AII-6).

Case B remains at an initial stage of planning for H&SC integration and the findings from this study do not reveal the stage at which the case stands in terms of a joint board and/or joint officer being appointed. Interestingly, managers do not show any preference for an integration model (as either Body Corporate or Lead Agency) and largely refer to past experiences of attempted integration and the challenges of attempting it. Managers are passive about future structural arrangements to be decided leaving such matters at the executive level. This is not to say that service managers or their teams are incapable or unable to operate in a new integrated structure since joint working ability and the infrastructure to support it are strong and successful in Case B.

Case C is already placed in an integrated structure with joint CHCP board and CHCP management team in place for several years. Furthermore, since the Case C CHCP operates in practice on the basis of a Body Corporate model (even though not legally a separate entity to parent organisation), it confidently envisions a Body Corporate model since this would be

make for a natural transition towards meeting legislative requirements. Preparedness for future change is ample since integration is seen as an already much travelled journey which now further provides the impetus to combine processes and accountabilities and more services while taking on new challenges such as integrating performance management systems and workforce development. Key to this preparedness and advantage over other cases is the co-location of both agencies which over time has enabled them to develop shared learning, shared goals and shared practices.

Case D in its preparedness for integration and change is deficient and irritated even though in an existing H&SC partnership arrangement and organised as a CHCP that enjoys exclusive co-terminosity. The effort to address issues is lacking which is further aggravated with the joint accountable officer (responsible for addressing issues of H&SC financial governance) having withdrawn from the post after lobbying. A pathfinder board is under planning to look into the challenges of integration and potential options for a model.

What Emerges

Further analysis of these cases in view of the findings from Phase 4 would suggest that the integration agenda needs to go beyond encouragement if any progress is to be made by agencies. Legislation is perceived as lacking guideline and prescription for HOW to deliver integration and lacks context (see X1). Furthermore, it may be too early a stage for integration since ground level operational issues and partnership working for managers must be addressed before moving towards integrated structural formations (see X2 and X3). This validates findings from Phase 3 of refraining from introducing too much change too quick and over expecting from the integration agenda (see AIII-11).

Key observations from this cross-case analysis under theme 1 reveal the following:

- Attitude of managers towards H&SC change as directed through legislation bares influence upon how they (and fellow managers) may perceive the purpose of integration and the associated challenges. This influences their willingness and readiness at both the personal and service level to engage with integration and change.

- Over time, the degree of preparedness at the senior level and past experiences as an organisation begin to reflect upon middle managers and shapes their outlook towards integration and it's given opportunities and challenges. Culture develops through managerial mind-sets.

- Preparedness for upcoming legislative change at the planning and executive levels has a bearing upon how managers perceive H&SC integration, its opportunities and challenges

- The past history of joint working and any attempts to integrate structures has a large bearing on their attitude towards integration and change and their purpose.

- Exclusive co-terminosity between an NHS Board and LA produces contrasting outcomes in different cases. In Case A which serves an urban population and not in a pre-existing formal CHCP arrangement: it remains active; prepared and embracing of H&SC integration and change. Case D which serves a rural population and in an existing CHCP partnership faces difficulties and lack of planning. This contrast between cases would assert that structural arrangements (i.e. being exclusively co-terminus or in a CHCP) are not a good parameter upon which to determine service design and management performance. Instead, the contrast between both cases demonstrate the importance of different contexts and cultures shaping the perceptions of integration and the ability to address change.

6.2.2.2 Theme 2: Managing with complexity and ambiguity

Managers identify a range of complexities and ambiguities associated with change in the integration of H&SC leading into the future. These problems can be distilled into five collective issues.

Complexity and ambiguity of the change process itself

Complexity and ambiguity of cultural and operational differences between both agencies.

Complexity in matters pertaining to financial governance with focus on budgetary concerns arising from aligned and pooled budgets.

Complexity and ambiguity arising from managing different T&Cs of employment and performance in joint teams

The analysis can reveal that managers in all four cases nurture these five issues but their perceived implications of these complexities and ambiguities vary. Further to this, what also varies are their motives to then address them. Below, I engage in more detail with this outlined analysis using the four core issues outlines above: *the change process; cultural and operational issues; Financial governance: aligned and pooled budgets; managing staff with different T&Cs for employment and performance.*

The Change process

Case A shows concern for how change as decided at the larger political agenda can be translated into practice at the local level. The implication of this is that change periods (as witnessed in past from moving from LHCCs to CHP formations) hinder and slow down joined service delivery for users because capacity is affected, coordination breakdowns and staff are replaced during these transitions (see AIII-6).

Case B associating the change (and integration) with structural re-design, report it as enforced upon them. The implications of this are fear, frustration and disparity for managers. Particularly, the ambiguity they associate with it is not knowing what integration model will prevail, the implication of which is negativity and insecurity for managers due to the lack of information about the direction in which they are headed, as experienced in the past (see AII-6 and 9).

Case C observes the change process as one enabling them to work towards interdisciplinary practices in an existing integrated formal partnership. In doing so, the appointment of a joint

accountable officer (existing alongside an integrated CHCP management team and a Joint CHCP Director) creates a single point of access further strengthening the ability to deal with forthcoming legislative changes (see CII-5)

Case D sees change as forthcoming, but emphasises on agency shortcomings and lack of planning between agencies disabling managers to deal with the change process. The repercussions are anxiousness among managers about what services are subjected to integration, defensiveness of resources, tension and fallouts between management of both agencies and reverting to professional grouping. The implications here are the lack of trust and incentive among senior managers and the executive levels to engage in planning for change. And further to this, the implication arising is the hesitation to make decisions about change in any integrated manner owed to the ambiguity.

Cultural and Operational Differences

Case A highlights that different processes in health and social care cause complexity and ambiguity about who sets rules and procedures and who one reports to. Complexity also arises due to the LA having great degree of political influence in how they do things and how the make decisions, making it more hierarchal (e.g. the involvement of locally elected counsellors in decisions of service). The implications of this for managers are being weary of integration, lack of cooperation and engagement with counterpart managers in the Local Authority and reverting to professional groupings. In other words, resisting change because of not fully understanding how the partner agency does things. There remains a lack of dialogue between agencies in resolving such differences.

Case B managers' report differences between the NHS and Local Authority in terms of how decision making is done. The LA depends on individual-orientated (authority based) and rigid decision making in a rigid centralised system while the NHS relies on collective service orientated (empowered) decision making based on devolved authority. The Local Authority operates via centralised uniform policies applied across its service functions while the NHS relies on de-centralised and varied policies across a variety of service functions. Furthermore, this is related to the nature of what both agencies do as involving different levels of risk and accountability in the services they provide: the Local Authority dealing with greater risk and accountability than health (see BII-4). These differences are realised in reflection to past experience of working with the LA in an integrated structure. These cultural and operational differences are seen as existing realities that must be confronted.

Case C addresses cultural and operational differences as narrowing over time with processes and practices integrating over time. Being co-located enables better learning of each other's ways of working and learning to develop shared goals and shared practices with time. This evolution is represented in the language and discourse of managers since the challenge for them is about learning 'different cultures and operations' rather than 'differences in cultures and operations'. The implication of this is positivity about the differences and a co-existence of managers who are motivated to narrow cultural and operational divides and improve shared understanding and practice.

Case D remains in a position where cultural and operational differences between agencies are intense and aggravated further by the inability of executive levels to plan with one another for future integration. The implications are negativity and frustration among managers about working in an integrated H&SC partnership due to the enormous differences of culture and ways of working (see DIII-6, 8, 14).

Financial Governance: Aligned and Pooled Budgets

Case A considers matters of financial governance being resolved over time as part of the re-structuring by agencies due to the guidance that legislation will provide and with the right planning behind it (see AII-3).

In contrast, Case B sees the move towards joint financial governance (i.e. pooled budgets) a point of discontent and disparity since it affects the established ways in which health service plan and disproportionally distribute budgets for localities based on health inequalities. Where disproportionate and unequal distribution of budgets is a need in order to address varied health inequalities in different localities, joint financial governance makes the process complicated since the partner agency may look for fair or equal resource distribution of budgets for services and localities (see BIII-9, 10 and 11).

Case C observes joint financial governance a natural progression from existing structures of aligned budgets and resources towards pooled budgets and resources. A joint board, a joint CHCP Director and a joint accountability officer provide the necessary structure here to integrate financial governance with legislation providing the necessary drive for it.

Case D managers views of financial governance as the spine of future H&SC integration since working with aligned budgets is considered a first step has not yet been achieved given the trust deficit and planning between agencies. Even where managers are appointed in joint

posts, there lacks coordination and delegating of budgetary responsibility from the LA. Until planning around the financial arrangements cannot begin to occur, integration cannot be proceeded with and any committing of budgets towards partnered activity is considered to be of a commissioning and competitive nature (see D-III7, 8 and 11).

Managing staff with different T&Cs for employment and performance.

All cases identify complexity and ambiguity arising from the different T&Cs of staff that will have to be managed in inter-agency teams. Case A managers see these as challenges which include managing different staff in the same teams (doing similar work and sharing same outcomes) but with different pay scales; different working hours and holidays. Even though this remains a challenge for managers, it is treated as a limitation of integrated working in a partnership arrangement under a Body Corporate model. This perceived limitation is accepted by managers as the lesser of two evils: the alternative model being lead agency where staff contractual arrangements and T&Cs of employment from one agency will have to be transferred to the other (see AII-12, 13 and 14). Further complexity relates to managers in joint posts having to work with two sets of policies and reporting streams as staff from different agencies will have separate performance management criterias outlined by the parent agency (since staff are retained by parent organisation under a Body Corporate model). Managers see this complexity requiring resolution over time but are unclear of how this can be achieved, especially since they have not engaged with these complexities yet.

Case B managers' associate the different T&Cs of staff creating uncertainty and threat for managers because parameters are not clear enough: not being clear about their role and the fear of having to do something outside the parameter of their job role or responsibility (see BII-10). The need to define the scope of managerial work is identified here to help managers in dealing with different T&Cs of staff in joint teams. Nevertheless, being able to do so is considered a limitation of partnership working especially when there is uncertainty about what integration model will prevail in Case B. Managing staff under separate performance management systems is seen as complex because it required managers in joint posts to understand and apply two sets of policies and processes: applying two different absence management policies and procedures and disciplinary management policies and procedures for two separate staff sets. With past attempts of trying to do this in integrated teams and an integrated structure, loss of influence and loss of managerial clout are an implication that results.

Case C over time has learnt to work in aligned ways while keeping T&C of staff under separate arrangements. Because a Body Corporate model is expected to naturally progress

out of an existing structure that has become experienced in doing together, Case C managers view these differences of T&C as manageable rather than as complex but nevertheless requiring managers to keep learning (CIII-8). Being in a co-located workplace and coming together for shared planning and forged relationships while working towards a joint workforce plan is their testimony to such maturity (see CII-6 and 8). Nevertheless, even if consistency and combined performance management processes are envisioned, separate performance management systems for the time being will have to be worked with due to statutory requirements and compliance towards national targets in health. Case C nevertheless sets a benchmark in terms of forward progression with managing complexity and ambiguity.

Case D reports the managing of staff under different T&C and performance management systems as causing a shift in the responsibility of managers: becoming multi-agent and requiring boundary spanning. Due to issues of financial governance, managers are perceived to experience tensions and fallouts while reverting back to professional groupings. Another complexity reported is the duplication of effort that occurs in managing staff through two separate sets of policies and procedures: as a result of which managers struggle to understand their roles. Similar to Base B, the need to clarify expectations and accountabilities in the managers role, especially when agency differences prevail and there is a lack of coordinated planning for integration (see DIII-9 and 14).

What Emerges

Further analysis of these cases in view of the findings from Phase 4 would suggest that complexities and ambiguities associated with managing different T&C of staff in multi-agency teams is not only a definite limitation of integrated working, but a complete blockage because these issues are ingrained with the actual work that managers do at the local level and therefore can only be resolved within the given context (see X4). This is exemplified in Case C where managers over time, have learnt, adapted and matured to address (rather than resolve) such issues (given they are limitations for the time being) and have found ways of working around them within their own set-up and context. A major finding which emerges from Phase 4 to support this analysis is the coincidental reference by the field expert to specifically Case C as an example of an organisation that has found ways to deal with the limitations of complexities and ambiguities associated with different T&Cs of staff (see X5). This is an interesting observation given that the identities of the four cases was kept anonymous.

These complexities and ambiguities will persist for the time being while integration models begin to emerge and managers at present do not have clarity about where there responsibilities and accountabilities lie (X5). This is evident is Cases A, B and D. There need to learn from organisations and integration models that are finding ways to deal with such complexities and ambiguities and feeding back to other organisations that are now attempting to integrate is important (X6). Key observations from this cross-case analysis under theme 1 reveal the following:

- The change process is viewed differently by all Cases: change as an accepted political agenda; change as an enforced structural re-design; change as an enabler of further integrated practice; change as further complication to lack of planning and financial governance. Therefore, the implications of change are different in each case

- Cultural and operational differences among cases vary with different perceived implications: as being difficult to address and resulting in lack of cooperation, engagement, dialogue and resistance; as existing realities that must be confronted and worked with; as narrowing over time by improving shared understanding and practice; as enormous leading to the inability to plan and mistrust among agencies and causing frustration for managers.

- Cases remain at different stages with different outlooks in terms of their planning and preparation around financial governance. The transition from aligned budgets to pooled budgets is viewed as an outcome of legislation to support and facilitate integration; a natural progression towards inter-disciplinary management; a solution of lack of planning and trust, a cause for disparity in how services will be designed and prioritised based on public need.

- While acknowledging the complexities and ambiguities of different T&C of employment and performance as limitations and complex challenges, managers across agencies must develop understanding and ways of working around these rather than be restricted by them if they are to attempt working in future H&SC partnerships. The ability to do so is dependent on maturity between agencies and is incremental by nature.

6.2.2.3 Theme 3: Service Logic and Value

Managers across all studied cases have identified ideas surrounding existing management models and their transformation, the focus on users, the importance of context and localities.

Based on the emerging outcomes of the analysis, these ideas comprise service purpose, management models, value derived from users and the important of context and locality. Given that this theme looks as service logic and value, the ideas become conceptually entangled and nested into a single category: *User-Context based purpose and management.*

User-Context based Purpose and Management

Case A shows critique and reflection on management paradigms and models. Existing management practices and service design is seen as driven by output and the ability to measure performance with disregard for culture and people in organisations. Market driven models applied to health care services management are seen as rationalistic and ignorant of the complexities of managing joint services (i.e. as analysed in Theme 2). Managerialism is referenced and NPM practices are reflected on with a view that they dominate how management in the health service is done because executive leaders oversee their implementation, because they are prevalent in the processes and practices designed over time and because they offer simplicity and efficiency: ideal outcomes to have in an environment of increasing service demands and decreasing resources (see AII-26 to 29). Service purpose is driven by efficiency and target for health outcomes driven politically and through executive mindset, rather than by varied user needs. However, managers in Case A relate with and promote the shift away from such purpose since they see service innovation (i.e. improvement) as being about services coming together in localities to serve user needs rather than because of structural change which is politically driven and is seen to divert attention from quality care provision. A need to look past structure and political change to focus on the purpose of service provision as needed by users is highlighted by managers. For this reason, managers treat the H&SC integration agenda as an opportunity (that provides governance and guideline) to innovate user-led services and creating something new at the local level. Also, there is realisation that shifting service purpose from organisational efficiency to user-betterment, the change must be driven bottom-up and that new generations of managers overtime replace existing leadership will provide the needed transition: for services to be driven by user needs and consensus rather than by a few individuals. It is about integration at the local level based on needs rather than about integration as a national model (even though adhered to) (see AIII-15). Change driven bottom up rather than top down: form following function rather than function following form becomes important.

Case A engages with a programmed and project approach to doing joint work with other agencies. They are loosely coupled and networked with other agencies such as the Local Authority. Managers aspire to a holistic view of services: integrated service delivery in

localities for users that brings agencies together locally. Value is derived from user focus rather than management or structural arrangements. Going into the future, the desire is to focus on users as the product and users enabling agencies to work closely together in localities to make things happen. In the attempts to deliver user-focused services, exclusive co-terminosity is not cited as playing a role even though it is cited an advantage is implementing legislative changes to structure and governance.

Case B managers demonstrate a strong association and focus on user focused outcomes. To the extent that they detach themselves with the national integration agenda and instead choose to commit and dedicate their efforts to quality joint services in localities since they don't the latter as being dependent on the former (see BII-1). The services operate in a toughly coupled network of inter-agency services where service managers have excelled at working with one another but in separate organisational arrangements. Service design and delivery is based on user needs, for this reason a variety of service functions and service arrangements are observed in Case B. Managers are much focused on meeting user needs in localities and achieving user–defined outcomes and this supersedes as well as trumps structures and top down change. Rather, integrated service structures compromise service quality because they thwart user-orientated decision making. This is a result of past efforts into re-structuring for integration: from which managers have learnt to work better in joint ways but as separate agency structures and governances (see BII-2). Such strong views about service purpose and service design independent of integration (seen as structural and political) has enabled Case B to acknowledge and shift service values towards user centrality. Hence, it is the only case that reports the importance and need of co-produced services in localities: user involvement in determining and governing service outcomes leads to best-fit service pathways (i.e. design) (see BII-11 to 14). This is a direction in which Case B seems to be heading while alongside managing an imposed integration agenda. Crucially for managers, it is about maintaining constructive and critical partners that want to deliver user-led services together, regardless of what structures they end up in.

Case C maintains a conducive environment in which to plan and deliver services jointly with shared goals and processes that get stronger with time. This promotes a shared sense of user-centres services and enables both agencies to joint define focal points and agreed ways of joint planning and service delivery: jointly derived outcomes precede service design. In contrast to Case B however, user focus is associated with merits of the H&SC integration agenda because further integration enables single point accessibility for service users: integration enhances inter-agency service design (an already existing advantage). Integration

also enhances the ability of managers to develop a wider perspective that observes and prioritises beyond the agency: something that is facilitated by being co-located. Even though co-production of services (involvement of users) does not emerge in the analysis of Case C, managers aspire for a holistic service system in which staff of all levels can learn to look beyond organisational boundaries, separate functions and professional silos: being able to treat services as part of a combined and collective system of services (CIII-11)

Case D managers given the lack of planning and concerns of financial governance view user (patient) needs being compromised as agencies are not willing to go beyond their confines to plan or commit resources required for integrated care delivery. Managers' show strong understanding and focus for delivering user-focus services and see the importance of locality: that national programmes cannot be implemented in the same manner and service design and delivery must be adapted locally: be context derived (see DII-20 and 21). The geographical set up (size and rurality) and co-terminosity are cited as an advantage in matching localities, working together and attempting integration (DII-16, 17 and 18): nevertheless services in Case D are managed in a loosely coupled network of agencies where cultural and operational differences are under friction and hinder future integration efforts. Management models are deemed as transitional based on a change in leadership at the executive level and the nature of performance is differentiated from private sector models: That is, performance being user and demand driven as opposed to rational efficiency (see DIII-16). These views align with the analysis in Case A.

What Emerges

Key observations from this cross-case analysis in view of the outcomes from Phase 4 findings reveal the following under Theme 3

- That emerging service systems are about inter-agency and multi-organisational relativity. That services because of a common shared purpose become interlocked with one another. They are merged in to a close network where dependencies are created. This translates into different contexts for different cases and managers therefore must make sense of the context in which they work and manage within it (see X7). This finding supports the analysis which reveals that managers are attempting to make sense and manage within localities. In each case, the context and mode of management greatly varies: Case A with a programmed and project approach, loosely coupled and networked with other agencies; Case B operating in a toughly coupled network of inter-agency services and driven by localities and user-involvement; Case C in an integrated interdisciplinary system of services that is co-

located and Case D operating in a loosely coupled network of agencies with exclusive co-terminosity as advantage for locality level management.

- The need to look beyond separate service functions and the organisation is increasingly the need for managing services that are moving towards 'whole' forms: being able to do this comes through experience and maturity (see X8). This is in line with the analysis of Case C which reveals that managers have begun learning to see the wider picture by working jointly and developing shared ways over time.

- Even though user needs and context should dictate the way in which management is done, the need for efficiency and achieving targets remains an important element of modern day public services (see X9). Nevertheless, if service quality and delivery are to improve, they need to be based on different logic and value (user-centred and services-driven) to private sector logic (efficiency-centred and organisation-driven) as recognised by managers (see X10). This also supports the analysis of managers highlighting the need to go beyond existing management paradigms and models based on organisational efficiency towards paradigms and models that are based on user and context dependent.

6.2.2.4 Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

The cases analysed demonstrate the different ways managers in each case view roles, responsibilities and relationships altering with H&SC integration. A limitation when analysing this theme was how managers engage with a discussion on issues surrounding the managerial remit without being able to provide specific context or examples of RRRs. The result of this is varied and diverse ideas based experience of the past but perceptions of the future. Therefore, when engaging with this theme, the theoretical coding and judgement encouraged using a lens of What managers do and How they do it as a way of distilling. The analysis is grouped into one core issue: *transitions in remit*.

Transitions in Remit

Case A reveals that managers in the RRRs will have to expand beyond the single agency and deal with a wider circle of stakeholders when making decisions and utilising resources: something they are not accustomed to. This will create complexities for them. Accountabilities change here because managers must go beyond traditional ways of working

(e.g. defined service pathways within the NHS) that they are accustomed to and move towards a user-led service system comprising of multi-agency working. Managers will have to engage with two separate performance management systems (due to different T&Cs discussed in Theme 2) and engage with increasingly multi-profession teams, a phenomena that arises out of H&SC integration. This will mean engaging with new processes and new ways of working. How they deal with these transitions in the managerial remit will depend on understanding changing accountabilities and the remits of other agency staff. More democratic decision making; political intelligence; moving away from traditional career pathways are also ways forward. To enable this, managers suggest experimenting integrated ways of working with parts of services, learning from this and moving to other parts of services (see AII-20 and 21).: an incremental process advocating both action based learning and experiential learning

Managers in Case B reveal a need for an expansion to the managerial remit: going beyond coordinating with agencies in a network and taking on board more responsibility for work and processes in other agencies. They must also be able to use multiple systems and engage with a wider set of stakeholders. How they do these things will depend on demonstrating certain behaviours: being flexible; being patient; demonstrating new values and relationships with the wider stakeholder group; exercising influence and being able to motivate different staff groups. Being tenacious and willing to learn new cultures and governances is crucial here (see BII-15 to 17). Grasping an understanding of political agenda's at both the national and local levels becomes important is being able to do this.

Case C demonstrates the RRRs of managers to extend beyond the profession and the organisation to encompass RRRs in an entire system comprising of services. Managers report the need to widen their ability to lead since they will not have expertise in neither one single discipline nor multiple disciplines: an element of the multi-profession teams they will manage in the future. For this reason, their authority is likely to be challenged on the basis of professional knowledge. This demonstrates the need to be able to lead challenging teams. For Case C, the managerial remit is largely about learning different agency cultures and ways of working in order to manage multi-profession teams. Since a Body Corporate model is exercised in practice with a clear view that existing T&Cs of employment will be retained, there is acknowledgement that service managers in both agencies are still far from working in such a new remit, nevertheless there is optimistic and constructive outlook maintained by the CHCP management team who envision the managerial remit capable of working in integrated ways (see CIII-2): a joint workforce plan is a way forward for this vision.

Case D managers draw on similar issues as in other cases, but interestingly add two further observations for the managerial remit. Firstly, they question the ability of service managers to deal with future integration in their remit. Secondly that their remit will need to deal with the lack of trust and loyalty as they attempt to engage across agencies. Managers are advised to develop credibility therefore and make sense of what they will contribute to integration. Further this this, there is fear that managers will revert to authoritarianism when tensions and dissatisfaction arises (DII-26). As highlighted by managers in other cases, The RRRs of managers will have to deal with separate agency performance systems: but in Case D this is seen to restrict managers from serving as per local need. The outlook remains doubtful and embroiled with difficulty for the managerial remit in future integrated services.

What Emerges

Reflections from phase 4 reveal that it is difficult to generally prescribe for the managerial remit in integrated services. While acknowledging the need for managers to go beyond the single agency and profession and develop a wider outlook as analysed in all four cases, it is actually a matter of what managers and organisations are willing to do about it. Further to this the analysis reveals:

- In supporting managers, there needs to be prescribing for exactly what the role is rather than engaging with pre-set notions of RRRs (see X11).

- It becomes necessary to enable managers and give them space as part of their remit. On the part of managers this is about active and conscious engagement: and therefore it is about a behavioural transition. On the part of organisations, it is about wanting professional managers that can be recognised as professionals (see X12). In Case C, this evolution becomes evident where managers and the organisation have willingly and pro-actively engaged in a co-located setting to develop shared and new ways of learning and doing.

- Suggestions for how managers do this lies with doing on basis of given contexts as opposed to expected outputs. The challenges here are that managers are traditionally more driven by performing and achieving as a solution to problems rather than by reflection and learning as solution to problems (see X12). The emphasis is placed on treating reflective learning as a compulsory element of the managerial remit (see X13)

- Existing management paradigms demand that the managerial remit be role and task driven (i.e. through job descriptions and responsibilities; demonstrating of expected competences). This places boundaries upon what managers do and how they do while limiting the scope of their remit. It is only with time and experience that managers typically learn to grow beyond the defined scope and limitation of their remits. Integrated service delivery will require a shift that goes beyond defined limitations and boundaries for the remit of managers since it is people and processes that managers deal with: both unpredictable by nature and in their outcomes (see X14 and 15).

6.2.2.5 Theme 5: The learning, training and development of service managers

Under this theme, I engage with a cross case analysis of a range of issues related to the learning, training and development of managers. The analysis under this theme is particularly challenging for the reasons that even though the interview and focus group questions distinguished between terms and constructs such as Training, Learning and Management Development, the respondents used the terms and the constructs interchangeably. As the researcher, one had to draw careful distinction in terms of how the analysis could be structured without compromising meaning and/or what respondents were referring to. Based on what emerged from the cross case analysis, the issues are carefully sorted and organised into three groups: *transformation in T&D; transition in leadership; reframed MD and new L&D.*

Transformation in T&D

The cases reveal shortcomings and inadequacy within existing T&D provisions in the NHS. Particularly, this is to do with a lack of T&D for individuals moving into service management roles and secondly; its content in terms of supporting the H&SC integration agenda; its form in terms of suitability for a given context; support for T&D

Case A management highlight that the required support from the executive level for T&D relevant to partnership working is not occurring. The T&D of managers here is considered important in terms of succession planning for the future: that being middle managers replacing senior retire to find themselves unprepared to manage integrated teams in a complex inter-agency environment that they inherit. Managers call for T&D provision which:

- enables managers to lead and develop relationships in multi-disciplinary teams,

- improves their ability to work beyond existing accountabilities,

- enables to them understand the roles of other agency staff

- incorporate skills of collaborating and integration: without specifying what these may be

- develop resilience rather than the need to know all

Support from national T&D providers is identified by managers in Case A. They see organisations such as the JIT and IHM supporting them and their organisation through the integration agenda. This is a result of an active OD function in Case A that coordinates with national T&D providers for T&D support with the integration agenda (see AIII-38 to 40). Support from the OD function is pro-active and engaged with teams in localities and takes up a professional endeavour of supporting managers and teams through change: however this does not equate to T&D provision by the OD function and instead translates into other forms of L&D support which I will discuss a bit later.

Case B management identifies a lack of T&D opportunities for individuals moving into middle management roles. Existing T&D forms are deemed formal and generic and not useful for addressing the challenges for service integration and considered to be repeated in form and content (see BIII-20 and 21). Managers' desire T&D provision which:

- Can enable managers to identify structural and change processes of integration: the result of which is engagement with context based learning

- Can help develop values and behaviours as understood by managers for their own context.

- Can impact their behaviours and attitudes: it is about behavioural change since existing skill sets and tools possessed by managers are seen to be transferable to the partnership working context.

- Improves their willingness and motivation to engage with change and become adaptable: behavioural shifts.

Support from national T&D providers or any coordination with them is not identified. The OD function in Case B while recognising the need to support managers in developing new behaviours, currently refrains from any planning and activity to support this until more clarity is gained about the integration model and structure that will prevail in Case B.

Case C management identifies existing T&D provision to be organisational specific and focused on individual performance. Even though Case A operates in an integrated CHCP

partnership with a joint CHCP management team, the T&D functions of both agencies remain separate and currently do not engage in joint T&D planning or delivery for the H&SC integration agenda. This has been put on hold post-legislative change. Similar to Case B, lack of support for individuals entering into middle management roles is highlighted (see CII-15). Similar to Case A and B, no comprehensive skill set of competences are identified for integrated partnership working and existing skills are deemed transferable. Further to this, pre-defined constructs of competence are opposed in favour of enabling competences and skills suited to context. Managers identify future T&D provision which

- Can promote new ways of working
- Enable flexibility and improvisation: behavioural shifts
- Develop willingness to go beyond intra-agency to inter-agency management and single agency relationship building to multi-agency relationship building
- Enable detachment from and going beyond professional siloes and organisational boundaries to treat services holistically.

The last two bullet points above are met with the challenge of managers being conventionally educated and trained for professions, which reinforces professional grouping and professional body membership: hence siloes (see CII-12. The role of national T&D providers is seen to be irrelevant to CHPs and what service managers do at the practice level. No coordination with them for the H&SC agenda exists as the CHCP management team show preference for addressing T&D issues in-house and have a workforce development plan in its initial stages to provide a way forward. An OD function is not identified in Case C.

Case D management reports a severe lack of T&D for joint working and report having just begun to contend with it. This is owed to the lack of encouragement and support for T&D and a lack of respect for the manager role. Managers therefore are seen as unprepared for a multi-agency multi-profession environment. Case D is the only analysed case that draws a comparison with T&D provision in the Local Authority seeing it as more progressive than the NHS. Managers challenge competence based management. Managers highlight future T&D provision which:

- Develops leadership capability as opposed to management competences

The role of national T&D providers is seen as irrelevant and no coordination or planning between Case D and them exists for the H&SC integration agenda. The lack of an OD function in Case D resulting from a cost-cutting exercise is observed as a lost opportunity to deal with change.

T&D as existing in all four cases is identified as inadequate and irrelevant for the changing service context and particularly for managers to engage with inter-agency and multi-profession teams in integrated H&SC partnerships. Managers identify a lack of support for T&D and even though they can point to what needs to be done differently, they propose no ideas of how this occur or who is going to address it. T&D delivery remains scattered and fragmented across services and localities and managers are unable to prescribe specifics.

Transition in Leadership

The analysis synthesises a strong element of leadership across the cases as a result of exploring the learning, training and development of managers (Theme 5).

Case A highlights the need for managers to lead multi-disciplinary teams and the need to develop leadership ability at a fast pace if managers are to keep up with a fast changing remit and change. For this, the following necessitates:

- Rethinking leadership as adaptive and context based as opposed to traditional models of command and control leadership.
- Leadership based on locality needs (context) as opposed to leadership competency frameworks
- Relying on collaborative leadership as opposed to management models: as a means of enabling managers in complex service environments

Case B begins to reconceptualise leadership in new ways. These include:
- Leading on the basis of relationships as opposed to leading on basis of supervision
- Leadership as a way of operating: as a behaviour as opposed to Leadership as a designated role.
- Demonstrating leadership behaviour across all levels and functions as opposed to traditional leadership exercised at the top level: multi-layered leading instead of single layered leading

Case C emphasises the lack of leadership training alongside the lack of management training. Management highlights that successful managers who can lead integrated teams will be those who don't get caught into professional siloes. New leadership will entail:

- Detaching from professional grouping and serving larger interests (seeing the bigger picture) than those of the profession.

Case D, currently experience a lack of direction and planning owed to top leaders in both organisations, highlight that the focus is on leadership as opposed to management (see DII-28). Managers highlight the following going forward:

- the need to invest in leadership T&D as opposed to management T&D
- being able to effectively lead rather than demonstrating defined competences

The analysis reveals the need to support managers in ways that can enable them to lead in a changing service environment where managing inter-agency and multi-professional teams will challenge them. It is about behaving in new ways and in new contexts. Transformational, adaptive and collaborative forms of leadership are welcomed (see AIII-35 and 36) A transition in how leadership is thought about and can be supported is clearly evident across the cases.

Reframed MD and New Learning

This issue concentrates on an analysis of how the L&D of managers is being supported and altering as services move towards partnership working and integrated structures. It also analyses the use of MD interventions in each case.

Case A takes ownership and responsibility for the L&D in localities and the provision of MD interventions. Coaching and ALSs comprise part of a formal MD programme and are supported through the OD function in Case A. The OD function provides consultants and change managers to support managers through change. ALSs even though considered a useful intervention by service managers, remain underutilised and unsuccessful for the L&D of managers for the H&SC integration agenda because service managers could not decide a need for it collectively or be able to shape it (see AIII-27, 28 and 29). Given the presence of a strong OD function in Case A (which service managers appreciate and value) there is a

strong inclination for avoiding generic MD programmes and instead, supporting organic and tailored MD interventions that are context based to support managers

Similarly, Case B highlights the need for flexible and intuitive learning where managers can tailor to themselves based on need. A range of in-house programmes are available across different pieces of change that support mentoring, coaching and shadowing interventions and are interchangeably referred to as both MD and Leadership programmes. However, it becomes difficult to ascertain from the accounts of respondents as to the specifics or success of these programmes and interventions since they exist and operate in a disjointed manner across Case B which a fairly widespread organisation serving a large but diversified population region.

As Case C is looking to support new ways of working, flexibility and developing a holistic service perspective, there is opposition to pre-ordained constructs of MD or pre-determined competences (see CII 16 and 17). Pre-ordained MD interventions (generic and programmic in other words) are seen to de-track managers from being able to deliver user-led service outcomes (context specific). Learning for new environments cannot be pre-determined or pre-designed (see CIII-22). Rather the following two elements are suggested to be important in determining the content and design of future MD interventions for the integrated service context:

1. the nature and composition of multi-disciplinary teams being managed
2. the basis on which they are being organised: geography (locality) and client group (users)

ALSs and Shadowing are considered useful interventions as managers are keen to support learning that is incremental and experiential. The particulars of such MD programmes or their success are not specified by managers (see CIII-21 and 23). However, availing the advantage of co-location as services, shared learning and the exchange of experience enables managers to break down barriers and facilitates new learning and a shift towards integrated service delivery (see CIII-24). As a CHCP which engages in joint planning and decision making, consideration has not been given to joint planning for MD. A joint workforce development plan is however envisioned and planned as part of the shift towards H&SC integration post legislation.

Case D places emphasis on creating the capacity to learn and allowing managers to make mistakes through experience. Coaching as an intervention is identified as a useful

intervention both in terms of facilitating the L&D of managers and as a T&D intervention where managers can be trained as coaches.

A case of re-framing MD to move from generic and programmed forms towards tailored and context specific forms that can support new forms of managerial L&D. The basis on which MD interventions (both in form and content) are designed needs to be re-framed and occur on the basis of factors relevant to the integrated H&SC service context: locality and users.

What Emerges

Distilling from the cross-case analysis of theme 5 and taking on board what emerges from Phase 4 findings, the following can be synthesized:

- The analysis reveals that T&D needs to support behavioural shifts to enable managers to work in an integrated environment. All cases identify the kind of transformation that T&D needs to make in form and content, but don't show any understanding or direction regarding what can be done about it. This is because T&D in the NHS remains highly complex, fragmented and contested on the basis of its purpose and increasing irrelevance (Sambrook, 2005; Khurana 2007; Locke and Spender, 2011; Thomas et al, 2012 Edmondstone and Western, 2002). This is further verified through the analysis of Phase 4 findings which indicate that T&D in the NHS is highly fragmented and disparate while its focus is on mainly the efficiency agenda in a time of austerity. Its irrelevance to the changing service environment is exemplified by the respondent with reference to workforce planners in the NHS deciding staffing levels without any reference to the need of individuals, teams or what they need to be delivering in a changing service environment. The suggestions here are for enabling managers to reflect and grow with the context they work with which itself is transient. For this reason, the development of managers is fundamentally about knowledge of contexts and behaviours within contexts: being resilient; acting with courage and integrity; being confident (see X16 and 17).

- To analyse further, this is essentially what managers are calling for in this study when they advocate a shift in leadership thinking, leadership development and leadership practice: transitions in behaviour of the manager be aided for then to lead in inter-agency and multi-profession environments where they will be challenged on the basis of their knowledge, authority and accountability. Phase 4 findings validate this further with the emphasis being placed on developing ways of behaving rather than models of managing change (see X18)

- The analysis also reveals the need to re-frame MD for a changing service context. The move from generic, programmed and pre-ordained forms towards organic, tailored and context specific forms is highlighted across all cases to support new forms of L&D for managers while the basis on which MD form and content is designed needs to be locality and user based. Further analysis on this issue verifies the need to respect what managers are attempting to do by listening to what they actually want in terms of L&D support. The need to move beyond traditional notions of programme and study and encouraging managers to select their own ways of L&D than can help them is the need going into the future. This would mean MD moving beyond intervention types and supporting managers to reflect and learn in the broadest possible way so they can develop resilience and confidence (see X19). For this, managers need to assess themselves against a MD framework that is meaningful to themselves, rather than looking for answers in existing MD programmes (see X20)

- Taking managers to account, the analysis from Phase 4 reveals that managers struggle to define the reasons and the context for which they need L&D support when the remit extends beyond the level of their day to day work (X21 and X22). This supports our analysis of the four cases where managers have lacked preciseness in defining what it is within their changing context that challenges them and in identifying specific the LTD needs they may accordingly have.

- Policy and legislation by their very nature are not seen to provide direction for future MD (see X23). Neither are organisations seen as being able to develop managers unless they intentionally become progressive and willing to listen to what managers actually want and encourage learning networks. It is managers themselves who will need to take the initiative and responsibility to define their contexts, their MD needs and the framework through which they will fulfil them (see X24): the case for the future becomes one about self-determined and self-directed MD.

6.2.2.6 Synthesis and Conclusion of the Cross-Case Analysis

Below, I provide a closing synthesis of what has emerged from this cross-case analysis by distilling critical issues, pulling together important outcomes and highlighting their significance to facilitate progression to the discussion of the analysis in light of the literature.

	Synthesis and Significance of What Emerges
Theme 1 *Perceptions of CW, integration and change*	• Health and Social care integration is referred to using a range of terminology (i.e. coordination, joint-working, partnership) and integrated service is conceptualised as different forms (i.e. coordinated; joined-up, fully integrated; partnered) • Attitude towards H&SC change, driven by legislation, influences perceived purpose of integration and challenges. • Past history of joint working in the organisation and existing managerial mind-sets shape management culture and the willingness to engage. • Exclusive co-terminosity does not yield consistency in terms of outlook towards integration, preparedness for change or management practice in any two given cases. This asserts that structural formation is not a sound parameter upon which to determine service design or management performance: the importance of context (locality) is asserted. • The integration model that future H&SC partnerships adopt is seen as influencing their ability to manage the challenges of joint working, particularly with respect to people management and financial governance.
Theme 2 *Managing with complexity and ambiguity (C&As)*	• C&As are inevitable in healthcare service management and embedded in the work that managers do. These C&As are transient with changes at the political and organisational levels. • C&As particularly in relation to the different T&Cs of employment of staff and their separate performance management in multi-agency teams are ones that cannot be resolved. Managers need to work with this given limitation. • The only means of addressing (rather than resolving) C&As is to intentionally attempt understanding them within the given context and proactively working around them at the local level (rather than being restricted by them). Organisations are at different stages and different capability levels in being able to do this: therefore managers in each case studied perceive the complexities of the change process differently. • The professed implications of cultural and operational differences when attempting future integration vary in type and degree of severity across cases. Nevertheless, cultural and operational differences are seen as the main challenges to integrating services. • Integration in terms of joint financial governance is seen to bare different outcomes for partnership working: these outcomes range from 'supporting progression towards interdisciplinary management practices' to 'creating disparity for quality needs-based healthcare service'
	• Even though user needs and context (locality) are critical to managers and should dictate how management is done and how service pathways are designed, the focus remains on the

Theme 3 *Service Logic and Value*	need for organisational performance efficiency and national measurable targets. • For an integrated service context where service organisations become interlinked and inter-dependent, service quality and delivery need to be based on different logic and values to the private sector: user-centred and services-driven as opposed to efficiency-centred and organisation-driven • Managers highlight the need to look beyond separate organisations and service functions if they are to manage integrated services which are increasingly moving towards 'whole' forms (a holistic service system). Being able to do this requires maturity: derived from joint working (inter-agency) experience. • Emerging service systems are increasingly about inter-agency and multi-professional relativity where different agencies and their services share common interlocked purpose (i.e. the same users) and common dependencies (i.e. pooled budgets and joint financial/resourcing decisions)
Theme 4 *The managerial remit: roles, responsibilit ies and relationship s (RRRs)*	• What managers do and how they do it in terms of RRRs will increasingly be about managing multi-agency and multi-professional teams where the authority and knowledge of managers will be challenged • To support managers in future service systems (i.e. integrated services), the support needs to be specific for what they are doing in a given context rather than supporting them on pre-set notions of what their roles, responsibilities and relationships are. • Doing this requires giving managers space as part of their remit in order to reflect on their RRRs. For managers this means active and conscious engagement: wanting one self to do different than before: therefore a behavioural transition. On part of organisations this means recognising and treating managers as professionals. • To derive the appropriate remit (engage with the right type of RRRs) for the integrated service environment, it is about doing on the basis of given contexts (i.e. localities) rather than expected outcomes. It is about RRRs that are not restricted by defined boundaries or ways of working (i.e. job descriptions and competence based management). • Existing management paradigms prevail and demand that the managerial remit be role-driven and task-driven; that RRRs be pre-defined and pre-determined in terms of their scope and accountabilities. • The other limitation to engaging with the needed RRRs for a changing service system (integrated service environments) is the inclination of managers to be driven by performing and achieving as solution to challenges. The transition needed is about engaging with reflection and learning as solution to challenges • The managerial remit for the future is about inter-agency and multi-profession operability that requires a shift away from defined limits and boundaries of RRRs, since it is about managing people and processes: it is about managing unpredictability.
	• T&D for middle managers entering management roles is lacking and existing T&D in its various forms and content remains fragmented across the system. T&D is contested in terms of its ability to the serve the H&SC integration agenda and primarily focused around the organisational efficiency (more with less) agenda. • Managers highlight that T&D must transform to take up the agenda of supporting managers to make (or develop) behavioural shifts that enable working with multi-agency and multi-

	profession environments. But managers struggle in defining how this can be done via T&D
	• The development of managers is fundamentally about knowledge of transient contexts and the behaviours required for them: these encompass resilience, courage; courage, confidence, tenaciousness.
	• A transition in leadership thinking and practice is signified. The need to demonstrate leadership as a behaviour becomes important in new service systems where managers will be challenged on the basis of knowledge and authority in multi-agency multi-profession team environments. Future management becomes more about leading capability as oppose to management competence.
Theme 5 *The learning, training and development of service managers*	• Leadership transitions to new service environments include: from hierarchical and authoritative forms to collaborative and relational forms; shifts from command and control based to adaptive and context based; from leading from the centre to leading in localities; from traditional leadership exercised at top level and executive function to leadership exercised across all levels and functions.
	• Reframing MD form and content for managers in a changing service system necessitates moving away from generic and pre-ordained forms towards organic and context based forms. MD form and content must support L&D that is locality and user based
	• Even though non-programmed interventions such as ALSs and mentoring are being used by organisations, their effectiveness to serve the L&D of managers for the integrated service arena is mostly underutilised and unsuccessful. Implementation of such MD interventions and their impact cannot be ascertained as they are highly fragmented and varied. Nevertheless, managers are keen to support MD interventions that allow learning which is incremental and experiential
	• New forms of MD must take account of the shift from single-agency single-profession teams to multi-agency multi-profession teams and the basis on which they are organised in the future
	• Joint planning for MD between agencies for the H&SC integration agenda does not presently occur.
	• MD interventions must be about support and enablement for managers in the widest possible ways. This advocates reframing MD to move away from traditional pre-ordained notions of 'programme' or 'intervention type' towards MD where managers are supported in self-determining and self-directing a framework that suits their L&D needs based on their own context.
	• Presently, managers struggle to define the reasons and context for which they need L&D support. They must take up the challenge of defining both and self-initiating their own MD since the organisation and policy are unlikely to provide the necessary.

7. DISCUSSION

In this chapter I engage with a discussion of the findings from my study and with my analysis of these in light of key theoretical propositions and my research questions.

The aim of this thesis has been to enquire how the nature of managerial work is changing as healthcare services become increasingly integrated, how Management Development (MD) alters as a result and how MD can be re-framed. To do this, I set out to explore issues and complexities service managers face when engaging with joint working and service integration and how it affects their roles, responsibilities and relationships (the remit). Further to this I explored the changing nature of managerial learning, training and development as a result of joint working and integration and assessed how MD in form and content alters to facilitate managers in new service systems.

The study adopted Scottish CHPs as the setting for this enquiry since health and social care (H&SC) integration was discovered to be the prime context which the healthcare service (the NHS) was engaging with.

In order to meet these research objectives, the following research questions, exploratory in nature, are set out for inquiry:

1. What challenges and opportunities arise from joint working and service integration for service managers in Scottish healthcare services?

2. How do joint working and service integration influence the role, responsibilities and relationships (referred to as remit) of service managers and what does this implicate for managerial skills and behaviours?

3. What are the implications of joint working, service integration and an altering remit for managerial learning, training and development?

4. How can Management Development (in form and content; as concept and practice) be reframed with the future needs of an integrated healthcare service system to prepare and enable managers to deliver effective services?

An attempt to address these questions in light of the emerging issues and theoretical concepts is made, using the five themes that emerged from the fieldwork.

7.1 Theme 1: Perceptions of collaborative working, integration and change

Having analysed managers' perceptions of joint working, integration and change, with the CHP as the setting, the following emerges.

The attitude of managers towards change (arising from legislation) influences the perceived purpose of H&SC integration and its challenges. Here, past history of joint working and partnership arrangements in the organisation and the past personal experiences of managers attempting joint working shapes management culture and their willingness to engage with the challenges associated with change. As Besharoff and Smith (2013) note, the integration of H&SC services is marred with multiple institutional logics in the attempt to deliver. Burnes (1996) essential argument that past experience reinforces behaviour lends support to these findings. The Scottish Government (2010) policy for moving towards partnership working as a means of service improvement endorses these perceptions of managers by acknowledging that attempts to engage in partnership working will not be independent of tensions and challenges. However, the study finds that such policy does not go beyond this point to demonstrate or exemplify what these tensions and challenges associated with integration may be or how they arise.

The findings reveal further that managers perceptions of integration as a concept is variable as the cases reveal managers to use terms such as partnership working, collaborative working, joint working and integration interchangeably to understand and describe H&SC integration. This is supported by Robson's (2013) view on integration that such simultaneous use of terminology is commonly the case in the context of the Scottish NHS where the different terms are used to refer to the concept of joined-up service delivery of NHS and Social Care services. Further to this, the cases also reveal how managers conceptualise integrated H&SC services in different ways. These range from: challenge of integrating across health and social care organisations; integrating acute and primary services within health; jointly funded services with pooled budgets. This is in accordance with Robertson (2006, p.8) who discusses variations in how integrated healthcare is conceptualised or what it means. Armitage et al (2009) advises caution in conceptualising integration given the large and overwhelming diversity of terminology and meaning given to it.

To support Leutz (2005) theorising of integration, the findings also establish that integration for healthcare services is understood and referred to by managers across all cases as a 'form':

either coordinated; partnered; joined-up; fully integrated. Conceptualising integration as a level of occurrence (Ramsay, Fulop and Edwards, 2009, Reed et al 2005, and Glendinning, 2003) managers perceive integration to occur at the 'service' level and not the 'vertical' or 'horizontal' levels. This is because change as politically driven, is perceived to affect the re-organising of services across health and social care. O'Leary and Vij (2012) and McGuire (2012) suggest that there remains a difficulty of not being able to distinguish between forms of coordination, cooperation, alliances, partnership, integration and so forth. In the context of this study, this happens to be so due to the lack of clarity about what will constitute change or to what degree change will prevail in terms of H&SC integration. An example of this is uncertainty among managers in Case D about what services within the NHS are to be subjected to integration.

As revealed from the comparisons between Cases A and D, one can argue that exclusive co-terminosity (arrangement of the NHS Board and Local Authority as sharing the same and one geographical coverage) does not yield consistency in terms of the organisations preparedness for integration. This is so even when legislation indirectly encourages co-terminosity by requiring Health Boards and Local Authorities to integrate into single entity formations (i.e. the CHSCP). Both Cases, even though they will attain exclusive co-terminosity as a future CHSCP, are at very different stages of planning, possess very different perceptions of change and challenges in integration, and are contrastingly different in terms of their size and geographical coverage: that is, Case A serving an urban population with a large geographical coverage while Case D serving a rural population with a small geographical coverage. These findings are supported by critics who question of value of integration given issues and differences of size of organisations, and their structural and geographical differences (Boone, 2000; Robertson, 2011). Nevertheless, managers in both cases do perceive exclusive co-terminosity as an advantage because exclusive co-terminosity is perceived to make it less complicated to plan for service delivery in localities (since boundaries of service coverage become the same for both agencies).

Furthermore, managers treat integration as politically driven and primarily as being about structural re-design and efficiency gain. They do not associate this politically driven H&SC integration agenda with better user outcomes or better localised services. Rather, they consider change associated with integration as disruptive to user-centred service delivery because of the challenges it creates (e.g. slowing down of services, breakdown in coordination, changes in staff formations; compromising already existing work arrangement between agencies). Neither do managers associate perceived change and future integration of

H&SC to be about more user involvement (i.e. co-produced services). Suggestions from Lang (2011) and Ham et al. (2012) for the inclination to integrate services for reasons of service demand and austerity are supported. However, involvement of users in health policy and practice for more participatory public management (Lang, 2011; Ham et al. 2012) is not support by these research outcomes since managers do not associate change (as driven by H&SC integration) with the concept of user-involvement or co-production of healthcare services. Even though 'user-focused services' are treated as priority and the H&SC integration is judged against it, 'user-involvement in service design' is not. This reaffirms (Simmons et al, 2012) argument that the degree to which the input of users is recognised by organisations and management is contested.

The arguments of Fledderus et al (2015) that co-production may increase uncertainty for organisations maybe the case here. As seen from the managerial perspective, change is driven by the re-structuring and efficiency agenda rather than by user outcomes or user betterment. This supports an extensive range of theory supporting the position that collaboration and the integration agenda are driven by cost efficiency and the NHS desire for reorganising organisational structures in response to it (Tschirart et al, 2009; Segar et al, 2013; Mark and Scott, 1992). Even though government policy and strategy intends for H&SC integration to serve the purpose of 'better services for users' and 'user participation' in service design, managers do not perceive so. Hopson (2013) reaffirms this position, since for managers in healthcare, change remains the only constant in which H&SC integration remains the latest mantra.

A further issue emerging is the managerial perception of how adopted integration models (Body Corporate and Lead Agency) influence the manager's ability to address the challenges of joint working, particularly with reference to managing staff and financial governance. All cases reveal an inclination and expectancy to adopt a *Body Corporate* model for a future H&SC partnership as a means of easing the challenge of managing staff in joint teams with different T&C of employment and performance. Interestingly, managers do not draw any association between an adopted integration model and its possible implications for users. The *Body Corporate* model is also perceived as means of improving financial governance and resolving budgetary issues, or the lack of planning for it. It sets in motion for the jointly appointed board of the future CHSCP, a move from aligned budgets to pooled budgets. This move is perceived and treated by managers as a step further to integrated governance arising from legislative change; as a form of better control and accountability. However, the pooling of budgets resulting from integration is also viewed negatively (Case B) because it is

perceived as obstructing the ability to resolve health inequalities in localities (e.g. it compromises needs-based health service delivery). This is because equal distribution of resources is encouraged when budgets are jointly governed, meaning that certain localities will be deprived based on need (since some localities will have more health care needs than others). A range of research is able to support this issue of 'pooled rather than aligned' budgets and resource distribution being a challenge for integrated healthcare service delivery (Robertson, 2011; Coxon, 2005, Heenan and Birrell, 2006). The findings give us an insight to the implications of adopting such integration models and how management perceive their utility: primarily as being means to better financial governance when in a formal partnership.

From the cases studied, it is revealed that organisations remain at stages of cooperating and coordinating in networks. Managers within the cases acknowledge the attempt of moving towards integrated services with joint planning, pooled funding joint management positions and inter-organisation multidisciplinary teams. This can be supported by Kodner and Spreewenberg (2002) who strategize service integration as being a continuum from co-operation between separate organisations via coordination to fully integrated services with joint planning, pooled funding joint management positions and inter-organisation multidisciplinary teams.

Conclusion

The issues that have emerged provide an awareness and outlook of CHP cases and managers towards H&SC integration. To reflect on the first research question of this study: *What challenges and opportunities arise from joint working and service integration for service managers in Scottish healthcare services?* The discussion has enabled an insight to how managers create perceptions of joint working, integration and change in light of legislation and the issues that arise in practice when planning for integration. Particularly, the first theme has enabled to identify challenges and opportunities managers' associates with the H&SC integration agenda. The arguments provided can help inform future strategy and policy about the limitations of moving towards integrated H&SC services and an integrated workforces from the management practice perspective. The findings have also helped to further understand the different ways in which service integration is conceptualised by managers.

7.2 Theme 2: Managing with Complexity and Ambiguity

The analysis has revealed that the complexities and ambiguities (C&As) of managing healthcare service are embedded in the work that managers do. Such C&As are seen as inevitable yet transient with changes at the political and organisational levels that consistently affect the NHS as a service and create uncertainty for managers. This can be supported by Ciller's (1998) argument that it would be realistic that service management not expect predictable or rational state of equilibrium. Further to that Haynes (2003) suggests that managers in any complex system are positioned against inevitable periods of instability in the PSO. Further to the analysis, the C&As associated with change in healthcare services are reported by managers in an inconsistent and varied manner across the four cases. This is supported by proponents of complexity theory as Cilliers (1998) argues that change yields non-linear and unpredictable outcomes because services involve human interaction. Sweeney (2005) further supports these outcomes arguing that the change process remains non-linear and involves complex dynamics of human interaction and relationships.

The C&As related to managing staff with different *T&Cs of employment and performance* in joint teams (see section 8.2) remain the strongest challenge discovered for the H&SC integration agenda. What has emerged from the study in that managers must work with the C&A of different *T&Cs of employment and performance* as a limitation because it cannot be resolved. A wide range of theory highlights that addressing the T&Cs of employment through HR decisions early in the integration process is something organisations delay until later in the integration journey (Robertson, 2011; Coxon, 2005, Heenan and Birrell, 2006). While this is found to be the case, these theories fall short of accounting for the phenomena of different T&C being a future limitation of integrated working. They also fall short in conceptualising what can be done about this perceived limitation of managing joint teams in integrated services.

The perceived implications of cultural and operational differences between agencies reported by managers when attempting future integration vary. These cultural and operational differences (i.e. ways of working) are owed to different degrees of political influence and different styles of decision making (hierarchical as opposed to autonomous) in the NHS and Local Authority. Even though managers acknowledge the need to resolve cultural and operational differences in order to engage with service integration, it becomes difficult for them to identify and explain how this can be done. Rose and Lawton (1999) suggest that blurriness as to how integration can be operationalised ends up being a network of

organisations that rely on and make use of the same ways of working as before. Bardach (1998) observes that value-creating collaborations fail to occur because the task of collaborating is a difficult one that requires cooperation as a fundamental element. This supports the outcomes of this study where it can be seen that Case C is better able to address cultural and operational differences because they have learnt over time to develop shared ways of working and shared learning facilitated through co-location of NHS and Local Authority. It is about developing new culture and new ways of working that are shared. Bardach's (1998) position that operating in networks as agencies cannot assume that cooperative working will naturally occur, supports the outcomes of the research. Boone (2000) suggests that to operate successfully in integrated healthcare services requires a great deal of commitment at a time when major challenges are posed to service managers: therefore necessitating that the integrated effort must engage particularly with identifying and resolving cultural clashes. This is observed where in Case D, the lack of planning and initiative among senior management to resolve cultural differences ends up frustrating mid-level service managers and hampers the integration effort. Being able to collaborate rather than compete becomes a challenge therefore when a commitment to resolving differences is lacking (Robertson, 2011; Coxon, 2005, Heenan and Birrell, 2006). The study observes this occurrence for Case D where the lack of cooperation and planning in resolving budgetary issues is viewed as competition (i.e. commissioning) for services in any future integrated structure: while other organisations that engage better with planning for change view pooled budgets as providing more consistency, as found in Cases A and C.

Another outcome emerging from this study is that successfully addressing (rather than resolving) C&As requires intentional effort to understand differences within a given local context and proactively working around them to develop new ways of learning and doing. *Within the local* context becomes important here for managers because change is complex and organisations may always operate in uncertain conditions which there is little control over while a constant state of flux (Burnes, 1992). Therefore, generalised ways of working around C&As cannot be adopted from one context to another (Haynes, 2003) and issues must be resolved within the locality. Shacklady-Smith (2006) asserts further on this emergence, highlighting that rather than pre-planned or pre-determined responses determining change, it is about the local service context and as-per-need responses that should determine change.

Integrated service systems create complex governances and accountabilities and make programmes of health and social care complex and messy (Hudson, 2002; Flinders 2004;

Segar et al, 2013; Land, 1991). It is likely therefore, that C&As shall always remain for managers. Answers lie in finding ways to work around them and reduce cultural and operational differences with the given context (localities) in which managers and organisations attempt to integrate. New ways of working and learning will be the need in future public service systems. In traditional and complex systems, the nature of C&A has been organisation-centric and limited to organisations in networks that come together and collaborate but where the accountabilities of managers do not alter. Integrated management in new service systems bring forth new challenges and novel forms of C&As because managers and the task of managing cross boundaries to take up new accountabilities (i.e. being responsible for performance and budgets in inter-agency teams for staff and resources of other agencies). The system comprising the integrated services becomes porous and permeable where managing change is not restricted to the confines of the organisation or pre-determined in terms of the scope and nature of C&As. This requires managers to consciously take up the challenge of resolving challenges in the best possible ways within their localities as established by this research. Haynes (2003) supports this position stating that complexity needs to be viewed as creative tension rather than an occurrence of a negative event. Goleman (1996) argues the need for emotional intelligence here, which this study argues is about making behavioural shift as a manager in how they perceive and address challenges within their given context. Furthermore, it is about managers in the service system negotiating and improvising among one another and across organisations for improved processes that begin to eliminate C&As. For this reason management in networks does not provide the necessary drive or causality for dealing with C&As.

The present approach as observed in the cases studied remains the network approach. It is important here to understand that the network encourages organisational forms while service-as-systems are about combined service flow. Service networks restrict to thinking and doing only as organisations because they not allow managers from separate organisations to get to the very core of challenges: which require to think and act collectively and beyond their agency for the integrated service environment. Service networks are composed of managers and organisations therefore that deliver services to users but who remain partially-engaged and partly-concerned in that overall system: hence organisations and managers that are not accountable to each other.

Based on the findings of this study, the need therefore is for conceptualising beyond the organisation or network to Services-as-a-System which is characterised by various inter-agency exchanges that are user-centred (sharing common purpose) and which has multiple

services coming together based on user needs. This phenomenon is observed in the cases to be occurring as it is what managers intend to and attempt to do. Managers in such a holistic service system get better at addressing challenges and complexities (and therefore at integrating) via trial and error: practising to become better at resolving. Unlike the traditional and complex system which desires consistent performance as a means to resolving complexity in the organisation, S-A-A-S desires adaptable user-relevant service that can resolve complexities locally. The emerging theory here advocates the S-A-A-S approach as a way forward for thinking about and conceptualising complexity and ambiguity in new public service systems such as the integrated H&SC partnership. As Osborne (2010) highlights, increasing fragmented service design and delivery and increasing complexity within a system, leads to the emergence of new public governances.

Conclusion

The emerging issues and insights enable one to address in part the research question of *what challenges arise from joint working and service integration for service managers in Scottish healthcare services.* The discussion has not only identified what challenges arise from joint working and integration for service managers, but also develops new ideas and novel ways of conceptualising the complexities and ambiguities associated with joint working and integration. Such a way of conceptualising encourages the move away from networks to Services-as-Systems in order to understand and address the complexities and challenges of managing integrated services in new public service systems.

7.3 Theme 3: Service Logic and Value

The insights from the analysis of cases reveal that managers associate purpose with users and local context when attempting to manage service delivery. The findings of the study also reveal that even though managers believe that user needs and localities should dictate how management is done and how services are designed, the focus still remains on organisational efficiency and achieving national measureable targets which dictate how management is done. These findings attest the idea of a prevalent NPM paradigm where management is done on the basis of private sector management style where measurable standards, routinized performance and emphasis on output control is the norm (Hood, 1991; 1995). As Kelman (1973) argues, routinisation dehumanises individuals. The views of managers across the cases studied reveal explicit views about the prevalence of managerialist practices as being

dominant in the NHS that expect standardised ways of performing and achieving from them. Management practices as they prevail do not pay attention to the variations of complexity and inter-connectedness of services and organisations: hence they convolute the integration effort which requires adaptation from management across different contexts. Standardising performance and outcomes regresses on the very purpose of managing, because it disregards the variance found in service delivery due to factors such as local communities, demographic differences and resource availability. This therefore restricts managers to adopt or respond to local variation in improvised ways since performance is prescribed. Managers point to the organisation being concerned with efficiency and results. Lynn (2006: 108) supports this position of managers arguing that NPM has distorted understanding of public management adaptation, change and reform. Gray and Jenkins (1995:87) argue that efficiency is valued over accountability and responsiveness is valued over due process.

Across the cases, an issue which arises is managers detaching themselves from the larger political agenda (i.e. forthcoming legislative changes for H&SC integration) and concern themselves with the ability to address such political level changes within their given context. They do so because they perceive the existing paradigm of nationally determined service outcomes (i.e. targets) and standardised ways of management as not suitable for the need to deliver services in varied ways based on user needs. This can be supported by Walsh et al (1997) who argue that NPM advocates that managers perform using set criteria's: therefore pre-defining accountability and responsibility. In some instances, managers in the Cases take a position that the integration agenda is enforced and imposed upon them and causes detriment to effective service delivery for users and stifles joint working. To support this, Osborne (2010) argues that the very intention of NPM over time has been to replicate private sector mentality: detachment for policy and emphasis on inputs and outputs and performance management for it.

Even though managers in the studied cases demonstrate strong user attachment and derive service value from user-focus rather than management structures, they become restricted to prevailing NPM practices because the system and its leadership habitually advocate old ways of working embedded in a culture of target attainment and performance outcomes. Stoker (2006) verifies this by arguing that under the NPM paradigm, management and managers are encouraged to pursue organisation specific targets rather than broader service goals. Milgram (1974) notes that such purpose translates into upward responsibility without downward responsibility and a focus on administrative processes rather than social outcomes.

Managers despite wanting to focus on users and localities, are bound to managing in dominant organisation-centric ways even when they network with other organisations for joint working. The focus remains on delivering measureable outputs rather than valuable outcomes: operational efficiency for organisations rather than service effectiveness for users. NPM practices as deeply rooted for time being. O'Toole and Meier (2010) and Page (2005) highlight here, that novel forms of organising and practicing such as partnership working, networks, decentralising, cross-functional, inter-organisational collaborating are all new forms of NPM practice since the priority still remains with the organisation and its efficiency: not integrated service to users.

Increasingly as services move towards integrated structures, the relevance and usefulness of NPM may begin to diminish. Hannigan's (1998) argument that NPM thinking and practice is deeply rooted and likely to remain can be contested since NPM practice may be rooted (e.g. via statutory performance requirements), however the middle management mind-set has moved beyond NPM as demonstrated through the cases in this study.

Rather, managers begin to show resistance to past management practices focused around the organisation and demonstrate preference for management based on user and local needs in an increasing inter-agency and multi profession environment. Based on the insights of the study, one can establish that for an integrated service context where service organisations become interlinked and inter-dependent, service quality and delivery need to be based on different logic and values to the private sector: user-centred and services-driven as opposed to efficiency-centred and organisation-driven. NPM becomes misfit for purpose therefore. Extensive backing can be drawn to support this finding and argument with Radnor and Walley (2008) identifying a high rate of failure in the use of lean projects in the NHS and Radnor and Osborne (2013) who review the extensive use of lean management tools in the public sector arguing that they do not have potential to create impact upon public service reform. Our study verifies this further where issues arise in being unable to manage performance of inter-agency staff in joint teams as per need because of having to comply with statutory performance management systems in the NHS such as the eKSF and HEAT targets. Based on Neely's (2001) argument that just like strategy for firms cannot be generalised, the study demonstrates that neither can performance for integrated service management be generalised. In the case of managing the NHS and other public services, using NPM approaches such as lean methodology fail because they ignore the increasing interconnected and interdependence of agencies and service delivery in terms of purpose, outcomes and accountabilities (Hood, 1991; Kelly, 1998; Lynn, 1998; O'Flynn 2007; Stoker

2006; Radnor and Walley, 2008; Kinder and Burgoyne, 2013; Osborne et al., 2012). Further to this, Lapsley (2008; 2009) argues that NPM fails to relate with the complexity and diversity of the local context of PSOs in an austerity era. NPM for a changing public service system becomes contested (Pollitt and Bouckaert, 2004) and is increasingly viewed as a failed paradigm for managing public services and a disappointment for users of services (Farnham and Norton, 1996; Lapsley, 2009).

Managers increasingly detach themselves from the organisation as priority and attach to users in terms of service purpose. As demonstrated in the cases studied, managers reveal such a strong logic of services in future integrated environments as being contextual, with different capabilities and opportunities and presuming active involvement with users and stakeholders. They therefore maintain that national programmes cannot be implemented in the same manner across a region and must be adapted locally (context derived). Campbell (2012) through empirical study reveals that managers treat national public policy as a starting point, negotiate with it discreetly via their performance and establish local goals and arrangements creating workarounds that enable them to improvise and as a means of dealing with complexity and manage integrated service locally. Our study reaffirms this point as managers intend to address future legislative changes using such strategy.

Hence, managers place an emphasis on localities when it comes to delivering integrated user-focused services and are keen to translate legislative changes into opportunities for innovating at the local level. Therefore, service design must be dependent upon local factors and circumstances and the ways in which managers approach these. Edvardsson et al's (2011) empirical study based on goods dominant and service dominant attributes supports this revealing that professional subjectivity makes service replication difficult. Brown (2008) argument that good service design varies with complexity and empathy between users and providers also confirms the case for user-based and context-based service design. Britnell (2013) supports such positions suggesting that integration can only work if it acknowledges authentic patient involvement.

Based on such logic, managers derive value from user focus and local context rather than pre-defined national outcomes and structural arrangements. Hence, they treat service improvement being driven bottom up rather than top down. I argue based on the findings of this study that managers demonstrate a service-dominant (SD) approach to services as they treat and idealise services to be driven based on user value and local contexts. Housden (2013) makes an important point to support this position: that opportunity lies in acknowledging the local context and responding to it. The case for managers demonstrating

a service-dominant approach can also be supported through Vargo and Lusch (2004; 2006; 2008) position that value-creation in services is pulled by users: which managers show a preference for. The SD approach emphasises on user experiences and aligns with ideas of service personalisation (Osborne et al, 2012) as seen in the case of managers giving preference to delivering user focused services in localities. To reconceptualise service purpose with the SD approach recognises services as they are experienced by users and bids for user satisfaction and outcomes driven approach to service design and delivery (Kinder and Burgoyne, 2013)

However, the other issue also revealed is that demonstrating such a SD approach does not equate to what managers do in actual practice. Managers still remain subjected to practices that can achieve pre-determined performance usually defined by national programmes and targets. As a response however, managers promote the idea of trying small 'bits of change' in localities and not 'over expecting' of themselves in the H&SC integration agenda. They initiate trial and error and incremental change in localities because the SD approach encourages them to focus on bottom-up learning and doing rather than relying on top-down programmed management for innovation. Housden (2013) lends support again acknowledging that it is the locality level from where innovation must come. Managers recognise the move towards a service dominant logic where services are demand-driven and consider users and both active and engaged (see figure 2). Britnell's (2013) argument that despite the faith placed in integration, it is easy to confuse structural integration with what users really want. In the case of service managers, such confusion is not the case as they are able to clearly distinguish what users want from expected structural re-design in H&SC integration.

The point here is that managers keep on trying, improvising, doing in different and new ways when opportunity arises and moving towards users and localities: all when faced with expected ways of performing. Haynes (2003) highlights this dilemma stating that policy asks public service managers to innovate while at the same time imposes narrow definitions of performance. Any paradigm shift is likely to be non-linear, incremental and emergent and occur through unstructured processes. Vargo and Lusch (2008) suggest that an overly managerial approach to managing services becomes a challenge and value creation is both subjective and experiential in nature: therefore shaped and collated over time and requiring interaction.

Having demonstrated and discussed the inadequacy and misfit of NPM for future integrated services and the move towards a SD-approach by managers, there lies the opportunity for

new ways of thinking about such transitions. Kinder (2013: 422) suggests that the age of austerity is reshaping the public sector (i.e. H&SC integration as a response for example) and now comes the time where PSOs must respond to and characterise an emerging post-NPM paradigm. As managerial perceptions and focus shifts towards more user-engaged services and go beyond NPM thinking and practice, the evolution can be better conceptualised through the NPG domain that captures the complexities and challenges faced by managers and pays attention to the pluralist complexities of public service delivery (Osborne, 2010).

The NPG paradigm pays heed to new governances and accountabilities that arise from increasing user focus and participation and acknowledges a state where multiple inter-dependent actors contribute to the delivery of public services. NPG advocates that concern and attention be paid to inter-organisational relationships and processes since new governances are created in the interaction of PSOs in the changing environment where the emphasis is on service effectiveness and user focused outcomes and user involvement (Osborne, 2010). Nevertheless, with both NPG and SDL placing an emphasis on the co-production of services as significant element of future service design in a post-NPM era (Osborne et al, 2012; Normann, 2002), the study and its findings can only provide evidence from Case B for managers desiring user-involvement in the design of public service delivery. The other three studied cases, while placing all emphasis on user-needs and user-focus, do not associate with co-production as a desired element in future public service systems. These findings would lend support to arguments from Simmons et al. (2012) and Fledderus et al. (2015) that co-production may be contested because it creates perceived uncertainty for organisations.

Moving further with issues that have arisen, managers highlight the need to look beyond separate organisations and service functions if they are to manage integrated services which are increasingly moving towards 'whole' forms (a holistic service system). Burnes (1996) argues that the ability to perceive the whole picture enables managers to successfully align with context. Emerging service systems are therefore increasingly about inter-agency and multi-professional relativity where different agencies and their services share common interlocked purpose (i.e. the same users) and common dependencies (i.e. pooled resources). This requires organisations to move beyond networked forms of management and service delivery. Reasons for this can be supported by reference to O'Toole (1997), who suggests that organisations and practitioners need to begin incorporating the network concept to the context of contemporary public management (i.e. inter-agency operability) by accounting for and without neglecting its current inter-connectedness and complexities. Organisations must

move beyond the limited accountabilities of the network if they are to create value from integration.

Manschot and Sleeswijk Visser (2011) argue that the social return-on-investment of services is heightened depending on how much value organisations can place on outcomes and users in their processes. This is where the difference between service networks and services-as-systems becomes important. Managers in networks are inter-connected but not necessarily sharing the same goals. Unlike in networks, people in S-A-A-S understand shared goals since they agree on processes and outcomes over time. Tighter coupling of people and organisations takes priority over organisational goals. Therefore, managers are tightly coupled in S-A-A-S then they are in a network and the system is open to constant learning and better ways of working. Such a service system is open to changes that are made on a collective service basis and not by individual organisations (Bertalanaff, 1981; Chesbrough, 2010). Being in network formations attempts to eliminate vertical hierarchies, which happens in terms of a change in structure (i.e. service re-design). But eliminating hierarchy in actual practice will only occur if the people within a network can come together and be tightly coupled to function in a unified system (Williamson, 1985). Kinder (2003) lends support to our study arguing that networks in the public sector are at the most inter-organisational and purposive arrangements: where agencies and their people are loosely coupled in the network which prevents them from collectively acting as a system.

On the whole, the study observes Case C as intentionally and pro-actively beginning to break such barriers and beginning to move their network arrangement towards a holistic service system where managers are tightly coupled. In an environment of integrated services, this becomes important to do since services are about a flow of multiple and complex processes rather than being stationary. As managers within a service system try to innovate, it becomes important that they carry shared goals and shared accountabilities. As the analysis of the findings in this study suggest, the effort lies with the intention of organisations and managers to think of the bigger holistic picture and act beyond separate functions and organisations while being committed to resolve conflicts that occur in the process.

NPG propositions deem organisational networks as unequal and power negotiated alliance arrangements that must over time reach effective ways of working and where value in the network is dispersed and contested (Osborne, 2010; Osborne et al, 2012) . NPG theory lends support since professional relationships between agencies and ways of governing are set to alter in light of more user-engagement and the need for services to have more service-orientation rather than a good-orientation (Edvardsson et al., 2011). Since the NPG paradigm

and SD approach argue that public services should not be viewed and treated in terms of inter-related organisations or products but rather as services and systems focused on the user (Osborne, 2010a; Normann, 2002), they lend support to the S-A-A-S approach as a step beyond inter-organisational collaboration forms such as networks for integrated healthcare service management. The S-A-A-S approach advocates that services become pulled by the needs of active users and where managerial effort facilitates bottom up interventions that treat service delivery holistically but deliver them locally.

The study can acknowledge that while organisations and managers are certainly not there yet, they definitely show the inclination, desire and intention to move towards S-A-A-S because they clearly demonstrate values and purpose as those which are embedded in the NPG paradigm.

Conclusion

The research findings and insights discussed under this theme enable one to address the questions of *what challenges and opportunities arise from joint working and service integration* and *how joint working and service integration influence the remit of the service manager and what does this implicate for managerial skills and behaviours*. They tell us that service organisations and service management are in a state of flux and transitioning in the midst of a changing paradigm represented by post-NPM thinking in an austerity era. The challenges arising from service integration are related with the need to think and act beyond separate organisations and service functions in more holistic ways if integration is to work. Managers must operate in ways different to before and must tightly couple with their counterparts in other agencies to develop shared accountabilities and solutions. The work of managers will be increasingly inter-agency and multi-professional requiring them to go beyond networks and move towards a unified system of services (S-A-A-S) in order to meet the challenges of joint working. This does represent both challenges and opportunities. Challenges lie with having to work in organisation-centric ways that prioritise organisational performance and centrally defined outcomes, while the opportunity lies with incrementally moving away from such imposed management practices to work in new ways that innovates service around users and localities. The findings help us to better understand the challenges of integration for organisations and managers in a post-NPM paradigm and help us to further characterise management in a NPG paradigm.

7.4 Theme 4: The managerial remit: roles, responsibilities and relationships

The discussion under this theme enables us to address the question of *how joint working and service integration influence the roles, responsibilities and relationships (remit) of service managers and what this implicates for managerial skills and behaviours.*

The insights from the study establish that the remit of the manager will increasingly be about managing multi-agency and multi-professional teams where the authority and knowledge of managers will be contested. Jonas (1984) and Beck (1992) suggest that increasingly, responsibility is viewed as distributed and less deterministic and Williams (2002) argues that working across boundaries, managers are met with multiple accountabilities and non-hierarchical structures where power dynamics begin to disperse. Integrated service systems create complex accountabilities making health and social care complex and messy (Segar et al., 2013; Land, 1991). Further to this, managers in this study report that accountabilities become unclear since RRRs for the future cannot yet be predicted. Rose and Lawton (1999) highlights that there lacks distinction regarding the location of responsibility and accountability of actors within the network. Haynes (2003) refers to this as a major weakness of the manager where function and context become missing when attempting to describe what they do. However, the study establishes that what managers do and how they do it will entail going beyond existing accountabilities of their existing RRRs since integrated H&SC service delivery demands dealing with different challenges than before. As Salamon (2002) argues, the emphasis shifts from bureaucratic management to enablement that brings people to work interdependently. There is acknowledgement from managers in the studied cases that the relationships they engage with must widen and extend to include stakeholders and users.

Segar et al (2013) support these findings by arguing that the service manager's environment changes to become complex and messy because the dynamics of inter-professional and inter-agency relationships are changing. Particularly in the integrated service delivery context, assigning tasks and duties becomes contested since the integration remains in-process and scattered without any boundaries. Hence, this is why managers in the study find it a challenge to be specific about how their RRRs will change and leave characterising until after legislative changes have occurred and new structures have emerged.

Managers also reveal that to derive the appropriate remit (engaging with the right type of RRRs) for the integrated service environment, it is about doing on the basis of given context (i.e. localities) rather than expected outcomes (i.e. health improvement targets). Lauria

(1997) highlights here that the acceptance of context by managers is a starting point to building a service system. Further theoretical propositions that support this position can be derived from Hales (1986) that roles will vastly vary depending on the given context since tasks and jobs must serve the needs of the changing role. Roles are enacted therefore to a set of expectations situated increasingly with locality and users: context becomes crucial therefore to the role. Based on Zambonelli et al. (2003) conceptualisation, the role becomes the abstract description of the managers expected function. It is the functions of managers in new service environments that begin to transform in non-linear ways.

Research findings indicate towards future RRRs that are not restricted by defined boundaries or ways of working (i.e. job descriptions and competence based management) because the future managerial remit will be about inter-agency and multi-profession operability: a shift away from defined limits and boundaries for the managerial remit because it entails managing unpredictability of people and processes. O'Leary and Vij (2012) emphasize that such a shift occurs since it is through individuals that any collaboration can materialize. Endorsing this, Segar et al (2013) point that how managers embrace increasingly complex roles is what will facilitate the integration of services. Arendt's (2003) argument that responsibility becomes socially situated within communities and cannot be detached from the context in which judgements are made, further asserts the research findings since managers are interested in catering to users and localities: both critical components of any community. Therefore, managers argue that previous ways of working will not be suited to an integrated context. Haynes (2003) verifies here that generalizable good-practice applied from one situation to another ends up being flimsy since what works in one context may not work in a different context. The S-A-A-S approach advocates that managers work bottom up in an integrated service system where local context and close psychic distance serve as a means of innovating integrated service delivery (Kinder, 2012). More broadly, it is about a managerial approach that shifts focus from things to processes and from entities to interaction (Lissack and Roos, 1993:3). As managers go beyond managing in the singular organisation and the network, the inter-play of RRRs expand beyond just function; profession; organisation; sector. They extend to include users, multiple stakeholders and other organisations in the service system as being vital elements for RRRs.

The research analysis reveals that existing management paradigms prevail and demand that the managerial remit be role-driven and task-driven; that RRRs be pre-defined and pre-determined in terms of their scope and accountabilities. Being accustomed to such ways of working, managers remain inclined towards and are driven by *performing* and *achieving* as

solution to challenges rather than *reflecting* and *learning* to do differently (a promulgation of NPM thinking and practices achieved over time). Sparrow (2000) attests this to be the case arguing that that over-burdened managers devote large time to task and skill of information searching and little time to learning from it. In such environments, middle managers are typically and formally (by job description) accountable upwards for budgets and targets, horizontally to users for implementing care plans and downwards to their own teams of specialist staff. Bell et al. (2008) support such a position arguing that service integration in practice takes time to make sense of. I argue this is even more so when managers intend for user-orientation in the design of services because traditional remits cater for upward responsibility to the organisation and focus on administrative processes rather than social outcomes. Using old ways in new places: standardised pre-determined management practice to do management in inter-agency multi-professional integrated environments, creates ambiguities because performing in old ways breaks down in a new service environment (Rhodes, 2000; Haynes, 2003).

The argument I make here is not that national policies and guidelines are bad for management practice: infact national policies and guidelines can inform and guide good management practice, but they should not dictate the managerial agenda. Instead it should be the needs of users that determine the managerial effort and performance. It is about enabling managers to utilise tacit knowledge and prior experience to adequately shape RRRs in order to effectively respond to change in the best manner possible. In S-A-A-S, services as well as the RRRs of managers become pulled: the managerial effort becomes a natural response, one that is different to the NPM advocated management practice where managers using a GD approach work top-down to achieve pre-defined service targets and where performance is pre-determined through pre-set remits (e.g. through job specifications and competence frameworks). The management effort here is a frustrated one because it is trying to apply standard solutions irrespective of user need, even if done in networked formations. Users are treated as passive recipients of standardised management practice. In the network model, services and their management are pushed and the managerial effort is pre-engineered and pre-ordained: a GD approach to managing.

The findings reveal that for a changing service system where services and organisations are interlinked through complex processes and where there are undefined boundaries and changing accountabilities for the managerial remit, managers instead need to engage with reflection and learning as a solution to challenges. Vygotsky (1987) suggests that critical in the process of change is knowing what the relationships are which can help sense making

during complexity and ambiguity. In other words, any progress to be made is in the reflecting and learning to do differently. I argue that relying on the same RRRs as before for a new service context cannot enable managers to address the complexities and ambiguities of collaborative inter-agency working. Support for this argument can be drawn from Rose and Lawton (1999) who argue that blurriness as to how policy can be converted into operational action remains because managers in the network formation continue to make use of NPM advocated practices and techniques. Managers in the studies cases demonstrate that they are also prone to professional grouping and reverting to silos when RRRs start to divert from defined ways of operating.

The study outcomes reveals that in order to support managers in future service systems (i.e. integrated services), the support needs to be specific for what they are doing in a given context rather than supporting them on pre-set notions of what their roles, responsibilities and relationships are. It also requires giving managers space as part of their remit in order to reflect on their RRRs within a given context. Managers demonstrate a strong desire to manage and innovate services at the locality level with users at centre stage. Lauria (1997) assertion that building a service system from bottom up requires acceptance of different contexts as a starting point, therefore becomes clearly evident among managers in the studied cases. Ricoeur (1995) suggests here that renegotiating responsibilities requires sufficient time (a surrogate for space). Findings suggest that on the manager's part this means active and conscious engagement: wanting oneself to do different than before: therefore a behavioural transition. On part of organisations this means recognising and treating managers as professionals. In other words, organisations taking managers and the work they do with seriousness. Clarke (1994) supports this position arguing that the manager's behaviour becomes a decisive factor in creating an agenda for any organisational change. Tschirart et al (2009) go further than this to state that managers will have to challenge their own assumptions because moving towards integration will be a frustrating experience driven by the efficiency imperative and which brings blurriness in terms of its definition and formation. Fenwick (2008) crucially argues that new service models will only be possible if and when managers become reflective practitioners who are able to review their ways of working. Carmo (2003) conceptualises this well stating that the person within a role can only act, not the role itself: signifying that managers must consciously and actively take up the agenda to do differently since the role cannot which is typically restricted to a defined scope. As demonstrated in Case C, managers aspiring for an integrated service system model necessitates new roles, remits, responsibilities and relationships which actually devolve more importance and authority to middle managers. For this reason, co-location of

NHS and Local Authority management teams (as only evident in Case C) acts as a vital strategy and tool enabling the exchange of experience, developing shared values and culture. This essentially allows for new learning to occur over time and an improved service design to emerge. Burnes (1996: 355) proposition that managers, based on their experience gained and by interpreting the environment over time, form opinions of what works and why becomes evident in the cases studied.

So far, this issues discussed have highlighted the need to go beyond traditional theories that define and position the remit of the manager in single organisations which has little relevance for modern day management in public services. This is because they do not cater to the dynamics and complexities of inter-agency environments and the role of users. Managers in this research study show a clear understanding of this. Burnes (1996) highlights that in contemporary public service management where boundaries are blurred and the scope of work goes beyond the confines of the single organisation, service managers become inquisitive about the context in which they operate and begin to question the appropriateness of their actions. Managers in this study clearly challenge rational and normative forms of management ideology and practice as they begin to move towards inter-agency management of integrated services, as a result, disturbing the managerial remit that has long prevailed (Barley and Kunda, 1992). Especially here, as witnessed in this research, managerial responsibilities and accountabilities begin to shift towards users in order to determine service design and delivery: a fairly new emergence in public management. Fenwick (2013) confirms here that managers currently are at a heightened state of transition as they are responding to changes of policy, restructured work arrangements and users. This findings reveals the desire and potential of managers to cope with change, however the migration to new work sites and cultures which Fenwick (2013) further aspires for managers, is not revealed in our cases. This may be due to the fact that H&SC integration is yet to be enacted structurally and due to the desire for managers to try pieces of change incrementally.

The SD approach advocates that the managerial remit will slowly adopt and develop towards service users and localities. The S-A-A-S approach advocates that managers will negotiate and improvise RRRs within an inter-agency environment to best fit the purpose of serving users in localities, while resisting pre-defined and organisation centred remits of the past. Noordegraaf (2000) asserts that managers in the new public service arena are sense-makers who adopt within unstable settings. The case made here is for an organic rather than systematic transition to new RRRs that are context specific. What managers do and how they do it in S-A-A-S will increasingly be influenced by users to whom they become accountable

in ways that previously have not been a phenomena of public sector management. Managers will learn to manage in new ways as services become user-centric and as service providers being tightly coupled. Holman and Hall (1996) eloquently establish this direction stating that certainly, managers will renegotiate what practice means through their activities. The managerial remit over time refines based on the needs of users and inter-agency partners in the service system.

Conclusion

The research findings and insights discussed under this theme enable one to return to the question of how joint working and service integration influence the roles, responsibilities and relationships (remit) of service managers and what this implicates for managerial skills and behaviours. Joint working and service integration influences managers because it creates a transition towards inter-agency and multi-professional working where their accountabilities begin to change. Increasingly engaging with the uncertainties of operating in such new environments, this means both change in their RRRs, but also more ambiguity. The implications of joint working in integrated services will further mean that service managers amongst themselves in an S-A-A-S will negotiate, improvise and learn new ways of working and form new relationships with an increasing focus on users and localities as an inter-agency commonality between them. Going into new service environments will mean undefined boundaries and accountabilities until these can be negotiated over time. Joint working and service integration as critical elements of future public service management demand that managers (and their organisations) will need to move away from the confines of role and task driven remits and instead focus on remits that are flexible and adaptable to user needs, partners and localities. The implications of joint working and integration in new public service systems will also mean that managers guard themselves against the pressures and demands of established, formulaic and rational management practices that prevail, instead finding opportunities and ways to incrementally innovate services in their localities. In doing this, managers begin to question and challenge existing management ideologies and practices as part of the remit. The skill and behavioural shift for managers is one about resolve and conscious engagement with new RRRs that requires flexibility and negotiation over time around common purpose.

7.5 Theme 5: The Learning, Training and Development of Service Managers

The insights from this study reveal firstly the complexity faced by managers of being able to distinguish between training, learning and development as concepts and form. They use the concepts and the terminology simultaneously without the need or ability to distinguish between them. Lees (1992) deems MD as attracting multiple and conflicting definitions and conveying different things to people and organisations. This natural emergence from the study becomes crucial to the MD debate as Garavan (1997) argues that differentiating between concepts of managerial education, training, development and learning is primarily a sematic one and the need to distinguish features and differentiate between the concepts may be unnecessary since they are all complementary components of the same process: which is to enhance managerial potential. Even though in past MD practice such distinctions have been drawn, it may no longer be helpful differentiating between them if the intention is to understand the needs of the managerial remit in a complex and intertwined service environment (Garavan, 1997). Further support for these findings is provided by Easterby-Smith (1994) who highlights that approaches to learning, training and development become loosely clustered under the term MD to include various activities even though traditional distinctions have become increasingly blurred. Separating and distinguishing between management education, training, development and learning becomes outdated in an environment that no longer has clear boundaries and where there is increasingly an overlap among these due to the speed of change in organisations (Hammett, 1994; McCarty, 1994) and due the speed and complexity of information flow exposed to managers which requires them to process and adopt quickly to change (Reid, 1991). Traditional distinctions between managerial learning, training and development are further blurred when traditional work design and career pathways alter as managers begin to conceive, negotiate and learn new accountabilities and relationships in inter- agency work of a new service system (van Wart et al, 1993; Kinder, 2007).

The insights from the study find that the T&D for middle managers entering management roles is lacking and existing T&D in its various forms and content remains fragmented across the system. T&D is contested in terms of its ability to the serve the H&SC integration agenda and is perceived as primarily focused around the organisational efficiency (more with less) agenda. These emerging issues can be supported through a range of research which confirms that attempts to develop service managers in the a complex healthcare service such

as the NHS are undermined (Head, 2010; Van der Wal., 2011; Powell et al, 2013; Hyde et al, 2013).

Managers address the issue of a lack of T&D opportunities and support when entering middle management roles, which Neirotti and Paolucci (2013) confirm is confined to senior management level. This could be, as Stewart (1994) argues, because MD in the NHS has never been fully planned and carries a poor history owed to separate authorities, bureaucracy and professional rigidity. We see in the findings that even though managers can identify a range of national MD programmes, they cannot ascertain their impact and only relate them with the performance improvement agenda. Edmondstone and Havergal (1995) in reviewing MD programmes across the NHS find them to serve *fit for all* circumstance and focusing primarily on structures and processes to meet the needs of executives and senior managers.

Managers in this study reveal that T&D is highly fragmented and disparate while its focus is on mainly the efficiency agenda in a time of austerity. Managers contest the appropriateness of existing T&D for the changing service environment and consider it to be irrelevant. Ducey (2009) argues that training in the NHS ends up therefore becoming a false promise and ends up contradicting what managers are attempting to do. Considerable evidence can support these findings to suggest that NPM orientated T&D methods have been unable to develop managers in the NHS for a changing service environment (Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Collins and Holton, 2004; Hamlin and Cooper, 2005). Particularly, the research findings are supported by drawing criticism of such T&D for service managers as being formal, programmic and unrelated to current practice (Khurana 2007; Locke and Spender 2011; Thomas et al 2012) and therefore being unable to deal with the existing multiple logics and unclear and conflicting purposes in managing the changing healthcare service (Sambrook, 2007; Powell et al, 2013; Hyde et al, 2013). The insights revealed and the extensive support available to support it would confirm the argument from Osborne et al. (2012) that much of the learning and development practice in the healthcare is based on NPM-driven internal efficiency rather than the creation of effectiveness and value. Ducey (2009) confirms such a position arguing that NPM orientated M-LTD concerns itself with organisational performance and does not improve the quality of work managers engage with or services themselves.

In the majority of cases studied, the findings show that that support from national T&D providers or coordination with them for the purpose of developing service managers for H&SC integration does not occur. National policy and strategy documents such as the 'Force for Improvement' (Scottish Government, 2009) which consider the T&D of NHS workforce

as key to supporting new service delivery models suggest that T&D agencies such as the NES and JIT will play a major part in the process of developing managers for the integration agenda. This is not found to be the case as the study reveals because service managers deem such T&D provision as not relevant to what they are attempting in H&SC integration. They view the content of T&D from such T&D providers as geared towards clinical leadership and strategic change in H&SC integration. Only in Case A, it is found that the OD function is coordinating with and utilising an external T&D provider for support towards H&SC integration planning at the Joint Board level. Other than this, external T&D providers do not provide any added value to the development of service managers, as perceived by service managers. Neither do managers point out to the possibility of utilising T&D provision from sectors outside healthcare (i.e. Higher Education providers) for future integrated service models. Managers both in the present and for the future see T&D provision as internally driven and internally sourced. Adopting Fenwick and McMillan (2013) suggestion that any potential co-creation of MD between providers and clients will require both time, relationship building and trust over time, support these findings.

Managers highlight that T&D must be transformed to take up the agenda of supporting managers to make behavioural shifts that enable working in multi-agency and multi-profession environments. The development of managers is fundamentally about knowledge of transient contexts and the behaviours required for them: these encompass resilience, courage, confidence, and tenaciousness. Aligning with this, Bardach (2011) argues that the styles required in a collaborative and integrated setting will differ from those of the single organisation, particularly when, as Kinder (2010) argues, the manager's remit becomes that of transforming services in an integrated setting. In support of these findings, Entwistle and Martin (2005) suggest values like trust building and conflict resolution to be important for the manager. Broussine's (2003) findings also suggest that increasingly, it will be about demonstrable behaviours such as critically reflecting and tolerating ambiguity. The need to define a particular skill set becomes increasingly futile given that as integrated service contexts will differ, so will the skills of managers to deliver them (Bardach, 1998; Agranoff and McGuire 2001a: 2001b). As managers in the study report, good skills are transferable to the integrated context while the need is that of appropriate behaviours and values for the integrated context. Currie and Procter (2001) in line with this argue that, what lacks is being able to enhance the willingness and ability of middle-level managers to take on people related issues.

With such a transition in thinking and practice desired, the need to demonstrate leadership as a behaviour becomes important in new service systems, particularly so when managers will be challenged on the basis of knowledge and authority in multi-agency and multi-profession team environments as discussed in the previous theme. Future management becomes more concerned with *leading capabilities* as opposed to *management competences*. This is interesting as the emphasis is placed by managers upon MD being about leadership ability for the new integrated service context. Lippitt (1982) with reference to cultural change, signifies MD as a process of growing leadership as has been established through these findings. The concern with leadership capabilities as opposed to management competence here, aligns with a range of critique that competency based MD initiatives are overly functional; over simplified and individualistic being unable to address the range of behaviours and activity associated with what managers do (Stewart and Hamlin, 1992; Ashworth and Sexton, 1990). That such MD initiatives are unable to take account of the complex, contextual, and constantly changing nature of managerial roles (Canning, 1990). Sambrooke (2005) suggests MD in the NHS largely ignores the critical pedagogy of the individual manager which has diminished due to a dominant business culture and approach to MD. Therefore, the weakness of the competency approach is in its managerialist approach that is insensitive to context (Currie, 1997). Horton (2000) and Smith (2000) further verify that competency-based management is widespread and largely influences how management in the NHS is done. Dawson et al (1995) also argue that the desire for competence approaches remains prevalent in the NHS. The result of implementing competence based MD over time is that it leads to managers distancing themselves from national MD programmes and becoming reluctant to participate in them (Smith, 2000). This is observed in our cases as managers deem national programmes to offer nothing valuable in relation to what they are attempting to do going into future integration.

Even though attempts may be made to categorise managerial competences (Virtanen, 2000), what matters is the context laden capabilities that managers will need when delivering integrated services that are relevant to users and localities. Here, leading in uncertain environments becomes an emphasis for managers and context-based leadership capabilities take emphasis beyond defined competences. Views on leadership transition for new service environments that have emerged from the findings suggest that leading becomes relational, flexible, adaptive and context-bound across the inter-agency service system as opposed to leading in hierarchical, function-bound and centralised ways of the traditional organisational

structure. For this, Rhodes (1997) and Williams (2013) suggestion for *boundary spanning* ability in inter-agency and complex environments becomes relevant and managers highlight the importance of this as the analysis reveals. Denis et al.'s (2010) argument that diverse leadership ability is needed because managerial authority and relationships become ambiguous and contested resonates with the findings from cases.

In a changing service system, reframing MD necessitates moving away from generic and pre-ordained forms towards organic and context based forms. MD form and content must support L&D that is locality and user based. New forms of MD must take account of the shift from single-agency and single-profession teams to multi-agency and multi-profession teams and the basis on which they are organised in the future. Storey (1989a; 1989b) critiques MD theory for advocating universal remedies for the development of the manager without due regard for context. In S-A-A-S, MD moves away from traditional pre-ordained notions of 'programme' or 'intervention' towards MD where managers are supported in self-determining and self-directing a framework that suits their learning and development needs based on their given context. Garavan et al. (1999) and Storey (1989) highlight this transition as infact a debate about whether the nature and aim of MD can align with the changing role of the manager, as is the need identified in the cases. Doyle (1994) theorises MD as being linked to the context and reality of what managers do while Beddowes (1994) theorises MD strategy as catered to the development needs of the individual manager. Talbot (1993) argues that alternative MD provisions for a new environment are different to those of the past: that they are about individual development in a broader sense as opposed to narrow focus on proficiency in achieving specific tasks. MD therefore is not a means to any end as traditionally treated and cannot be unified as a concept and practice (Storey, 1989a, 1989b). Because the managerial remit is complex, in a state of flux and moving towards a service system which increasingly take on user-led and context specific dimensions, MD in its definition, purpose and delivery as being universal would not be realistic. Fulmer (1992) argues that if MD is to have any real value, then it must be adapted and implemented in congruence with changing needs and expectations. These emerging perspectives from the study are validated further by Engeström and Kerouac (2007) and Haskins and Shaffer (2012) who argue that coherent universal models, frameworks and the application of scientific principles to MD are not feasible because there are varied cultures and contexts across agencies and public services that cannot be excluded from the planning effort. Winterton and Winterton (1999) in a review of NHS cases highlights MD programmes to be

based on set standards and functional competences that desire linkage with organisational performance. Holman and Hall (1996) argue that such standardised MD competence approaches restrict the very nature of managerial effort that wants to do the very opposite: interpret, improvise and adopt.

The findings establish that even though non-programmed interventions such as Action Learning Sets (ALSs) and Mentoring are being used by organisations, their effectiveness to serve the learning and development of managers for the integrated service arena is mostly underutilised and unsuccessful. Implementation of such MD interventions and their impact in this study are difficult for managers to ascertain as they are highly fragmented and varied. Nevertheless, managers are keen to support MD interventions that allow learning which is incremental and experiential. The findings reveal that it is increasingly a case for tailored MD that can support reflection as a means of learning new ways as, opposed to MD that prescribes learning. Oliver (1994) asserts here that the workplace (i.e. the NHS) lacks association with such learning for managers and is fixated on developing abilities to perform task. This relates back to the findings discusses in theme 4 of managers being nurtured to perform and achieve as a means of solution, as opposed to reflecting and learning as solution. Mumford (1987) argues against such an over emphasised GD approach to the treatment and development of managers who gets treated as developed products of a planned process. Margerison (1991) advocates MD approaches that can be *process-orientated* rather than *product-centred* and be *learner-orientated* as opposed to *instructor-dominant*. MD practice remains product-centred and consumed by a GD logic with an intention to enhance managerial competence that can deliver organisational performance against pre-set standards and targets. Such MD gets recognised as being a formulaic MBA approach to the development of the manager (Mintzberg, 2004) and as an application of business management (Holmes, 1995)

Reflections on MD that emerge from this study point out that that MD in healthcare service is currently grounded in the organisation and in the task of managing efficient performance. It therefore fails to be flexible and does not account for the inter-agency dynamics and users with whom managers must engage going into an integrated service system. MD activity is scattered across the cases studied and existing MD interventions such as ALSs and Mentoring remain underutilised and unsuccessful for the very reason that managers do not see them as relevant to the altering remit or the needs of a changing service system. Essentially, what is missing from MD interventions is the inclusion of context in which they

take place (Cunningham, 1994). The competency based MD model also ignores this variety of context. McGurk (2009) supports this finding arguing that MD interventions for middle managers disregard the practice and reality of managerial work and broader service outcomes and are instead fixated the ability to implement top down strategy and regulatory compliance.

Presently, managers struggle to define the reasons and context for which they need learning and development support. Therefore they also struggle to define the type of T&D interventions they would require. This finding can be support with arguments by Colley et al (2007) that managers get caught up in transition made up of conflicting responsibilities. The research findings suggest that managers must take up the challenge of defining and self-initiating their own MD since the organisation and policy are unlikely to provide the necessary. It is about actively developing new cultures for successful integrated healthcare (Robertson, 2011; Heenan and Birrell, 2006). As emerging from this study, Tsoukas (2006) argues that reframing MD for it to serve any purpose in enabling managers for the future, needs to be based on the individual managers learning as shaped by the context in which learning occurs. Management learning therefore cannot be prescribed or formulaic as the goods-dominant approach to MD would intend for. These outcome negate the treatment of learning by those such as Craig (1994) and Salaman and Butler (1994) who confine managerial learning to classifications and types and restrict the purpose of learning as servitude to the organisation.

Conclusion

The research findings and insights discussed under this theme have enabled one to address the *implications of joint working, service integration and an altering remit for managerial learning, training and development.* To address this question further, I argue that in a changing service system, managers must proactively begin to identify their learning needs from the work they do and the practices they begin to negotiate in the inter-agency and multi-professional environment. As managers begin to engage with service integration and with changing remits, they begin to identify learning and development needs from their interaction with other managers and increasingly from their interaction with service users. This leads to the potential for new forms of co-produced MD (Poell and Krogt, 2007). Managers must themselves lead this agenda. Fenwick (2013) argues here that how learning is treated comes down to how individuals view professional transition.

This marks a changing paradigm as to how managers go about engaging in the work that they do and how they construct their own learning needs leading to new public governances (Osborne, 2010a). Kinder (2012) suggests that to transform local public services places importance on the ability to lead as managers and approaches that are informed by learning amongst each other in an inter-agency environment which enables close psychic distance. Active learning that is multi-dimensional therefore, becomes both a critical process and resource for the manager where the intention must lie with managing change rather than delivering stability. Fenwick (2008; 2010) suggests here that new service models are only possible if managers across the system act as reflective practitioners and be willing to revise their ways of working while appreciating that learning is messy and existing as a multiple rather than singular object. As it remains, current ways of learning remain questionable in their ability to prepare managers for a pluralist world. Infact, the findings reveal that manager remain too occupied with performing with no time for engaging with learning. They remain passive rather than active learners.

Managers in the cases studied have shown preference for learning incrementally from trying small pieces of change. The essential principle of such action based learning here is that it is acquired in the midst of doing where managers can critically reflect upon practice. They can examine and question. Such learning therefore, Raelin (2006) argues, becomes a concurrent by-product of practice. Nygaard and Bramming (2008) suggest that pedagogy is in learning through action and reflection in real life experience. The study reveals future MD in organisations will be about supporting managers to make sense of complexity in an environment where there is ambiguity and evolving partnership arrangements. This shall be done through MD forms that can support action learning for managers within localities and that which enables them to reflect upon their ways of working with inter-agency partners and users in the service system. Adopting Fenwick and McMillan's (2013) suggestion, MD offers an opportunity for learning to learn where outcomes are negotiated over time. This is not necessarily in the context of co-produced MD between MD providers and clients as Fenwick and McMillan (2013), but in the context of co-produced MD between managers in a service system who in their inter-agency work begin to negotiate and learn new accountabilities and begin to identify shared MD needs and engage with them by reflecting upon their work.

In addressing the question of *how Management Development can be reframed with the future needs of an integrated service system to prepare and enable managers to deliver effective services*, I have highlighted the need for re-framing MD in ways where managers can

themselves determine and initiate a personalised MD framework that fits their needs and aligns with what they actually do. Wallingford (2012) support such reframing of MD, arguing that it should be designed on the basis of action learning where the emphasis is on active participation from managers who are engaged in the process of self-determining and self-evaluating their learning and development. McGurk (2009:475) reaffirms that the real challenge for MD going into new service environment of H&SC integration is that MD interventions can only be successful for middle managers if they reflect accurately the realities of the particular managerial role in its specific operating context. This is where co-location as a future strategy to support action learning carries potential. This position is further supported by Fenwick (2013) who argues that outcomes are negotiated and co-constructed over time through reflective learning. Hence it is at the intersection of inter-agency working where managers are negotiating accountabilities and developing new ways of working and from where learning takes place and further learning and development needs are identified. Schon (1988) suggests that managers must become reflective practitioners capable of contingent action and reflective conversation within situations, so that they can learn rather than be taught the skills needed to be effective. This aligns with the idea of learning while engaged in work (Irby, 1992; Raelin, 2008) as well as the idea of having the managerial capacity for learning to learn (Argyris and Schön's, 1978; Kinder, 2010; 2012). This is why leadership ability emerges as being critical since managers must take the lead on the learning and development.

Taking a socio-cultural learning perspective here, it will be about reframing MD where contextual learning matters most (Engestrom and Kerouac, 2007; Schein, 1985) and where managers enhance their ability for double loop learning: an absorptive capacity developed over time and experience (Kinder, 2010: 2012). Service managers in new public service systems will be open to learning and experimenting (Chesbrough, 2010) and will embrace change over stability (D'Netto et al., 2008). The case for reframing MD becomes one of supporting individual managers to engage with reflective and action based learning in situated contexts. It also becomes therefore a case for enabling them to develop appropriate behaviours that create the desire for engagement.

7.6 Summary

This chapter has engaged with the most critical issues that emerged from the research findings and discusses these in light of the theories and ideas reviewed earlier in the study. In this, I have attempted to address the research questions and highlighted areas of both

importance encountered in the process of discovery. I now move to the conclusion of this thesis, where I discuss the outcomes of this research, issues and implications for future consideration and the contributions made to both theory and practice. I also engage with a self-evaluation of this research.

8. CONCLUSIONS

In this chapter, I present the main conclusions of the research study and provide a self-evaluation of the research which, inter alia, addresses inevitable limitations, discusses the issue of generalisability and reflects on how the research objectives were met. The chapter also addresses perceived gaps in the literature and discusses how the research outcomes might help address such gaps and contribute to theory and practice. Finally, recommendations for future research in the area are provided.

8.1 Outcomes of the Research Study

The main outcomes of the research study are drawn from the five themes that emerged from an examination of the findings and which were used to structure the analysis and discussion chapters of this research. These main outcomes of the research study comprise the following.

Past history of joint working in the organisation, prevailing partnership arrangements and managers personal experiences of attempted joint working with other agencies shape the management culture and the willingness of managers to engage with change and its associated challenges. Managerial perceptions of service integration as a concept vary and it remains difficult for them to distinguish amongst the varying forms this takes while using terms interchangeably (coordination, cooperation, alliance, partnership, joined-up, integrated). This is in line with findings from previous studies (see McGuire, 2012; O'Leary and Vij, 2012).

Exclusive co-terminosity between Health and Social Care organisations in the build up towards an integrated partnership does not ensure preparedness for integration. Managers nevertheless envision it as an advantage for the future on the basis that it will make planning for service delivery in localities less complicated. Integration is perceived as politically, structurally and efficiency driven. Managers do not associate it with better user outcomes or user involvement and perceive it as disruptive to user-centred service delivery. In terms of integrated H&SC services, user-centred and user-focused services are prioritised by managers in service design and delivery, however user-involvement and co-production are not. This phenomena is in line with arguments that the degree of user input in service design is contested (Simmons et al., 2012) and that co-production may increase uncertainty for organisations (Fledderus et al., 2015)

A Body Corporate model, one of the two available models to adopt for H&SC integration, is envisioned and preferred by managers for future H&SC integration because it potentially eases the challenges of managing staff, performance and financial governance. However, managers do not draw any association between an adopted integration model and the implications it may have for service users. Healthcare organisations remain at different stages of partnership working ranging from 'cooperation' to 'coordination' in networks. They acknowledge moving towards better joint planning, pooled budgets, joint management positions and joint multi-disciplinary teams as part of the forthcoming change for future integration.

Complexities and ambiguities of managing integrated services are inevitable and transient with change at the political and organisational levels and will remain embedded in the work managers do. C&As associated with different T&Cs of employment and performance, cultural differences and operational differences prevail. Addressing these complexities and ambiguities becomes dependent on developing new culture and shared ways of working over time and requires cooperation (Bardach, 1998) and commitment (Maley, 2000) among managers across agencies. Generalised ways of working around complexities and ambiguities cannot be adopted across different contexts and therefore, response to change must be derived as per local need and service context rather than through pre-planned or pre-determined change management. As complexities and ambiguities will always remain, managers must consciously take up the challenge of responding to them in the best possible way. Remaining in service networks limits the ability to do this since the priority remains with addressing organisational challenges while the move towards services-as-systems facilitates better problem solving as the priority attaches with combined services and their work flow.

Managers begin to detach from the larger political agenda and change for service integration and concern themselves with interpreting and addressing the political agenda and change within their given context. They do this because they contest the existing paradigms of nationally determined service outcomes and standardised ways of doing management that are not suited or applicable to managing in varied ways depending on local conditions. As services move towards integrated models, the usefulness and applicability to NPM practice begins to diminish because the managerial mind-set has moved beyond it. There is the inclination to drive change bottom-up through localities due to the recognition that top down change will remain to serve the interests of the organisation and national outcomes (i.e. targets) only. Managers want to act and do in ways that benefit users in localities, but are

restricted from doing so as they are bound to comply with standard and organisation-centric ways of performing.

There is a strong association with the need for services to be based on a different logic and set of values to private sector market models. Managers demonstrate service logic and value to be user-centred and service-driven as opposed to efficiency-centred and organisation-driven. Taking a SD approach to services, managers derive value from users and local context rather than pre-defined outcomes and structural arrangements, aligning with a range of research that demonstrates value creation in services as being user-pulled (user outcome driven), localised and personalised as beneficial for service innovation (Housden, 2013; Osborne et al, 2012; Britnell, 2013; Kinder and Burgoyne, 2013). Therefore, managers promote (and attempt) trying small pieces of change in localities, learning from them and informing practice at a larger level where possible, without over expecting in the attempt to do so. They take a bottom up approach to innovating services rather than relying on top-down programmed management. They improvise and attempt new ways of improving service pathways in their localities in the desire and purpose to move towards users and localities: all while performing in expected ways and achieving expected nationally derived outcomes.

Managers' abilities to see beyond the restrictions of NPM advocated management practices, their resistance to it and their bypassing of it at local level management indicate towards a post-NPM era where service purpose and service value (as understood by managers) begin to align with the NPG paradigm which acknowledges the plural complexities of integrated service delivery and advocates a SD approach to managing based on effectiveness and outcomes for users (Osborne, 2010; Kinder, 2013). Highlighting the merits of moving from networked management to managing in S-A-A-S (a holistic service system), the effort lies with the intention to think and do beyond separate functions and organisations (networks) and function in ways that take on a wider and holistic perspective to services where managers develop shared goals and shared practices and are committed to resolving conflicts arising from shared processes and outcomes.

The future managerial remit will be about managing inter-agency and multi-professional teams where authority and knowledge become contested. Accountabilities become unclear since RRRs cannot be predicted in an integrated service setting. However, managers highlight that RRRs (and therefore their accountabilities) will widen and extend to include users and multiple stakeholders. The managerial remit for an integrated service set-up will be derived on the basis of a given context (i.e. locality) rather than expected outcomes (i.e. NHS

targets) and RRRs will not be restricted by defined boundaries or pre-conceived ways of working. Lauria (1997) asserts that this realisation and acceptance is a preamble to building service systems. RRRs expand beyond a given function, profession, organisation or sector and extend to include users and other organisations. The challenge managers are met with are the existing paradigm that demand the managerial remit to be task and role driven and where RRRs are pre-defined in terms of their scope and accountabilities (i.e. job descriptions and CBM) . Managers continue therefore to rely on performing and achieving within prescribed remits as a solution to challenges, rather than reflecting and learning (to do differently) as a solution to challenges as established in this study and previous research (Sparrow, 2000; Bell et al., 2008). Predefined ways of working and pre-defined RRRs do not enable managers to operate in integrated service environments.

S-A-A-S advocates that RRRs become pulled and the remit be derived from the needs of users and localities. It is about enabling managers to utilise tacit knowledge and experience and amend and expand the remit as per need in order to respond to change and complexity in the best possible way. Improvised and negotiated remits will be the need for new public service systems. Therefore, the support managers will require must be specific to what they do in a given context and it is about giving managers the space to do differently. More so, it will be about active and conscious engagement on the part of managers: wanting to do different to before, reflecting and learning to change how things are done and deliberately going beyond prescribed RRRs. This self-initiation remains well supported theoretically (Fenwick, 2008; Carmo, 2003; Burnes, 1996). It is therefore a case of behavioural transition. The SD approach advocates that the managerial remit will slowly adopt and evolve to suit users and localities. In S-A-A-S, managers will negotiate and improvise RRRs to best fit purpose while resisting pre-defined remits of the past. This will happen when managers want it to via a proactive approach.

There remains the challenge of understanding, using and distinguishing between Training, Learning and Management Development as concepts and practices. This naturally arises as they are all complementary components of the same process which tries to enhance managerial ability. Increasingly, it becomes unnecessary to distinguish between learning, training, and development since they become loosely clustered, they overlap and become blurred with no clear boundaries. Traditional distinctions between M-LTD become further irrelevant when work design alters as managers begin to negotiate new remits in changing service systems (Van Der Wal, 1993; Kinder, 2007)

T&D in its various forms remains contested and fragmented across the NHS and managers contest its appropriateness for a changing service environment and deem it irrelevant. Support from national T&D providers or coordination with them for the H&SC integration agenda is lacking. The potential for co-produced MD is not an immediate concern for managers going into H&SC integration because they see the role of national T&D providers as not relevant to what they are doing and they show preference for in-house MD. Fenwick and McMillan (2013) argument that any co-produced MD may require time, relationship building and trust over time is important here. In the cases examined, it seems a matter of relationship building and time rather than necessarily trust. For the integrated service context, T&D must take up the agenda of supporting managers to make behavioural shifts that enable working in multi-agency and multi-professional environments.

Future management becomes increasingly concerned with leading capability and demonstrating leadership behaviour. MD begins to be identified as a means of developing this. Even though there has been the tendency to categorise management competences, the emphasis is upon context based leadership capabilities and behaviours. Leadership transition for new service environments is highlighted as being different to that of traditional leadership models. This transition moves away from hierarchical and function bound leadership to flexible, adaptive, relational and context-bound leadership that enable boundary spanning.

Reframing MD requires moving away from generic and preordained forms. MD must serve the function of supporting L&D of managers in organic ways. New MD forms must account for the shift from single agency to multi-agency management and move beyond MD programmes that are standardised and based on functional competences (Doyle, 1994; Haskins and Shaffer, 2012; Holman and Hall, 2006). In S-A-A-S, MD moves away from any preordained notion of programme or intervention towards MD that supports managers to self-determine and self-direct a framework that suits their L&D needs based on their given context. Managers are keen for MD interventions that enable reflection and allow for learning that is incremental and experiential, rather than prescribed.

Managers, even though struggling to define the reasons and the context for which they need L&D support, must take on the challenge of articulating and initiating their own L&D. This essentially comes down to how learning is treated and how professional transition is embraced. Learning is seen as complex and multi-dimensional and the transition to new service models is only enabled when managers actively engage with reflective learning: a result of which is it transformation in behaviours and change in their ways of working.

Reframed MD for the future must support managers to make sense of the complexity and change in their environment by doing and reflecting. It therefore becomes a case for supporting action learning and reflective learning.

8.2 Self-Evaluation of the Study

8.2.1 Generalisability to other Settings

This study examines the views of managers about joint working and service integration and explores how the nature and function of management is seen to change as a result. It also explores the complexities and challenges they face in moving towards service integration and how the managerial remit alters as a result. The research has also explored how joint working and service integration affect the nature of managerial learning, training and development and how MD alters to facilitate managers in future service systems. Even though this has been done in the context of health and social care integration, the research can provide useful insights into the nature of middle management working and their M-LTD in other public service settings across the UK where integration models are being attempted. This is particularly so when other public services face the same macro-level challenges that include austerity and increasing service demand.

Even though focused on the CHP setting in Scottish healthcare services, I believe that my study can provide useful insights for similar integrated service partnership arrangements being attempted across other universal healthcare PSOs such as NHS England and Health Canada. This is especially so as CPM as an area of inquiry lacks distinction and comparable studies due to its fairly recent emergence in the public sector (O'Leary and Vij, 2012). The dynamics of management and the work managers do in partnered public service arrangements is resonant across different public service sectors such as voluntary and social care, therefore enabling this study to be generalised across other collaborative endeavours in different sectors that partners with healthcare.

The findings of this study in relation to the transition in the managerial remit and the changing nature of M-LTD can provide relevance for what is required of managers and how they can be better prepared. Dynamics of service design such as integration models like the Body Corporate and factors such as co-terminosity are applicable to service designs across sectors which this study can inform. Certainly, this study focusing on mainland Scotland CHPs as a sample, can be generalised across other CHPs in Scotland giving it external validity (Bryman and Bell, 2011).

As the effectiveness of MD provision is contested across the public sector, the findings of this research provide useful insights for reframing MD in a changing public service context which can be adapted across the public services sector. The generalisability of these findings can also provide insights for external MD providers who cater to the public healthcare sector.

8.2.2 Limitations

This research has had to battle with ambiguity of concepts and terminology across two domains. Firstly, the ambiguity and lack of clarity between forms of joint working, collaboration and integration. The terminology and conceptualising remains loose and these terms and concepts are used interchangeably to describe the one phenomenon. This is a perceived limitation for both the research and the researcher since conceptualising integration becomes a challenge (Robson, 2013; Armitage et al., 2009) while sound assumptions and judgements have to be made in the process of data collection and interpretation of findings to ensure that the interpretation remains genuine to what the respondent intended in terms of meaning.

Secondly, there remains the limitation of overlapping terminologies and conceptualising when referring to forms of management learning, training and development. Managers use concepts such as T&D, L&D, MD intertwiningly and this natural emergence remains a challenge because one is dealing with intangible and fluid constructs while these are different components (derived semantically) that refer to the same process of enhancing managerial potential (Garavan, 1997; Hammett, 1994; Easterby-Smith, 1994; Reid, 1991). The challenge throughout the research has been being able to distinguish between them, not because it is conceptually required, but because of the need to ensure that the researchers interpretation remains coherent with what the respondent is intending to mean. Another limitation faced is the extent and variety of MD across the NHS that remain scattered across time and place. The MD effort in the NHS remains fragmented, is largely varied and involves a complex range of stakeholders that are transient with time (Sambrook 2001; 2004; 2006; Garavan, 1995). This limitation imposed a challenge of being able to draw out specific information and views from managers about MD programmes since they faced the challenge themselves of not being able to describe the specifics and particulars of MD programmes, except for being able to recall names or titles, that too with a degree of clarity.

The extent of political reform, change and restructuring in the NHS also acts as a limitation to the research since the researcher needs to determine and derive a research context in the midst of a wealth of reform and change. What this has meant is embracing the NHS as a

research setting and research context that is highly complex and messy (Storey et al., 2011). This demands of the research and researcher that sound judgement be exercised as to the issues that are investigated and the literature that is addressed. Making sense of the variety and speed of change remains a challenge for doing exploratory research in the context of the NHS and the UK public sector in general. Added to this, the extent of literature on management in the NHS is also very diverse but more so, can be deceiving when reviewed because terminologies associated to 'management' overlap and/or can be used interchangeably between clinical management and general management. There is also the vast challenge of distinguishing between political and management reform and management practice in NHS Scotland and NHS UK (i.e. England) which operate on very different basis and ideologies yet share contradictions and similarities in terms of their histories of management reform and devolution.

Nevertheless, the research has intended to address these limitations both in terms of the empirical enquiry made and the secondary research conducted in the form of an extensive literature review. The methodology adopted for this research may also draw the limitation of not being able to draw any definitive conclusions on issues and being restricted to inferring on the basis of four cases. The research design has been exhaustive using a four phase study approach which has proven challenging to implement under a limited time period

As with any research that is context specific, this research is also faced with changes and developments in environment and context. Especially in the context of this study, political reform and change in NHS Scotland and the UK Public Sector have occurred during the time this research was conducted. This research explores the views of managers and studies issues at a time when H&SC integration becomes subject to legislative change and leads up to the events in time where legislation is being passed through parliament but waiting to be enacted. The issues and challenges explored are based on perceptions of managers across that given time and context where managers and organisations where envisioning and planning for H&SC integration. As the research reaches its end and makes contributions, the trajectory changes and the context develops further to the point where legislation is now being enacted and organisations have begun to actually enter partnership formations and engage with integrated service management arrangements. Nevertheless, the study has attempted in the best possible manner to ensure that cases and managers were tracked in real time collaboration and over a course of period enabling both cross-sectional and longitudinal elements into the research design.

8.2.3 How Research Objectives Have Been Met

This research intended to meet two objectives. The first was to explore the issues and complexities service managers face in engaging with joint working and service integration and how this affects their roles, responsibilities and relationships. This objective is addressed by this research through exploratory means where new insights and theory begin to emerge from the cases studied. Firstly, past experiences influence their perceptions of joint working and service integration and shape the management culture and their willingness to engage with change. Managers critically question the purpose of integration with reference to re-structuring and its benefits for users. The complexities for managers in engaging with joint working and service integration become a constant in their occurrence but remain transient depending on context. Particularly, these complexities are associated with managing staff in joint teams with different T&Cs of employment and performance and also complexities that arise from the cultural and operational differences of organisations that are attempting to integrate services. As managers begin to contest NPM-driven practices that are organisation-centric and pre-determined, they move to translate and adopt change from the larger political and legislative levels and address them through a SD approach at the local level by initiating bottom up practices in localities that are improvised for the local context and are increasingly user focused.

In addressing complexities and engaging with service integration, RRRs become contested because accountabilities become unclear and because the service manager's knowledge and authority are challenged in an inter-agency and multi-profession team environment. Therefore, as managers move towards an integrated service system, they begin to determine and negotiate RRRs based on the context in which they operate since previous RRRs that were restricted to set boundaries become outdated and increasingly irrelevant for an integrated service environment. The RRRs of service managers become pulled towards the needs of service users and localities. What managers do and how they do it begins to be derived from learning and reflecting in practice and as negotiated over time amongst other managers in the service system. The research objective has been met with new insights about the issues and complexities managers face as they engage with joint working and service integration and how their RRRs begin to transition from management in networks to management in S-A-A-S.

The second objective of this research was to explore the changing nature of managerial learning, training and development brought upon by joint working and service integration in healthcare services and to assess how MD can alter to facilitate managers in new service

systems. This objective is addressed by this research through exploratory means where new insights and theory begin to emerge from the cases studied. The nature of learning, training and development becomes contested because present traditional forms of MD are viewed as increasingly irrelevant to what managers are attempting to do in delivering integrated services and does not relate with an altering remit which managers negotiate and derive in new service systems. Different from past practices where M-LTD took on agendas of pre-determining and prescribing the learning and development to be done for organisational efficiency, future M-LTD must take on the agenda of supporting managers to make behavioural shifts and develop leadership ability so as to enable them in working in multi-agency and multi-profession service environments and to support them in managing services specific to context. It is increasingly about M-LTD that enables new leadership abilities that are relational, collaborative, adaptive and flexible so that managers are able to span boundaries in their RRRs. Here, the critical factor is that of treating learning as multi-dimensional and not restricted to the development or demonstration of pre-set competences. Rather, it is about learning that is reflective and derived out of action and which is a result of incremental experimentation.

As the nature of M-LTD changes due to joint working and service integration, the research goes on to assess how MD can alter to facilitate managers in new service environments. The findings reveal that MD can be reframed to move away from generic and preordained forms to L&D enabling and L&D supporting forms; from organisation focus to multi-agency service focus; from standardised to organically tailored.   In S-A-A-S, MD begins to move away from the pre-ordained notion of a programme or intervention towards MD that is about supporting managers to self-determine and self-direct a MD framework that suits their learning needs based on, and specific to, their given context so that they can make sense of their integrated service environment and be better enabled to address the challenges that arise from it.

8.3 Gaps in Literature and Theory

In this section I discuss aspects of theory that are emerge as a result of this study.

This study establishes that key policy and literature focused around the integration agenda acknowledges that tensions and challenges arise from joint working and service integration, but does not exemplify these tensions and challenges associated with joint working and service integration or how these challenges arise. More specific theory in relation to healthcare service integration is required and this can arise from generating similar studies

that examine health and social care integration. This opportunity aligns with literature that suggests progress made via arrangements such as partnerships in the public sector are in their early days and not enough is known about how they shape public performance (O'Toole and Meier, 2010)

As this research highlights that managers must be prepared and willing to engage in new remits and with new learning in integrated service systems, there remains a gap in theory that can address the changing RRRs that the manager will engage with for integrated service environments. This requires fresh situational analysis and invites further research in the public service context. O'Flynn (2007) highlights that we are limited in our knowledge as to the move towards integrated inter-agency service systems and this has implications for knowing what is required of service managers and how they can be prepared.

The learning, training and development of managers that can enable inter-agency and multi-disciplinary working is a gap in theory to address specially in the context of services-as-systems where M-LTD becomes user orientated and context specific. Largely, the literature addressed M-LTD as focused around roles and tasks in the organisation rather than a holistic service system and establishes that MD in its current forms are ill equipped and incapable of supporting the learning and development of managers for the healthcare service context (Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Collins and Holton, 2004; Hamlin and Cooper, 2005).

The research discovers that future service integration models (i.e. Body Corporate and Lead Agency) besides being identified as a means of addressing staff T&C differences and financial governance by managers, are not associated or related with implications for service users. This is a particular concern since policy intends for service integration to improve user outcomes and user participation in service design and delivery. While certain literature looks at the implication of service integration models of T&Cs of staff and financial governance (Robson, 2013:3; UNISON, 2014), more research is invited to advance theory in how service integration models and their perceptions among service managers influence service users.

As managers begin to contest and challenge rational and normative (NPM advocated) thinking and practice, new ways of thinking and working start to emerge where managers are concerned with users and localities and more interested in service design that leads to better processes and user outcomes. Critique presented towards rationalistic management practices by managers in this research invites future research that can study emerging management

thinking and practice beyond a post-NPM paradigm and how this rests with the NPG paradigm (Osborne, 2010; Kinder, 2013). For NPG to contribute to the evolution of public services management it needs to explore managerial challenges in the integrated service environment.

The study identified different T&C of employment and performance for staff in integrated teams to be treated as an issue that cannot be resolved. Theory that can address this issue of resolving this limitation is lacking within the literature body. Cultural and operational differences in integrated service management prevail become context specific in S-A-A-S. This therefore require more theorising based on studied case examples.

It emerges from the study that managers associate exclusive co-terminosity between Health and Social Care organisations as a future advantage for the reason that it will make planning for service delivery in localities less complicated. However, managers do not associate co-terminosity with better user outcomes or user involvement in integrated healthcare service design. This could be for reasons that user participation is contested as some theory suggests (Fledderus et al., 2015; Simmons et al., 2012). More theoretical insight is required as to how management perceive and treat service integration models in connection with user participation for service design.

With an emphasis placed on leadership capability, being able to lead in uncertain environments becomes important for managers. Context based leadership takes priority over competence based management in integrated service systems. McGurk (2009) suggests that potential leadership building in managers is a neglected area and contextual research is required into the outcomes of MD across public service contexts in relation to this. Theory that can enable us to better understand transitions in leadership thinking and practice as well as leadership behaviours for new (i.e. integrated) service systems is invited.

The case for reframing MD to support reflective and action learning and enabling managers to self-determine and self-initiate personalised MD frameworks that suit their learning needs and context, requires new conceptualising and research in future service integration studies. This is particularly so when the theoretical and practical focus has been on standardised and programmic approached to MD (Doyle, 1994; Haskins and Shaffer, 2012; Holman and Hall, 2006). Here, the potential for co-location of services as an opportunity for learning in new service environments (Bardach; 1998; Kinder, 2010; 2002; 2003) and co-produced MD in future public services as an opportunity to innovate M-LTD (Fenwick and McMillan, 2013) invite further theory development.

8.4 Contribution to theory and practice

Realising that the move towards inter-agency partnership management and integration of services is a fairly new emergence in the context of the UK public sector, partnership working arrangements and structures such as CHCPs are in their early days and little is known about how they will shape public service performance and service user satisfaction (O'Toole and Meier, 2010). Therefore, such models of partnership working are little tested and their evaluations remain generally inconclusive (Forbes and Evans, 2008). The outcomes of this research contribute to extending knowledge in this area as it studies CHP cases over a current and critical period of change. The outcomes contribute to knowledge with respect to managerial perceptions of partnership working arrangements (i.e. H&SC integration) and the complexities and challenges that arise in managing services under such new service arrangements. Furthermore, the outcomes of this study which examine how managers deal with and prepare for collaborative working in the integration of health and social care services and how their RRRs transform as a consequence. This contributes to CPM theory and attempts to fulfil the need to understand and extend knowledge of how collaborations actually perform over time by examining real time collaborations (O'Leary and Vij, 2012). Furthermore, this research contributes to the need for more sophisticated understanding and comprehensive approach to the practice of public policy implementation and public service delivery (Osborne, 2010).

As the ability of the NHS to develop managers for a healthcare service is contested and MD provision is deemed inappropriate for what managers do in practice (see Khurana 2007; Locke and Spender 2011; Thomas et al 2012; Sambrook, 2007; Powell *et al,* 2013; Hyde *et al,* 2013; Mintzberg, 2004; Edmondstone and Western 2002; Hamlin 2002b; Smith 2002; Collins and Holton, 2004; Hamlin and Cooper, 2005). This research contributes to this theory domain. The research outcomes draw out the reasons for why current MD is increasingly irrelevant to what managers do and contributes to knowledge on how MD can be improved and made for relevant to what managers do and to support the L&D of managers in a changing public service that moves beyond networks to holistic systems (S-A-A-S). This contribution to theory builds upon the need that we remain limited in our knowledge as to the move towards integrated service systems which have implications for knowing what is required of managers and how they can be prepared (O'Flynn, 2007). Acknowledging that the development of human resource in the public sector remains a 'wicked' problem (Brown et al, 2014:4) where no resolution can ever be reached, this therefore highlights the need for contextual research about the outcomes of MD in public

services (McGurk, 2009), This research contributes to theory in this domain with the knowledge that self-initiated and self-directed MD frameworks that can enable leadership capabilities in managers to do sense making and boundary spanning is a direction going forward. As managers are increasingly needy of being able to network, lever resources and build relationships beyond the organisation and learn in different ways than before (Stoker, 2006; O'Flynn 2007: 361), this research addresses these needs by examining and better understanding the challenges and issues managers face and how they can be enabled to fulfil them.

The outcomes of this research also contribute to a theory of managerial learning in new public service environments using an S-A-A-S approach. It contributes to how learning transforms to become reflective and action based and how the dynamics of learning become multi-dimensional yet context-laden (Fenwick, 2013). Particularly, how this occurs for managers in new integrated healthcare service environments is an area where new insight and knowledge is required. Kinder's (2013) suggestion that progress lies with new ways of learning in PSOs at the local level using a whole systems approach (S-A-A-S) is an area to which this research has contributed. Having explored how the nature of managerial work is changing and how the learning and development needs of managers alter, this contributes to the rethinking and reframing of Management Development in changing public service systems.

The research, based on insights from managers and their practice, has also confirmed the shift towards NPG at a time and place where post-NPM ideology is evident among managers as they move towards integrated practice. The study explores the present day challenges of the changing public service environment (i.e. integrated H&SC service delivery) and informs managerial practice. This can be recognised as an empirical contribution towards the contribution of NPG in the evolution of public service management. Particularly, it contributes the two of the fundamental questions upon which NPG theory can move forward. Firstly, the Values question: *what values underpin public policy implementation and service delivery in emerging systems?* The outcomes contribute that values associated with user-focus and localities (user-context purpose) underpin the management of integrated service delivery in new public service systems. Secondly, the Relational Skills question: *what key skills are required for relational performance?* The outcomes contribute to knowledge about leadership behaviours and skills of intentional engagement that enable managers for relational performance in new public service systems. Thirdly, the Accountability question: what is the nature of accountability in fragmented pluralist systems? The outcomes

contribute to knowledge about how managers improvise and negotiate their management accountabilities in relation to their RRRs in an inter-agency and multi-profession service environment where authority and knowledge are challenged. Collectively, the research contributes to the advancement of NPG theory at a time where NPM theory is disputed for conceptualising modern day public services.

Through the cases studied, the research can inform management practitioners and organisations alike in similar case settings across the NHS where service integration is being attempted. Particularly so when managing change in the NHS and the public sector remains messy and complex (Storey et al., 2011). Managers engaged with joint working in partnership arrangements across the NHS can better understand the complexities of a changing service system and be able to better inform their practice: particularly in terms of understanding and influencing their managerial remit and M-LTD. Given that the individual manager has received little attention within the NHS since collaborative public management research has largely focused at the level of collaboration between organisations and little on collaboration between individuals (Huxham, 1990; 1993; O'Leary and Vij, 2012), this research can help inform theory and practice at the level of collaboration between managers. Further to this, the research contributes to practice as the HR function can gain an understanding of the complexities and challenges associated with different T&Cs of employment as the organisation and managers enter integrated partnership structures. The OD function in organisations may also take reflections from this study to better understand change processes associated with managing in integrated partnership arrangements.

The research outcomes also provides insights to national T&D providers such as the IHM or NES about the M-LTD challenges managers face in integrated healthcare service delivery with the potential for them to rethink their MD provisions and offerings and improving the chances for co-produced MD. The outcomes of the research also provide insights to policy makers for future strategy around management and leadership development in public services and for more informed public policy making around partnership working.

Overall, this thesis had explored an area of increasing importance in the management and development of public service provision and managers within them. This is done particularly with reference to the increasing direction towards partnership working and service integration in healthcare services. This has been achieved through an in-depth study of NHS Scotland and 4 CHP cases within it as the setting. Focusing on the challenges that face managers in a changing service environment, the study identifies critical issues that arise and draws together a set of conclusions that enhance knowledge and understanding in an

emerging field of collaborative public management. The study therefore hopes to extend knowledge in the field of management whilst providing implications for management practice.

8.5 Recommendations for future research

The issues, findings and emerging theory presented within this research now require further exploration, clarification and theoretical extensions in the context of management and MD in H&SC service integration.

This study should be extended to include a larger section across the population both in terms of more CHP cases and more participating service managers in situated studies. Particularly for managers and organisations involved with delivering integrated healthcare, this can facilitate cross-sectional comparisons of the changing remit of the manager, the associated behaviours for inter-agency management and the reframing of MD in new public service systems.

More studies related to management and change in integrated healthcare services are invited so as to develop a larger empirical base from where new theory can emerge. This is particularly important as both CPM and integrated approaches to public service design and delivery are in their early years of study and practice. This also sets the precedence for moving forward with developing empirical studies that can support the progression of NPG theory and new public service management models in a post-NPM era.

8.6 Summary

This chapter has intended to discuss the main outcomes of this research study while engaging with an evaluation of the study where the generalisability and limitations of the research have been discussed while assessing how the research outcomes meet the objectives of this research. Further to this, I have discussed how the research outcomes enable identifying gaps in literature and theory and how these might be addressed. Finally, the contributions of this research to theory and practice have been discussed and recommendations for future research are made.

8.7 Final Words

The improvement of public service delivery and the development of managers remains a never ending pursuit since they will always involve people and human processes; and therefore pluralities and emotions. Nevertheless, in the endeavour to make services and their outcomes more purposeful and meaningful for public wellbeing and social welfare, this research calls upon other researchers to continue work in pursuit of better understanding and improvement of public service management, particularly in respect of health services which face rising demand and resource constraints.

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