Integrated care for people with complex health needs:

PRACTICE IN THE MAKING

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Certificate of authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Date:

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Abbreviations and terminology

ANT	Actor–network theory, associated with the work of Bruno Latour (2005), John Law (2004, 2007), Annemarie Mol (2002) and Vicky Singleton (2005).
ARC	Australian Research Council
CSCW	Computer supported cooperative work, a research field that addresses how collaborative activities and their coordination can be supported through computer systems
GP	The GP, or general practitioner, plays a central role in the delivery of health care in the Australian community and is most likely the first point of contact in matters of personal health.
GPLN	The GP liaison nurse is a senior clinician who supports the enactment of the HealthOne model of care by liaising with service providers to improve clients' care and access to services.
NSW	New South Wales
WHO	World Health Organisation

Abstract

Improving health service delivery through integrated care has been the aim of governments in Australia and internationally for three decades. Implementing policy changes in practice is challenging and it is still unclear how integrated care can be achieved. This study examines how a model of integrated care evolved as an approach to caring for people with complex conditions and vulnerabilities. The specific case is HealthOne, a NSW government healthcare initiative, located in primary health care. The ethnographic study extended over 21 months and across many locations in western Sydney. It drew on complementary conceptual resources and empirical data collected through shadowing of HealthOne liaison nurses, observation of meetings, semi-structured interviews and collection of documents. The multi-sited, mobile ethnographic fieldwork spanned acute care, primary care and community-based services, encountering 60 professionals from health and social care.

This study advances knowledge about the complex phenomenon of integrated care by exploring the translation of policy into practice. Against a backdrop of upheaval and change, the enactment of integrated care through HealthOne emerged as a relatively unstructured form of integration, understood as *linkage*. In this study, integrated care was accomplished in practice as an ongoing, fluid process of negotiation and adaptation. Thus the study challenges policy expectations about achieving integrated care as a triumphant, stable endpoint.

Practice change evolved in uneasy tension with stability, rather than as a straightforward replacement of old with new. Practitioners struggled to understand the HealthOne model of care. Making sense of HealthOne arose

through practice over time and was central to this developing form of care. Integrated care unfolded through an interwoven array of embedded, revived, remade and emergent practices. The tension between stability and change as practice altered was foregrounded in an interplay between practices that concurrently promoted and reacted to this model of integrated care.

Enacting integrated care entailed relational practices beyond those that were envisaged in the model of care. Integrated care was accomplished in practice in a fluid way, where care was adapted and attuned to clients' health status and practitioners' immediate concerns. HealthOne liaison nurses and case conferences acted as key mechanisms of integration, holding together shifting relations and emerging practices, despite the absence of structural and funding arrangements to sustain coordination, communication and collaboration. In drawing together practice theory, actor–network theory and integrated care literatures, this study contributes to better understandings of integrated care and how it can be achieved. ■

Chapter one

A study of integrated care in practice

Improving health service delivery through integrated care has been the aim of governments and policy-makers both in Australia and internationally (Australian Government Department of Health and Ageing 2010; Curry & Ham 2010; Kodner & Kyriacou 2000; Keast, Brown & Mandell 2007; Leutz 1999; NSW Health 2007, 2014; Oliver-Baxter, Bywood & Brown 2013, Valentijn et al 2013). A recent British report identifies why integrated care is important:

> Health and social care services must be capable of providing ongoing support over time, anticipating and preventing deterioration and exacerbations of existing conditions, and supporting a person's multiple needs in a well coordinated way. At present, the system often fails to do this, with divisions and gaps between different agencies and professionals meaning that patients and families experience a fragmented service. Integrated care is the response to this failure, and represents a fundamental transformation in the way that health and social care services are delivered. (Naylor, Alderwick and Honeyman 2015, p. 11)

Policymakers anticipate that integrated care will lead to better outcomes in terms of reductions in cost and in the burden on health services, and in improvements in patient experiences and the quality of health care. Yet implementing policy changes in practice through redesigning health care is challenging. This is 'especially difficult when one is trying to change routine

processes and procedures to alter how people conduct their everyday work, individually and collectively' (Institute of Medicine 2001, p. 111).

Healthcare transformation through integrated care calls for 'new ways of working that span traditional service and organisational boundaries', and for 'more integrated models of care' (Naylor, Alderwick & Honeyman 2015, pp. 15, 73). These are intended as the solution to challenges faced by fragmented systems in meeting the requirements of aging populations and increasing numbers of people with 'multiple chronic conditions and complex needs' (Naylor, Alderwick & Honeyman 2015 p.11). Although this UK-based research report (Naylor et al 2015) recognised the complexities of introducing new models of care, giving examples of challenges, strategies and models, there was little attention to the actual practice of integrated care. The report upholds the vision of integrated care. In so doing, the report reinforces the rationale for studies of 'how' policy enactments can or do achieve integrated care.

My study explores how integrated care was enacted in practice. The model was HealthOne, a New South Wales (NSW) government initiative (NSW Health 2007), located in primary health care. The HealthOne model of care aimed to provide integrated care for people with complex conditions and vulnerabilities by bringing together general practitioners, community health and other health and social service providers, to facilitate communication and access to services, and to support care coordination across patient conditions, settings and services over time (NSW Health 2012b).

This ethnographic study extended over 21 months and across many locations in western Sydney. Drawing on multiple theoretical resources, the study examines how the HealthOne model of care evolved, and how this change initiative achieved integrated care. The study explores the work practices associated with HealthOne carried out by a wide range of professionals from primary care, community-based services and acute care.

This study was undertaken as part of a larger Australian Research Council (ARC) Linkage research project, entitled 'Remaking Practices', with NSW Health as the industry partner. The ARC project was researching practice change in primary health care, and how learning occurred (Solomon et al 2010). That research aimed to contribute to the understanding and achievement of change in health services and professional practices by producing rich descriptions of health practices in local settings; practice improvement resources; and new theorisations of professional practice and learning. The findings in this doctoral study were developed independently from the broader ARC project yet contribute to its aim. The conceptual framing of practice as everyday action that is situated in the context of professional health care (Solomon et al 2010) underpins this study. This chapter introduces the focus of this thesis: how a model of integrated care located in primary health care, was enacted in practice.

Improving health care in Australia through integrated care

> A high quality, high performing health system needs a strong, *integrated* primary health care system at its centre. Health systems with strong and effective primary health care can achieve better health outcomes at a lower cost than health systems that are more focused on acute and specialist care. (Standing Council on Health 2013, p. 2)
>
> Stronger, more effective and better *integrated* and coordinated primary health care services are the best way to achieve better outcomes for patients and ensure a sustainable health system into the future. (Australian Government 2015, p. 4)

Improved integration of service delivery and coordination of services is aimed at managing Australia's emerging health issues, including the ageing population and the burden of chronic disease (Australian Government 2011, 2015; NSW Health 2007; McDonald et al 2006). The Australian government

maintains that integrated care would enable the fragmented primary health care sector to become stronger and more cohesive, thereby improving health status and cost-effectiveness and access to services (Australian Government Department of Health and Ageing 2010; Australian Government 2015), while decreasing health inequalities (McDonald et al 2006). Other challenges include disconnected services, a lack of coordination, service duplication, and delayed or absent services (Australian Government 2015). At the time that HealthOne was developed, issues included timely and appropriate access to general practitioners, particularly in areas of socio-economic disadvantage, access to allied health practitioners and 'affordable specialist care' (NSW Health 2007). A 'more consistent service response' was needed, bringing health professionals together to deliver a 'more cohesive service' which met the needs of complex and vulnerable clients and protected GPs from 'burn out' (NSW Health 2011d, pp. 5, 4, 6). Thus integrated care was represented as the 'streamlined' solution (NSW Health 2007) to a number of problems (Evans et al 2014).

The policy position held in common by the Australian, State and Territory governments was that strengthening primary health care was the answer to managing the growing cost of health care (Australian Government Department of Health and Ageing 2010; NSW Health 2011b; NSW Health 2011c; Interview, 14 October 2011). The assumption was that this would reduce the burden on the acute health care system. Accordingly, Australian States and Territories were required under the National Healthcare Agreement funding arrangements to report results on performance indicators, for instance, 'selected potentially preventable hospitalisations', and 'selected potentially avoidable GP-type presentations to emergency departments' (Council of Australian Governments 2011a). Thus, integrated care aimed to improve the health status of the population, manage complex conditions, decrease the demand for acute care and reduce costs.

However, different ways of thinking are needed in order to achieve improved health outcomes through integrated care. The scholarly debate about integrated care has not reached consensus about what integrated care is and 'how it can be achieved' (Evans et al 2014, p. 126). There is a substantial body of work on developing conceptualisations. There is a comparatively smaller body of empirical literature on integrated care, which investigates various models of integrated care, measuring outcomes against the policy objectives, noting particular elements of integrated care that are more effective or describing challenges and success factors. The essential elements of models of care are still under examination (e.g. Minkman 2016b; Valentijn et al 2015a). Hence there 'is a jumble of stand-alone integrated care initiatives in practice' (van der Klauw et al 2014, p. 2). Empirical studies of integrated care have rarely drawn on theorisations of practice. Even within the empirical literature, the professional and organisational dimensions of integrated care have been 'the prime focus of practice, science and policies' (Valentijn et al 2015a, p. 10), leaving a gap in evidence about how integrated care is actually achieved.

Research aim and research questions

The aim of this study was to contribute to better understandings of integrated care and how integrated care is enacted, by focusing on integrated primary health care at the practice level.

This study examines how a model of integrated care evolved as an approach to caring for people with complex health needs in western Sydney from 2011 to 2013. Rather than evaluating how effectively HealthOne was implemented in the study settings, the study examines how this model of care was enacted in practice.

The first research objective was to focus on everyday practice, in order to understand and explain how a model of integrated care was enacted on the ground in community-based services. The second research objective was to

draw on theorisations of practice to establish how integrated care was enacted. The research questions were:

1. What were the realities of enacting the HealthOne model of integrated care?
2. How was integrated care unfolding?
3. How was a model of integrated care accomplished in practice?

This study makes original contributions to the knowledge base about integrated care. It does so by exploring three perspectives on the enactment of integrated care through working in new ways with existing conceptual resources (explained further in chapter three). The wording of the research questions is theoretically informed to foreground in turn very different aspects of integrated care practice in the making. Employing concepts from Actor-network theory (ANT), question 1 explores *what* 'realities' took form in practice. The term 'unfolding' in question 2 alludes to working with Schatzkian conceptualisations of practice change to uncover *how* practice altered. Question 3 takes up the ANT notion of translation as an ongoing accomplishment to explore *how* the process of transformation was achieved. By rethinking the complex phenomenon of integrated care from different theoretical angles, the study presents innovative understandings of integrated care in practice.

Clarifying terminology

Integrated care is the central focus of this thesis; it is a key feature of HealthOne, and also of contemporary health literature. However, the case for this study of integrated care is the HealthOne model of care, which is located in primary health care.

Primary health care

The terms 'primary health care' and 'primary care' are often used interchangeably across the literature (Valentijn et al 2013, p. 2; see also Tieman

et al 2006). Nevertheless, the terms 'primary care' and 'primary health care' are not regarded as synonymous in this study, and they carry different meaning for practitioners.

In Australia, 'primary care' has been generally regarded as the first point of contact between an ill person seeking treatment and the health system, namely a healthcare provider who is usually a general practitioner (GP) (Leeder, Rubin & Russell 2008). 'Primary health care' is broader than 'primary care', covering aspects of integration, collaboration and multidisciplinary care, from initial contact to screening and health promotion activities for individuals and populations; that is, more of a philosophical and systemic approach (Tieman et al 2006) across the spectrum of care. This broader concept is often referred to as 'comprehensive primary health care' (Powell Davies et al 2006).

The principles of primary health care include accessibility, illness prevention, health promotion, advocacy, intersectorial collaboration, client participation, and maximisation of individuals' and communities' capacity to manage and improve their health (Australian Primary Health Care Research Institute 2005; McMurray 2007; Wass 2000). Those principles were declared in the seminal Alma-Ata statement on health for all through system integration at the 1978 International Conference on Primary Health Care (NSW Health 2013; Smith & Bryant 1988; World Health Organisation (WHO) 1978) and subsequently, in Australia's national primary health care strategy (Australian Government Department of Health and Ageing 2010).

Interconnections between the concepts of 'primary health care' and 'integrated care' (Frenk 2009; Goodwin et al 2012, Kodner 2009; Valentijn et al 2013; van der Klauw et al 2014) remain across the literature. Some suggest that 'integrated care' is a contemporary reframing of 'primary health care' which emphasises the combination of intersectorial, interorganisational and interprofessional approaches to coordination of client services across the

continuum of care that are implicit in the principles of primary health care (Frenk 2009; Greenhalgh 2013; Valentijn et al 2015a).

Integrated care

The global vision for integrated care calls for 'health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course' (WHO 2015, p. 7). Throughout their life, people with chronic conditions, disabilities and complex health needs require care that brings together a range of professionals and skills from across the health and social care sectors. Internationally, integrated care has been seen as offering a 'promising set of strategies to improve coordination, continuity, quality, and efficiency in the delivery of health and social services to vulnerable populations' (Kodner 2005, p. 1).

Hence, the definition of integrated care as 'a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors' (Kodner & Spreeuwenberg 2002, p. 4) has underpinned the interpretation of integrated care in this study. In addition, degrees and dimensions of integrated care as recognised in classifications by Leutz (1999), and Valentijn et al (2013) have informed the analysis.

Integrated care is an approach to the delivery of health care that has been an aim of governments, policy makers and health organisations for three decades (Leutz 1999). Early initiatives focused on managed and integrated care across health and social care systems for vulnerable populations such as the young, the elderly and the chronically ill (Evans et al 2014; Kodner & Kyriacou 2000). The

burden of chronic disease that is expected to cause three quarters of all deaths by 2020, the ageing population, illnesses requiring multiple, complex interventions and growing concerns about healthcare costs (WHO 2015) precipitated reforms through integrated care. The HealthOne approach resonates with integrated care strategies internationally that have increasingly focused on 'community-based partnerships across the continuum of care, operational and cultural change, quality and patient-centred goals, and targeted patient populations' (Evans et al 2014, p. 149). Efforts to implement the approach in Australia are influenced by the specific and complex structure of the Australian health system, which is described in the following section. This is followed by an outline of the case for integrated care from the perspective of governments and policy makers.

The health system in Australia: an overview

Australian health care is funded and governed by multiple levels of government—national, state and local—as 'a complex web of services, providers and structures' (Australian Government 2014 p. 17). Although States and Territories have responsibility for public hospitals and community health, and the national government has responsibility for primary care, the private and not-for-profit sectors play significant roles in health care in Australia. Local government also has some responsibility for community care (Powell Davies et al 2009a).

Most health care in Australia is provided in the community. In any two-week period, almost one in five people visits a general practitioner and one in ten visits an allied health professional, a term that includes pharmacists, psychologists, radiographers, social workers, physiotherapists and dieticians (Australian Bureau of Statistics 2013).

Community health services funded by States and Territories and based in community health centres provide a range of general nursing e.g. child and

family health and various allied health services, as well as designated services such as mental health, refugee health, indigenous health and multicultural health (Powell Davies et al 2009a). Some general practitioner-type services are also provided in public hospital emergency departments (Australian Government 2014). Specialist care is also provided in the community, mostly funded through the national government.

Health insurance was introduced in Australia in 1950 as a voluntary scheme. Universal health insurance was introduced in 1975 with Medibank and re-established in 1984 as Medicare (Australian Government 2014). Australian health care consumers have few restrictions on access to services and providers, other than the impediments of long waiting lists, co-payments, and the gatekeeper role of general practice in making referrals from primary care to specialist care.

In comparison to the situation in the United Kingdom, Australians are not tied to any particular general practitioner or practice. It is not uncommon for many people to visit a range of primary health care providers, most of whom are private practitioners, across a range of different professions and services in general practice, community health, allied health and indigenous health (Garling 2008; Powell Davies et al 2009a). Australia is dissimilar to the United States where Medicare, Medicaid, and health insurance plans determine access to services and providers (due to lack of universal insurance), or Canada where primary physician care is provided universally without co-payments, and specialists are accessible with or without referrals (Goodwin et al 2014; Starfield 2010).

Policy reforms

The pace of health policy reform increased in Australia from the early 2000's. A range of initiatives at national and state level aimed to integrate and coordinate care, strengthen primary health care and manage the problem of chronic

disease. Integration and continuity of care, fewer unplanned hospital admissions, prevention and self-management were key priorities (Esterman & Ben-Tovim 2002; McNab, Mallit & Gillespie 2013; NSW Health 2014b). The Australian government, concerned about the burden of chronic non-communicable diseases, formulated disease-specific, population level policies to improve chronic disease management (McNab, Mallit & Gillespie 2013). The strategy, based on principles supporting a population health approach, person-centred care, health promotion, illness prevention and 'coordinated and integrated multidisciplinary care across services, settings and sectors', was expected to achieve better health outcomes (National Health Priority Action Council 2006, p. 10).

Australian policymakers and governments were focused on reducing potentially preventable hospital admissions and net healthcare costs through delivering more care in community settings through integrated care (Russell 2012). This research coincided with major policy reforms in health service delivery in Australia, which were intended to bring about more effective primary health care, shifting the 'centre of gravity' in the health system from acute care to primary health care (Australian Government 2011, p. 3). Reforms in primary health care were instigated with the 2009 report from the National Health and Hospitals Reform Commission and the first national primary health care strategy (Australian Government Department of Health and Ageing 2010). Under the theme of connecting care, the National Health and Hospitals Reform Commission recommended the voluntary enrolment for people with chronic and complex health needs in a 'health care home' located in primary health care (Bennet 2009). However, it was not until the Health Care Reform Agreement of 2011 that increasing concerns about the pressure on the public hospital system saw national funding directed to improve integration and coordination of health care across primary care and community health. Although the national

primary health care strategy envisaged that the Australian government would take full responsibility for funding and policy in primary health care, resistance from States and Territories to proposed funding arrangements led to a continuation of shared responsibility for funding and health care through partnership between the Commonwealth of Australia and the eight States and Territories.

National reforms were foreshadowed by a number of States and Territories that funded programs aimed at integrating health care services (Russell 2012). The state of NSW, where this study took place, was influenced by a key report, the Garling Report, which argued that a reduction in hospital inpatient stays through strengthening primary care and community health services would be beneficial to the hospital system, reduce costs and increase patient satisfaction (Garling 2008). Policymakers called for a new model of integrated care, framed by the vision of 'an integrated and coordinated primary and health care system working in partnership to promote the health and wellbeing of our community' (NSW Health 2007, p. 1). The policy's implementation plan featured HealthOne, an innovative model of care based in community health, as a strategy to achieve integrated care.

The inception of HealthOne in 2006 (McNab, Mallit & Gillespie 2013) preceded a national initiative developed with a similar intent and which led to the establishment in 2012 of Medicare Locals. These were 61 regional bodies accountable for planning, integration and coordination of primary health care services (Standing Council on Health 2013). In 2015 Medicare Locals were replaced by Primary Health Networks. Thus different initiatives to develop integrated primary health care services were established nationally through Medicare Locals and GP Superclinics, and through the NSW government initiative—HealthOne—as well as the South Australian initiative—GP Plus Centres (Powell Davies et al 2009b). HealthOnes were state government

initiatives with responsiblity for a local community, in comparison to Medicare Locals, which had strong links to general practice and were responsible for regional integration. Consequently, there were complex and overlapping state and national arrangements, albeit with a common vision for integrated care.

Across Australia, the new network of national government-funded primary health care organisations, Medicare Locals were established, replacing the existing Divisions of General Practice. Medicare Locals were now responsible for the coordination and funding of services to meet the health care needs of the community and to work with local health care providers ensuring provision of appropriate care (Australian Government 2011). Local Hospital Networks were responsible for public hospital services, and for working closely with the Medicare Locals with a corresponding geographical boundary. This was intended to improve integration between public and private primary health care providers.

Contemporary strategies: new models of care

'Integration' is now on the policy agenda for state and national governments. The Triple Aim to improve the health of the population, improve patient experiences of care and reduce costs of health care, first described in 2008 (Berwick, Nolan and Whittington 2008), is increasingly important. States and Territories have become progressively more 'involved in integrating health services, particularly through preventative health and primary care activities' (Australian Government 2014, p. 10). Significantly, state-funded initiatives have placed a greater emphasis on involving community health, which had 'a more troubled history of integration with general practice than do private allied health providers' (Powell Davies et al 2009b, p. 32).

In 2013, further Australian government policy specifically took a 'comprehensive view of primary health care' (Standing Council on Health 2013, p. 1). It set out responsibilities for primary health care as shared with States and

Territories, with integration as a feature of the strategy. The strategy encouraged the development of innovative care models that supported more integrated care, for instance, primary health care services were to be 'integrated and coordinated within the primary health care sector and across the wider system' (Standing Council on Health 2013, p. 12). Consequently, a new model of primary health care to support integrated care was under consideration by the Australian Government in early 2016. Drawing on the recommendations of the Primary Health Care Advisory Group's report, the Australian Government announced a two-year trial of Health Care Homes in March 2016. The aim was to provide a coordinated approach to chronic disease management in primary care and 'integrated patient care across the continuum of the health system' (Primary Health Care Advisory Group 2015, p. 4).

Following the national strategy in 2013, NSW Health committed $120 million in its Integrated Care Strategy for 2014 to 2017 to implement new, innovative 'locally-led models of integrated care' (NSW Health 2014a, p. 1). Since 2006/07, the NSW government 'committed more than $45 million of capital funds to the development of HealthOne NSW services' (NSW Health 2012c). This followed the establishment of HealthOne in western Sydney, firstly at Mount Druitt in 2008 and then at Auburn in December 2010. By 2016 a further $5 million per annum was dedicated to support nursing, allied health and service integration positions within HealthOne and other primary and community health services. In early 2016 there were 25 operational HealthOnes across NSW, with an additional three in planning. While the HealthOne integrated care initiative developed over the same policy space as chronic disease management (McNab, Mallit & Gillespie 2013), the 2014 evaluation of the Chronic Disease Management Program (CDMP) led to a redesign process that aligned the Chronic Disease Management program with the Integrated

Care program. In 2016, the NSW Health Integrated Care Strategy for People with Chronic Conditions was released.

New models of integrated care remain on the agendas of government and health policymakers, with the NSW Health Minister setting 'integrated care' as her next priority (Sydney Morning Herald, March 19 2015, p. 10). Integrated care is one of three strategic directions in the NSW State Health Plan: Towards 2021. This 'involves the provision of seamless, effective and efficient care that reflects the whole of a person's health needs….in partnership with the individual, their carers and family. It requires…..better access to community-based services close to home' (NSW Health 2016).

Principles and key features of the HealthOne model of care

In policy documentation about this NSW government initiative, HealthOne was ambitiously positioned as a new type of service that would encompass public and private primary care and community health sectors, with integrated patient-centred care provided by multidisciplinary teams. HealthOne was intended to change service delivery in NSW towards comprehensive primary health care:

> the key features of HealthOne NSW services that distinguish them from other primary and community health services are: integrated care provided by general practice and community health services; organised multidisciplinary team care; care across a spectrum of needs from prevention to continuing care; and client and community involvement. (NSW Health 2011c p. 1)

Although primary health care has traditionally been delivered in Australia through a complex arrangement of nationally funded fee-for-service general practitioners, private allied health providers, non-government organisations and state government funded community health practitioners (Wiese et al 2011;

Australian Government 2014), the intention was that HealthOne would bring disparate and fragmented components together:

> HealthOne NSW aims to create a stronger and more efficient primary health care system by bringing Commonwealth-funded general practice and state-funded primary and community health care services together. (NSW Health 2012a)

Underlying the HealthOne model of care were objectives about the reduction of preventable hospitalisations, the minimisation of the impact of chronic illness and complex conditions, and increased support for client self-management of health (NSW Health 2007, 2011a, 2011b, 2011c). The HealthOne initative in NSW 'built on a long history of chronic care planning' (McNab & Gillespie 2015, p. 3) and its principles were aligned with the national chronic disease strategy. It was intended that through HealthOne, health consumers would have greater access to a broad range of primary and community health care services, better health outcomes, and reduced 'health disadvantage', while health professionals would realise greater efficiencies in resource utilisation, decreased hospital admissions, 'increased job satisfaction, professional development and support' and strengthened partnerships with health consumers (NSW Health 2007, p. 9).

In this study, the HealthOne model of care is understood as a policy approach to integrated care that involved a number of practices and arrangements. The HealthOne approach as articulated in policy documents, for example, the HealthOne Model of Care (NSW Health 2011d), proposed multidisciplinary collaboration and integration of service provision; and it placed a senior clinician, the 'GP liaison nurse', with a community health team, to assist clients with risk factors and/or chronic conditions. In the study settings, other than the employment of liaison nurses to act as the 'linchpin' of the HealthOne model of care (NSW Health 2011d, 2012b), there were no structural

or ongoing funding arrangements put in place to support HealthOne. However, a governance agreement between Western Sydney Community Health and the Western Sydney Medicare Local formalised this partnership in terms of roles, responsibilities and processes (NSW Health 2011d).

The objective of the HealthOne model was to 'achieve integrated service delivery' (NSW Health 2007, p. 6). It was intended to be patient-centred. It also involved elements of intake (i.e. enrolment), care planning, identification of services for eligible clients, referral, case management and case conferencing, as shown in figure 1.1 below.

Patient-centred care was a core element of the HealthOne model of care. Consequently, the aim was 'client-centred care at an individual level, client–clinician–carer involvement in planning care pathways or client journeys, and community involvement in planning for local health services to meet their needs' (NSW Health 2011c). The three findings chapters will explore how the client was the focus of the model of care and central to its activity.

During this study, there were restrictions on eligibility for HealthOne, for it was not offered universally to all community health clients. HealthOne was targeted at those clients considered by health professionals to be 'at risk' or 'vulnerable' (NSW Health 2010c, p. 8). NSW Health had also developed a range of policies and programs to improve care for people with chronic illness (McNab & Gillespie 2015), managing clients with specific chronic diseases through the Connecting Care in the Community program (chronological record January 24 2013). Enrolment in the HealthOne model of care relied on clients meeting criteria of complexity and vulnerability that included being diagnosed with chronic and complex illness or mental illness, having severe end stage disease, having been admitted four or more times to an Emergency Department in the past 12 months, being known to community services, and having refugee status or psychosocial issues (NSW Health 2011d).

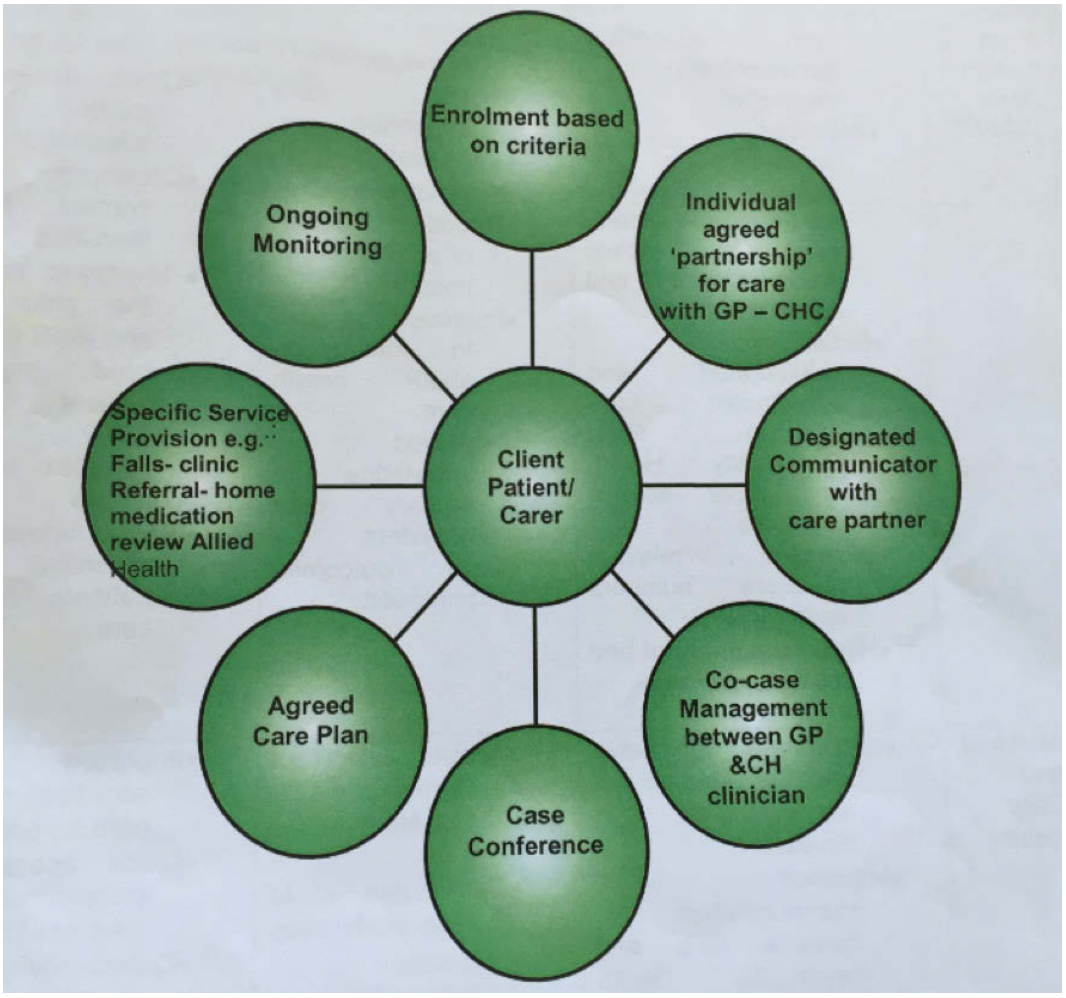

Figure 1.1 HealthOne Model of Care (NSW Health 2011d)

Clients eligible for HealthOne often had multiple chronic and complex health conditions. In the study setting, there was added complexity due to complicated social histories, multi-faceted family genealogies, and disadvantaged local communities (NSW Health 2012c). Clients enrolled in HealthOne could also be referred to as 'frequent flyers', since they had multiple annual acute care admissions, 'multiple service providers, multiple medications' (NSW Health 2010c, p 8), and frequent presentations to emergency departments and health and community services. Such clients were the focus of integrated care policy reforms.

Theoretical approach

'Practice' has a central place in this study. Since a 'unified practice approach' does not exist (Nicolini, 2012, p. 214; see also Mol 2010a), the thesis draws on two complementary theories: Actor–network theory (ANT) (de Laet & Mol 2000; Latour 2005; Law 2004, 2007; Law & Singleton 2013, 2014; Mol 2002, 2010a, 2010b), and practice theory (Schatzki 2002, 2005, 2012, 2013). As explained in chapter three, ANT and practice theory both support an interest in practice and the study makes use of these theories in discussing how integrated care was enacted. Practice theory provides conceptual resources to answer the second research question, 'How was integrated care unfolding?' Concepts from ANT better inform the exploration of questions about the realities of enacting integrated care and how integrated care was accomplished in practice. These theorisations offer different conceptual resources to investigate the complexity and tension of enacting and changing practice through models of care. Drawing out insights from the two approaches enables a nuanced and deeper understanding of the enactment of integrated care.

Methodology

The methodological approach for this study was ethnography, as explained further in chapter four. This ethnographic fieldwork was carried out from September 2011 to June 2013 across many geographical locations in western Sydney. The following methods for data collection were used: shadowing of key practitioners, observation of meetings, semi-structured interviews, and collection of documents. Data was collected from almost 160 hours of shadowing and from observation of 22 meetings about HealthOne. Data contributing to the findings was also sourced from 140 documents collected during the fieldwork and from 22 interviews conducted as part of the broader ARC project.

The extended, mobile fieldwork spanned acute care, primary health care and the community, encountering doctors, nurses and other clinicians, as well as allied health, community health, and social services professionals. Some of these 60 professionals were encountered frequently throughout the fieldwork while many others were encountered once or twice. The study was not designed to elicit the client's experience of HealthOne. However, activity related to 26 clients emerged during the shadowing.

By the end of the study, the organisations in which the model of care had unfolded and the practitioners who had championed it, had been restructured, had disappeared, or had changed to other structures and roles. Thus, a backdrop to this research was upheaval and change in arenas identified as sources of variation in local practices: the political and policy-making context, the institutional/organisational context and the context of workplace and information systems (Gärtner & Wagner 1996). The workplace settings, policy and structural context, and the cultural backgrounds and health status of HealthOne clients, have arguably given a particular character to the practices of integrated care observed during this research. The following section describes the settings for this study, since 'practice cannot be understood without reference to a specific place, time, and concrete historical context' (Nicolini 2009, p. 1396).

The study settings

This study focused on activities associated with HealthOne in two settings, along with the links to the various organisational networks in which they were situated. Rather than comparing the two HealthOnes, this study draws insights from the entire dataset collected during ethnographic fieldwork located in many workplaces associated with either HealthOne. These included diverse locations such as hospitals, doctors' rooms, clinics, homes, offices and cars.

The first HealthOne had a strong focus on chronic illness and child and family health and was located in a new and growing community. Previously semi-rural, the locality had been sub-divided into housing blocks, and infrastructure was still under development. The area lacked a community health centre, and this HealthOne was based in an office in a suburban shopping centre, with support from the (then) Division of General Practice. Although metropolitan, the area lacked rail links and a major hospital.

The other HealthOne was based in an established metropolitan area. It was located in a new community health centre, adjacent to a hospital. This HealthOne focused on chronic, aged and complex care and child and family health, working closely with mental health and refugee health. There was a high birthrate in this area. The local population was culturally and linguistically diverse; 64% were born overseas, including recent immigrants from the Middle East, Africa, and Southern Asia, as well as refugees and asylum seekers. The area was one of the top ten refugee settlement areas in Australia. Health status was poor amongst many in this rapidly growing population, and there were pockets of extreme socio-economic disadvantage. There were reportedly 170 service organisations based in the local government area. The 27 general practices in the area were among the busiest in Australia (NSW Health 2012b).

The Local Health District in which the study was located was upgrading its health information systems and was a pilot site for Wave 1 implementation of the national electronic health record system. Electronic discharge summaries, sent from hospitals to GP systems, were being trialed, as well as the electronic blue book, an information system for child and family health that included 'apps' for new mothers. Laptops were also being introduced for community health nurses to use on home visits. Thus, innovations were underway to implement large-scale, interoperable information systems.

Two new entities with similar geographic boundaries and overarching responsibility for health care had been also recently established in western Sydney. These were the Western Sydney Local Health District, responsible for providing primary, secondary and tertiary public health care to residents of the Greater Western Region, and the Western Sydney Medicare Local (WSML), responsible for supporting and developing general practice and other primary health care services. The WSML was the first Medicare Local in metropolitan Sydney and the main delivery mechanism for the national primary health care strategy (Russell 2012).

Thesis structure

This thesis is presented in eight chapters. This first chaper has provided an introduction to the topic and an overview of the context in which the study was conducted. Chapter two situates the study within the context of literature on integrated care. The chapter discusses existing literature and identifies the gap that this study seeks to address. Chapter three explains relevant theoretical approaches to the study of practice and key concepts from Actor–network theory and practice theory. Chapter four explains the methodology, describing the methods, how the data collection and analysis were undertaken and ethical considerations.

Chapters five, six and seven report findings from the empirical investigation. These three chapters explore how integrated care was enacted in practice, by focusing on integrated primary health care. These chapters build the argument that a relatively unstructured form of integrated care was unfolding in the study settings, with key actors acting as mechanisms of integration to facilitate this process.

Chapter eight brings together the findings of the study and the thesis argument to explain how this study advances knowledge about how integrated care was enacted in practice. The HealthOne model of care became an approach

to instilling integrated care through practices 'in the making' (Latour 1987, p. 13). ■

Chapter two

Situating the study

About this chapter

The aim of this study was to contribute to better understandings of integrated care and how integrated care is enacted, by focusing on integrated primary health care at the practice level. The chapter critically engages with the literature on integrated care as a field of inquiry in order to establish the rationale for this study.

There is broad support for the vision of integrated care, and the anticipated outcomes are ambitious. However, there is a lack of consensus in the literature on what integrated care is and how it is achieved. In situating this study in relation to the literature, the chapter makes the case for explaining how integrated care is enacted in practice with a theoretical lens.

The chapter engages with a range of research that contributes in some way to understanding the complex phenomenon of integrated care, as the field of inquiry stood in August 2016. Since literature of relevance to this study of integrated care is transdisciplinary, broad searches to locate studies from a number of fields of healthcare research were utilised. Methods used included data base searches, searches of the International Journal of Integrated Care and the Journal of Integrated Care, continual monitoring of primary health care and other information alerts and snowball searches of citations. As Evans et al (2014) recognised, confusion and changes in terminology and the transdisciplinary nature of the literature, may mean that some studies were overlooked. However, contemporary literature reviews of the field (e.g. van der Klauw et al

2014; Valentijn et al 2015a) have informed this review. The review does not discuss the entire literature on integrated care. Instead it engages with a range of studies of integrated care that contribute to establishing the rationale for this study. Although very few studies located reflect the approach taken in this study to research the practices of integrated care through long-term ethnographic engagement in the workplaces of primary health care, a number of studies that set a precedent will be highlighted.

The chapter is organised into three sections. The first section examines relevant conceptual approaches to integrated care. The second section reviews the contribution of empirical studies of integrated care. The third section provides a summary to emphasise the significance of this study.

Conceptualising integrated care

The concept of 'integrated care' appeared in the literature in the 1950s (Uijen et al 2012), becoming a 'buzzword' in the 1990s (Kodner & Kyriacou 2000, p. 1). However, the research field of integrated care is emergent. In 2008 it was the view of Kodner, a key figure in this field, that integrated care was 'still evolving as a relatively new transdisciplinary area of inquiry and action' (Goodwin, Kodner, Smith & Manten 2008, p. 6). The literature has devoted considerable attention to developing definitions and theorisations in efforts to explain the concept of integrated care, as explained in the following section.

Although the policy vision to produce integrated care emerged strongly in the 2000s, the term 'integrated care' has been used frequently in the health literature for decades. A prominent researcher declared that 'integrated care means different things to different people. At its heart, it can be defined as an approach that seeks to improve the quality of care of individual patients, service users and carers by ensuring that services are well co-ordinated around their needs' (Goodwin et al 2012, p. 3). However, there are around 180 definitions, which has created confusion (Goodwin et al 2012; Kodner 2009; Valentijn et al

2013; van der Klauw et al 2014; Wistow & Dickinson 2012). There are multiple approaches to conceptual models of integrated care (Armitage et al 2009; Kodner 2009; Minkman 2012; Suter et al 2009). Many studies and literature reviews share the view that the concept of integrated care is confused and ambiguous (Axelsson & Axelsson 2006; El Ansari 2011; Evans et al 2014; Goodwin et al 2012; Kodner 2009; Tieman et al 2006; Valentijn et al 2013; van der Klauw et al 2014). As van der Klauw and colleagues put it:

> This confusion reflects the polymorphous nature of a concept that is applied from several disciplinary and professional perspectives and associated with diverse objectives. This lack of specificity highly impedes successful application and expansion of integrated care systems in practice. (van der Klauw et al 2014, p.2)

However, scholars maintain an ongoing interest in defining conceptalisations of integrated care and its underlying principles and mechanisms (Minkman 2016a). There are a number of recent reviews of the literature (Evans et al 2014; Martínez-González et al 2012; Martínez-González et al 2014; Nicholson, Jackson & Marley 2013; Sun et al 2014; Valentijn et al 2015a; van der Klauw et al 2014). These attempt to clarify the conceptual ambiguity, and to resolve 'the organisational and professional uncertainty, which is currently apparent', making it challenging to apply integrated care in practice (van der Klauw et al 2014, p. 16).

Certain conceptual work has become particularly influential. The definition of integrated care as 'a coherent set of methods and models … designed to create connectivity, alignment and collaboration within and between the cure and care sectors' (Kodner & Spreeuwenberg 2002, p. 4) is used frequently in current literature (e.g. Calciolari & Ilinca 2011; Cash-Gibson & Rosenmoller 2014; Cumming 2011; Curry & Ham 2010; Janse et 2016; Martínez-González et al

2012; van der Klauw et al 2014). This definition was cited in chapter one and anchors use of the term throughout the thesis.

Conceptual frameworks

Leutz's classification (1999) of integration as three levels or degrees of integration: linkage, coordination and full integration, has been used in subsequent studies (e.g. Kodner & Kyriacou 2000; Lewis et al 2013; McDonald, Jayasuriya & Harris 2011; Shaw, Rosen & Rumbold 2011) and has been a 'useful starting point' (Kodner & Kyriacou 2000, p. 3) for further conceptual work (e.g. Kodner 2002; Valentijn et al 2013; Valentijn et al 2015a). Some agreement has been reached that integrated care has a number of dimensions, including organisational, professional and service (also termed clinical) (e.g. Kodner 2002; Shaw, Rosen & Rumbold 2011; van der Klauw et al 2014; Valentijn et al 2013; Valentijn et al 2015a). Although Leutz (1999) suggested a scale of clients' health needs, an extensive and subsequent range of abstract frameworks and mechanisms (discussed below) focus largely on functional, service, professional and organisational dimensions, where the patient remains the object of care.

In an early and seminal paper, Leutz (1999) defined integration as connecting the health care system (acute and primary) with other sectors, for example, housing, with the aim of improving clinical outcomes, efficiency and satisfaction. Leutz's classification shows how various sectors might 'work together' in a small number of operational domains at three different levels (Leutz 1999, p. 84, pp. 86-87). This classification concentrates on key clinical service activities with clients, a scale of client severity and financial aspects. Other features of integrated care such as technology and governance are not included. The simplicity of this framework may explain its appeal and use in subsequent research. Its value also lies in suggesting that integration may occur in degrees, beginning with linkage (Kodner & Kyriacou 2000). Furthermore, depending on context, the highest degree may not be required (van der Klauw

et al 2014). This thesis draws on Leutz's classification of degrees of integrated care in chapters five and seven as a tool for analysing how integrated care was enacted through HealthOne. The classification is provided in detail in table 2.1 below.

Operations	Linkage	Coordination	Full integration
Screening	Screen or survey populations to identify emergent needs	Screen flow at key points (e.g. hospital discharge) to find those needing special attention	Not important except to receive good referrals
Clinical practice	Understand and respond to special needs	Know about and use key workers (e.g. discharge planners) to link	Multidisciplinary teams manage all care
Transitions/service delivery	Refer and follow up	Smooth the transitions between settings, coverage and responsibility	Control or directly provide care in all key settings
Information	Provide when asked; ask when needed	Define and provide items / reports routinely in both directions	Common record as part of daily joint practice and management
Case management	None	Case managers and linkage staff	Teams or 'super' case managers manage all care
Finance	Understand who pays for each service	Decide who pays for what in specific cases and by guidelines	Pool funds to purchase from both sides and new services
Need [client]			
Severity	Mild/moderate	Moderate/severe	Moderate/severe
Stability	Stable	Stable	Unstable
Duration	Short to long term	Short to long term	Long term or terminal
Urgency	Routine / non urgent	Mostly routine	Frequent urgency
Service scope	Narrow – moderate	Moderate-broad	Broad
Self-direction	Self-directed or strong informal	Varied levels of self-direction and informal	Weak/informal self-direction

Table 2.1 Levels of integration (Leutz 1999)

Using Leutz's (1999) definition and classification, Valentijn et al's (2013) conceptual framework of integrated care incorporated vertical and horizontal directions of integration, and dimensions: macro (system), meso (organisational and professional) and micro (clinical). It also referred to key elements of primary health care and the importance of both person-focused and population-based care as the base for system integration. By defining each of the dimensions, it is suggested that this framework (see table 2.2 below)

provides a 'simplification of reality which helps to better understand the complex interactions of integrated care' (Valentijn et al 2013, p. 9). Nevertheless, this framework, which is intended to support evaluations, remains theoretical and high-level, detached from the realities of practice.

Although integrated care is described in terms of multiple dimensions, a recent literature review found that organisational and professional dimensions are 'the prime focus of practice, science and policies' (Valentijn et al 2015a, p. 10). However, the framework by Valentijn et al (2013, p. 3) has been a useful guide in exploring how integrated care was enacted through HealthOne.

Dimension	Description
System integration	The alignment of rules and policies within a system
Organisational integration	The extent to which organisations coordinate services across different organisations
Professional integration	The extent to which professionals coordinate services across various disciplines
Clinical integration	The extent to which care services are coordinated
Functional integration	The extent to which back-office and support functions are coordinated
Normative integration	The extent to which mission, work values etc. are shared within a system

Table 2.2 Dimensions of integration (Valentijn et al 2013)

There has been some convergence around the definition of integrated care from Kodner & Spreeuwenberg (2002), and the conceptual framework provided by Leutz (1999). Both have informed the analysis of empirical data taken up in later chapters of this thesis. Thus, conceptual frameworks outlined above provide insight into the multifaceted phenomenon of integrated care. A key problem is that they 'lack practical guidance to illuminate the concept of integrated care by describing mechanisms to achieve integrated care' (van der Klauw et al 2014, p. 2). Consequently, a further body of literature has been devoted to mechanisms of integration.

Mechanisms of integration

There has been considerable attention to deconstructing integrated care through defining mechanisms of integration. The additional level of specificity about particular elements conceived as the means to achieving integrated care offers somewhat more clarity than the abstract frameworks of integrated care. However, the 'lack of conceptual consistency' also applies with these 'mechanistic conceptions' (Evans et al 2014, pp. 126, 152; see also Dickinson 2014). A limitation in this work is related to the reductionist approach it adopts. The various mechanisms of integration defined in the literature remain abstract, decontextualised and rarely based on empirical evidence.

These mechanisms encompass a range of strategies, methods, processes and actors, for instance, organised meetings, patient navigation and information communications and technology (van der Klauw et al 2014). However, a recent literature review aimed at understanding which mechanisms achieve integrated care questioned the methodological quality of selected studies and found that few were based in empirical data (van der Klauw et al 2014). Many integration mechanisms could reasonably apply to any health care program. For example, mechanisms of integration defined in the literature encompass processes such as appropriate targeting of population (Kodner & Kyriacou 2000); quality management (Leichsenring 2004); performance measurement (Armitage et al 2009) as well as professional attitude (van der Klauw et al 2014). Drawing from a rigorous qualitative and quantitative study using surveys with experts and a three-round Delphi process, Minkman et al (2009, 2013) suggest that the development of integrated care is characterised by unpredictable and non-linear progress through four different phases and a total of 89 different processes or mechanisms.

Nonetheless, some commonalities emerge from the various framings of mechanisms of integration (see table 2.3 below for examples). Care management

across the continuum of services, space and time; team care (multidisciplinary, interdisciplinary or interprofessional); and a patient focus are consistently mentioned. Similarly, these processes were also identified as key in two systematic reviews: one of integrated care programs for adults with chronic conditions (Martínez-González et al 2012), and another identifying principles of integrated care (Suter et al 2009). The HealthOne model of care also incorporates co-case management, multidisciplinary team care and client involvement as key elements of the model (NSW Health 2011c, 2011d).

Author	Mechanisms	
	Commonalities	**Other**
Kodner and Kyriacou 2000, pp. 14-15	Longitudinal care management, spanning time, setting and discipline; intensive, interdisciplinary team care	Philosophy and focus, including a central role for the primary care physician; organised provider and clinical arrangements to achieve horizontal and vertical alignment; appropriate targeting of population; mechanisms to pool funding streams
Leichsenring 2004, pp. 6-11	Case and care management; interdisciplinary needs assessment and joint planning; joint working	Hospital/community interface; integrating social services; supporting family carers; quality management; consumer-directed services (e.g personal budget)
Armitage et al 2009, p. 7	Patient centredness; services across the continuum of care; health care teams	Strong leadership; performance measurement; information sharing; focus on primary care
Van der Klauw et al 2014, p. 6	Professional: multi / inter disciplinary teams Service: case management, patient centredness - care plans, self-management support	Functional: technology, electronic tools, performance monitoring and financial incentives Organisational: connections between organisations, patient navigation / clinical pathways, policy / leadership Professional: assignment of roles and responsibilities, education, information sharing, organised meetings, professional attitude Service: guidelines, infrastructure, family involvement, chronic care, proactive care

Table 2.3 Examples of integration mechanisms

Although there is some commonality, overall there is a lack of consensus about mechanisms of integrated care, and little guidance on how these are operationalised in practice. Organisational and professional (meso) integration remains the primary focus of mechanisms that have been defined in the literature. There is little attention in the integrated care literature to studies exploring mechanisms of integration with empirical data. The range of mechanisms defined in the literature do not illustrate how integrated care is achieved in practice, leaving 'health-care professionals, researchers as well as policy-makers guessing about which integrated care mechanisms have best chances of success given a certain context' (van der Klauw et al 2014, p. 2; see also Valentijn et al 2015a). Reinforcing this, Dickinson (2014, pp. 189, 190) recently argued that this 'scientific approach' to isolating specific mechanisms that facilitate integration was 'not sufficiently equipping practitioners' to undertake 'working practices'. The multiple descriptions of mechanisms offer a vocabulary for integrated care initiatives rather than guidance on how to accomplish practices associated with the complex phenomenon of integrated care.

Although an academic conversation emerged on the concept of integration and integrated care from the 1980s onwards (Evans et al 2014), few studies included in this literature review predate the millennium. The *International Journal of Integrated Care*, an open access peer-reviewed journal, was first published in 2000. The first study of models of integrated care of relevance to this review was also published in 2000 (Kodner & Kyriacou 2000). Since then, integrated care has gained increasing attention both from policy-makers and from researchers in a number of countries (Minkman 2012; Sun et al 2014). The following sections consider empirical studies of integrated care in order to situate this study within that field.

Empirical studies of integrated care

Efforts to conceptualise integrated care dominate this field of inquiry, with empirical research constituting less than half of the literature on integrated care (Evans et al 2014). The conceptual ambiguity is not always seen as a problem. It supports flexible interpretation and operationalisation of integrated care, allowing individuals 'to make sense of integration in their own way' (Wistow & Dickinson 2012, pp. 679). While ambiguity allows practitioners to interpret, understand and apply integration in different settings and contexts (Williams and Sullivan 2009), with the possibility for a process of negotiation among different interests (Grenier 2011), 'the result is a jumble of stand-alone integrated care initiatives in practice' (van der Klauw et al 2014, p. 2). Only a few studies conceptualising models of integrated care have then tested these with empirical data (for example, Axelsson et al 2014; MacAdam 2011; Sampalli et al 2012). Hence a recent literature review called for more detailed studies about models of integrated care that were based on theorisation and empirical data, 'to further unravel the concept of integrated care' (Van der Klauw et al 2014, p. 7).

There are clear gaps in this emergent field of inquiry. In July 2016, an examination of the application of integrated care in England concluded that important research questions 'relating to how to best define, enable and enact integrated care' were still to be answered (Stokes, Checkland & Kristensen 2016, p. 3). A contemporary literature review highlighted that empirical studies in this field are poor at explaining 'specific integration strategies and processes that can be replicated locally' (Sun et al 2014, p. 9).

After 20 years of academic research and implementation, the focus of integrated care strategies has evolved. There have been shifts in the conceptualisation, research and practice of integrated care (Evans et al 2014), for example, from:

- acute care to broader community-based health and social services
- an emphasis on economic rationale to quality improvement
- organisational-focused evaluations to measuring patient experience
- modifying organisational structures to transforming ways of working
- all patients to specific populations.

However, integrated care practice and research is less well developed in community health and primary care compared to within acute care and between primary and acute care (Borgermans et al 2014; Evans et al 2014). In early 2015, a literature review on features of integrated care concluded that although primary care is now the 'cornerstone' of approaches to integrated care, 'despite the increasing popularity of developing integrated service models in a primary care setting, a solid knowledge base is lacking' (Valentijn et al 2015a, p. 2).

Overall, empirical studies of integrated care vary widely in regard to their methods, client population of interest, interventions and outcomes (Tieman et al 2006; Tieman et al 2007; van der Klauw et al 2014). There are many opinion pieces and descriptive studies (Cameron & Lart 2012; Valentijn et al 2015a). However, most studies lack detail about methods (van der Klauw et al 2014). Notably, many studies do not provide much detail on the model of care (Cameron et al 2012; Powell Davies, McDonald, & Jeon 2009b) to 'clarify which integration strategies produce the desired outcomes and under what conditions' (Evans et al 2014, p. 151). It is apparent however, that the models are diverse (van der Klauw et al 2014). The conceptual ambiguity adds confusion when comparing findings from various research studies.

Management of chronic disease through integrated care has been a key domain for research (Sun et al 2014; van der Klauw et al 2014). As found earlier by Tieman et al (2006), many descriptive case studies continue to be published

about models of integrated care in specific population groups or service streams, for example, the frail elderly (Kodner & Kyriacou 2000; Kodner 2002); people with complex needs (Bruce, Wistow, & Kramer 2011); child and family health (Busch et al 2013); dementia patients (Clark et al 2013); rehabilitation (McColl et al 2009); palliative care (Masso & Owen 2009). These studies mostly emanate from the US and Europe but all identify and discuss challenges, success factors and learnings, although the models of care vary. Two further domains of integrated care research, information system integration and legislation (Sun et al 2014) are not included in this literature review, since those topics do not contribute to this study's aim of exploring the enactment of integrated care.

Theoretically informed empirical work in the field of integrated care is relatively rare and studies of practice are sparse and more recent. Policy and structural approaches to integrated care have both attracted considerable attention (Sun et al 2014; Valentijn et al 2015a). Studies of policy initiatives and models of care have focused on organisational and professional dimensions in order to demonstrate effectiveness and improvement. However, there is mounting evidence that clinical or service level integration has "the greatest impact on patient experience and outcomes" (Naylor et al 2016, p. 14; see also Curry & Ham 2010; Evans et al 2014; Janse et al 2016). In support of the quality improvement logic underlying the policies (Valentijn et al 2015a), many empirical studies measure outcomes against the policy objectives or highlight particular mechanisms of integrated care that are more or less effective. A major focus in the literature has been the identification of challenges, success factors or learnings that might enhance future effectiveness (e.g. Ling et al 2012; Shaw, Rosen & Rumbold 2011).

Patient-centred approaches and the patient experience have been neglected until recently. Little has been known of the clients' views and experiences of integrated care programs (Howarth & Haigh 2007; Kodner in Goodwin et al

2008). The development of a narrative for defining integrated care from the client's perspective has emerged in the UK as a person-centred approach; it will 'almost certainly' be the source of measurement' for patient experience (Redding 2013, p. 323). Two recent evaluations from Curry et al (2013) and McNab, Mallit and Gillespie (2013), and studies by Sheaff et al (2015) and Waibel et al (2015) were among the few studies investigating the clients' experience of integrated care. Thus, earlier paradigms have persisted, for example, the benefits and outcomes of integrated care are largely reported from the organisational and professional perspective.

Policy implementations

Empirical studies of integrated care policy implementations have largely focused on analysing outcomes of policy initiatives, while some also set out strategic directions for future initiatives. Studies analysing policy outcomes are diverse and context-specific, since integrated care policies have a range of different objectives, for instance, investments in public private partnerships; service and provider integration; or addressing patients' needs (Borgermans et al 2014). Despite the claims that integrated care will address the burden of chronic disease and ageing populations on the health system, and reduce costs and hospitalisations, the outcomes are somewhat inconclusive and therefore disappointing in terms of meeting policy objectives. The equivocal nature of findings from a range of studies using various measures and markers of success does reveal the methodological challenges of researching and evaluating the complex phenomenon of integrated care.

Yet assumptions about achieving policy objectives remain central in iterations of integrated care policy, for example, the HealthOne model of care. Typically, studies of policy implementations demonstrate mixed results. This lack of success highlights that efforts to study 'what' policy implementations

achieve might more usefully shift to questions of 'how' policy enactments achieve integrated care.

Measuring and evaluating integrated care

It is difficult to establish that integrated care policy initiatives have had positive impact on outcomes with limited evidence of this (Armitage et al 2009; Minkman 2012; Suter et al 2009). A review of 50 years of integration in the National Health Service concluded that 'much had been promised but little delivered'; moreover, 'the evidence base is patchy' (Wistow & Dickinson 2012, p 678; Cameron et al 2012, p. 18). These policies may in fact not deliver better health outcomes (Wistow & Dickinson 2012), as indicated by studies below.

A meta-review of integrated care initiatives for adults with chronic conditions highlighted the lack of evidence for reduction in costs, and concluded that improvements were reported in 'reduced mortality, reduced hospital admissions and re-admissions' and quality of life (Martínez-González et al 2014, p. 565). However, analyses of outcomes show disappointing and mixed results in the United Kingdom (UK) (e.g. Curry et al 2013; Rand, Ernst & Young 2012) and Australia. An analysis of the first Australian Coordinated Care Trials (1997 to 2005) showed mixed results with a significant reduction in hospital admissions seen in only a third of the trials; improved health and well-being of the participants was not demonstrated (Esterman & Ben-Tovim 2002). Instead demand for other resources might increase (Tieman et al 2006). Similarly, another Australian study found that 'where hospital admissions decrease, the burden on primary health care may increase and resources will be needed to support the demand' (Katterl et al 2012, p. iii). This analysis of policy outcomes, including those of HealthOne NSW, found that reductions in potentially avoidable hospitalisations were not necessarily associated with better clinical outcomes (Katterl et al 2012).

Lack of evidence is considered by some to be a risk to the 'integrated care agenda' (Goodwin et al 2008, p. 6; see also van der Klauw et al 2014). Hence empirical studies of integrated care have spent considerable effort measuring effectiveness. Studies of the effectiveness of integrated care have used a range of different indicators, showing mixed results on population-level outcome indicators such as well-being, health care costs, service utilisation, and hospitalisation (e.g. Hébert et al 2003, 2008; Huber et 2106; Looman, Fabbricotti & Huijsman 2014; Martínez-González et al 2012; Powell Davies McDonald & Jeon 2009b; Tieman et al 2006). Most have focused on specific populations such as diabetes and chronic heart failure patients (e.g. Martínez-González et al 2012), or the frail elderly (e.g. Hébert et al 2003; Looman et al 2014; Melis et al 2008).

Despite the limited evidence for the effectiveness of integrated care (Stokes, Checkland & Kristensen 2016), there are common underlying assumptions to much of the literature. Quality improvement is viewed as an argument for integration (Evans et al 2014). As a recent study concluded: 'the vast majority of research on integrated care is based on an industrial-quality improvement logic which holds that quality standardisation leads to better outcomes and allows for more systematic evaluations' (Valentijn et al 2015a, p. 13).

However, evaluations show mixed results. For example, an evaluation of a Victorian integration policy initiative, Primary Care Partnerships, found improvements in care coordination, particularly across state funded health services. There was 'variable success in engaging general practice', and little impact on 'integrating service planning and development' (Powell Davies et al 2009a, p. 6) or evidence of improved health outcomes (McDonald et al 2006). Again, despite its rigorous methodology (Greaves et al 2013), the evaluation of the north-west London integrated care pilot was inconclusive. Goals to reduce emergency admissions or attendance and costs of care were not met in the first year of the pilot, possibly due to the brief time (three months) that use of

services was tracked (Curry et al 2013). A large-scale evaluation of integrated care interventions in over 30 sites in the National Health Service also could not provide evidence of reductions in emergency hospital admissions (Bardsley et al 2013). Evaluations agree that 'integrated care takes a long time to develop' (Curry et al 2013, p. 13, see also Bardsley et al 2013; McNab, Mallit & Gillespie 2013).

The evaluation by Curry et al (2013) highlights the need for different perspectives on understanding the enactment of integrated care. Progress was slow and the evaluation results were equivocal, pointing to the need for more in-depth analysis of processes that created variable responses from both practitioners and clients. Although this study was rare in investigating the patient experience, feedback from patients was disappointing; 54% of the patients surveyed did not identify 'any changes at the point of care provision' (Curry et al 2013, p. 9). Over half of patients participating in the pilot could not remember when surveyed if they were part of the pilot, although patients with care plans were mostly enthusiastic about the process of care planning. A total of 58% of professionals expressed concern about the extra time required to develop care plans (Curry et al 2013). There was some progress in organisational integration, with the vision still not 'embraced at a clinician or middle manager level' (Curry et al 2013, p. 10). Although key functional and organisational elements of integrated care were present, including financial arrangements, established governance structures, shared vision, a shared information technology platform and common care processes, participation was voluntary and active engagement by clinicians was variable.

In contrast, an evaluation of HealthOne Mount Druitt during 2010–2011 was more positive in concluding that emergency department presentations and length of stay in emergency were 'significantly less than in the 12 months prior to enrolment' in HealthOne, and that clients' quality of life improved (McNab,

Mallit & Gillespie 2013, p. 3). This evaluation also found that referrals for HealthOne clients to allied health increased and that a wider range of multidisciplinary services were delivered e.g. case conferences, care planning and provision of information. McNab, Mallit and Gillespie (2013, pp. 4,8) reiterated that 'facilitating change was a slow and on-going process', requiring the building of trust and 'a common understanding of what HealthOne Mount Druitt was', before new ways of working were embraced. This evaluation also highlighted success factors and challenges. Findings were based on service utilisation patterns, patient outcomes and interviews with clients and health practitioners associated with HealthOne, thus incorporating both qualitative and quantitative analysis. While McNab, Mallit and Gillespie (2013) highlight the importance of the HealthOne liaison nurse and of understanding the model of care, the evaluation lacked detailed analysis of these factors or of practices enacting integrated care.

Challenges

Given the mixed results of policy analyses, a number of policy studies of integrated care initiatives from Australia, the UK and New Zealand note challenges. Their descriptions are brief and at an organisational and professional level. The findings generally align with other studies of barriers and facilitators to health care improvement (Ling et al 2012).

For example, an analysis of New Zealand policy reforms dating from the 1980s to achieve integrated care by reducing fragmentation in funding and service delivery concluded that despite the 'continued lack of research', anecdotal evidence pointed to 'slow and patchy' change, largely at a local level, and that 'many budgets and services remain in silos' (Cumming 2011, pp. 9, 10). Health care providers faced challenges in working together to achieve integrated care, 'needing 'to take time to develop co-operation and collaboration', while success factors included reassurance about privacy

concerns when sharing information, adequate start-up funding, involvement from clinical staff, enthusiastic leadership and champions, and 'political commitment to change' (Cumming 2011, p. 9). The policy analysis by Ling et al (2012) also noted challenges related to privacy and data sharing, commitment from leadership, GP engagement and relationships across professional groups. Many challenges resonate with those associated with enacting the HealthOne model of integrated care that are explored in greater depth in this thesis in chapter six.

Theoretically informed studies

There are relatively few empirical studies drawing on theory to better understand integrated care. It has already been acknowledged that some empirical studies of integrated care (e.g. Lewis et al 2013; Valentijn et al 2015a) draw on Leutz's (1999) classification, and that quality improvement notions underpin many studies of policy implementations. Hence a recent literature review across the field of integrated care called for additional empirical research working with existing theorisations and frameworks (van der Klauw et al 2014).

Some have raised the utility of complex adaptive systems theory (Edgren 2008; Evans et al 2014; Sibthorpe 2004 in Smith & Ovenden 2007) as an approach to theorising complex change initiatives such as integrated care, possibly influenced by the seminal report on quality in health care proposing complex adaptive systems theory as a theoretical framework (Institute of Medicine 2001). A recent systematic review of multidisciplinary collaboration in primary health care used Donabedian's framework of structures, processes, outcomes (Schepman et al 2015, p. 2), as did a study of professionals' perceptions of integration processes for delivery of integrated care (Janse et al 2016).

Examples of theoretically informed studies include a case study that aimed to understand the balance between structural factors and individual agency in

managing integration, using theories of agency to explore three models of integrated care (Williams & Sullivan 2009). In acknowledging the conceptual ambiguity, this case study interpreted 'making sense of integrated care' in terms of individual agency, whereby individuals understood integrated care in different ways, reflecting their background, role, interests, history and political/economic frame. Arguing that 'structural factors provide the "space" for actors, both individual and collective, to act', the study also highlighted the role of key actors who shaped meaning and facilitated the process of integration (Williams & Sullivan 2009, p. 9). Both local circumstances and actors shaped the outcomes. The 'intransigence of professional interests' called for individual trust and commitment, hence the study found that there was an interwoven and complicated mix of agential and structural factors constraining and enabling action and called for more research to understand the 'interplay between the main factors' in different contexts (Williams & Sullivan 2009, p. 11).

Two studies of collaboration in integrated care used different theoretical approaches. Stuart (2014) used a theoretical framework of structure, agency, identity and empowerment. This action research study aimed to understand the lived experience of practitioners in 'the social practice of collaboration' (Stuart 2014, p. 3). In foregrounding the collective work involved in delivering integrated care and the importance of practitioners' awareness of structural context, the study proposed a model of collaborative agency to support practitioners' day-to-day working together. Organisational theory was used to highlight that as organisations from the private and not-for-profit sectors become involved in integrated care, this called for informal, voluntary 'intersectorial collaboration' to overcome the fragmentation of responsibilities and separate management hierarchies (Axelsson & Axelsson 2006, p. 80).

The chronic care model (Wagner et al 2001) was developed to guide quality improvement and chronic disease management in primary care. The model

comprises six systems changes: community resources, self-management support, clinical information systems, decision support, delivery system design and healthcare organisation. It is suggested by some that components of the model are integral features of patient-centred medical home models (for example, Coleman, Austin, Brach and Wagner 2009). However, most empirical studies reporting on the model's effectiveness examined clients with a single chronic condition (Coleman, Austin, Brach and Wagner 2009). Busetto (2016) developed a model for studying the context, outcomes and mechanisms of integrated care, categorising components, that is, mechanisms, of integrated care interventions according to the chronic care model. Busetto (2016) argued that this was a useful way of analysing the relationship between mechanisms, context and outcomes.

The chronic care model has also been used as a framework to analyse particular integrated care initatives (for example, Gress et al 2009; Davy et al 2015; Hernandez et al 2015) to ascertain which factors were more effective. Both Hernandez et al (2015) and Davy et al (2015) suggested that aditional factors to those in the chronic care model might contribute. Thus, a meta-review of integrated care initiatives for adults with chronic conditions (Martínez-González et al 2014) used an alternate framework developed by Suter al (2009) that describes ten principles for successful health systems integration.

The field of Computer Supported Cooperative Work (CSCW) considers how collaborative activities and their coordination can be supported through computer systems. Workplace studies of coordination practices in health care and cooperative work have been undertaken for over two decades, using CSCW concepts such as distributed work and articulation work, more recently turning to practices across different organisations and settings. There are also a few studies of integrated care working with concepts from the CSCW field, for instance in exploring how distributed tasks are incorporated to manage the

patient trajectory (Star & Strauss 1999; Strauss et al 1985). Winthereik & Vikkelso (2005) discussed integrated care in regard to interorganisational communication between hospitals and general practice, particularly the discharge letter. Winthereik (2008) studied a pilot project for an online maternity record and whether this supported shared care across organisational boundaries. Abou Amsha and Lewkowicz (2014) studied the work practices of an inter-professional home care team, highlighting the place for coordination mechanisms in dynamic team configurations. One discussion of the range of CSCW research in health care over the past 25 years emphasised the need to broaden the focus from single–site workplace studies 'to examine how different practices and settings collaborate in order to reflect the increased pressure on the different sectors in health care to offer integrated and shared care to patients and the public' (Fitzpatrick & Ellingsen 2013, pp. 649).

Practice

Investigating what practitioners do in the 'actual practice of integration' is now emerging as crucial (Dickinson 2014, p. 193; see also Minkman 2012). As Evans and colleagues remark, 'The extent to which the peer-reviewed academic literature accurately captures integration practices as they have unfolded over the years in real world contexts is debatable' (Evans et al 2014, p. 151). Exceptions include Abou Amsha & Lewkowicz (2014), Lewis et al (2013), Petrakou (2009) and Stuart (2014).

One case study was unique in that study methods included site visits as well as interviews and workshops (Lewis et al 2013). The study of three virtual ward projects in the UK with similar aims to HealthOne (reducing unplanned hospitalisations and improving care for clients with complex needs) described use of cross-organisational practices, for example, shared care planning, data sharing and multidisciplinary meetings. Challenges and strengths were also described. Integration largely occurred at the micro-level (patient and

practitioner interaction) and the meso-level (clinical structures and process), through coordination and linkage (Lewis et al 2013). Little detail was provided of how practices for care of complex clients were enacted.

In a rare study of practices in community-based services, Lawn et al (2015) explored care planning for chronic disease management using interviews, focus groups and observation with GPs and primary health care practitioners. The study focused on identifying enablers and challenges. Recommendations to improve communication and information sharing were an outcome of the study.

A study considering the gap between theory and practice in integrated care focused on performance evaluation through benchmarking and measures of service utilisation, costs and outcomes (Nuti et al 2016). Practice was perceived in terms of organisational best practice in diabetic foot care. Audits of patient data and patient surveys to assess perception of quality of care were undertaken, as well as an assessment of barriers to integrated care. This study highlights the fact that to many health professionals, 'theory' refers to best practice clinical pathways and quality of care, in particular, effectiveness. The study was not supported by theories of practice, and the term 'practice' was used in the familiar sense.

Using ethnographic methods, recent doctoral research in a stroke unit in an acute care hospital examined boundary working between doctors and nurses, how this 'unfolds through everyday care practices in a newly created multidisciplinary team', and their effects on the delivery of integrated care (Liberati, Gorli, & Scaratti 2016, p. 32). Exploring the effects of boundaries through 180 hours of observation and conversations with practitioners and using theories of boundaries, the findings focused on identity, control and resistance. However, the study provides a narrow perspective of integrated care in practice as it was confined to acute care.

The field of integrated care has also recently turned to the study of collaborative practice (Stuart 2014). Stuart's study focused on the social practices of collaboration, and the extent to which it supported the delivery of integrated care. It was suggested that 'multiagency groups trying to achieve integration could be hindered by a lack of collective awareness, collective decision making or collaborative action' (Stuart 2014, p. 2).

Factors contributing to integrated care

Empirical studies of integrated care reveal rather mixed results and a number of challenges. Studies continue to draw out challenges and barriers at a high level, e.g. Hernandez et al (2015), Lyngsø, Godtfredsen and Frølich (2016). The continued recognition in the literature of challenges to integrated care indicates the importance of inquiry, strengthened by empirical evidence, into effective mechanisms of integration and factors achieving integrated care.

There is no single 'best practice' model of integrated care (Curry & Ham 2010; Goodwin et al 2014; Smith & Ovenden 2007; Williams & Sullivan 2009), with a plethora of mechanisms identified in theory. Despite recent efforts and investment in evaluations, studies have failed to produce certainty about factors that were more effective (Dickinson 2014). Therefore, some suggest that 'what we need is not only more research, but particular types of research which are able to isolate the specific factors that make integration work' (Dickinson 2014, p. 193; see also Shaw, Rosen & Rumbold 2011; van der Klauw et al 2014).

Consequently, more recent empirical studies of integrated care have placed greater emphasis on identifying which factors contributed to integrated care. For example, common characteristics of effective policy initiatives included 'early identification of patients who are at risk of hospitalisation; care coordination and integration of services; multidisciplinary care team' (Katterl et al 2012, p. iii). From three case studies, Lewis et al (2013) identified key integration processes as the pooling and management of shared health care data

about patients, agreement on eligibility criteria, and regular multidisciplinary team meetings. A research report synthesising evidence from seven integrated care programs in Australia, Canada, New Zealand, and the United States, including HealthOne, found that most of the models of care involved 'close personal, often face to face contact between the members of the care team, often a care co-ordinator or care manager, and the client' (Goodwin et al 2014, p.16).

Care coordination

Coordination was classified as the mid level of integration in Leutz' framework (1999). It is concerned with organising or aligning distributed but joint tasks (Keast, Brown & Mandell 2007) 'to maximise the value of services delivered to patients' (Van der Klauw et al 2014, p. 2) and was identified in a systematic review as a key objective of integrated care programs for chronically ill patients (Ouwens et al 2005). However, there is little attention given in the literature on integrated care to studies of coordination across the spectrum of care, unlike that found in the broader health literature. Only one study of care coordination from the perspective of integrated care has been found. This study investigated the coordination of integrated home care work for the elderly, and the challenge of work distributed in time and space, aiming to understand how 'daily work is actually carried out in situ', with a CSCW methodology (explained on page 43) (Petrakou 2009, p. 2).

A review of mechanisms used in integrated care interventions found that one of the most common was a care coordinator role (Roe & Normand 2013). In reviewing American linkage and coordination integration efforts, Leutz (2005) pointed out the importance of persons named as a 'single point of contact' who identified potential clients, facilitated referrals, and provided clinical information to services involved in the client's care. Case studies of models of integrated care continue to recognise the important contribution that key individuals can make, such as a designated care coordinator (Goodwin et al

2014; Masso & Owen 2009); boundary spanner (Williams & Sullivan 2009); or care navigator (Bruce, Wistow & Kramer 2011), working in 'multi-agency and multi-sectorial environments' (Williams 2011, p. 27). Several recent studies about coordination of care in primary and community care also focus on roles such as care navigation (e.g. Doolan-Noble et al 2013; Manderson et al 2012; Plant et al 2013), boundary spanners and chronic care coordinators (e.g. Ehrlich, Kendall & Muenchberger 2012; Parker & Fuller 2016). A literature review of boundary work supporting integration reported that the building of relationships is an important feature of this role (Gilburt 2016).

There are two recent studies of the role of the HealthOne GP liaison nurse in improving integration and coordination of services. McNab et al (2016) drew on a mixed-methods evaluation, including interviews and a focus group, to assess the difference in care and the range of services provided through the GP liaison nurse. This study noted that flexibility was a particular strength of HealthOne and the activities of the liaison nurse; however, a theorised interpretation was not provided. Wilkes et al (2016) used a three-round Delphi study to identify 33 functions of the liaison nurse in 11 role domains. Both studies relied on analysing practitioners' perceptions, rather than observation of practice. Wilkes et al (2016, p. 76) acknowledge that their study did not capture the 'nuances of the different roles and functions' in distinct disciplines e.g. child and family health or chronic and complex care, and that 'further clarification of the [liaison nurse] role' is needed. Hence in extending the body of research on factors contributing to integrated care, this study will shed light on how HealthOne liaison nurses act as a mechanism of integration.

At odds with the vision of integrated care is the reality in Australia that primary care and community health have traditionally operated as 'parallel streams of care' and general practitioners have regarded themselves as the 'main coordinators of care' (Wiese et al 2011, p. 998). Hence there has been

substantial attention to coordination of care in Australia in the primary health care literature, for example, systematic reviews by Tieman et al (2006) and Powell Davies et al (2008), and studies by Banfield et al (2013), Masso & Owen (2009) McDonald, Davies, & Harris (2009); Plant et al (2013), Tieman et al (2007), Walker et al (2013). An Australian systematic review of care coordination in primary health care found two main strategies: '(i) communication and support for providers and patients, and (ii) structural arrangements to support coordination'. The reviewers concluded that interventions using multiple strategies were more successful than those using single strategies (Powell Davies et al, 2008, p. S65).

Multidisciplinary team meetings

Arrangements for coordination of care may occur through multidisciplinary teams (Strandberg-Larsen 2011; Goodwin et al 2014). Multidisciplinary teamwork and case management (combining professional integration and coordination activity) has become a key focus for the integrated care literature (Stokes, Checkland & Kristensen 2016; Sun et al 2014), illustrating the continued interest on factors that contribute to making integrated care work. Multidisciplinary team meetings are often highlighted in discussion of integrated care features as effective mechanisms, although challenges are recognised. The notion of multidisciplinary team meetings denotes some degree of collaboration among a group of professionals from different disciplines brought together for discussion and decisionmaking.

Harris et al (2012) found that multidisciplinary teams participating in weekly case review meetings considered these valuable. Axelsson et al (2014, p. 5) noted that a strong focus on multidisciplinary teamwork was an element of interprofessional integration in the research setting (a hospital), with established networks for various managers and regular meetings to share information, discuss problems, and evaluate and plan various activities. Lewis et al (2013, p.

8) noted that 'regular multidisciplinary team meetings ('ward rounds') attended by professionals from community health care, primary care and social care' were among 'the most important integrative process in the virtual ward'. An Australian study of rural palliative care noted that multidisciplinary team meetings including GPs were among the most common interventions in an evaluation of 15 projects that were focusing on integration between community-based health providers and GPs (Masso & Owen 2009).

Some studies reported that multidisciplinary meetings were dominated by medical staff and presenting general practitioners (Harris et al 2013) and that these were not 'fostering a significant cultural shift in ways of working' (Curry et al 2013, p. 6). Schmied et al (2010) noted that multidisciplinary meetings were considered time consuming and could create feelings of professional anxiety amongst participants who could be inhibited by perceptions of status. However, multidisciplinary meetings 'are becoming increasingly common as a collaborative forum' for the management of complex cases (Fitzpatrick & Ellingsen 2013, p. 632).

One UK study that focused on communication patterns in multidisciplinary group meetings in the context of integrated care conducted a content analysis of communication patterns to measure the degree that case discussions 'foster an integrative way of working between the participants' (Harris et al 2013, p. 2). The study concluded that the meetings were consultative and that 'there was evidence that participants were, overall, integrating as a result of the case discussions' (Harris et al 2013, p. 6). Meetings were held regularly to discuss clients and consider care plans with the intention of improving care and coordination and reducing hospitalisations. There was an emphasis on exchanging patient or individual information, although this was not followed through with forward actions. Meetings also offered a forum for learning more

about local health services and other participants, who included general practitioners.

There is little literature that directly considers case conferences or case meetings, although these are mentioned occasionally as integration mechanisms (van der Klauw et al 2014) for joint planning and working, for example, Holmesland et al (2010), Naylor, Alderwick and Honeyman (2015). Tieman et al (2007, p. 63) conclude from a literature review that case conferences as well as care planning and team approach are interventions in integrated care 'seen to offer potential benefit'. Engeström, Engeström and Kerosuo (2003) published a study of professional case meetings held to discuss patients with multiple chronic conditions. Through discourse analysis, Engeström et al (2003) foregrounded multiple types of discussion occurring: co-narrating, joint decision-making, modeling as future oriented framing and historically oriented reflection, and giving the client a voice. This study, using cultural-historical activity theory, was conducted through laboratory sessions with practitioners, clients and carers to pilot 'negotiated knotworking', as a care agreement tool between acute care and primary health care (Engeström et al 2003, p. 289), thus conceptualising a new mode of collaborative care, much like 'integrated care'. Although parts of the tool, that is, care plans and feedback, are recognised elements of integrated care, Engeström et al's (2003) notions are not taken up in the subsequent integrated care literature, and instead are largely followed by literature from the fields of education, workplace learning and linguistics.

Australian literature specifically refers to case conferences, for example, Tieman et al (2007), McDonald et al (2006), Reed et al (2014) Schmied et al (2010). This is possibly because the Enhanced Primary Care Program funded multidisciplinary case conferences as part of an Australian policy initiative encouraging GP involvement in multidisciplinary care of complex clients. A literature review of multidisciplinary approaches to care for the frail elderly

concluded that case conferences were an effective intervention even where patients were not present (Tieman et al 2006, p. 24). However, Shelby-James et al (2012) found that information exchange dominated over care planning activity. A number of Australian studies of case conferencing in palliative care have emerged (e.g. Davison & Shelby-James 2012; Phillips et al 2013, Shelby-James et al 2007, Shelby-James et al 2012), beginning with a literature review examining effectiveness and barriers and facilitators, from the perspective of participants and patients (Tieman et al 2006). This review pointed out that uptake of case conferencing by GPs with other health care professionals (in the period 1999 to 2001) was low, compared to other claimable items and that case conferences could not be attributed to improvements in quality of life, although an increased use of services, 'improved practice' and 'identification and resolution of problems' were results of case conferences (Tieman et al 2006, p. 20). Case conferences were seen as 'temporary knowledge building and information gathering systems' that were characterised by complexity due to the range of practitioners involved with the client who did not participate in the conference (Davison & Shelby-James 2012, p. 118).

Wistow & Dickinson (2012, p. 677) suggested that the success of integrated initiatives lies in their 'contribution to improving processes of joint working'. Other scholars now support the view that integrated care initiatives achieve process improvements (Bardsley et al 2013; Curry et al 2013; Evans et al 2014; Rand, Ernst & Young 2012). In recognising that the classification by Leutz (1999) was intended as a 'framework for thinking about how to design joint working according to the needs of the populations served' (Leutz 2009, pp. 43, 44) across health and social services, this review now considers whether perspectives on ways of working together contribute to understanding the enactment of integrated care.

Joint ways of working

'Connectivity, alignment and collaboration within and between the cure and care sectors' calls for joint ways of working (Kodner & Spreeuwenberg 2002, p. 4). Although integrated care did not emerge as an umbrella term until the late 1990s and 2000s (Shaw, Rosen & Rumbold 2011), a number of elements of joint work are dominant in the broader health literature, for example, multidisciplinary care 'in the 1960s; partnership working in the 1970s; and shared care and disease management in the 1980s and 1990s' (Shaw, Rosen & Rumbold 2011, p. 4). Greenhalgh identified components of contemporary primary health care, including 'close liaison [with multiple professionals] across interprofessional, interorganisational and intersectoral boundaries' to consistently manage a client's multiple conditions and care pathways (Greenhalgh 2013, pp. 3). Inter-professional working, integrated delivery networks, shared decision-making, and integrated care pathways are more recent trends in the health literature in the 2000s (Shaw, Rosen & Rumbold 2011). This might explain why there has been limited exploration in the integrated care literature of joint ways of working in comparison to the large number of studies focused on outcomes, success factors or challenges of integrated care. As some researchers claim, 'The evidence base on joint working remains lacking' (Cameron et al 2012, p. 18).

To date, studies of integrated care across disciplines, organisations and sectors suggest that this calls for new ways of working together (Kodner & Spreeuwenberg 2002; Leichsenring 2004) such as releasing resources and control (Bruce, Wistow, & Kramer 2011); 'loosely linked relationships like partnerships and alliances' (Evans et al 2014, p. 145), networking (Kodner 2002) and 'linkage terms such as cooperation, coordination, and collaboration' (Keast, Brown, & Mandell 2007, p. 9).

Collaboration

Creating collaboration within and across organisations, professions and services is an important aspect of integrated care (Kodner & Spreeuwenberg 2002; Kodner 2009). There are multiple dimensions to integrated care, including organisational, professional and service levels (e.g. Kodner 2002, van der Klauw et al 2014; Valentijn et al 2013, 2015a). However, these call for 'much closer collaboration' between general practice, community health and allied health (Powell Davies et al 2009b, p. 2), and with the broader social services sector. A literature review of models of integration found that almost 10% of the selected studies featured interprofessional collaboration while around 25% featured interorganisational collaboration (Valentijn et al 2015a). Until now, top-down policy and structural initiatives have had more attention in the integrated care literature than service level factors such as collaborative working (Williams 2011). The following section does not explore the broader literature on collaboration, for it has its own debates, interests and various conceptualisations (e.g. D'Amour 2005; D'Amour 2008; Legare et al 2011; Reeves & Lewin 2004; San Martín-Rodríguez et al 2005). Instead the intention is to highlight whether literature on collaboration across sectors, organisations or professions contributes to understanding integrated care in practice.

A recent doctoral thesis by Valentijn (2016, see also Valentijn et al 2013, 2015a) aiming to understand how integrated care can be achieved, focused on collaboration mechanisms and processes underlying integrated care. Valentijn et al (2015b) undertook a longitudinal study of interorganisational, interprofessional and also intersectorial partnerships, using regression analysis to analyse survey data. However, results were based on surveys undertaken with steering committee members and partnership coordinators, rather than with practitioners, policymakers or clients. This study showed that mutual gains, process management, and the change in relationship dynamics were predictors for perceived success in collaborative partnerships, indicating the

importance of 'the building of relational capital 'during the process (Valentijn et al 2015b, p. 38). Other recent studies, for example (Carswell 2015; Gilburt 2016; Wodchis et al 2015) have also noted the importance of relationship building in integrated care initiatives.

A number of research studies explore the role of collaboration in integrated care, although mostly from the organisational perspective, for example, Axelsson and Axelsson (2006). Studies of interorganisational collaboration in integrated care frequently follow the paradigm of identifying challenges (e.g. Lawn et al 2014, Holmesland et al 2010, Reed et al 2014), with various aims for example, developing recommendations (Reed et al 2014); developing electronic tools to support collaborative work (Davoody et al 2014); identifying success factors (Schmied et al 2010); or assessing effectiveness (Kyriacou & Vladeck 2011). Some studies found that collaboration between professions was fraught with concerns for instance, about lack of respect (Holmesland et al 2010), territorial behaviour (Lawn et al 2014) or lack of autonomy, with such concerns creating resistance (Schmied et al 2010).

Beyond the field of integrated care, Australian research has made a significant contribution to illuminating interorganisational and intersectorial collaboration in primary health care and its challenges. Using resource dependency theory and transaction cost analysis, McDonald, Jayasuriya & Harris (2012) explored the influence of power and trust on multidisciplinary collaboration through a case study of nineteen organisations in a rural city, acknowledging that the particular funding arrangements and structural divisions of the Australian health sector made collaboration difficult. The study found that power was used to protect health practitioners' autonomy, that there were particular power dynamics between the public and private sector, and that power was maintained through reducing dependency on other health

practitioners. Trust was based on demonstrated competence and developed over time with good communication.

One study considered interprofessional collaboration as well as interorganisational collaboration between primary health care providers, by reviewing four partnership models in terms of governance and Leutz' levels of collaboration. These were 'essentially voluntary alliances', where the level of collaboration was dependent on a range of interests and allegiances (Mcdonald, Davies, & Harris 2009, p. 267). McDonald et al (2011, p. 263) also analysed the influence of organisational factors on collaboration between private and public sector primary health care services for diabetes clients, finding that 'collaboration across private and public sector services was more difficult to achieve than collaboration within each sector'. A 'low intensity of collaboration' was attributed to structural and cultural differences, lack of financial incentive for the public sector, and lack of mechanisms that 'enabled clinical staff from different organisations to get together, and plan, develop or deliver their services in a coordinated way' and to develop and maintain relationships or improve communication (McDonald et al 2011, p. 262).

Patient-centred medical homes

Patient-centre medical home models have emerged since 2007 when the Joint Principles of the Patient-Centred Medical Home were developed by a group of physicians from the United States. The medical home is an approach to primary care reform expected to increase efficiency and improve patient experience (Pourat, Charles, & Snyder 2016). The approach is a new way of joint working through a sustained partnership between the patient and family and a medical practice.

The medical home approach involves not only the basic tenets of primary care but also reimbursement changes, developing practice capability and 'new ways of organising practice' (Stange et al 2010, p. 602). These include quality

and safety, disease registries and greater patient engagement. Building a patient-centred medical home also requires: a personal physician; reimbursement; empanelment (patient registration); continuous and team-based healing relationships with patients; organised, evidence-based care; patient-centred interactions; enhanced access to care; and care coordination (Commonwealth Fund 2012; Pourat, Charles, & Snyder, 2016).

The empirical literature on patient-centred medical homes is still small. It is mainly focused on evaluating and investigating the anticipated improvements in outcomes, for example, better preventative care, improved quality indicators, by using provider-reported data. A five-year demonstration project in 65 practices in the United States was conducted as part of the Safety Net Medical Home Initiative. Results indicated positive progress through process changes such as care teams, open access scheduling and registries to track patients (Sugarman 2014). Friedberg et al (2015) analysed medical claims for almost eighteen thousand patients attributed to 27 pilot and 29 comparison practices and reported relative improvements in quality, lower use of emergency department, hospital, and specialty care, however primary care utilisation increased.

The growing international interest in the medical home is not accompanied by definitive data on impact at the population level or clarity about which principles lead to the desired outcomes (Pourat, Charles, & Snyder, 2016; Rosenthal 2016; Westfall et al 2014). Particular medical home principles such as continuous relationship with a personal physician and chronic care management seem to result in fewer visits to emergency departments (Pourat, Charles & Snyder 2016). A recent study using patient-reported data investigated whether three principles: having a personal doctor, an individual treatment plan and coordinated care were likely to improve outcomes (Pourat, Charles and Snyder 2016). Patients whose care conformed to these principles

received more outpatient care indicating greater efficiency, however emergency department visits were not reduced. Insights from the demonstration project in the United States highlight the extended time taken to show progress, including the considerable work required to build infrastructure and engage patients and leadership, and also note the benefit of 'face-to-face, peer-to-peer interaction in learning community events' (Sugarman et al 2014, p S9).

The patient-centred medical home concept has been taken up by the Australian government and the Royal Australian College of General Practitioners and gives more attention to holistic, whole-of-patient care. The provision of primary health care through Aboriginal Community Controlled Health Services to Aboriginal and Torres Strait Islander people is often considered as the original model for medical homes in Australia. In the Australian context, a medical home has been defined as a 'regular doctor or source of primary health care that is very or somewhat easy to contact by phone during office hours, always or often knows the person's medical history and always or often helps coordinate care from other doctors or sources of care' (Powell Davies et al 2009a, p. 3). However, at the time of this review, the model was yet to be formally studied or evaluated in Australia.

Conclusion

Integrated care has been represented as the 'streamlined' solution (NSW Health 2007) to a number of problems and there is overwhelming support internationally and nationally for integrated care. Although there is growing recognition that integrated care does not generally meet the expectations of the policy makers, attempts continue to demonstrate its perceived benefits by measuring and evaluating policy implementations at organisational and professional level and identifying factors that facilitate or challenge integrated care initiatives.

Empirical research constitutes less than half of the literature on integrated care, while efforts to conceptualise integrated care have been a major focus. Convergence on conceptualisations of integrated care has emerged only recently, as this review has highlighted. However, most studies lack detail on methods (van der Klauw et al 2014) or models of care (Cameron et al 2012; Powell Davies, McDonald, & Jeon 2009b). A recent meta-review concluded that future studies of integrated care 'should provide a detailed description of the components and interventions of integrated care examined' (Martínez-González et al 2014, p. 568). The conceptual ambiguity adds confusion, making comparison of findings across studies difficult. As Sheaff et al point out:

> There is a 'babel' of research on health-care integration … Not as much research is available on the question of … what approaches to integrating care work under what conditions, for whom, and whether or not the health gains are worth the transaction costs. Nevertheless, think tanks and policy-makers persist in demanding more integrated primary care. (Sheaff et al 2015)

Despite the expectations that integrated care will reduce the burden on the health system and improve service delivery, this review shows that results are somewhat inconclusive. The quality improvement logic underlying much of the literature persists, for example, a recent doctoral thesis concludes that 'further work is needed to understand how integrated care mechanisms act as a means for improved health and cost-related outcomes' (Valentijn 2016, p. 2). Rather than studying 'what' policy implementations achieve, it is timely to turn to questions of 'how' policy enactments achieve integrated care.

Significantly, empirical research of integrated care has rarely taken a theoretical approach other than through the logic of quality improvement or the classification by Leutz (1999) of degrees of integration. To many health professionals and researchers, 'theory' refers to best practice clinical pathways

and quality of care, in particular, effectiveness. However, there are indications of a shift in this field of inquiry. Some studies work with more nuanced research objectives and methodologies that draw on existing theorisations (e.g. Liberati, Gorli, & Scaratti 2016; Valentijn et al 2016; Williams & Sullivan 2009). These studies take a different approach to the complex phenomenon of integrated care by asking 'how' integrated care is enacted. This study will extend this nascent body of work.

Some integrated care strategies and studies have considered processes of integration, and how these bring practitioners and organisations together to embed integration initiatives 'in working practices' (Wistow & Dickinson 2012, p. 678). However, this review of literature from the field of integrated care has not uncovered detailed understanding of how integrated care is enacted. Few studies have taken practice as the object of inquiry. Most studies of integrated care follow the conventional approach in using the organisation, the model of care, or the health professionals as the unit of analysis. Pracitioners' perceptions have been a frequent focus, rather than the practices in the workplaces.

Fine-grained exploration of work practices associated with models of integrated care to explain how integrated care is enacted is an important area of research that demands attention, as the academic literature is now recognising. Until recently, there has been little attention given to studies that deal with the complexities of providing integrated care through collaboration and coordination across organisations, sectors and professions. Studies of joint ways of working focus mainly on evaluation, offering limited information about practices and arrangements or discussion of factors that advance or hinder joint work (Cameron et al 2012). Barriers to integrated care are continually identified. However there are few studies that extend this knowledge by explaining with theoretical resources these challenges or the interaction between factors

facilitating the enactment of integrated care. This thesis offers new ways of understanding these blind spots in the literature.

Interest in identifying mechanisms of integration continues, yet it is not clear how these act in practice. There is a 'rich and varied' range of integration mechanisms identified in the literature, however, these are 'thin, both in their empirical foundation and in their description of the mechanisms' (Van der Klauw et al 2014, p. 7; see also Evans et al 2014). Hence a theorised exploration in this study of how HealthOne liaison nurses and case conferences act as mechanisms of integration will extend the literature on factors that contribute to the enactment of integrated care, and build on related bodies of work.

There is little empirical research on the practices of integrated care or how models of integrated care are accomplished in practice across time and settings. Thus this thesis contributes to this field of inquiry by exploring the enactment of integrated care policy through processes and activities across workplaces. The definition of integrated care from Kodner & Spreeuwenberg (2002) and the classifications of degrees (Leutz 1999) and dimensions (Valentijn et al 2013) of integrated care inform the analysis of empirical data taken up in later chapters of this thesis. In acknowledging the conceptual ambiguity surrounding integrated care, this study will explore how practitioners make sense of a model of integrated care and apply it in practice. Thus the thesis will provide insight into how a model of integrated care was accomplished, rather than assessing how effectively it was achieved.

Many studies concluded that integrated care does not immediately meet the expectations of the policy agendas, and that integration takes time. 'Changes to practice often took much longer to achieve than anticipated' (Rand and Ernst & Young 2012, pp. ii). Short-term studies of integrated care initiatives showed limited results. There has been a lack of longitudinal studies of models of integrated care to explore the development of integrated care (Minkman 2012),

yet a 'more longitudinal approach to explore the effects' is needed (Looman 2014, p. 9). A recent exception was Valentijn et al (2015b) who undertook a longitudinal study through administering surveys at the start and end of a three-year project. Very few studies reflect the approach taken in this thesis to study the enactment of integrated care through theoretically informed extended ethnographic engagement in the workplace. Chapter three will introduce the methodology used in this study, by explaining the theoretical approach for this study. ■

Chapter three

Relevant theoretical approaches to the study of practice

About this chapter

This study was undertaken to explore practices associated with an innovative NSW government model of care known as HealthOne, located in primary health care. The aim was to understand how this ambitious change initiative was enacted as integrated care in practice. Thus 'practice' has a central place in this study.

Throughout the study, HealthOne was evolving and in a state of flux. It became evident during the data collection that a wide range of health and social services professionals were carrying out various practices related to care of HealthOne clients across multiple settings. Although people and objects related to care of HealthOne clients were not incidental to how the model of care unfolded, it was through practice that this new way of working became most evident and intelligible.

This chapter reviews the theoretical resources selected to explain how integrated care was enacted. The previous chapter provided a critical account of the academic literature on integrated care and reviewed studies of ways of working together across sectors, organisations and disciplines. In illuminating the progression, strengths and limitations of the integrated care literature, the literature review demonstrated the shortage of in-depth research on the practice of integrated care, particularly theoretically informed empirical studies. In

addressing this gap in the literature, this thesis has drawn on two theoretical perspectives to establish how integrated care was enacted in practice: practice theory and actor–network theory (ANT). Since a 'unified practice approach' does not exist (Nicolini 2012, p. 214; see also Mol 2010a), the thesis engaged with two complementary theories to provide a nuanced and deeper understanding of the enactment of integrated care.

Taking practice as the object of inquiry allowed this study 'to engage with the core logic of how practices are produced, reinforced, and changed' (Feldman & Orlikowski 2011, p.1242) as the model of care was enacted. Centring this study on practice enabled exploration of the complex phenomenon of integrated care, amidst ever-changing policies, structures, and actors, as described by Nicolini:

> The attraction of the practice idiom stems in particular from its capacity to resonate with the contemporary experience that our world is increasingly in flux and interconnected, a world where social entities appear as the result of ongoing work and complex machinations, and in which boundaries around social entities are increasingly difficult to draw. (Nicolini 2012, p. 2)

Seeking to contribute to understandings of integrated care, the study worked with concepts that both reframe current understandings and bring new resources (Bazerman 2012, p. 265) to thinking about integrated care in practice. Each of the three research questions has been explored by drawing on concepts from within a distinct theoretical framing, in order to ensure a 'coherent theoretical stance' (Nicolini 2009, p. 1394).

This chapter firstly shows how Schatzki's practice theory was used to explain an enactment of integrated care. The chapter then explains how applying ANT provided different perspectives and contributed to greater understandings of integrated care in practice. A number of concepts from

practice theory and ANT that guided the analysis in this study are explained. The intention in this chapter is to provide a rationale for the choice of these conceptual tools.

Explaining integrated care through Schatzkian notions of practice

Practice is at the heart of this study of how integrated care was enacted in the settings and organisations associated with HealthOne clients. Uncovering a range of social activities and arrangements changing practice toward a form of integrated care called for a reading of the data using practice theory. This is a theoretical lens that understands the elements of social phenomenon as collective, embodied action bound with arrangements. The range of sources and influences means that practice theory cannot be described as a 'canon' or a singular approach (Feldman & Orlikowski, 2011; Nicolini 2012). Originating in the work of philosophers Heidegger and Wittgenstein, many theorists have contributed to theorisations of practice. Overall, the commonality amongst practice theorists is that they see practices as social phenomena, composed of social activities undertaken collectively by multiple people (Kemmis & Trede 2010; Nicolini 2012; Schatzki 2012).

This study takes up Schatzkian notions of practice and practice change in chapter six. These have provided a robust theoretical frame for explaining the interplay between existing and new practices as integrated care was enacted. Social theorists Bourdieu (1977) and Giddens (1984) and cultural theorist Reckwitz (2002) provide alternative practice theorisations, as does the work of Gherardi (for example Gherardi 2008; Gherardi & Nicolini, 2000) and Orlikowski (2002) on knowing in practice. Bourdieu's theory of practice offers an understanding of three key concepts: habitus, field and capital. The social world is understood as 'as encompassing social spaces (fields and sub-fields) where activities take place and produce capital' (Price 2013, p. 33). Giddens (1984) developed another version of practice theory by framing a theory of

stucturation (Reckwitz 2002). Giddens (1984, p. 3, 9) suggests that human life is a 'continuous flow' and that human beings are purposive agents, with agency or capability for 'doing things'. For Schatzki (2001, p. 2) the social world is a field of 'embodied materially interwoven practices' and the field of practice is where one studies 'the nature and transformation of their subject matter'. While Giddens and Bourdieu are important contributors to theorisations of practice, recent developments in Schatzkian practice theory presented resources more relevant to the analytical demands that arose in this study. More recent work offered a perspective on change (Price 2013; Schatzki 2012, 2013) that allowed the study to uncover the emergence and persistence of practice.

Schatzkian theorisation of practice lends itself to empirical research, particularly in regard to practice in complex organisational settings. A few studies resemble this study in contributing to the conversation about practice through ethnographic fieldwork. Schatzkian practice theory has been usefully applied in ethnographic studies of health care, for example, Manidis & Scheeres (2012), and Nicolini (2012); and public sector organisations, for example, Price, Scheeres, & Boud (2009) and Price (2013), to explore the organisation, enactment and remaking of practice.

Schatzki's practice theory

As both a term and a theoretical concept, practice may mean different things (Kemmis 2009, p. 19). For instance, practice can denote performing an activity once, or repeatedly carrying out an activity (Schatzki 1996, p. 89). Schatzki's practice theory has been founded on notions of practice as unfolding in activity and social interaction, as what people do, with an understanding that practices are done, both as doings and sayings and in 'relatings' (Kemmis 2009, p. 23; see also Schatzki 2012).

Schatzki's philosophical approach to practice theorisation has progressed over a number of works (1996, 2002, 2012), with practices as the central notion in

understanding social life and human coexistence. Drawing on the work of various theorists, Schatzki describes practice as a 'social phenomenon' which 'embraces multiple people', consisting of organised activities together with their context (Schatzki 2012, pp. 13, 14). This means that practices are carried out by many people who co-exist socially through mutual connection in a field of practice (Nicolini 2009). Hence the applicability of Schatzki's practice theory to an explanation of practices unfolding through HealthOne, for activities associated with its clients involved multiple practitioners.

The social ontology of Schatzkian practice theory is a way of looking at the world in which practices are central and are seen as 'building blocks of social reality' (Feldman & Orlikowski 2011, p.1242; see also Schatzki 2001, 2012). Practice is made up of overlapping, continuing activities carried out amid objects or material entities in social contexts. Organised activities and arranged things are the building blocks and 'stuff' of social life (Schatzki 2001, 2010).

The notion of a continually evolving bundle of practices and material arrangements is central to Schatzkian practice theory, with arrangements embracing 'four types of entity: human beings, artifacts, other organisms, and things' (Schatzki 2005, p. 472; see also Schatzki 2012, p. 16). Explaining the interrelationship, Schatzki (2012) proposes that practices and arrangements 'bundle' together, although at times, other terms such as mesh and nexus are used to describe this relationship. Practice unfolds through a 'constantly evolving nexus of arranged things and organised activities' (Schatzki 2002, p, xi), 'a contingently and differentially evolving configuration of organised activities and arrangements' (Schatzki 2002, p xii).

The organised activities composing a practice are bound up with material arrangements. Arrangements can prefigure the perpetuation of practices or practice change by making possible change more or less difficult, time-consuming and so on (Schatzki 2012). Thus materiality matters, and this

study considers the material arrangements amid which practice was enacted. However, the exposition of the unfolding of integrated care in chapter six foregrounds practices, rather than materiality. The empirical analysis revealed that emergence of the model of care largely relied on altered and new practices, while the material arrangements associated with the model of care were not distinctive of, or particular to, HealthOne.

Over the course of developing practice theory, Schatzki has refined both the theorisation and terminology. For instance, practice-order bundles (Schatzi 2002) became practice-arrangement bundles; elements organising practice, initially referred to as understandings, rules and teleoaffective structures (Schatzki 1996) (explained below), were later expanded to include practical and general understandings. For some time around 2010, Schatzki turned his attention from practice to activity and then consolidated his thinking in a seminal discussion of practices (Schatzki 2012). In both early and later work Schatzki gives pre-eminence to practices as fundamental. Schatzki has also offered a perspective on change that is a further development of his 2002 book chapter on the topic. Now a central concept of his social ontology, Schatzki (2012, 2013) recognises the ongoing, and unpredictable nature of change, where stability co-exists with change. Schatzkian notions of practice change have underpinned the explanation of existing and new practices that were unfolding as integrated care was enacted.

The next section provides a reading of the following Schatzkian concepts that have informed the analysis in chapter six of how integrated care unfolded in practice: practice, intelligibility, elements organising practices and practice change. These terms are familiar, but have specific meanings in Schatzkian practice theory.

Practice

Schatzky's theory describes practice as a concept that relates to activity, which is guided by rules, understandings, purpose and emotions (Schatzki 2012). Schatzkian practice theory recognises that practice consists of bodily activity that happens across space and time as the organised activity of different people. Practice also involves understandings, both conscious and unconscious, by those involved. Finally, practice involves an element of purpose or intention linked with emotion and mood (Schatzki 2012; Nicolini 2012). Practice is always situated, and it shapes and is shaped by context and material conditions (Green 2009; Kemmis 2009).

In early work, practice was explained as 'a temporally unfolding and spatially dispersed nexus of doings and sayings' (Schatzki 1996, p. 89). In more recent work, practice is described as 'an organised constellation of different people's activities' (Schatzki 2012, p. 13). Thus activities are part of practices and practices are composed of doings and sayings carried out by humans. Participating in a practice involves doings, sayings and relatings that are characteristic of that practice (Kemmis 2009).

Importantly, practices consist of individual bodily performances and are understood as performances over time (Rouse 2007). Schatzkian practice theorisation foregrounds the notion of the temporal unfolding of practice. This notion recognises practice as an ongoing flow of activity (Green 2009). Practice has a temporal element. Moreover, human activity happens in a setting in the material world. Applying these concepts to this study, I viewed the unfolding of integrated care in practice as an ongoing process of collective human activity over time and space.

Intelligibility

Originally referred to as 'practical intelligibility' (Schatzki 2002), Schatzki (2012) makes a later shift to the term 'intelligibility'. This Schatzkian notion refers to

what 'makes sense' for an individual 'to do' (Schatzki 2002, p. 74). Intelligibility arises through practice. This is a key concept in the analysis of how integrated care unfolded.

Schatzki argues that practice-arrangement bundles form through a range of relations including intelligibility (Schatzki 2002, 2012). Practices and arrangements can be linked in several ways; one of these is 'through participants in particular practices making sense of the elements of arrangements in specific ways' (Schatzki 2013, p. 40). Schatzki (2002, p. 100) posits that practices are where the meaning of arrangements or entities can arise. Thus the notion of intelligibility is also concerned with how arrangements give meaning, or are intelligible, to practitioners (Schatzki 2012, p. 17). The meanings that arrangements have are 'tied' to the practices that people carry out (Schatzki 2012, p. 17).

Contributing to this theorisation of intelligibility, Rouse (2007, p. 516) talks of 'shared presuppositions' or 'unarticulated commitments', which are understood or shared by those participating in a practice, and need not be articulated. However, intelligibility is stressed as an individual phenomenon, which is not ruled by shared norms or rationality. Intelligibility guides or 'governs' an individual's practice (Schatzki 2002, p. 81).

Organising practices

Rules, understandings and teleoaffective structures are important elements organising practice. Theoretically and empirically activities may be elements of more than one practice. These become organised as part of a practice, if they express 'one of the understandings, rules, or teleoaffective elements that organise that practice' (Schatzki 2012, p. 15).

In later work, Schatzki further develops the concept of understanding, differentiating between practical and general understanding. Schatzki (2010) describes practical understandings as the ability or skill to do the actions

comprising a practice, and knowing how to undertake the 'desired actions through basic doings and sayings' (Schatzki 2012, p. 29). Examples of practical understandings are the ability to generate and send an email, or the understanding of how to make a referral to another practitioner. In contrast, a general understanding relates to more commonly held understandings in the abstract sense about manners or actions (Schatzki 2012), for example, understanding about shaking hands when introduced to a person, or handwashing before clinicians examine patients.

Practice also has an element of purpose, intention or 'oughtness', linked with mood and emotion (Nicolini 2012, p. 166; see also Schatzki 2012). Schatzki labelled this 'teleoaffective structure'. This embraces 'ends, projects, tasks, purposes, beliefs, emotions and moods' (Schatzki 1996, p. 89) that pertain to a practice as a property of that practice (Schatzki 2002), i.e. as 'enjoined and acceptable ends, purposes, and emotions' (Schatzki 2015, p. 2). For example, in the Shaker community, religious beliefs and the notion of community were two teleoaffective structures that infused the lives and activities of the community (Schatzki 2002).

In practice theory, rules are principles, instructions, and precepts that must be followed in performing the practice (Kemmis 2009; Schatzki 2002). However, the indeterminacy of activity means that the manner in which activity eventuates is uncertain until the performance of an activity determines what it has become (Schatzki 2012, p. 20). Action is always done knowing that the outcome is uncertain, while reflection on practice leads to understanding of those particular practices (Kemmis 2009, p.23). Grasping a practice-arrangement bundle's rules, teleoaffective structure, and practical and general understandings arises through practice.

Doings and sayings may be components of several practices. However, a distinctive set of doings and sayings expressing an interconnected array of rules,

teleoaffective structures and understandings distinguish a particular practice-arrangement bundle (Schatzki 2002). Where understandings, rules and teleoaffective structures start to change, the ensuing instability or transition gives way to different bundles (Schatzki 2013). In this way, Schatzki's theorisation accounts for the emergence of practice- arrangement bundles that form phenomena such as in the case of this study, models of integrated care.

Practice change

Practice theory argues that change is inherent to practice for practices evolve over time as circumstances, ideas and practitioners change (Schatzki 2005, 2013). In more recent practice theorisation, there has been some discussion of practice change, for instance, Kemmis (2009, pp. 19, 20) considered practice as an 'evolving social form which is reflexively restructured and transformed over time'. Schatzki suggests that stability is required for a practice-arrangement bundle to exist, and persist. Where a reasonably stable organisation does not exist, ongoing metamorphosis is likely (Schatzki 2002, 2013).

Although perpetuation of past activity is the usual, practice change can happen at any time (Schatzki 2014). Schatzki contends that there is a concurrency of change and continuity, with some practices and arrangements being maintained, while others are altered (Price 2013; Schatzki 2002, 2005). Thus stability and change co-exist. Schatzki rejects the dualism of stability replaced by change, instead accommodating both in his notion of change as experimentation amid stability simultaneously (Schatzki 2002, 2013). 'Old/new' is another dualism that Schatzkian theorisation rejects in favour of 'overlapping phenomena', which together are a mesh of existing, altered and new practices, and old and new material arrangements (Schatzki 2002, p. 256; see also 2005).

Chapter six takes up these notions to show how integrated care was unfolding through an array of practices. The conceptualisation proposes that, in the HealthOne case, practice evolved through an array of practices: embedded,

revived, remade and emergent. The HealthOne practice–arrangement bundle became a mesh of existing, altered and new practices and old and new material arrangements, thus accommodating evolution and perpetuation simultaneously (Schatzki 2005, p. 476).

This lens has shaped the analysis in chapter six, which draws on Schatzkian practice theorisation to answer the second research question: How was integrated care unfolding? Human action as the primary source of change (Schatzki 2005) and the co-existence of change and stability (Schatzki 2002) are tenets in Schatzkian practice theory that have offered theoretical resources to explain how integrated care was unfolding.

Drawing on two theoretical lenses

This thesis is not a reading of Schatzkian practice theory from first principles. Instead, this study brings to light rich understandings of the practices enacting integrated care, through shifting 'theoretical lenses' (Nicolini 2012, p. 219). Both practice theory and ANT offer theoretical resources that allowed this study to cast new light on practice and to develop answers to the research questions.

In drawing on two relevant theoretical approaches, this study has been influenced by Jackson and Mazzei (2011, 2013) and Nicolini (2009, 2012) who both argued for an open-minded thinking about data by employing multiple theoretical perspectives. This opens up possibilities for creating new knowledge about complex phenomenon such as integrated care in practice. I find support for this approach in Nicolini (2009, 2012), who recommended switching theoretical lenses 'to study practice empirically' Nicolini (2012, pp. 213).

To guide my analysis, I draw on concepts from practice theory and ANT to study integrated care in practice. I draw on both theories because I do not consider that any single theory is able to investigate the complexity and tension

of enacting and changing practice through new models of care adequately enough to answer the research questions.

Both theories contribute tools to studying practice because these theorisations have different foundations, and offer different conceptual resources. Essentially, practice theory starts with organised human activities, or practices, as the object of analysis (Schatzki 2012). ANT considers the social and material world as the effects of relations, exploring actions as 'relational effects' (Law 2007, p. 6). Despite, or more likely, because of their differences, both theories offer advantages for the study of integrated care in practice through foregrounding in turn very different aspects of practice in the making.

Applying ANT to studying integrated care

The HealthOne model of care was understood in this study as a policy approach to integrated care. The research questions discussed in chapters five and seven use tools from the ANT repertoire to explore how an integrated care policy was enacted in practice. Change, uncertainty, movement and formation were constant during the fieldwork. In exploring the translation of policy into practice, ANT offered conceptual resources that shed light on the complex and precarious nature of emergent practices and relations.

ANT was applied to analyse how the HealthOne model of care was translated into practice, and how shifting relations and emerging practices were held together in an enactment of integrated care. For ANT is especially helpful as a tool in approaching the ongoing process of innovation, the forming and transforming of social and material processes and associations (Callon 1986; Latour 2005), such as the enactment of a model of integrated care. Thus in this study, ANT's catch-cry 'follow the actors' became 'follow the actors in their weaving through things they have added to social skills as to render more durable the constantly shifting interactions' (Latour 2005, p. 68).

In analysing the enactment of the HealthOne vision of integrated care with an ANT sensibility, this study follows in the footsteps of ANT accounts that have considered policy in practice such as Law and Singleton (2014), Singleton (2005) and Singleton and Michael (1993). A small number of more recent ANT studies have attended explicitly to practice. Examples include Mol (2002) who studied the practices of treating atherosclerosis; Moser and Law (2006), who studied information flows in medical practice; Bruni (2005), who followed practices associated with digitisation of medical records; Law and Singleton (2014) who studied the practices of foot and mouth disease; and Singleton and Law (2013), who undertook an ethnography of beef cattle farming practices.

ANT as an approach emerged in the late 1970s to early 1980s from a number of sources, particularly sociology and the sociology of science. The label 'actor–network theory' which emerged in about 1983, has been attributed to Michel Callon (Law 2012). The approach originated from calls 'for a new social theory' which could be applied to innovation in the fields of 'science, technology and society' (Latour 2005, pp. 10, 94).

The ANT 'diaspora' (Law 1999) started in earnest in the 1980s with Latour (1987), Callon (1986) and Law (1987) who worked the approach into accounts of social systems. This new sociology of associations (Latour 2005, p. 9) did not give society, humans or the social precedence. Instead, an ANT sensibility understood the social and material world as the ongoing assembling and re-assembling of associations (Latour 2005, p. 7). The quotation below captures the essence of an ANT sensibility:

> Precarious relations, the making of the bits and pieces in those relations, a logic of translation, a concern with materials of different kinds, with how it is everything hangs together if it does, such are the intellectual concerns of the actor–network tradition. (Law 2007, p. 6)

ANT is a repertoire, a family of approaches and methods, which are partially connected through the accounts of those who practice ANT (Law, 1999, 2007, 2012; Mol 2010a). Many ANT scholars such as Callon (1986), Law (1999) and Mol (2010a) would dispute that ANT can be called a theory. Instead they regard it as a toolbox of 'sensitising terms', a sensibility, and a 'theoretical repertoire' (Law & Singleton 2014 p. 382; Mol 2010a, pp. 261, 256). ANT 'plays' with terms rather than defining them (Mol 2010a, p. 257), and researchers have taken the repertoire in many directions. ANT was applied in this study as an approach or sensibility, rather than 'a creed or a dogma' (Law 2007, p. 2; see also Baiocchi, Graizbord, & Rodríguez-Muñiz 2013; Law & Singleton 2014), as explained by Mol:

> If ANT is a theory, then a 'theory' is something that helps scholars to attune to the world, to see and hear and feel and taste it. Indeed, to appreciate it. If ANT is a theory, then a theory is a repository of terms and modes of engaging with the world. (Mol 2010a, p. 262)

This section begins with some general precepts that have informed the analysis, and then explains how ANT concepts have been used. The notions of actor and actor–network are central to an ANT sensibility. An actor is something that acts (Mol 2010a); a thing that modifies 'a state of affairs by making a difference' (Latour 2005, p. 71). In doing something that has an effect, the act is heard, sensed or seen, for example, a door might act to keep the rain out and allow people entry (Mol 2010a). Actors may be components of networks and may also be an actor–network (Law & Singleton 2014), and might be objects, things, animals, humans, ideas, organisations or concepts and so on. The world is materially heterogeneous, as are actor–networks.

An actor–network exists through its relations. Actor–networks are composed of nodes or actors that are connected by relations and it is these relations that are making the actors act. In holding a relational view of the

world, an ANT sensibility explores the assembling of relations between both human and non-human actors, since the different actors are formed and shaped by relations (Law 2007; Law & Singleton 2014). Actor–network theory breaks down the division between structure and agency (Callon 1986; Law & Singleton 2014). According to Latour (2005) a network is a concept, not a thing, and not necessarily a shape and may thought of more as a form of spatiality that constrains the number of possible relations (Law 1999).

Several ANT concepts that guide the analysis are explored below: translation, realities, matters of concern, fluidity, and the relational. These are 'slippery' concepts that receive different treatments by different authors over the course of their appearance as part of the ANT sensibility (Baiocchi, Graizbord & Rodrigues-Muniz 2013, p. 330; see also Mol 2010a).

Translation

Translation is understood as a process that turns or changes one thing into another, yet makes allowance for complexity, flux and the messiness of practice (Law 2004). The study draws on the concept of translation to shed light on how policy, or the vision of the HealthOne model of care, was enacted in practice. Rather than assuming that a policy enactment will be framed exactly as the policy intended, or else cast as a policy failure, the ANT notion of translation makes room for adaptation to realities that are encountered in the work of enacting policy in practice. Chapter five, the first of three chapters of research findings, provides a picture of the translation of policy into practice by answering the research question: What were the realities of enacting the HealthOne model of integrated care? The study explores how the model of care was translated into practice and displaced by multiple realities, in order to reveal how practice with HealthOne clients was being transformed.

The notion of translation highlights the ongoing occurrence of transformation and of continuing movement over time (Callon, 1986; Latour

2005; Nicolini 2010). In an early work, Law (1999, p. 8) noted that the use of this concept had already somewhat disappeared. However, it features in later ANT in explorations of innovation, where translation is understood as transformation and displacement. For instance, Stoopendahl and Bal (2013) use translation to describe the process of innovation in quality improvement practices as an activity of displacement. Jacka (2007) explores cultural change at the Australian Broadcasting Commission as translation. Jacka describes the change as a process of displacing 'one program of action into another program of action', that occurred 'not by tectonic shifts or major structural changes, but by the endless flows and realignments of the networks' (Jacka 2007, pp. 56, 63). As ANT theorists note, the process of displacement and transformation can be precarious, insecure and susceptible to failure (Callon 1986; Law 1999, 2007) for translation can produce resistance, reactions, and contradictory interpretation (Callon 1986; Nicolini 2010).

Chapter seven explores how integrated care was accomplished to answer the third research question. The chapter takes up Callon's (1986, p. 196) notion of translation as a process that is never a completed accomplishment. This draws out the continuing nature of transformation and displacement where activity is precarious and uneven, and resistance is encountered (Callon 1986). This ongoing process of translation is an effect of the lack of symmetry between policy and practice. Translation of policy into practice is interpreted as a process of negotiation where innovation is adapted to suit the actors involved (Stoopendahl & Bal 2013). While translation is a connection in the actor–network that transports transformation (Latour 2005, pp. 132, 108), there is a continual process of making and remaking the components in an actor–network (Law 2007). The concept of translation helps to make visible the transformations at different nodes in the network (Jacka 2007). Chapter seven argues that in the

HealthOne case the actor–networks associated with the policy's clients were transformed through particular actors acting as mechanisms of integration.

Realities

A central focus for ANT has been how realities are enacted in practice, and hence the first research question explores this in relation to the HealthOne model of care. The ANT notion of ontology, or of reality as 'what is', challenges traditional social science, for ANT scholars consider that reality takes form in enacting practices (Law 2004, 2007). Early ANT studies presumed that enactment would generate a single reality, a single actor–network, that is, a singular ontology (Law 2007, p. 13; 2008). However, Mol (2002) posited that there can be multiple realities rather than a single reality, arguing that multiple realities were shaped within multiple practices (Mol 1999, p. 75). Latour (2005) also took this view in his seminal work on the social, disputing that there was a single reality, as did Law (2004, 2007).

Later ANT studies extended the notion of multiplicity, allowing for multiple actors, practices and realities in multiple actor–networks at different times (Cresswell, Worth & Sheikh 2010; Law 2004, 2007). Not only was the world complex and messy, it was also 'ontologically multiple' (Law 2008, p. 637). This multiple ontology does not understand the world as 'specific, certain, definable and decided' (Law 2004, pp. 24-25). Realities are social and material, yet they are uncertain and not fixed as one particular thing. Instead, realities take form in practices (Law 2004). It follows that if the practices cease, then so do the realities, for 'realities only exist in the practices that materialise them' (Law 2010, p. 178). An example of this in this study is that when the position of HealthOne liaison nurse for clients with complex and chronic conditions was vacant, the work of HealthOne with these clients halted and the actor–networks dissolved.

Multiple realities can also interact and interfere with each other (Law 2004, p. 61). Just as Mol (2002) argued that atherosclerosis was not a singular disease in practice, this study argues that the model of care was enacted as multiple realities and practices rather than a singular reality. Chapter five illustrates the effects of the multiple realities that materialise in practices (Law 2010, pp. 177, 178), in adopting an ANT sensibility to explore the enactment of the HealthOne model of care. Tracing the effects of multiple realities shows that the model of care was enacted as a relatively unstructured form of integration.

Matters of concern

Chapter five draws on Latour's notion of matters of concern to illuminate the realities of enacting the HealthOne model of care. Multiple realities included enactments of uncertainty and absence, and these are traced as matters of concern (Latour 2005). In an ANT perspective, since realities are not fixed, decided or certain and instead are enacted in practice, their effects can be traced not as 'facts' but as 'matters of concern'. According to Latour, 'reality is not defined by matters of fact' but by 'highly complex, historically situated, richly diverse matters of concern' (Latour 2005, pp. 232, 237; see also Latour 2004).

In contrast to scientific facts and figures, matters of concern may dispute the facts, may be multiple, and show the realities of 'what the real world is really like' (Latour 2005, p. 117). Matters of concern take into account the impact of historical and contextual factors, contradictions and controversy. As Latour explains: 'When agencies are introduced they are never presented simply as matters of fact but always as matters of concern, with their mode of fabrication and their stabilising mechanisms clearly visible' (Latour 2005, p. 120). Exploring matters of concern yields rich and diverse insights into how realities are enacted and what mechanisms might stabilise them (Latour 2005).

In tracing distinctive matters of concern that encroached on the enactment of integrated care in the HealthOne context, these are unpacked as a multi-

factorial matter of organisational, client and job-related concerns. Thus rather than holding a positivist view, where benefits and outcomes of integrated care are foregrounded as quantitative measures as part of a scientific logic seeking matters of fact, an ANT sensibility takes a more pluralistic view to draw out matters of concern.

Fluidity

In the course of data analysis, I realised that attributes of flexibility and adaptability were significant in accomplishing integrated care. Realities were being enacted differently in different practices, and more varied versions of the model of care were being enacted. These notions resonated with the ANT concept of fluidity. In an ANT perspective, fluidity helps to interpret realities that are not fixed or neatly determined (Mol & Law 1994).

De Laet and Mol (2000) introduced the concept of fluidity into their account of the technology of the Zimbawe bush pump. Bush pumps were able to transform themselves from one arrangement to another by changing shape, adapting to and transforming actor–networks in which relations were not stable and boundaries were unclear. The pump's successes and failures were a matter of degree rather than achieving a clear-cut outcome, although overall it is suggested that the pump contributed significantly to the health and wellbeing of local communities by providing clean water. Aspects of the pump's fluidity were that it worked to some degree because it was malleable and could be adapted to local environments for its boundaries were not sharp or solid (de Laet & Mol 2000, p. 252; see also Law 2007). In this way, fluidity engendered transformation in practice.

The concept of fluidity is used in chapter seven to explore how two actors, HealthOne liaison nurses and case conferences, were intrinsic to the accomplishment of integrated care. The notion of 'fluid ways of working' has been used by Law and Mol (2011, p. 14) in relation to clinical veterinary

practices which were adapted to different locations and animals, variable testing methods, various stages of disease and so on. This suggested that actors were able to act in a variable, adaptable and inexact way (Mol 2010a, 2010b; Mol & Law 1994), depending on the actor–network with which they were associated. The notion of fluidity is a tool to analyse how relations were held together as changeable, flexible associations (Law 2007, p. 13, 14) in an enactment of integrated care.

The relational

The concept of relations is used to guide the analysis of the third research question: How was a model of integrated care accomplished in practice? Various terms such as associations, relations and assemblages, have been used to describe the notion of relations (Mol 2010a). A key tenet of ANT from its beginnings has been that the world, which is heterogenous, is relational, and that actions can be understood as the effect of relations (Law 2007; Law & Singleton 2014). This notion is central to an ANT sensibility and to practice (Law 2007; Law & Singleton 2013, 2014). ANT studies seek to explore the relational character of associations in actor–networks, how these form and how these hold together (Law 2007; Mol & Law 1994).

ANT holds that relations are how everything takes shape—people, the social, the material world (Law 2010). Relations can be material, that is, between objects or things, and can also form between actors such as ideas, words or concepts (Law 2007). An actor–network exists through its relations, for associations are paramount and actors are secondary (Latour 2005). As a sociology of associations (Latour 2005), ANT is most interested in how relations are assembled rather than in seeking rationales for this assemblage (Law 2007). To understand these relations, Law & Singleton (2014) argue that one needs to explore the practices and materials that shape the social, rather than reducing

relations to explanations of, for example, social factors, such as class, power or gender.

Singleton (2005) examined public health policy in practice to reveal the complexities of the relational and the tensions of enacting policy where relations have to be negotiated, made, and maintained. She argued that the complex, demanding relational work of making healthy citizens is invisible. I take up this idea in arguing how particular emergent, relational practices were not formally part of the HealthOne model of care, but important to its accomplishment. In chapter seven, I consider the activities of the HealthOne liaison nurses as relational effects that connect actor–networks associated with HealthOne clients. Since actor–networks were unstable, and many actors were resistant, I use the notion that relations must be constructed for the actor–network to hold together, and that this is not easy work (Mol 2010a).

Relations may shift (Law 2010), and Latour suggested that relational stability is momentary (Latour 2005, pp. 65). Relations and materials continue to shift, for they are connected at particular locations momentarily (Law 2008, p. 632). I use these ideas to explore relations in the HealthOne actor–networks, and how these hang together momentarily in different shapes in the HealthOne case conference.

Therefore, in using ANT in chapters five and seven to explore how a model of integrated care was enacted, I take 'enactment' to mean 'an occasion in a location, a set of actions with a series of effects' (Law 2000, p. 349). Rather than searching for causes ANT argues that it is the how, the relational and the effects that matter (Law 1999, 2007; Mol 2010a). Importantly for this thesis, ANT holds that all activities are 'relational effects' (Law 2007, p. 6), and that actors are 'network effects' (Law 1999, p. 5). An actor does not act alone (Latour 2005, p. 46). Instead in this relational view of the world, there is a network of relations making the actor act. Hence in chapters five and seven I consider the effects of

heterogeneous actors (human and non-human), and practices, and trace the assembling and reassembling of relations. I also indicate the multiple configurations of actors in webs of relations or actor–networks associated with HealthOne clients. Tracing the effects of these relations is what distinguishes an ANTish sensibility from other theorisations (Mol 2010a; Nicolini 2009). I draw on these ideas to analyse the HealthOne actor–networks' enactment of a form of integrated care.

Rationale for using two theoretical approaches in a study of practice

This study draws on complementary but different theoretical perspectives to explore an enactment of integrated care, since there is not a singular theoretical approach to practice. There are synergies between ANT and practice theory that support their applicability to the study of practice. These theories are broadly connected through their focus on social and material phenomena that emerge through practices. Both theories share an interest in connection and interaction between people and in the processes of collective action. They have other commonalities: for both theories, theorisation is oriented to dynamic, evolving activities in practice; and empirical research, largely ethnography, is central to theorisation. There is a joint recognition (more so in later ANT studies), that the social and historical contexts in which practices are located, shape these practices (Nicolini 2009, 2102; Schatzki 2002, 2005). Notably, practice theory accepts that the actions of humans as well as nonhumans contribute to the development of practices and practice-arrangement bundles (Schatzki 2012 p. 21), possibly influenced by ANT's notion of heterogeneity, which embraces both human and non-human actors.

ANT and practice theory both support an interest in practice and relations, and this study makes use of these notions in discussing how integrated care was enacted. Insights from ANT regarding relationality and materiality have more

recently influenced conceptualisations of practice (Feldman & Orlikowski 2011, pp. 1243, 1245). Schatzki pointed out that 'all social phenomena share the same basic ingredients—practices, arrangements and relations among them' (Schatzki 2012, p. 20), and later claimed that 'associations' (Latour 2005, p. 108) bore a clear resemblance to 'arrangements' (Schatzki 2015, p. 3).

Nevertheless, ANT is not generally regarded as a theory of practice. In making this distinction, Schatzki referred to the work of Callon and Latour as 'theories of arrangements', rather than practice theories, and pointed to areas that were not aligned (Schatzki 2002, p. xii). Earlier ANT scholars, for example, Latour (2005) and Law (2004), did not consider practice specifically, regarding it as an 'overused' term (Mol 2010a, p, 260). However, practice as the object of study was apparent from the beginning. The seminal work by Latour (1987) about opening the black box of science explored laboratory practices (Law 2007, p. 4). As early as 1999, Mol, in developing her notion of multiplicity, was referring to reality being done or enacted in a diversity of practices. Later ANT theorists also explored practices, shifting 'analyses from ideas to practice' where practices denoted 'situated events' (Mol 2010a, p. 260). More recent discussions of ANT as a theorisation give explicit attention to practice, for example Law (2010, 2012) and Law & Singleton (2014). Law (2012, p. 229) asserts that attending to practices is 'surely what Bruno Latour meant when he said that we should 'follow the actors' and Law has written extensively on the practices of foot and mouth disease (e.g. Law & Mol 2011; Law & Singleton 2014).

ANT presented tools that could not be met by other theorisations to explore an enactment of integrated care policy in practice for ANT appreciates complexity and messy practice. The multiple ontology of ANT attends to the emergent, the heterogeneous and the relational. Where a research question called for attention to practice change, the resources of Schatzkian practice theory on the emergence and persistence of practice, for instance, Price (2013),

Schatzki (2013), provided alternatives not offered by ANT or other theories. However, ANT and practice theory work well (Nicolini 2009, 2012, p. 180) in a complementary manner in this thesis to explain an enactment of integrated care.

I have built my argument on the strengths of each theory rather than synthesising them, so that resources from practice theory and ANT are deployed to explore different perspectives on the enactment of integrated care. 'Plugging' data into two different theorisations (Jackson & Mazzei 2011; Jackson & Mazzei 2013, p. 261) has enabled a fuller, multifaceted, and less mechanistic interpretation of integrated care in practice than could be achieved through a rigid analysis and the use of a singular theoretical tool to answer the research questions.

Conceptual tools used to explain practice

In analysing my findings, I begin by exploring policy in practice with an ANT perspective, turn to a Schatzkian exposition of practice change, and then explore with ANT tools how integrated care was accomplished in the workplaces in which the HealthOne model of care was enacted. The conceptual resources I have selected illuminate how practice was enacted through a model of integrated care from three different theoretical angles.

By drawing on the concepts outlined in table 3.1 below to answer important yet overlooked research questions, this study contributes original perspectives on integrated care in practice. These concepts have given a framework for theorisation of the empirical work that is taken up in later chapters. Through this, the study will help to make sense of what has been a confused and contested terrain.

In summary, the foundation for this study is practice. As shown in table 3.1, I have drawn on an eclectic set of concepts to explore the enactment of a model of integrated care. Concepts from both practice theory and ANT have been

employed as tools to cast new light on practices and to develop answers to the research questions.

Research question	Concepts	Theory
1. What were the realities of enacting the HealthOne model of integrated care? **(chapter five)**	- Translation (Callon 1986; Latour 2005; Law 2007) - Realities (Law 2004, 2007, 2010; Mol 2002) - Matters of concern (Latour 2005)	Actor–network theory
2. How was integrated care unfolding? (chapter six)	- Practice change (Schatzki 2002, 2005, 2013) - Intelligibility (Schatzki 2002, 2012, 2013)	Practice theory
3. How was a model of integrated care accomplished in practice? (chapter seven)	- Fluidity (de Laet & Mol 2000; Law 2007; Law & Mol 2011; Mol 2010a, 2010b; Mol & Law 1994) - The relational (Latour 2005; Law 1999, 2007, 2010)	Actor–network theory

Table 3.1 The conceptual framework

Conclusion

This chapter has explained how this study has drawn on two complementary theories to explore how the HealthOne model of integrated care was enacted in practice. Practice is central to this study, and in this chapter I have therefore argued for the benefits of drawing on two theories that have broad synergies and yet offer different resources for analysing practice in the complex health care context. I have suggested that using both theories offers advantages for the study of practice by allowing the study to foreground in turn very different aspects of integrated care practice in the making.

I have sifted through both ANT and Schatzkian theory to adopt concepts that supported the creation of new knowledge about enacting integrated care. With an ANT sensibility, I explore in chapter five how policy was translated into practice, and enacted in multiple realities. I consider the matters of concern that emerged in relation to enacting the HealthOne model of care. Then in chapter six, I draw instead on Schatzkian practice theory, to consider how integrated care was unfolding as an array of practices. Schatzkian

conceptualisations of practice change and intelligibility support my analysis. In chapter seven I explore how practitioners accomplished integrated care, for translating policy into practice called for deliberate effort in light of multiple realities illuminated in chapter five. I use the ANT notions of fluidity and relations to explain how integrated care was accomplished in practice.

The conceptual framework, which employs concepts from both ANT and Schatzkian practice theory, is a new way of working with existing resources that reframes existing modes of thinking about integrated care in practice. The framework for this study has drawn on an 'eclectic set of sensitising concepts' to explore the practices of a model of integrated care, since practice is a 'multifaceted and multidimensional phenomenon' (Nicolini 2012, p. 215). Having now established the theoretical approach of the study, the following chapter explains the methodology. ■

Chapter four

An ethnographic study of integrated care

Introduction

Chapter two gave an overview of the literature on integrated care, and identified gaps in the literature, in particular in relation to empirical studies explicitly based on theory. Chapter three reviewed two theoretical approaches that were selected to explain the practice of integrated care. This chapter outlines the methodological approach taken in the study, and describes the methods used.

This study aims to address a gap in the literature on integrated care, but also enact a theoretical examination of the field, and thus contribute to knowledge of integrated care as a theoretical construct. The study is not an evaluation of the effectiveness or outcomes of integrated care. Rather, it is an exploration of the everyday practice of integrated care, with a view to understanding how an enactment of integrated care policy was achieved.

The methodology for this study was developed to address the research questions, informed by analysis of methodological approaches in related literature, and refined in response to my early experiences of fieldwork as part of the 'Remaking Practices' research team. The study enacted a theoretically informed approach to the collection and interpretation of data (Leslie et al 2014; Savage 2000).

Orienting the study

This study was undertaken as part of a larger ARC project titled 'Remaking Practices' that aimed to explore practice change in primary health care through studying HealthOne, a NSW government health reform initiative. Policy documentation described HealthOne as a new type of service with integrated patient-centred care provided by multidisciplinary teams (NSW Health 2011c).

During the early fieldwork it became apparent that establishing core components of the HealthOne model of care was not straightforward. Each operationalisation of the model of care was different as it reflected local environment, clients and practitioners. HealthOne activities seemed to traverse acute care, primary and community care and social services. The workplaces in which the HealthOne model of care was being enacted were diverse, messy, and fragmented.

Rationale for methodology

In contributing to the objectives of the broader ARC project, my aim in this study was to explore the HealthOne model of care in practice. Since HealthOne as experienced during the early fieldwork was emergent and complex, my research design had to accommodate this. I aimed to extend the existing literature by exploring the realities of enacting integrated care through a qualitative study. My research aim to focus on practices could be best enacted through methods that allowed for multifaceted appreciation of the activities and arrangements related to clients and practitioners associated with HealthOne. As a qualitative methodological approach, ethnography afforded a means to study the diverse and everyday world of integrated care in practice across time and space. Ethnography invites fieldwork that has a closeness to practice, hence it was chosen as the approach for this study. The following section justifies further my methodological approach.

An ethnographic study of practice

The methodological approach for this study is ethnography. In the broadest meaning, ethnography is a qualitative enquiry into how people act and organise their everyday lives. Enquiry is conducted with a sensibility attuned to exploring and developing explanations through an engagement with theory (Leslie et al 2014; Waring & Jones 2016).

Although the term itself has been defined in various ways (Savage 2000), ethnography is an approach to research distinguished by methods of empirical enquiry producing rich, contextualised understandings. The strengths that ethnography offered are that it could capture 'emergent and habitual' practice (Hopwood 2013, p. 237), and it was 'capable of surfacing silenced voices, juggling disparate meanings, and understanding the gap between words and deeds' (Star 1999, p. 383). In other words, it did not depend on practitioners' accounts of what was important (Nicolini 2012). This approach to research relied on the researcher's close engagement with, and observation of care practices (Liberati et al 2015).

Ethnography responds to the challenge of exploring practices in organisations, communities and social groups, by 'studying phenomena in their natural settings' and by producing rich and subtle descriptions of actions, occurrences and contexts (Blomberg & Karasti 2013, p. 2; Forsythe 1999; Reeves, Kuper & Hodges 2008). As used in social science and qualitative research, ethnography is a theory-driven approach (de Laine 1997; Leslie et al 2014). While each ethnography has its unique conceptual frame and theoretical approach (de Laine 1997; Savage 2000), there is some constancy about the set of methods used by ethnographers. Data is produced through observation, interviews, conversation, and occasionally analysis of documents, and by immersion in the research setting. Interpretation of ethnographic data relies on an authentic, non-superficial absorption, a questioning of assumptions, and

thoughtful conceptualisation of the phenomena encountered (Forsythe 1999; Greenhalgh & Swinglehurst 2011). Moments of unexpectedness and unpredictability can be catalysts for key insights (Mills & Ratcliffe 2012). 'The power of ethnography as a research approach derives from use of the data-gathering methods together with the philosophical stance and the conceptual structure in which they are grounded' (Forsythe 1999, p. 129).

Widely used in health services research, studies of science and technology, computer supported cooperative work, organisational studies, and now the business sector, ethnography has moved beyond its anthropological foundations, and the divisions between North American, and British anthropological traditions. Originally social anthropologists favoured a period of extended fieldwork, such as that undertaken by Malkinowski and Mead (Caroll & Mesman 2011; Mills & Ratcliffe 2012). More recently, researchers privilege mobile, multi-sited ethnographies and sociologically-oriented ethnographies, with the temporal dimension becoming a primary feature of contemporary multi-sited ethnography, rather than location (Hine 2007; Marcus 2011; Mills & Ratcliffe 2012).

Empirical studies of integrated care have rarely used ethnography. In fact, detailed description of methods is lacking from many studies of integrated care (van der Klauw et al 2014). Where methods were described, interviews with professionals and managers were used frequently (e.g. Axelsson et al 2014; Curry et al 2013; Lewis et al 2013: Valentijn et al 2015b). Focus groups or workshops with clinicians and managers were also popular (e.g. Axelsson et al 2014; Curry et al 2013; Lawn et al 2014; Lewis et al 2013). Surveys were used in several studies (e.g. Looman, Fabbricotti & Huijsman 2014; MacAdam, 2011; Valentijn et al 2015b). Some reported using document analysis (Curry et al 2013) or content analysis (Harris et al 2013). Some studies indicated that quantitative

data analysis had been utilised (e.g. Curry et al 2013; Looman et al 2014; Valentijn et al 2015b).

Observation has seldom been included as a method in studies of integrated care. Exceptions to this include Curry et al (2013) where 50 hours were spent observing governance and multidisciplinary group meetings, and Lawn et al (2015) whose study of care planning included 56 observation sessions of consultations, group meetings and informal gatherings.

Ethnography in the workplace

Ethnography attends to the ways that the world is constantly re-shaped by practices (Mol 1999; Schatzki 2012). In recent organisational and health care studies, there has been increasing interest in understanding how 'real-time practices are carried out in the workplace' (Nicolini 2009, p. 1392). For example, there has been a growing interest in ethnographic studies of organisational practices (e.g. Bjørkeng, Clegg & Pitsis 2009; Hopwood 2014; Liberati et al 2015; Manidis & Scheeres 2012; Mol 2002; Orlikowski 2002; Price, Boud & Scheeres 2012).

Furthermore, ethnographic methods are well recognised in the health care services field (Liberati et al 2015) and have been used to study a diverse range of health care topics. Examples include studies of home care work practices (Abou Amsha, & Lewkowicz 2014); temporal coordination in surgical departments (Bardram 2000); culture and behaviour (Dixon-Woods et al 2013b); information technology (Greenhalgh & Swinglehurst 2012); collective learning in primary care teams (Greig, Entwhistle & Beech 2012); self-management by people with diabetes (Hinder & Greenhalgh 2012); patient safety (Dixon-Woods et al 2013a); safety and quality (Leslie et al 2014); and multidisciplinary team meetings (Robertson et al 2010).

The state-wide evaluation of the NSW Health Chronic Disease Management Plan used a mixed-methods approach, dominated by quantitative aspects.

However, the final report called for an ethnographic study to delve into 'some elements of the 'black box' of local processes / activities / approaches' (NSW Health 2014b, p. xxvii).

> Routine data collections will however never fully articulate some critical nuances of drivers of success in local innovation. Ethnographic and observational data – as used in the Aboriginal evaluation component – should be used to focus on elements such as leadership, how professionals and service users interact, and how work is re-organised in reality as opposed to on paper, and have the potential to offer valuable insight with more intense data collection and provide benefit in the unpacking of the 'black box'. (NSW Health 2014b, p. xxvii)

The evaluation report explained that ethnographic methods would provide a more nuanced understanding of the program's impact, reach and equity to integrate care for individuals living with chronic disease and complex health conditions.

An ANT ethnography

This ethnographic study of integrated care in practice was infused with an ANT sensibility (as explained in chapter three). In doing so, I applied the theoretical repertoire of ANT by seeing, hearing and engaging with the world of HealthOne without a predetermined analytical framework or hypothesis (Callon 1986; Mol 2010a). This meant that my way of exploring realities and practices was attuned to the unspoken, the absent, the uncertain, and attended to tensions and sensitivities (Mol 2010a). My intention was to explore how multiple individuals enacted integrated care in practice:

> to catch up with their often wild innovations in order to learn from themwhat the collective existence has become in their hands, which methods they have elaborated to make it fit together, which accounts

> could best define the new associations that they have been forced to establish. (Latour 2005, p. 12)

I was not searching for 'causal explanations' for outcomes, or seeking to prove hypotheses and causal effects (Law 2004; Mol 2010a, p. 257; Somerville 2008). Drawing on the principle of following the actors (Latour 2005, p. 12) through ethnographic fieldwork provided the answer to my initial research dilemma of how to grasp the model of care and its practice. Such an approach to studying practice, termed by Mol as praxiographic, required me 'to take objects and events of all kinds into consideration when trying to understand the world' (Mol 2002, p. 158).

Ethnography is the usual choice for researchers using ANT, with theorisation woven into ethnographic accounts of fieldwork (Law 2012). Although the ANT diaspora has spread through developing relational conceptualisations as explained in chapter three, it is an ANT tradition to develop theoretical insights and make theoretical arguments through empirical case studies 'by integrating theory with empirical practice' (Law 2007, 2012, p. 225; see also Law & Singleton 2013, 2014). Ethnography is often regarded as the 'natural' method of choice for ANT, by facilitating deeper and more subtle engagement in the field (Baiocchi, Graizbord & Rodríguez-Muñiz 2013; Nimmo 2011). Ethnographic studies have consistently been used by ANT followers from the earliest days, for example, Callon (1986), Latour (1987), Singleton and Michael (1993), Mol and Mesman (1996). There are many empirical studies of health care employing an ANT sensibility and ethnographic fieldwork, such as Broer, Nieboer and Bal 2010; Bruni 2005; Cresswell, Worth and Sheikh 2010; Law and Singleton 2003, 2005; Mol 2002; Mol and Law 2004; Singleton 2005; Singleton and Michael 1993; Stoopendaal and Bal 2013.

Methods

Appreciating the multifaceted nature of practice through ethnography entails the use of multiple methods (Nicolini 2009; Schatzki 2012; Waring & Jones 2016). Schatzki (2012 p. 25) argues that to investigate practice, 'there is no alternative to hanging out with, joining in with, talking to and watching', that is, through an ethnographic approach. Therefore, to create a rich account of the emergence of the HealthOne model of care and to explore how practices were enacted, the following methods for data collection were used: observation of meetings, shadowing of key practitioners, semi-structured interviews, and collection of documents.

Observation

Observation, as an ethnographic approach, involved the collection of data through focusing on study participants interacting during an event or discussion, without engaging with participants through questions or conversation. To study integrated care in practice, it was more important to observe people engaged in their everyday activity, rather than to rely on interview responses (Forsythe 1999; Nicolini 2012). The actual doings and sayings (Schatzki 1996, 2012) of practices associated with HealthOne, and the 'messiness of organisational life' (Quinlan 2008, p. 1483) were of more interest than what was said in interviews about what was done through HealthOne. There were many opportunities during the fieldwork to observe a range of governance, planning, staff and clinical meetings.

Shadowing

A major component of the ethnography was the shadowing phase, with data gathered from 'actual events rather than reconstructions' through interviews or discussions (Quinlan 2008, p. 1482). Shadowing involves following practitioners during 'the course of their daily events and observing and conversing with them when possible without disrupting their normal flow of activities' (Liberati

2016). Shadowing centred on following two practitioners from HealthOne Corymbia, the liaison nurses, as the avenue into the practice of integrated care. This allowed the study of how the model of care was enacted 'through interactions in everyday situations' (Vásquez, Brummans & Groleau 2012, p. 145).

Interviews

Twenty-two semi-structured interviews were conducted as part of the initial research phase for the broader ARC project. During a face to face meeting, interviewees were asked to answer a consistent set of interview questions that focused on issues central to the ARC research objectives. The interviews were a means of ascertaining the views and understandings of practitioners and managers connected with HealthOne (de Laine 1997). Hence the data collected in this way represented individual experiences and opinions about HealthOne. From a practical perspective the interviews served the research team's needs for a sensitising tool and acted as a pragmatic introduction (de Laine 1997) to the settings, interactions, practitioners and complexity associated with HealthOne.

Document collection

While the 'messiness of practice' (Law 2004, p. 18) was relatively invisible during interviews and in formal documentation, documents were part of the materiality of HealthOne. During the fieldwork, I collected over 140 documents and took a small number of photographs as a way of attending to objects and information artefacts associated with the model of care. The production and exchange of documents was a dominant feature of everyday practice, and the multiple brochures and meeting papers were primary sources of 'official' information about past, present and future activities. These documents constructed 'particular realities' about health care practice (Law 2004, p. 21) and some were key reference materials for this study.

Data collection

This study evolved through extended, multi-sited, mobile ethnographic fieldwork (Hine 2007; Marcus 2011; Mills & Ratcliffe 2012; Vasquez, Brummans & Groleau 2012), where the multiple participants were dispersed in time and space. HealthOne activity was not restricted to a particular location. Hence there was a continual juxtaposition between extreme mobility (when events took place outside the HealthOne office), and extreme immobility (in the office). At most time points during the fieldwork, in following the actors associated with HealthOne, I crossed organisational boundaries, both virtually and in reality. For example, the shadowing fieldwork began each day at the community health centre when I entered the small HealthOne office. However, each day would unfold differently, depending on the liaison nurse's planned activities that day. These covered many diverse locations across western Sydney including hospitals, general practices, outpatient clinics, clients' homes, health service, offices, meeting rooms, cars, shopping centres and cafes.

Fieldwork boundaries were as fluid as the patient trajectories and activities associated with HealthOne. On one occasion the fieldwork crossed the borders of western Sydney to another health district for a joint meeting between HealthOne liaison nurses. The interviews were conducted in the interviewee's workplace or office and these were not usually co-located with a HealthOne site. I therefore encountered varied events, locations and practitioners. A broad range of professionals participated in this study as Table 4.1 demonstrates, including staff from community health, acute care, allied health, multicultural health, general practice, and social care organisations.

This study also entailed 'direct observation' of practitioners and shadowing of liaison nurses in their working environment over time (Leslie et al 2014, p. 100). Sporadic encounters with HealthOne during an extended time

enabled observation of developments and changes in practice that unfolded temporally as well as spatially (Marcus 2011).

The field site as an 'unbounded' space of 'possibilities' (Blomberg & Karasti 2013, p. 389) allowed for ethnographic study of complex practices. It was rich with opportunities to explore the enactment of integrated care. There was 'nevertheless a matter of careful, conscious method' (Forsythe 1999, p. 131). I entered the field with a focus on practice, choosing methods for their appropriateness to collecting a dataset for empirical analysis of integrated care in practice. 'If one wants to learn about the nature of [these] fluid innovative care practices, methods sensitive to this fluidity are needed' (Pols 2010, p, 188). In the next section I discuss these methods in detail.

The entire fieldwork took place over a period of 21 months, from September 2011 to June 2013. This extended fieldwork allowed observation of practices 'over time and in different settings' and the gathering of interview, shadowing and observation data regarding the same individuals, as a triangulation of data (Forsythe 1999, p. 138). In total, 60 professionals were study participants and 6 community health clients were encountered in person.

To explore practice, I carried out almost 160 hours of shadowing on 22 randomly selected days from Monday to Friday from September 2012 through to June 2013. I also collected many hours of audio recordings while in the liaison nurses' office, as 46 separate files. As part of the 'Remaking practices' team's study of HealthOne, I conducted twelve semi-structured interviews with health care practitioners and health service managers, in collaboration with other team members. I collected over 140 documents. During the entire fieldwork, I observed 22 meetings regarding HealthOne held in relation to workforce development and governance including staff meetings and steering committees, as well as eight case conferences or case reviews.

Method	Participants	Title	Discipline	Workplace
Shadowing, Interview	2	Liaison nurse	Child and Family Health Chronic, Aged and Complex Care	HealthOne Corymbia, HealthOne Angophora
Interview	1	General Practitioner	General Practice	HealthOne Angophora
	1	General Practitioner	General Practice	Private practice
	2	Practice Manager	Not applicable	Healthone Angophora
	2	Senior Manager	Not applicable	Local Health District
	8	Manager	Child and Family Health Chronic, Aged and Complex Care	Community health
Interview, Observation	3	Liaison nurse	Child and Family Health Chronic, Aged and Complex Care	Healthone Corymbia and Angophora
	1	Clinical Coordinator	Child and Family Health	Community health
Observation	4	Liaison Nurse	Child and Family Health Chronic, Aged and Complex Care	Various HealthOnes
	5	General Practitioner	General Practice	Private practice
	7	Multicultural health worker	Various	Community health or acute care
	1	Clinical Coordinator	Complex, Aged and Chronic Care	Community health
	8	Allied Health Professional	Social work, speech pathology, dietetics or psychology	Community health or acute care
	4	Nurse	Clinical Nurse Consultant or community health nurse	Community health or acute care
	7	Case worker	Social care	Various organisations
	4	Various	Not applicable	Medicare Local or Local Health District

Table 4.1 Professionals participating in the study

To explore how practitioners went about integrated care in practice, I chose to concentrate on shadowing the liaison nurses at a HealthOne site in metropolitan western Sydney. This took place over an extended period since

studying practice requires 'considerable 'participant observation'' (Schatzki 2005, p. 476; see also Nicolini 2012). Those randomly selected days of ethnographic fieldwork from spring 2012 to winter 2013 helped me to grasp a sense of the tasks, settings, arrangements, interactions and efforts involved in enacting integrated care for people with complex health needs.

Observation

The observation carried out during this fieldwork was overt, and consisted of attending meetings, including steering committees, clinical working parties and staff meetings. Since the numerous participants at these meetings were infrequently encountered in situations out of context to their usual daily activity, it was possible that this overt observation had an impact on usual interactions and practices.

There may be several types of observation: setting-oriented (space, furniture); person-oriented (from the perspective of a particular person or role); task-oriented (from the perspective of practices); and object-oriented (practices connected with the object) (Suchman et al 1999). To capture the embodied and material nature of practice (Hopwood 2013), I undertook observation from both a person-oriented and a task-oriented perspective. I also observed from an object-oriented perspective, with attention to information technologies and artifacts. 'Delineating the object of study' in this way does risk privileging some actors and marginalising others (Vásquez, Brummans & Groleau 2012, p. 149). However, in undertaking this research, I did not commence with a fixed sense of searching for particular practices, but remained aware of elements of spatiality and relationality.

Shadowing

My suggestion at an interview with one HealthOne liaison nurse that I would like to spend some time shadowing her during her work was received positively, without resistance. This is possibly because shadowing has been

commonly used as a training exercise in health care to learn how to do a particular job, a fact that was mentioned in an early interview (interview August 2013; Quinlan 2008). During my fieIdwork, I shadowed one liaison nurse working in child and family health, and another working in chronic, aged and complex care. Both were based at HealthOne Corymbia. At forums and meetings, I also encountered several liaison nurses working at other HealthOne sites.

Shadowing the liaison nurses offered a tangible point of connection to the practices of the HealthOne model of care in the study settings. Although shadowing has been used in organisational and social research, this method was not widely described or debated in the literature until recently (Czarniawska-Joerges 2007; Czarniawska 2014; Gill 2011; McDonald 2005). It is a 'research technique which involves a researcher closely following a member of an organisation over an extended period of time' (McDonald 2005, p. 456). Shadowing involves following someone closely to note what they do, rather than relying on talking about doing, and is especially suitable for research intent on exploring practices (Schatzki 1996, 2012) and social relations (Quinlan 2008). Thus I followed the day-to-day activities of liaison nurses as they worked and interacted with GPs, community health nurses, hospital staff, clients, carers, and other practitioners associated with HealthOne.

Much of the shadowing involved either sitting in meetings and presentations or attending case discussions or conferences, aiming to be 'flexible and unobtrusive' (Forsythe 1999, p. 128). Unlike the shadowing method proposed by McDonald (2005 p. 456) who asked questions to 'prompt a running commentary' and wrote a 'continuous set of field notes', I generally sat quietly in the background and avoided asking questions or being part of the activity, engendering 'conspicuous invisibility' (Quinlan 2008, p. 1491), relying on the audio files and making notes in the red notebook to inform the full set of data

(Czarniawska 2007). Given my professional experience in taking notes of meetings, these notes captured much of the conversation during meetings or discussions. At times however, I chatted with the liaison nurses; this was data that we co-created (Quinlan 2008), that was also included in the field notes.

The office in the community health centre, in which the two liaison nurses were based, was tiny. It contained three desks and shelves of books and folders on the walls above desks. My vantage point was often from the third desk. Activities undertaken here were primarily based around computers, phones or folders, with occasional visits from practitioners. The activities involved pool cars, powerpoint slides, computer screens, pens, mobile phones, ring binders full of papers, sign in sheets, and patient notes, and very little to do with instruments and procedures of health care.

However, the shadowing also involved 'fieldwork on the move' (Czarniawska 2007, p. 20), that is, travel by car or foot to an appointment or meeting, a time where I often talked more informally with the liaison nurses about their work. Notably the shadowing involved considerable contact with multiple other practitioners. This meant that the 'particular twosome' (Czarniawska 2008 in Vasquez et al 2012, p. 149) created by shadowing, was often mediated by multifaceted interactions beyond the twosome.

Cultivating trust with the HealthOne liaison nurses was importance to maintain their support for the research, as was maintaining a balance between friend and stranger; informed insider and objective outsider (Hammersley & Atkinson 1995). Although I disclosed that I had worked in health policy for some time, and did not have clinical training, I did not provide detailed information about my research interests or personal or professional background. I made an effort to maintain impartiality and objectivity, whilst being open enough to encourage reciprocal honesty. More than once, there were times when the liaison nurses that I shadowed asked for advice about their

work, and occasionally, the conversations and questions veered from the professional to the personal realm. Spending a full eight-hour working day with someone of the same gender, similar age and professional interests lent itself to a certain familiarity over time, particularly as some of us had attended high school in the same locality. This distance and yet closeness is a feature of the co-creation of the shadowing relationship not shared with other qualitative methods (Gill 2011; Quinlan 2008).

During this research, the clinicians whom I shadowed were welcoming and inclusive, and I was able to attend all meetings, events, activities and consultations. There were only two occasions when I was excluded; these were when a liaison nurse met with a line manager or with human resources. However, some would posit that the extended duration allowed me to become less obtrusive (McDonald 2005), and that it gave the 'shadowee' a source of insight and sense-making not available otherwise (Vasquez et al 2012). Indeed, one liaison nurse commented at governance meetings that this research had offered her that opportunity.

There were, however, circumstances when I veered from unobtrusive ethnographer to participant, for instance, the liaison nurses' annual planning day, which occurred about mid point of the shadowing. I suggested that we work on an agenda together, and that it might include an analysis of strengths, weaknesses, opportunities and threats associated with the HealthOne model of care. I also co-wrote an article on HealthOne with three clinicians, which involved several meetings to discuss the article (Hanley et al 2014). These co-creations of data were motivated by my curiosity to explore how the liaison nurses worked together, and were also a means of testing my evolving account. Rather than watching HealthOne model of care being enacted, my intention on these occasions was to observe discussion on how it was done. I recognised that I was momentarily disrupting my ethnography since 'the ethnographic study of

practices does not search for knowledge in subjects who have it in their minds and may talk about it, instead, it locates knowledge primarily in activities, events, buildings, instruments, procedures and so on' (Mol 2002, p. 32).

Interviews

Many studies from the literature on integrated care reported the use of interviews with professionals and managers. In comparison, I chose to concentrate on shadowing the liaison nurses during daily activities to explore how integrated care was enacted. My empirical analysis was thus derived largely from 'situated inquiry' (Law 2004, p. 3), through the observation of practices and shadowing of key practitioners associated with HealthOne. Interview data has been included in my analysis as a useful adjunct, for example, to demonstrate how individuals made sense of HealthOne.

The interviews were approximately one hour long and usually held with one individual in the participant's workplace. Some people were interviewed twice or as part of a small group. The interviewees were selected because they worked at one of the HealthOne settings in this study or because they were associated with HealthOne's governance in the Local Health District. Participants in these interviews were often managers or senior managers. As Table 4.1 demonstrates, only eight of the 18 interviewees actually worked at a Health One site.

The interview questions were determined prior to the interview, by the 'Remaking practices' research team (see appendix 3), hence the responses although open-ended were constrained to the topic and quite general. However, at times, there were deviations from the fixed interview schedule to ask follow-up questions, as probes. All interviews were recorded using a digital recorder, and then transcribed by a commercial service prior to analysis.

There is an essential step in any ANT study whereby the account of the study is provided back to those who have been described in the study, in order

to 'check how an account plays its role of assembling the social' (Latour 2005, p. 135). During this study, the research team presented their account to research participants on three occasions and invited their responses and concerns as a means of testing the evolving findings. I have also included this data in my analysis as a valuable resource providing access to practitioners' interpretations of the researchers' impressions.

Document collection

Prior to the fieldwork I undertook a review of organisational websites in relation to the HealthOne model of care. These resources served as foundational material in this research, for example, a NSW Health website outlined the principles of HealthOne (NSW Health 2011b; NSW Health 2011c). However, these sources provided only limited documentation directly relating to practice. It was not until late September 2012, on my second day of shadowing, and one year after commencing fieldwork, that I gained access to a copy of the HealthOne model of care (NSW Health 2011d) and also some historical information about HealthOne.

Notably, policy and procedure documents, business plans, or organisational charts were generally unavailable, while copies of internal reports and position descriptions were seldom available. Many of the documents collected during the fieldwork were meeting agendas and minutes, meeting reports, powerpoint presentations, or information brochures. There were also various forms or templates. Most of these documents were emailed, or distributed at meetings. Public information brochures were often found in reception areas.

A considerable amount of information was generated and distributed about HealthOne during the fieldwork, and its function was largely to present a formal organisational view of HealthOne. A handful of action plans for particular HealthOne clients suggested prospective activities. The effects of these documents on day-to-day practices seemed transitory and minimal.

Although I gleaned some useful information from the copious number of documents, only a few of these documents have figured in the data analysis. However, their very existence points to the importance to health practitioners of creating and sharing these objects as documentation about activities.

By October 2013 I had attended 30 research team meetings to discuss progress with the 'Remaking practices' study and our approaches to and understandings of the data. Notes of these meetings have informed my reflexive writing account, rather than being formally incorporated as data sources for my analysis.

Limitations of methodology

The shadowing phase of the study was reliant on access to HealthOne activity as afforded by the liaison nurses' good will and availability. My presence may have had some effect on the routine and activities (Gill 2011; Quinlan 2008). Although I cultivated trust with the liason nurses, and was rarely excluded from activity, there is a likelihood that the researcher's overt presence had an impact on interactions and practices. I became aware that the liaison nurses arranged case conferences for days I would be present, when they learnt I was interested in these. It is possible that the interviewees' accounts and the shadowing data were coloured by participants' subjectivities, level of commitment to the HealthOne model or a desire to present a positive picture of the model.

The 'Remaking Practices' research received clear support from senior health management and one chief investigator was a policy specialist from the Ministry. However, there may have been circumstances and situations associated with HealthOne that the researcher did not encounter. The data for this study was collected over many months on many different dates and days for shadowing were randomly selected by the researcher and then confirmed with the liaison nurses. A phase of continuous shadowing may have harnessed

new data. However, the liaison nurses often reflected on their activities and this may have reduced the risk of missing data.

The clients' experience and health outcomes from their HealthOne enrolment were not explored as part of this study. Interviews were not conducted with clients or with local general practitioners. The interview sample consisted of a range of practitioners and managers closely associated with HealthOne activity or its governance. This sample did not include the broader population of professionals encountered in the study settings whose clients were in contact with HealthOne.

Due to time constraints, the study did not achieve an intended goal to collaboratively consider final findings with key participants and to reflect on their impressions of the findings. Although the research team presented preliminary findings and discussed these with community health managers, the findings from this study were not tested with participants at the conclusion of the study. A complicating factor was that many key participants had moved to other roles and organisations by the end of the study.

The study settings, the cultural backgrounds and complex health needs of clients as well as the local social care and health service arrangements gave a particular character to this research. The model of care and its practice was evolving in the two study sites. Given these contextual factors and the broader structural and policy reforms, the study's location, timing and policy context were specific. The data and findings may not be representative of all HealthOne sites, or of a different timepoint in HealthOne's evolution.

A contemporaneous evaluation of another HealthOne (McNab, Mallit & Gillespie 2013) yields some insights into improved health outcomes achieved for clients with complex and chronic conditions. However as demonstrated in the literature review in chapter two, there are calls for new ways of thinking about how integrated care is achieved. This study has chosen a theoretically informed

methodological approach with methods that supported the collection of a rich descriptive dataset. In the following section I describe the process I used for creating and managing the qualitative data collected during this ethnography.

Documenting data

> The best way to proceed … is simply to keep track of all our moves, even those that deal with the very production of the account … from now on everything is data … The first notebook should be reserved as a log of the enquiry itself. This is the only way to document the transformation one undergoes by doing the travel. Appointments, reactions to the study by others, surprises to the strangeness of the field, and so on, should be documented as regularly as possible. (Latour 2005, pp. 133-134)

In keeping with the ANT sensibility and following 'ethnographic techniques of observation and writing' (Mol 2002, p. 158), I decided to gather data from my fieldwork in the following documents: a log of the enquiry; a chronological record of data; and a reflexive journal about the research (Latour 2005). During the fieldwork I created handwritten notes in small notebooks. I then transcribed these into the chronological record as soon as possible afterwards. The log of enquiry was often created on the train journey home, or soon afterwards, and is about one third of the length of the chronological record. This is where I documented the surprises, the reactions, the uncertainties, the confusion, and the highlights of the day's fieldwork. My 'learning journal', in which I kept a record of daily activities including reading and discussions during the doctoral candidature, became a forum for ad hoc thoughts, ideas and questions as I thought about the research. In effect this became my reflexive journal, which often triggered further reading, analysis or interpretation.

However, I did deviate somewhat from the format that Latour (2005) advised in that I also maintained a spreadsheet, in which to record summary

data, for instance, about where I went, a descriptor for that day, who I encountered, the meetings attended, and the start and finish time of observation. I also recorded when, what and how the documents emerged during the fieldwork. I recorded separately the names of those who gave informed consent and where this occurred. Much of the observation and shadowing were also audio recorded, and I listed the 46 audio files in this spreadsheet.

Bearing in mind Latour's admonishment that keeping track of my moves by creating these documents should not allow for 'some narcissistic indulgence' (Latour 2005, p. 133), the log of the enquiry provided a place to record my sensations, recollections and impressions. To offer a flavor of this data, I include below two extracts from this log that were written after a day of shadowing, November 30 2012, as described below.

> *November 30*
>
> *[extract 1] Another busy day at H1, including a trip at 11am with Tina [liaison nurse] to Corymbia Central for World Disability Day 'don't dis my ability', a visit at 1pm to a GP at … (corporate practice) with Kelly [liaison nurse], a home visit at 2pm (with Tina and Deanne, the community health nurse) to a H1 client with a newborn baby, and a discussion (in the room where Tina takes a break for tea at 4pm) with Julie and Tina about writing an article for … [professional journal] on H1.*
>
> *[extract 2] Following Ned's advice to look for the most boring thing and follow its trace, I did but nothing leapt out as boring. Well the most boring thing is waiting for the train at the station in the heat at 5.30pm after visiting the pastry shop, and also listening to the GPS telling Tina how to get to the client's house somewhere off Main Road in the next suburb. I listened into a number of phone conversations around the cancelled GP visit including one to the client, who seemed evasive, and several to locate Julie (who was also going to the GP).*

> *The most boring thing in the office are the email lists. I did notice Tina's folder of Safe Start patients with a row for each client with brief comments. I need to find out more about this.*
>
> *It was extremely hot today. I am tired but not completely shattered. I mainly took notes and had the tape on in Tina's office. The last discussion of the day in the tea room with Julie and Tina was interesting, about writing an article on H1 and about the job. Julie said something like 'you warm to this area'. But Julie has a new job to go to early next year (details unclear) but sounds like a promotion in the LHD.*
>
> *Tina didn't get time to put her stuff on CHIME today and will have to do it on Monday (we were out a lot of the day—Corymbia plaza, visiting Dr A, having a coffee break while Tina made phone calls, visiting the GP, visiting a HealthOne client). I want to look at CHIME again and review some patient stories now I know about a few H1 clients.*

Having described my processes for creating and managing the dataset, I turn now to a discussion of my approach to data analysis.

Data analysis

The ethnography generated a large body of data which afforded rich opportunities for analysis. I favoured a close absorption in the data, being open to what I might find when I let the data speak, rather than utilising a very structured, static categorisation and coding of data based on a pre-existing conceptual framework. As Quinlan (2008, p. 1483) recognised, shadowing can produce an 'overwhelming amount' of 'rich descriptive data' and 'the subsequent analysis requires considerable time and effort'.

The chronological record contained over 58,000 words and was 109 pages in length. By the end of the fieldwork, the log was almost 22,000 words and 35 pages in length. I had 44 pages of data from my transcription of 32 audio files recorded during the shadowing phase, which was almost 44,00 words in length.

In addition, I had collected numerous types of documentation related to HealthOne. I also had access to 22 interview transcripts, as part of the broader ARC study.

While coding software tools were visually appealing, and I experimented with them briefly, I did not use software for the data analysis. I considered that these would detract from my intention to understand practices enacted through activities and associations rather than as 'articulated in words and images and printed on paper' (Mol 2002, p. 32). Thus, I allowed the empirical and theoretical analysis to unfold together. Conceptualisations and understandings of integrated care practice arose in the space between data and analysis through various wonderings across this space and various iterations that 'combined in multiple assemblages of meaning' (Somerville 2008 p. 212). This iterative process developed a nuanced and multilayered understanding of the complex phenomenon of integrated care as called for by the research questions.

I describe below the progress of my data analysis that evolved over several months from August 2013 until June 2014, after completion of the fieldwork in the middle of 2013.

The data analysis process

This evolving process allowed theorisation and data analysis to work together to answer the research questions. There were a number of stages to this process, which followed the conventions of qualitative data analysis: reduction of data, display of data, and drawing conclusions (Holloway & Wheeler 2013; Miles & Huberman 1994). The ensuing conceptual framework, which deployed various conceptual resources from practice theory and ANT, was the subject of the previous chapter.

My engagement with the data was a selective, inductive process, funnelling from broad themes to an eclectic toolkit of concepts (listed in table 3.1). This was a subjective process, influenced by my professional background and interests,

memorable impressions from the fieldwork, the immediate resonance of the ANT literature, and a steady engagement with Schatzkian practice theory. My intention was to uncover integrated care in practice. I did not begin with hypotheses. Based on practitioners' doings and sayings, my dataset was an 'emic' account of the HealthOne model of care which became a researcher-imposed 'etic' approach to integrated care (Miles & Huberman 1994). While some readers could suggest that my interpretation was shaped by my biography and professional background, I carried out a transparent and extensive process of data analysis that was informed and underpinned by two complementary theoretical framings of practice. Thus discerning patterns in the data from which I inferred theoretical explanations rendered answers to my research questions.

Initial data analysis

To commence the analysis, I 'used a traditional approach of immersion in the text through repeated reading' (Hinder & Greenhalgh 2012, p. 87) in order to engage with what the data was telling me (Srivastava & Hopwood 2009). While 'mindful of the purposes' of this study and the theoretical lenses I was 'training on it', I was open to discovering unexpected ideas and concepts (Miles & Huberman 1994, p. 56). An earlier analysis in March / April 2012 for the 'Remaking practices' study focused on coding interview transcripts to identify themes, issues, questions, inconsistencies, patterns, and confusions. This approach had revealed how many potential avenues the data analysis could take.

Initial advice on how to do data analysis came from Latour (2005, p. 134), who advised that if I collected my data from the enquiry in a chronological record, I could 'dispatch them into categories which will evolve later into more and more refined files and subfiles'. Latour noted a preference for rewriting data on cards, however, the element I was influenced by was the reshuffling 'in

as many arrangements as possible … to become as pliable and articulate as the subject matter to be tackled' (Latour 2005, p. 134).

I began by developing some preliminary analysis and ideas about the data in the chronological record. By thinking about the data in the chronological record in a broad way highlighting ANT elements, and actors, rather than focusing on word-by-word or line-by-line analysis, I started to shuffle my data into arrangements. This analysis led to a presentation to a group of doctoral students in October 2013 where I introduced my findings in terms of the disruption between the vision and the realities that emerged in enacting the HealthOne model of care. Looking at the data with an ANT lens brought the absent, the invisible, and the multiple realities (Law 2007; Mol 2002) to the fore. These concepts were further developed as part of the first findings chapter, chapter five.

Subsequently, I carried out a process of immersion and review of the reflexive journal, and the log of enquiry, looking for themes and shifts in understanding. Through this process of reduction, I created a timeline of my understandings and questions about the data. The shuffling of data continued as I turned to code data in the chronological record by selecting 'some provisional analytical categories' (Hinder & Greenhalg, 2012, p. 87; see also Miles & Huberman) to tease out themes that emerged from this immersion. The resulting, unrelated mix of concepts from the literature, and elements associated with HealthOne, was as follows: collaboration, coordination, communication, cross organisation work, service oriented care, practitioners' role, information technology, information, governance, and new practices. These were high-level themes and a first pass in my effort to organise the data more broadly across the dataset.

Another major body of data that I grappled with in the first phase of analysis was the audiotapes. During this phase, I personally transcribed 32

audio files, as a means of absorption in this data source. Most audio files were transcribed in full. I chose not to transcribe some sections, for example, where practitioners disclosed their personal information, or where the chronological record had captured a complete account. However, I did not transcribe all 46 files, judging by the time I had completed the majority that the same stories and themes were repeating.

Practices began to emerge from the data analysis, and I drew out a preliminary categorisation of past and new practices. Remade practices as a concept also came to light in the review of the log of the enquiry that provided the example of the HealthOne case conferences. This early conceptualisation remained significant throughout the data analysis, and was further developed for the second findings chapter. However, it was not possible to draw conclusions until the last phase. In the meantime, the reflexive journal served as a place to work with the evolving analysis, and to track the steps in my data analysis.

Second phase of data analysis

The next step was to write an account of the study, according to my research aim, questions and theoretical interests (Srivastava & Hopwood 2009). Many of the themes that I noted in the log of inquiry from the beginning of the fieldwork and shuffled around in the continual process of thinking my way into the data, made their way into this analysis. I created extensive pieces of descriptive writing about caring for complex clients through the HealthOne model of care. This writing assembled chronological fragments of the work of the liaison nurses to consider how the emergent practices and relations enacted integrated care, and secondly how integrated health care was unfolding, by exploring practices that traversed professional and organisational boundaries. These accounts produced some notions about the multiple practices, activities and actors involved in the model of care. Themes of integration, coordination and

collaboration reflected my engagement with the literature, and concepts related to multiple realities and matters of concern emerged from my immersion in the data with an ANT sensibility. However, my conceptual framework was still preliminary.

Therefore, I decided to undertake a second more intensive data analysis, by coding the data line by line in terms of actions and processes, or gerunds (Charmaz & Mitchell 2001), instead of reducing the data to themes that had been dominant in relevant literature. This approach gave a very different picture of the data, as the codes emerged from the data and produced deeper understandings that had not been available before. A point in the coding of the chronological record was reached where no new codes emerged. The codes were then collapsed into multiple categories and then into analytic categories. The second tier categories were an aid in organising the data under the major analytical categories. My coding scheme is listed in table 4.2 below.

This second iteration of coding produced some surprises and marked a move from description to analysis. Concepts emerging out of this analysis have driven my interpretation of how the model of care was being enacted. The density of particular codes for instance, 'linking services around clients', 'working with GPs' and 'feeling safe to disclose' produced substantial patterns for analytical categories that had not been evident before. The relatively low density of codes related to technology and managing patient information placed an area of potential focus in the background. This process also highlighted where analytical categories and codes were related. For example, the multiple codes relating to 'engaging other health practitioners' and 'establishing relationships' offered insights into formation of partnerships. Hence in coding for actions and processes, this phase of data analysis allowed the array of practices associated with the unfolding of the HealthOne model of care to be brought to the fore and named (as discussed in chapter six).

Third phase of analysis: drawing conclusions

In the third phase of data analysis, I refined the relationship between what the data was revealing and the research questions. The key findings about how integrated care was enacted, now emerged from the analytical categories and codes, becoming the basis for configuring the thesis argument. The data analysis also highlighted more significant areas of practice or concern, later explored in the findings chapters. The analytical categories were an aid in unpacking integrated care in practice and my analysis was progressively arranged as an interrelated set of results.

This iterative process of analysis and thinking with theory, inspired by Jackson and Mazzei (2013), produced deeper connections between the data and developed an increasingly theorised interpretation of the research questions (Srivastava & Hopwood 2009 p. 77). Diagramatically representing the data analysis was a significant preliminary step in representing the links, relationships and patterns between the set of codes and categories (Holloway & Wheeler 2013). The coding scheme was a useful tool to draw out patterns and relationships in the data, and became the link to relating these to theoretical concepts.

In synthesising this set of analytical categories and codes into a coherent theorised account that rendered answers to the research questions, I created the thesis story. The argument emerged as a 'creation out of chaos' (Jackson and Mazzei 2011, p. 2), developed over several iterations. Articulating my argument as the thesis story helped establish my discussion of results as three separate findings chapters and theoretical perspectives.

Analytical categories	Second tier categories	Codes
Changing practices	Practice change	Working in new role; changing how care works; grappling with new entities
Matter of concern (client)	Client concern	Not meeting client need; speaking for client
Developing partnerships	Cooperative work	Engaging other health practitioners; establishing relationships
	Inhibiting cooperative work	Working with GPs – difficulty
	Building teams	Forming team; learning to work together
Developing understanding	Understanding	Explaining current practice; getting H1
Linking services	Managing client care	Following up client; working out what to do next (client care)
	Service oriented care	Linking services around client; coordinating services
Matter of concern (practitioner)	Structural concern	Duplicating work; Lacking staff; Juggling resources
	Practitioner concern	Expressing uncertainty; highlighting absence; reporting activity; relying on support from above; recognising work
	Managing patient information	Lack of linked systems
	Inhibiting cooperative work	Losing track of care; missing discharge summary; waiting for referrals; lacking information
Resistance	Client concern	Refusing to engage – client
	Inhibiting cooperative work	Refusing to engage – GP
	Practitioner concern	Working with clients – difficulty
Sharing information	Protecting confidentiality	Feeling safe to disclose; legitimising disclosure of patient information
	Managing patient information	Finding out patient information - from other services; finding out patient information individually - from IT; linking patient information via systems; recording patient information
	Cooperative work	Sharing patient information - with GP; sharing patient information - with other services
Technology	Technology	Using CHIME

Table 4.2 Coding scheme

I had now uncovered important relationships between the data and the theory. Matters of concern (Latour 2005) were a significant concept, with expressions of absence and uncertainty becoming a key feature of my interpretation in the first findings chapter. In addition, the codes 'getting HealthOne'; and 'explaining current practice, figuring frequently across the

dataset, resonated with the concept of intelligibility (Schatzki 2002, 2012) and as part of my argument about how practice unfolded. The Schatzkian notion of practice change and the elements of a typology for explaining this in the second findings chapter arose from an analysis of data associated with the code 'changing how care works'. This typology had arisen from the analysis of past and new practices, and was then refined and expressed as types of practices. The importance of key actors in the thesis story led to my naming the HealthOne liaison nurses and case conferences as mechanisms of integration. The 'mechanisms of integration' were the vehicle for explaining how the model of care was accomplished (in chapter seven). Thus, the structure, content, and sequence of my findings emerged out of this last phase of analysis and interpretation.

During my data analysis I worked iteratively with multiple analytical codes and categories, to create multilayered understandings and analyses of the data to answer the research questions. As explained in chapter three, the conceptual framework emerged out of the data, in the midst of 'plugging in' to the data with theory (Jackson & Mazzei, 2013 p. 264), and recognising the need for particular concepts to interpret the data. This iterative process of setting out the results allowed me to offer different theoretical perspectives on integrated care in practice and a means of elucidating how integrated care was enacted.

Ethical issues

The ethics application for this study was submitted as part of the broader ARC project and approved by two ethics committees under the project 'Remaking Practices: Learning to meet the challenge of practice change in primary health care'. This was an Australian Research Council (ARC) Linkage Project (LP100200435) undertaken by researchers from the University of Technology Sydney in conjunction with Partner Investigators from the NSW Ministry of Health, the University of Queensland, and Griffith University. The project

received ethics approval from the Sydney Local Health District (Protocol No X10-0309) and the University of Technology Sydney Human Research Ethics Committee (Approval Number 2011-029). A site-specific assessment was approved by Westmead hospital Human Research Ethics Committee.

Any research involving human participants must consider the benefits and risks to research subjects. In preparation for this study, I reviewed the National Statement on Ethical Conduct in research involving humans. Consent, collection, recording and disclosure of data was conducted in accordance with the ethics approvals listed above and the National Statement. Information sheets and consent form are provided at Appendices 1 and 2. All data presented in the thesis was gained with the permission of participants.

Unlike many doctoral students and ethnographers, my study did not involve a protracted period of relationship building and negotiation with the field setting, or with the ethics offices (Bosk 1985). This preparatory work was undertaken by the chief investigators on the associated ARC project, and was largely completed prior to my commencement as a doctoral candidate. Conceived as a linkage project with NSW Health, this meant that a senior policy specialist in the Department of Health (later Ministry of Health) was both sponsor of the project and a chief investigator. This relationship with the ministry was formalised through meetings from 2010. Chief investigators were introduced to many study participants at a presentation about the ARC project in July 2011. Consequently, I avoided any potential gatekeeper issues (Hammersley and Atkinson 1995) as support from senior health management for the project ensured that clinicians more junior in the hierarchy were supportive of the research project. However as discussed earlier I worked on developing appropriate relationships with the practitioners whom I shadowed.

Practitioners involved in this study were not directly recruited. I found that informed consent had already been provided by some participants during an

earlier encounter with a member of the research team, for instance at the initial presentation in July 2011. When introduced to practitioners, I described the research project briefly and distributed information sheets and consent forms (see Appendices 2 and 3) to those who had not already consented. These documents included contact details for a chief investigator and the ethics committees.

Gaining informed consent was at times problematic during this ethnography. When I arrived unexpectedly to attend staff meetings held in a room full of participants, a brief opportunity at the start of a long agenda might be the only window to seek informed consent. Consent forms and information sheets were routinely distributed. When attending staff meetings, verbal consent for my presence was sought from attendees who were peripheral to the study.

Participation was voluntary and in a professional, and not personal capacity. Involvement in health services research is an understood and accepted part of health professionals' work, and is encouraged as part of professional development. I did not receive any revocation of consent, and I only encountered one practitioner who did not want to be included in the research.

However, qualitative research that is linked to an identified service and location raises some particular ethical issues. To protect privacy and confidentiality, all participants, including clients, have been anonymised and given pseudonyms in accounts of the research. Despite this, identification of key health professionals in the study may be relatively simple for other study participants, since roles were specific to each HealthOne. In addition, the particular sites in which this study was conducted may be apparent to some familiar with western Sydney or the source documents. I have therefore made every effort to respect the confidentiality and reputation of clients, practitioners and organisations associated with HealthOne, while reporting their accounts

accurately and faithfully. Participants may recognise some features of their account; however, other readers should not be able to link any particular individual to data reported in this thesis.

Participant information sheets included the following statement "We cannot guarantee that you personally will receive any benefits from this study, but the study does aim to improve the safety and quality of patient care in the health system". The study offered health professionals who participated some opportunities to review and reflect on HealthOne, allowing them to articulate their understandings, confusion, and learnings about HealthOne. This benefit of the research for practitioners was acknowledged in unsolicited comments during the shadowing, and possibly this may have alleviated any negative effects from sites or practitioners being identified.

Ethical issues also arose during this research project, due to the nature of the client population in the study settings. The over-riding principle has been to avoid any harm, discomfort or distress to participants. Gaining informed consent was problematic when clients often had low levels of literacy and culturally and linguistic diverse backgrounds. However, informed consent was obtained in writing from the four HealthOne clients whose consultations I attended during the fieldwork. I did not interview these clients, however, I was conscious of the privilege in being granted access to details of their clinical and personal history during this study. Clients whose encounters with HealthOne informed this study, were anonymised by practitioners, before these accounts were divulged to myself or others not directly involved in their care. The sensitive and complex nature of HealthOne clients' clinical and social histories, and the obligations on practitioners and the researcher to maintain strict confidentiality, were matters given ongoing attention during the collection and reporting of data.

Data has been stored in a secure online environment, and backed up on a personal hard-drive, which is stored securely. Transcripts were held in locked cabinets. Data from interviews and the identity of participants in the research will not be communicated to the NSW Ministry of Health, or elsewhere.

Reflexivity: 'doing' ethnography

Employing an ethnographic approach for qualitative research involves letting go of certainty and expectation about arriving at firm conclusions or generalities (Law 2004). Such an approach can be 'slow and uncertain … a risky and troubling process' (Law 2004 p.10). In conducting an ethnographic study, I entered the fieldwork as a novice. A close reading of Latour (2005); Mol (2002); Nespor (1994), Hammersley and Atkinson (1995) and various ethnographic studies were the means of preparation. Techniques for recording notes were explained by supervisors, and a research team member gave me a small red notebook for taking notes. Armed with the consent forms, information sheets, the red notebook and an audio recorder, I started 'doing' ethnography.

Ethnographic fieldwork is unique in its capacity to put the researcher 'in touch with the human dimensions of social life in a way that no other method of inquiry does' (Bosk 1985, p.14). During this research I encountered the tragic, the distressing and the frustrating dimensions of human lives and medical histories, as well as the inspiring, the pleasurable, and the resilient. The practical work of ethnography can be exhausting physically and emotionally (McDonald 2005; Mol & Mesman 1996), requiring considerable emotional labour (Carroll 2012). Hence I deliberately carried out the shadowing phase over an extended time, usually one day per week, varying days of the week.

Practical issues of doing ethnography in health care soon emerged. Adding 90-minutes train travel time each way to a day of shadowing from 9am to 5pm required endurance, especially as the shadowing was largely conducted over summer when temperatures were in the high 30s (Centigrade). Dressing the

part to appear similar to those practitioners that I observed was given careful thought each morning. I usually took a day's supply of food as stops for food breaks were rare and often late in the day. Deciding when to use an audio recorder, when to take notes, and when to ask questions during case conferences and discussions about vulnerable clients with complex conditions, were all matters for moment-by-moment discretion. Producing comprehensive records of the observation, filing and recording artefacts, and writing a reflexive account was 'time-consuming and demanding' effort (Hammersley & Atkinson 1995, p. 48) that had to be completed as soon as possible after a site visit.

It has been argued by some that an ethnography can be flavoured by which role the researcher takes, either as 'outsider' or observer, or 'insider' or participant, and as an individual professional or member of a community of practice (Forsythe 1999; Hammersley & Atkinson 1995). Much of my professional career has been concerned with developing and consulting on health policy, guidelines and standards for state and national organisations. Rather than observing practice to understand practitioners' concerns and work, I was accustomed to consulting with health practitioners, representatives of peak bodies, and stakeholders. Not being a clinician meant that I did not carry 'insiders' tacit understandings' of the practice of health care, or the professional discourse or ideology (Quinlan 2008, p. 1490). I was an outsider with considerable experience and knowledge of health care and regarded this as an advantage, since it has been suggested that 'ethnography usually works best when conducted by an outsider with considerable inside experience' (Forsythe 1999, p. 130).

My reading of ANT helped to constrain me from privileging my knowledge of health care, and to refrain from judgment (Forsythe 1999). In a landmark ANT study, Callon (1986) set out some methodological principles. The first principle, general agnosticism, refers to indifference to the truth, so that the

researcher retains impartiality, refrains from judging accounts and from censoring stories, and does not privilege any viewpoint. The third principle is concerned with not imposing a 'pre-established grid of analysis' upon the actors, and their associations (Callon 1986, p. 199). My aims overall were to limit the impact of my presence on the participants (Hammersley & Atkinson 1995) and moreover, not to privilege one reality over another (Mol 2002), therefore maintaining impartiality, rather than applying a pre-existing analytical framework (Callon 1986).

Chapter summary

In this chapter I described the methodology used in this study of integrated care. I explained my ethnographic approach and the qualitative methods used to explore how the HealthOne model of care was enacted. I discussed my data analysis, and how this was undertaken. This was followed by a discussion of ethical issues, showing how these were overcome. This methodology allowed me to gain a sense of the 'non-coherent realities' (Law 2004, p. 98) associated with the messy, complex work of caring for clients with chronic conditions and vulnerabilities. The following chapter will explore the realities of enacting integrated care. ■

Chapter five

Integrated care: translating policy into practice

Introduction

This chapter—the first of three 'findings' chapters—provides a picture of the translation of integrated care into practice. It addresses the research question: 'What were the realities of enacting the HealthOne model of integrated care?' Drawing on data collected from shadowing, observation, interviews and documents, this chapter employs concepts from Actor–network theory (ANT), in particular, translation (Callon 1986), realities (Law 2004, 2007, 2010; Mol 2002), and matters of concern (Latour 2005), to explore how a model of integrated care was enacted.

This chapter begins by revisiting the policy vision for HealthOne, which was articulated in policy documents, public websites and interviews. Using Actor–network theory, I then explore the translation of policy into practice to illustrate the multiple realities of practising the HealthOne model of care (NSW Health 2011d). I interpret these multiple realities to include enactments of uncertainty and absence, and I examine these as matters of concern. I suggest that a degree of integrated care was emerging through HealthOne, despite the absence of structural arrangements and supportive technologies to sustain collaboration and communication. I argue that although absence and uncertainty were pervasive, the effects of the multiple realities were that the model of care became an approach to integrated care, translated as linkage.

HealthOne became an adapted response to the realities of enacting the vision of integrated care.

Rather than the conventional approach in much of the integrated care literature which highlights strengths, challenges and limitations, I explain how integrated care was enacted by exploring 'how realities are constituted in practice rather than taken to be fixed' (Law 2004, p, 77). In actor–network theoretical terms, the HealthOne model of care is a significant non-human actor in this study. Interpreting enactment as 'an occasion in a location, a set of actions with a series of effects' (Law 2000, p. 349), translation becomes a process through which the model of care was enacted. Thus, I employ an ANT sensibility that offers 'a repository of terms and modes of engaging with the world' (Mol 2010a, p. 262), as explained in chapter three. This sensibility has assisted me to 'tell cases, draw contrasts, articulate silent layers, turn questions upside down, focus on the unexpected' (Mol 2010a, p. 262) in explaining how HealthOne policies were translated into practices. In this chapter, I also use the classification of integration proposed by Leutz (1999) to illuminate how the vision of integrated care was translated into practice through the HealthOne model of care.

Before developing my argument, I reiterate that the purpose of this study was not to evaluate the effectiveness of the implementation of HealthOne in the study settings. Instead, the research focus was on how a model of integrated care was enacted in practice. In chapters six and seven I draw on alternate theoretical concepts to attend to practice change, and key mechanisms of integration associated with the model of care.

Translating vision into realities

As described in chapter one, this study was undertaken in the midst of reforms in the Australian health sector that were intended to produce integrated care. Policy in NSW was framed with the vision of 'an integrated and coordinated

primary and health care system working in partnership to promote the health and wellbeing of our community' (NSW Health 2007, p. 1). The delivery of services through HealthOne NSW, a new model of integrated care, was one of many strategies put in place to achieve integrated service delivery in NSW (NSW Health 2007). It was intended that primary and community health care activities and also planning and administration would be integrated (NSW Health 2011c). Integrated care was intended as the answer to the growing burden of costs resulting from rising demand for acute care, while improving the health of the community.

In this chapter, I explore the translation of policy into practice through the HealthOne model of care. However, before offering an ANT interpretation, I begin with a description of the HealthOne model of care as presented in policy documents, public websites, and interviews.

The HealthOne model of care

The HealthOne model of care (NSW Health 2011d) that is referenced in this study was developed as a policy document by community health practitioners for a HealthOne location that was the site of much of the fieldwork. This document was focused on a particular setting for HealthOne, but it was based on the key elements from the Western Sydney HealthOne model of care (displayed in chapter one, at figure 1.1), and the principles of HealthOne applicable across NSW (e.g. NSW Health 2011c). It was not apparent from the document how much involvement if any, there had been with general practitioners during its creation. However, this model of care was released as a NSW Health document. The vision for HealthOne proposed:

> integrated care provided by general practice and community health services; organised multidisciplinary team care; care across a spectrum of needs from prevention to continuing care; and client and community involvement. (NSW Health 2011c, p. 1)

The model of care featured 'key service pathway elements' including intake (that is, enrolment), care planning, ongoing monitoring and referral. In addition, it involved case conferencing and service provision and was based on patient-centred principles (NSW Health 2011c; NSW Health 2011d, p. 19), as described in chapter one. Distinguishing features of the HealthOne model of care were elements establishing a partnership between community health and general practice: individual agreed partnerships for care with GPs, and co-case management between GPs and community health clinicians. These particular elements were integral to the vision behind HealthOne. These elements had their origins in NSW Health policy (interview 2, October 2011), but were also core principles espoused by the original champions from general practice and community health. Introducing collaboration between groups of health practitioners who had traditionally been isolated (interview, December 2012) was to envision a systemic change. Therefore, the HealthOne model of care proposed broader change beyond that which impacted on individual services and practitioners.

In an early interview with the research team, a GP liaison nurse connected with HealthOne was asked to explain the HealthOne model of care. In response, the liaison nurse described the contents of this policy document (NSW Health 2011d), as shown in the interview extract below:

> Elizabeth: Can you talk a little bit about what you see as the HealthOne model of care?
>
> Liaison nurse: The HealthOne model of care—it's in two streams, so it's child and family health and complex aged and chronic care. What we've tried to do is truly try and integrate our service with other primary healthcare providers, namely, GPs in the area. So the model of care gives us a background around why it's necessary to think about changing the model that we currently work under; gives us

> some evidence around why we need to do that; just goes through the demographic profiles particularly of the Local Government Area but across Sydney West as well; gives us some flowcharts and pathways around how to best do that; strategies, procedures, that sort of—so the nuts and bolts basically of the position and how it would integrate with primary healthcare providers and within the teams within community health. (Interview, March 2012)

Initially, HealthOne enactments of the vision of integrated care allowed for flexibility and localisation, to meet local community needs. A senior community health manager and a prominent general practitioner were key figures in developing and implementing the HealthOne policy initiative in Western Sydney. They anticipated that general practitioners, community health services and other health care providers would 'collaborate to provide comprehensive and coordinated care', with shared governance including a steering committee, implementation groups and working parties (NSW Health 2010a, 2010c). However, localised implementations of HealthOne could be adaptable, depending on community needs and the health status of the population (interview 2, October 2011).

By the latter stages of the fieldwork, a set of HealthOne operating procedures were in development, under the guidance of senior community health managers. These operating procedures were aimed at moving practices towards a more standard approach to the HealthOne model of care in Western Sydney. However, some practitioners working on the ground with HealthOne were concerned that increasing standardisation would constrain their capacity to respond to differences between local communities (chronological record, December 13, 2012). However, this research was not given access to that set of documents since they were still in development. Thus the model of care referenced in this study (NSW Health 2011d) was developed in one site

operationalising the principles of HealthOne that were applicable across NSW (NSW Health 2011c).

In the remainder of this chapter, I explore how the vision of integrated care was translated into practice. I show how the HealthOne model of care, a significant non-human actor, was displaced by multiple realities.

The vision unfolding in multiple realities

> [as allegorists], a lot of the time we are crafting and manifesting realities that are non-coherent. That are difficult to fit together into a single smooth reality. (Law 2004, p. 92)

The realities of enacting integrated care through the HealthOne model of care were complex and multiple. Viewed from an ANT perspective, these multiple realities interacted, overlapped, and interfered with each other (Law 2004, p. 61). The data suggested that there were many factors related to people, objects and processes, or to 'materiality, relationality and process' (Law 2004, p.157), that impinged on enactment of the vision. One factor was that HealthOne clients were vulnerable: they usually had complicated psychosocial backgrounds and multiple conditions that were often unresolved. Translating policy into practice for these clients was therefore not an immediate or streamlined process.

To illustrate the multiple realities enacted through the HealthOne model of care and the lack of coherence between theory and practice, examples of the realities generated in the two HealthOne settings are described below. Here I follow the conventional approach of much of the academic literature on integrated care, highlighting the challenges of integrated care, albeit from a limited and high-level perspective. In contrast, the remainder of this chapter will then dive more deeply into the heterogeneous world of HealthOne, opening up different perspectives on how policy was displaced by multiple

realities, and giving a more nuanced picture of the translation of HealthOne policy into practice.

Many of the realities enacting HealthOne related to the new ways of working being established through HealthOne, particularly the reliance on key individuals such as the liaison nurse, the need for collaboration between community health and GPs, and the work of finding out information about HealthOne clients from other organisations and practitioners. Systemic change through HealthOne processes was very dependent on activity being driven by individuals in both management and clinical leadership roles. Other realities related to structural arrangements for HealthOne, for example, funding for HealthOne was largely restricted to capital funding. Initiation of HealthOne in a locality seemed contingent on establishing a physical presence and co-located services under the banner of HealthOne, despite the potential to deliver HealthOne virtually via practitioners distributed across the health system.

Many changes in staffing associated with HealthOne occurred during the research, and finding new staff to fill roles became a challenge. The model of care was extremely dependent on the liaison nurse, a role for which staff were difficult to recruit and retain. For example, the aged, complex and chronic care liaison nurse position at one study site was vacant for over a year. In addition, resources were stretched in both the public and private healthcare systems (chronological record, November 19 2011; February 14 2013). Thus coordination of care and service delivery for HealthOne clients in a complementary and timely manner by multiple providers and organisations, was constrained by waiting lists, eligibility criteria and lack of availability of health practitioners, and was also influenced by clients' choices about whether they would accept the services and referrals offered to them.

In turning now to present another picture of the realities of enacting the HealthOne model of care, the construct below in Table 5.1 uses elements of an

ideal model of practice in primary health care derived from the literature on primary health care process (Kringos 2010; Starfield, Shi & Macenko 2005) and core dimensions of quality (ACSQHC 2011). Drawing on data collected from shadowing and observation, this construct serves to illustrate the point that multiple realities were enacted through the model of care. These realities were heterogeneous, for a combination of economic issues, social concerns, resourcing issues, technology matters and even legal questions (Law 2007, p. 15) impinged on the enactment of the HealthOne model of care.

Quality dimension	Vision	Multiple realities
Access	Eligible clients receive an appointment	Long waiting lists, instability of staffing and resourcing
Appropriateness	Client assessment	Multiple services, multiple assessments
Appropriateness	Comprehensive, current health summary	Information emergent, voluminous, inaccessible, fragmented or withheld
Appropriateness	Complete care plan / care planning	Who does the care plan? Service oriented or patient centred care plan?
Coordination of care	Allocation of a 'key contact' person / case manager	The GP liaison nurse acting as contact person. Who is the case manager?
Coordination of care	Timely communication to health practitioners	Workarounds to enable shared communication due to lack of interoperable systems, e.g. information shared verbally, feedback forms emailed to GPs, but discharge summaries and referrals delayed/disappeared
Patient centredness	Satisfaction with patient experience	Clients having different priorities to health practitioners; showing resistance, reluctance to engage
Effectiveness	Client improvement / stabilisation	Clients' multiple, complex health conditions and psychosocial factors, e.g. family networks, living conditions, literacy, language; regulations e.g. citizenship status

Table 5.1: A view of vision and multiple realities

Hence, the HealthOne model of care became displaced by multiple realities, for its translation did not necessarily generate 'a single coherent reality' (Law 2007, p. 13). Multiple realities emerged in the enactment of the model of care, and these interacted and interfered with the translation of policy into practice. These multiple realities included enactments of absence and uncertainty. The next

section will explore enactments of uncertainty and absence as matters of concern to further illuminate the realities of enacting a model of integrated care.

Matters of concern

For health practitioners associated with the HealthOne model of care in the research setting, uncertainty and absence were continuing matters of concern, the former not unexpected, the latter present in many forms. Expressions and instances of absence and uncertainty were threaded continually through the data collected during the fieldwork. I examine these as matters of concern to distinguish their presence in the enactment of the HealthOne model of care. As Latour points out, 'reality is not defined by matters of fact' (Latour 2004, p. 232) but by 'highly complex, historically situated, richly diverse matters of concern' (Latour 2004, p. 237). Thus I now explore particular matters of concern related to uncertainty and absence that impinged on the enactment of HealthOne. I will then consider the effects of multiple realities on translating the HealthOne model of care into practice.

Uncertainty

> The world is not a solid continent of facts sprinkled by a few lakes of uncertainties, but a vast ocean of uncertainties speckled by a few islands of calibrated and stabilised forms. (Latour 2005, p. 245)

Uncertainty is a feature of the practice of health care, and health practitioners work in a state of incompleteness, disruption to plans and lack of continuity in their view of the patient trajectory. Health practitioners associated with HealthOne were accustomed to working in uncertainty (chronological record, November 19, 2012), and did not highlight it in their conversations. At the same time, their day-to-day work revealed multiple instances of uncertainty. However, given that uncertainty of various forms was not unexpected, it is not a major focus in this thesis.

Below I outline examples of uncertainty related to the enactment of the HealthOne model of care that concerned the follow-up of clients during their enrolment in HealthOne. For instance, providing feedback to GPs and other service providers regularly was one of the responses expected in the care delivered through HealthOne (HSW Health 2011d). This feedback mechanism was intended to reduce the duplication of information collection and subsequent interventions, and fragmentation of information. However, there was no certainty that a GP would follow up on a feedback letter or discharge summary. Nor was it certain that another clinician would issue a referral, or that the client would follow through on a referral (chronological record, April 2 2012; December 5 2012). Yet clinicians asserted that the feedback process was important:

> around the care of a client … the best way to engage is to have a conversation to some extent, but follow it through with a written format, something that's clear, to find something that can go in a record that can be then followed through … it's the thing that follows the client. (Interview 6, March 2012)

Conversations, notations on records and referrals seemed to anticipate that follow-up would occur, as demonstrated in the statement above made by a senior health practitioner. However, the realities were that referrals and requests for services could be mislaid, not made, difficult to achieve, late or overwhelming in volume. Reciprocity was rare, with little feedback to community health about HealthOne clients from other practitioners such as GPs. The traffic of feedback about HealthOne clients was one way, from the public sector to the private sector. Although the public healthcare system worked on the assumption that a referral was followed up and an appointment made, because there was no feedback circuit returning information about the

client, there was uncertainty about the subsequent interventions (chronological record, December 12 2012).

Clients also contributed to the constant uncertainty, for they could disappear, be reluctant to follow through on referrals, or not attend appointments, making follow-up difficult. The Safestart meeting (a perinatal mental health initiative) was a forum that the child and family health liaison nurse attended to identify potential HealthOne clients and to encourage referrals into HealthOne. The meeting confirmed the degree of uncertainty that seems to have been a feature of practices around vulnerable clients whose health was at risk. The participants discussed a homeless pregnant woman whose baby was ten days overdue. The woman had not yet arrived in labour at the hospital. It was noted on her hospital file that she was also booked in at a city maternity hospital. However, the information systems were not linked. There was therefore no way of tracking her progress through the health system, and if she was admitted to another maternity hospital, it would not have her antenatal file. During the meeting, the liaison nurse phoned the GP recorded on the client's file, but the GP had not seen the pregnant woman for four months. Another phone call to the city hospital elicited the information that the client had not presented to that hospital. Thus, follow-up was impossible, and practitioners were left with uncertainty about the wellbeing of mother and baby and about how to fulfill their duty of care.

Uncertainty as a matter of concern was not unexpected. Practising under 'conditions of partial knowledge and uncertainty' (Schmidt 2011, p. 3) goes hand in hand with primary health care (Greenhalgh 2013). An ANT approach to research recognises fluxes, indeterminacy and multiple realities (Law 2004; Mol 2002), and appreciates that change, uncertainty and formation are constant (Callon 1986; Latour 2005; Law 1999). However, the effects of absence on the

realities of enacting the HealthOne model of care were more unexpected as well as pervasive, as the following section will explain.

Absence

This section explores the presence of absence as 'whatever is absent but is also manifest in its absence' (Law 2004, p. 84), a recurring and pervasive motif during the enactment of the HealthOne model of care. Throughout the fieldwork, absences were made visible in conversations and activities associated with HealthOne, for example, in regard to multidisciplinary teams, people to fill community health nursing positions, communication channels with GPs, discharge summaries, service requests (referrals), pathways of clinical support for liaison nurses, an area specifically for HealthOne clients on the community health information system (CHIME), training to use the electronic Blue book application, access to computers in the maternity ward, GPs who spoke Eritrean amongst the 130 bilingual GPs across the local health district, GPs at case conferences, child and family health clinics in January, feedback from hospitals and GPs treating HealthOne clients, and mention of HealthOne on a HealthOne liaison nurses's handmade business card or the door to the liaison nurses' office. These instances of absence were noted in the chronological record of the enquiry. While some occurred repeatedly, others were apparent on one occasion only.

Thus, numerous expressions and instances of absence emerged frequently and unexpectedly in conversations between practitioners, and whilst shadowing the liaison nurses. Such matters of concern related to a combination of structural arrangements, economic issues and technology matters. The following section elaborates on manifestations of absence that impinged on the enactment of the HealthOne model of integrated care.

Absence of care plans and case managers

Important mechanisms of integrated care include care plans, and an identified case manager responsible for care coordination (Goodwin et al 2012; Ham & Walsh 2013; Janse et al 2016). These were both elements of the HealthOne model of care. However, care plans and case managers were not immediately visible during this study. It was several months before I heard the liaison nurses mention care plans that had been prepared in case conferences instigated by community health for HealthOne clients or care plans intended in the future. Over a year of fieldwork elapsed before I attended a HealthOne case conference (in January 2013) that involved a case manager and a care plan.

When I asked a liaison nurse about GPs completing care plans, the liaison nurse responded that she had been included on some care plans filled in by GPs, but that GPs reportedly found writing care plans time consuming and an activity for after hours (chronological record, October 10 2012). In an earlier interview she had commented that care plans were not normally prepared, since the type of care plan that GPs could do under the Medicare Benefits Scheme was restricted to mental health plans or chronic disease management plans. These were not necessarily appropriate for all clients. This was an effect of the Australian Government's policy that centred the delivery of primary health care in general practice and prioritised chronic disease management (Henderson et al 2014).

There was an instance of a HealthOne case conference that I attended, during which a care plan was presented for review and completion by the practitioners attending the case conference. However, the client was not present at the case conference. This plan received an unfavourable response from the client's case manager who worked for a community services organization, rather than for health. The case manager was critical of the plan, stating that 'this is not person-centred, this is a care plan that meets our organisational

requirements, the funding requirements, but it is actually not a person-centred care plan' (transcript, January 25 2013). During the fieldwork I did not see a single care plan completed in collaboration with the client.

However, some care plans did seem to have been developed for HealthOne clients, according to a patient satisfaction survey held at one of the HealthOne sites in 2011 and to which 67% of the HealthOne clients responded. The survey found that 50% of clients had found the care plan helpful, while approximately 30% of clients were unsure if the care plan was helpful (NSW Health 2011e). However, it was not evident from the survey report how the care plans were helpful, or in fact how many clients had care plans.

The intention under the HealthOne model of care was that the GP would take the role of case manager, while the HealthOne liaison nurse or another community health practitioner could take the care coordination role (interview 2, October 2011). However, in practice identifying the case manager was difficult. Many of the clients enrolled in HealthOne did not have a case manager, while some were allocated a case manager by another organisation. I was informed that the nurses providing care in the chronic, aged and complex care community health stream were case managing their clients, but that they had limited capacity to follow up the clients with GPs and multiple service providers. The child and family health nurses did not do case management. Commenting on the need for follow-up of the complex clients enrolled in HealthOne, one liaison nurse stated:

> We've got to get better at who is the case manager and it needn't be someone from community health, it hasn't got the capacity to do it. It could be someone from another service provider, a non-government [organisation]. (Transcript, December 12 2012)

This liaison nurse noted that an 'ongoing relationship' or 'access point' was missing without a case manager. Thus, locating the case manager was often

problematic, for this key element of the HealthOne model of care seemed absent in relation to many HealthOne clients.

Absence of information and integrated information systems

Enacting the HealthOne model of integrated care involved working with a wide range of distributed practitioners and organisations. One community health co-ordinator commented during the shadowing that 'it would make everything so much easier' if the information systems could 'talk' to each across organisations, for example, between community health and refugee health, community health across NSW, and between GPs and community health (transcript, September 14, 2012). However, in the study settings there was no sign of linked, interoperable systems for exchanging information about HealthOne clients between sectors, from health to community services, or a common repository or information space where HealthOne clients' information could be stored securely for shared access.

Development and piloting of new information technology solutions were ongoing during the study. For example, community health underwent enhancements to the Community Health Information System (CHIME) and a move from paper records to electronic health records; laptops were being allocated to community health staff in the field for remote access to CHIME; and electronic discharge summaries were being sent from hospitals to general practices. Nevertheless, information systems were not interoperable, leading to fragmentation of HealthOne clients' information, with different parcels of information held separately in acute care, community health, and public and private health services' information systems.

This lack of integrated information infrastructure and common information spaces for cooperative work meant that the liaison nurses frequently found out information about HealthOne clients through conversations with other practitioners and service providers, or by searching multiple information

systems. Thus there were persistent workarounds required to mitigate the absence of interoperable information systems and shared information spaces. The liaison nurses accessed multiple information systems to create an account of the patient trajectory. They brought together the client's information, and that was then transported, often verbally, to other health practitioners and service providers involved in the client's care. Hospital records of a patient admission were on different clinical information systems depending on the hospital, and the community health records were on yet another system, known as CHIME. The liaison nurses required considerable, individual effort to use these multiple technologies to search for and print off clinicians' notes to construct a material account of the patient trajectory. Their account was intended to be more complete and up-to-date than that available in the distributed information systems.

Meanwhile, practitioners in community health had become impatient waiting for information technology, as the following community health manager explains:

> [we had] the lack of compatible IT systems and we had working groups and we met … and they had a consultant and they spend hundreds of thousands of dollars and it was just like oh my God, can we just talk to each other? Let's just pick up the phone, let's not worry about having IT solutions because that was also a constraint: that was stopping us. We were waiting for something that would enable us to have a compatible system. (Interview, November 2011)

Since information systems were not interoperable, HealthOne liaison nurses carried out additional work to alleviate the absence of information about the trajectory of HealthOne clients. Thus, they made frequent phone calls, and expressed a preference to meet to talk to someone about a client because one can find out 'a lot more background information when you go and talk to

someone', a comment made by one liaison nurse (transcript, September 14 2012). Liaison nurses, other health practitioners and service providers spent considerable time discussing clients to fill in the gaps in clients' information. These discussions sometimes occurred opportunistically, and after an encounter with another service. For example, during a local partnership meeting, a liaison nurse learnt from community workers of the recent suicide of a young mother. By investigating further with the hospital social worker, the liaison nurse was able to ascertain that the woman, brought deceased into the hospital, was one of her HealthOne clients. However, information about her death had not yet reached either community health practitioners or the liaison nurse, nor was it recorded in CHIME. This demonstrates the lack of feedback loops about HealthOne clients from other services. The woman's postnatal mental health had been of concern, and after undergoing a mental health assessment, she had continued to see a psychiatrist in the private sector. However, she declined to attend the child and family health clinic with her baby, and feedback from other treating clinicians was not provided to community health. Finding out about the death in the partnership meeting was unexpected but it provided information that was absent from other sources.

In light of such gaps, in December 2012, a liaison nurse outlined to me her ideas about a template that would contain a condensed summary of current information about a HealthOne client. She described a health summary containing information, for instance, about who was involved in care, what they were doing, their contact details, the client's level of capacity, and client consent to share information. She hoped to scan this health summary into all the clinical information systems, for instance, CHIME, the various hospital systems and the GPs' system, with the aim of providing information for all those involved in a HealthOne client's care. The liaison nurse variously labeled this summary as a quality tool, and as a multidisciplinary continuity of care template. In fact, this

idea involved imagining an information space that might enable collaboration and communication, where practitioners could find current information about HealthOne clients. However, the proposal for a project to create the health summary did not proceed. The absence of information and integrated information systems remained a matter of concern that intruded on the enactment of the HealthOne model of care.

Absence of clients?

As in so many studies of integrated care, it seemed that 'patients [clients] were largely invisible apart from being the object of the information and coordination efforts' (Fitzpatrick & Ellingsen 2013, p. 653). The third day that I arrived to shadow a liaison nurse, I learned that she had already been to a planning meeting about a new mothers' group for local women under 25 years of age. 'I hope we get mums, its such an elusive community but we've got to try', she said back in the office (transcript, October 10 2012).

In the same way that Law and Singleton considered that 'the patient diagnosed with alcoholic liver disease is slippery, variable, elusive' (Law & Singleton, 2003, 238), the patients with chronic and complex conditions deemed eligible for enrolment in HealthOne were elusive and more often absent than present during my fieldwork. Throughout the entire fieldwork, I only encountered six community health clients in person. This was slightly more than another team member who encountered four clients during 116.5 hours spent shadowing a liaison nurse. The notes in the log of my first day at HealthOne Corymbia reflect the absence of clients at the community health centre:

> *Today was the first visit to Corymbia. We had a great macchiato at the station, got lost, walked about 2 kilometres down the main street into a residential side street, and then bang smack out of nowhere is the brand new hospital and adjacent community health centre with rooms for HealthOne. There are*

consulting rooms, a room for the child and family clinic, meeting room, and quiet room. No sign of patients, except a group behind closed doors. (log of the enquiry, March 1, 2012)

Figure 5.1: HealthOne consultation room, March 2012

During my fieldwork, there were also a small number of planned encounters when clients failed to materialise. Usually this was for a case conference with their GP and other clinicians. However, the elusiveness of particular communities in the Corymbia locality was apparent on other occasions, for instance, at the opening meeting of the new mothers' group when not one mother arrived.

Despite the lack of direct contact with many clients, the lengthy fieldwork afforded a unique indirect window into multiple patient trajectories. I became aware of the clients' social networks, the multiple settings where HealthOne clients were encountered, and the actor–networks of service providers assembling during these trajectories. From the early days of shadowing, it was apparent that the clients encountered in this study were complex and

vulnerable. They became visible through discussions taking place between practitioners from health and community services. These practitioners were working in a local government area (LGA) with a culturally and linguistically diverse population; 64% of the population was born overseas. LGA residents included refugees, asylum seekers, prisoners, international students, people from European, Asian, Middle Eastern, African, Arabic backgrounds and indigenous Australians, as revealed by the maps on the wall of the Corymbia community health centre meeting room, and the conversations and meetings about clients.

Typically, HealthOne clients' personal and medical histories were complicated and involved multifaceted family relationships. The clients' social histories and disadvantaged backgrounds compounded this complexity. One health professional voiced her concerns to the liaison nurse on my first day of shadowing: 'pretty much I don't know what to do with this family, it's so complex' (transcript, September 14, 2012). In her role as a speech therapist, this practitioner was delving into the psychosocial and clinical history of a young client. When she realised that multiple practitioners and services were working with individual members of the family, she sought assistance from the HealthOne liaison nurse to introduce a more coordinated approach from community and mental health teams for the family. Although I did not see this family during the fieldwork, they emerged from time to time as a 'manifest absence' (Law 2004, p. 144) when their care became the subject of discussions or meetings.

Thus, although encounters with clients were rare and I did not meet a client until the fourth day of shadowing in the 13th month of fieldwork, the practices of HealthOne did make traces of the clients visible for both practitioners and researchers. Despite little direct contact during my fieldwork, clients were continually present indirectly. In total, activities related to 26 clients became

visible to me during the fieldwork as I talked with and shadowed the liaison nurses. Many clients reappeared again over time during the fieldwork, some surfaced only once. Yet traces of HealthOne clients were present in the day-to-day practices of integrated care.

For example, case conferences and case reviews were a frequent activity during the shadowing. Table 5.2 below illustrates that case conferences or case reviews were held for many of the 26 HealthOne clients who were encountered either in person, or indirectly, during the shadowing. It is likely that other case conferences or reviews were held in this period. While GPs were rarely present, a broad range of practitioners participated in HealthOne case conferences, including staff from community health, acute care, allied health (AH), mental health (MH), general practice, and community services organisations. In comparison, case reviews observed during the fieldwork predominantly involved practitioners from nursing teams and allied health in community health and acute care. Clients were often present at case conferences, including three that I attended, but never at case reviews. Nevertheless, they were indirectly present as the object of discussion and planning. Case conference and case review data collected from the shadowing phase of my fieldwork makes visible the presence of clients as the nub of the HealthOne model of care.

Client	Activity	Participants	GP presence
Client I	1st case conference	1st – *client,* liaison nurse, hospital social worker, and registrar	No
	2nd case review	2nd – mental health team and child and family health nurse	No
Client IV	case conference at GP surgery	*Client,* 2 allied health professionals, community nurse, liaison nurse, GP	Yes
Client V	case review	Perinatal Working Party (perinatal acute care and community health staff, liaison nurse)	No
Client VII	1st case conference	1st – speech pathologist, liaison nurse and mental health professional	No
	2nd case conference	2nd - *client* and family with mental health and allied health professionals	
Client X	1st case conference	1st - paediatrician, hospital social worker, liaison nurse	1st – no
	2nd case conference	2nd- *client*, GP, liaison nurse, social care professionals	2nd - yes
Client XI	1st case conference	1st – *client,* liaison nurse and social care professionals	1st – no
	2nd case conference	2nd – *client*, GP, social care professionals, liaison nurse	2nd – yes
	3rd case review	3rd - Perinatal Working Party	3rd – no
Client XIII	2 case conferences	*client* and children, liaison nurse (other attendees unknown)	not known
Client XV	case conference at GP surgery	*client* and mother, social care professional, liaison nurse, interpreter, GP	Yes
Client XVI	case review	Perinatal Working Party	No
Client XVII	case review	Perinatal Working Party	No
Client XXI	case review	Safestart meeting (perinatal acute care staff and liaison nurse)	No
Client XXII	case conference	client's case worker, liaison nurse, 2 community health staff and 2 allied health professionals	No
Client XXIII	case conference	*client*, liaison nurse, 2 doctors, ward manager, hospital social worker, 1 allied health professional, discharge planner, post acute care planner	No
Client XXIV	case conference	case worker, parenting support person, bilingual health worker, hospital social worker, community nurse and liaison nurse	No
Client XXV	case conference	*client*, representatives from five social care organisations, 2 liaison nurses	No

Table 5.2: Case conferences and reviews involving 26 clients encountered in study

The effects of multiple realities

In conclusion, the realities of enacting the HealthOne model of care revealed matters of concern related to uncertainty and absence. Uncertainty was not

unexpected. However, absence was evident in many forms in relation to enacting the model of care, in processes, systems, technologies and actors. Instead of routine practices for case management of clients enrolled in HealthOne, supported by formally established multidisciplinary teams, case management was absent or shared informally, while care planning was present to some degree. Formal shared care arrangements between organisations, regarding shared responsibility of clients in common who had been enrolled in the HealthOne model of care, were not apparent. Technologies to sustain collaboration and communication were absent: interoperable information systems were not available to link practitioners to their HealthOne clients.

Responsibility for translating the vision designed by senior health managers and leaders in general practice fell to health practitioners working on the ground. Apart from the employment of liaison nurses, there were no other ongoing funding arrangements put in place to support the HealthOne model of care in an environment of budgetary and recruitment constraints and constant restructures (chronological record, November 19, 2012). Moreover, staffing capacity was limited across health (transcripts, October 2011; December 2012). Partnership between community health and general practice was an integral feature of the HealthOne model of care. Yet GPs were notably absent from most of the case conferences and all of the case reviews for 26 HealthOne clients recorded during the shadowing (shown in table 5.2 above).

Although capital funding had been allocated for purpose built new buildings in some HealthOne sites, other structural arrangements were absent. During 2011-13, the health and community services sectors in the research setting consisted of various components operated by Commonwealth and state governments, non-government organisations and private sector organisations. Services, organisations, disciplines, and management structures were still structurally separate, with disparate and complex funding sources and

governance arrangements. Planning and administration for the care of HealthOne clients was not unified or streamlined across organisations and units.

Overall, these absences reflected fundamental limitations associated with HealthOne and meant that enactments of the policy in the study settings were a diminished version of the vision. Policy and public information about HealthOne suggested that it would be a busy established service with community, allied health and general practitioners working in multidisciplinary teams, planning care pathways and referring clients, via connected information systems. However, the enactment of this vision was not straightforward. As the preceding sections have shown, policy was displaced by multiple realities. The last part of this chapter explains the effects of these multiple realities on how the HealthOne model of integrated care was enacted in practice.

The HealthOne approach to integrated care

The effects of multiple realities were an adapted response to enacting integrated care in practice. I now use Leutz's (1999) classification of levels of integration from linkage to full integration to explain how the HealthOne Model of care was translated as a relatively unstructured level of integration. It was intended that the HealthOne model of care would be operationalised in community health and general practice by providing multidisciplinary team care across a spectrum of client needs, through client-centred integrated care. Instead, the realities were that there were no formally established multidisciplinary teams or case management, no common records or information systems, and funding was not pooled for service delivery to HealthOne clients. All of these elements of full integration (Leutz 1999) were therefore missing (see table 2.1 in chapter two). However, a degree of integrated care *was* enacted through the HealthOne model of care in community-based services in the study settings.

The translation of the HealthOne model of integrated care into practice resembled what Leutz (1999) refers to as 'linkage', as the base level of a three-level categorisation of integration of care. Linkage occurs on an as 'needs' basis, when 'professionals know where it is appropriate in other systems to send people' (Leutz 1999, pp.84, 85). Thus, eligible clients were referred to HealthOne after other practitioners and services identified issues. In response to these issues, clients were referred to services. Practitioners provided information when sought rather than it being routinely available. Case management was absent, or responsibility for it was distributed between community health and community services organisations. Funding of services to HealthOne clients remained the responsibility of separate organisations, and there was little overarching service planning. The elements of linkage identified as a less structured form of integration (Leutz 1999, pp. 85, 86-87) have been evident in this enactment of the HealthOne model of care.

The language of health practitioners in the study indicated the significance of linkage. For example, in their discussions about HealthOne clients, practitioners continually referred to clients being '*linked* in'. The use of 'link' indicates the focus on referrals to other services in this model of care. Since HealthOne was not a discrete service provider, it did not have a unique physical presence and it did not employ staff other than the liaison nurse. Here are several examples of this usage of 'link':

> 'We need to know that the cleft lip people have linked her in and she's linked in to all these other supports.' (Transcript, September 14, 2012)

> 'She's linked in, she's being seen'; as long as she is linked into someone'; 'I think this baby is going to have some quite serious issues, but the good news is that its linked in.' (Transcript, September 14, 2012)

> 'So she's linked into playgroup'… 'invite her to the young mother's group and try and link her into some of the other services.'
> (Transcript, December 5, 2012).

In the words of a HealthOne liaison nurse quoted below, 'linkage' offered a benefit to the client and to community health, and enabled resource re-distribution:

> It increases the capacity of health by doing linkages properly – we've got a partnership with NGOs … by linking clients in to NGO's they do it better than us. It's only cost one GP liaison nurse salary. They've got that client supported, sustained, supported, they can do it better than we can. We link them in; we can increase that client's support.
> (Transcript, December 13, 2012)

Consequently, the HealthOne model of care approached integrated care as linkage (outlined in Table 2.1). This was an adapted response to the multiple realities of enacting the vision of integrated care. Care was individualised for complex and vulnerable clients, as practitioners responded to clients' immediate concerns and circumstances. This involved a multifaceted and complex web of people, technologies, activities, entities, and relations. The HealthOne model of care was thus not itself 'integrated'. Instead, it was enacted through dispersed networks of activities and actors that traversed acute care, primary and community health care, and community and social services, and where the liaison nurse was the connection between clients and practitioners. HealthOne clients and the liaison nurses were points of attachment to multiple actor–networks and interactions associated with HealthOne. The HealthOne model of integrated care became an approach to enacting collaborative, coordinated client-centred care as linkage, rather than a service embodied by formally established multidisciplinary teams.

Integrated care as linkage

This final section of the chapter illustrates how HealthOne's vision of integrated care was enacted in practice as linkage in community-based services. In essence, clients were referred to HealthOne from other services when complex and moderately urgent issues were identified. The HealthOne liaison nurse was active in creating referrals for the HealthOne clients, contacting the client's GP, and transitioning the clients to other services. However, the liaison nurse's contact with clients was not ongoing. Referrals from HeathOne to health and community services were opportunistic and sometimes unsuccessful, for they were negotiated based on the liaison nurse's assessment of the client's needs as these emerged and on the client's willingness to participate. Two examples follow that illustrate how integrated care was enacted through the HealthOne model of care as linkage (outlined in Table 2.1).

The first scenario concerns a new mother whose severe mental health issues were identified after delivery of her premature baby. The issues that emerged postnatally were complex, and the client was vulnerable. An enrolment in HealthOne was initiated by hospital nursing staff. The child and family health liaison nurse consequently became involved. A number of issues arose from the liaison nurse's first encounter with the woman: nursing staff were concerned about the woman's level of medication for mental health issues and also about her parenting skills; an interpreter was uncomfortable about translating some of the questions asked by health practitioners; the formal referral to community health had not yet arrived through the central referral system; and a file had not yet been created on CHIME. The client expressed a preference for a female psychiatrist and did not want her family to be aware of the appointment. The complexity of the client's medical and social history called for a range of follow-up actions, involving multiple practitioners. The liaison nurse gained information opportunistically from a hospital social worker, the mental health team, and staff in the maternity ward in the local hospital, and she made

referrals to the public psychiatrist, the interpreter service, a GP, the community health child and family health team, and a community services support program.

The liaison nurse took a coordinating role in following up this HealthOne client. She made efforts to access and provide information, and to set up referrals to other services for the client. She requested parental support services for the client from a social care program, although this application was rejected on the grounds that the client had adequate family support in place at home. After the client signed the HealthOne consent form, the liaison nurse was able to access the hospital files for the mental health notes and social worker's notes. However, the list of medications prescribed by the private psychiatrist was not available. A diagnosis from the mental health team could strengthen an application for support services. The liaison nurse therefore arranged an appointment with a female psychiatrist from the public mental health team. In addition, the liaison nurse had to negotiate about geographical boundaries between mental health teams to enable an interpreter's physical presence at the client's consultation with the psychiatrist. The nurse also had to arrange an appointment with a child and family health nurse on the same day at the clinic to ensure someone followed up the baby's condition. The liaison nurse then contacted the client's GP to update her on the issues that had emerged during postnatal care.

However, this HealthOne client declined further appointments with the public mental health team and the community health clinic. Despite a case review by community health staff, further follow-up was impossible. Although an intense round of activity and referrals after the initial enrolment had been activated by the liaison nurse in response to the client's immediate and emergent issues, this did not precipitate any further involvement with HealthOne.

My notes describe another example of how the practices of the HealthOne model of integrated care supported clients through linkage. In this example, a liaison nurse, Tina, is representing a client who has multiple issues, and whose case involves a number of providers, family and community members:

> *11.40 Tina phoned a colleague about a client—is she getting better? Talked about supporting the patient. 'She needs to understand that the help she is getting is short term to get her back on her feet'.*
>
> *The colleague sounds like a psychologist. They suggest that part of the client's recovery is to be in charge. But according to Tina, she needs a case manager to help her organise herself.*
>
> *[After the phone call] I asked how Tina got involved with this client. Tina tells me that the client has several children, her husband has mental health issues, and she has sustained injuries from an accident. The client went to a local support service and spoke to a financial counsellor, who spoke to the service's Child and Family manager, who called Tina. They had a mini case conference with client, then another case conference with GP and organised 30 hours per week childcare. Then Tina got the bilingual counsellor at Corymbia community health centre involved. Then she realised that this was a 3rd party insurance case, and that they [insurers] should pay.*
>
> *The neighbour helps mind the kids and takes them out. 'The neighbour is one of these Aussie battlers, has been in Corymbia forever.' She's in her 70s.*
>
> *Tina mentioned again that woman doesn't have a case manager, and the psychologist who does adult psychosocial counselling doesn't see herself as the case manager. The client is also seeing another GP for women's issues.*
>
> *We start looking at CHIME so that we could look at the sequence of events, discussions, and documents. (The client information section holds client related documents e.g. case conference notes, HealthOne consent form.) The trajectory unfolds:*

1. *There are notes of two case conferences.*
2. *Multidisciplinary case review was held on 9 April at the HealthOne Perinatal Working Party.*
3. *On 19 April there was a referral.*
4. *On 24 April there was a letter to the GP. (Chronological record, October 10, 2012)*

The string of events described by Tina, and documented on CHIME, involved repeated and asynchronous communication with health practitioners and other service providers. The care evolved as more and more practitioners became involved. Case conferences were organised (two); GPs (possibly two) engaged; services redirected (from the public to the private sector); there was collaboration with a community-based not for profit organisation. There was no case manager; this was apparent from comments made by the liaison nurse and the psychologist. Efforts were made to involve the GP, to provide information and to refer the client to other services. Although traces of these linkages were present on CHIME, the client did not present again during the shadowing.

Examples like this demonstrate how the multiple realities were enacted in practice. Linkage is still a type of integrated care, although it constitutes the base level of integration (Leutz 1999, outlined in Table 2.1). Despite the absence of structural arrangements and supportive technologies, the HealthOne model of care was enacted as linkage, where liaison nurses referred clients to services based on the client's immediate and specific needs and the availability of practitioners.

Conclusion

This chapter has explained how healthcare reform policies to integrate care were translated into practice through HealthOne. Beginning with the policy perspective of the HealthOne Model of Care (NSW Health 2011d), this chapter

captured how policy was displaced by multiple realities. Tracing the effects of multiple realities showed that the model of care was enacted as linkage. The empirical study of HealthOne in community-based services, reviewed in this chapter, provides evidence that supports Leutz's classification of the base level of integration as linkage (Leutz 1999).

The account has demonstrated that multiple realities related to people, objects and process impinged on the enactment of the vision. For health practitioners, uncertainty and absence were continuing matters of concern, the former not unexpected, the latter present in many forms. Although the model of care was designed for clients with complex and chronic conditions and vulnerabilities, in this research, HealthOne clients were infrequently physically present. Yet traces of the clients were continually discernable as a 'manifest absence' (Law 2004, p. 84). As multiple realities interacted and interfered with the translation of policy into practice, the HealthOne model of care became an approach to integrated care that was enacted as linkage. Having characterised the ways in which HealthOne's vision of integrated care was enacted in practice, in the next chapter I turn to how integrated care was enacted, as practices changed over time. ■

Chapter six

Integrated care: an array of practices reshaping care

Introduction

This chapter answers the research question: 'How was integrated care unfolding?' This is the second of three chapters in this thesis that explore how integrated care was enacted in practice, drawing on data collected from shadowing, observation and interviews. In the previous chapter I drew on ANT concepts to argue that although absence and uncertainty were pervasive, HealthOne was enacted as linkage, a form of integration characterised by a low level of structure.

In this chapter my focus turns from the enactment of policy to practice change, drawing on Schatzkian notions of practice. My theoretical analysis of practice adopts Schatzki's account of the social as 'a contingently and differentially evolving configuration of organised activities and arrangements' (Schatzki 2002, xii). The emergence of change comprises 'changed practices, changed arrangements, or altered links between practices and arrangements', and there are 'pockets of experimentation … amid stability' (Schatzki 2013, pp. 38, 39).

In my discussion I draw out the interplay and tension between stability and change as practice altered. Although I consider the material arrangements within which practice was enacted, in this chapter I foreground practices, rather than materiality, since practices are 'the key element for analysing social

phenonemena' (Schatzki 2015, p. 2). I uncovered practices during my shadowing of two GP liaison nurses, a position regarded as the 'linchpin' of the HealthOne model of care (NSW Health 2012b). However, as explained in chapter three, practices are the unit of analysis rather than the practitioners.

The unfolding of integrated care was an evolving process, creating new ways of working with others through an array of practices. Some practices fostered change, while overlapping in productive tension with existing practices. I establish that practice change co-existed uneasily with stability. Practitioners struggled to make sense of the new model of care through policy documents or information artifacts. Thus I begin by showing how the model of care became intelligible to practitioners in practice. I argue that Schatzki's notion of acquiring meaning through the practices was central to engaging practitioners in the practice of integrated care, and therefore was also central to its emergence as a new form of care. I then contend that integrated care was unfolding as an interwoven array of practices, encompassing not only altered and new practices, but also familiar practices. I argue that this array of practices consisted of embedded, revived, remade and emergent practices. Thus, I account for the coinciding dimensions of change and stability as four types of practices. Some practices promoted forms of integrated care more readily, while others perpetuated existing forms of care. Hence I show how practice change was gradual, uneven, ongoing and spatially dispersed, across community health and the broader health and social services sectors.

Making sense of the model of care

The emergence of integrated care was related to how practitioners made sense of the model of care. Meaning arose from the practices that people carried out, rather than being acquired from policy documents or information artifacts. This 'ongoing practical endeavour' (Nicolini 2012, p. 162) of 'intelligibility' (Schatzki 2002, 2012) fostered practitioners' engagement in the practices, for participation

in this model of integrated care was not mandatory. Central to securing practice change was the practitioners' acquiring a grasp of how to do the practices. The following section argues that as the model of care became intelligible through practice, the form of integrated care emerged.

To explain this, I draw on the Schatzkian concept of intelligibility, meaning what 'makes sense' to an individual 'to do' (Schatzki 2002, p. 75). As explained in chapter three, intelligibility is one of the types of relations through which practice-arrangement bundles form. Intelligibility, or the meaning that arrangements have for participants in a practice, is 'tied to the practices', guiding an individual's practice (Schatzki 2012, p. 17). Practices are the site where considerable intelligibility ('the meaning of entities) is articulated' (Schatzki 2002, p. 100). This means that neither the policy documents nor the other information artifacts created for HealthOne were the primary sources of meaning about how to enact HealthOne. Instead, I show that the meaning that the model of care had for practitioners was related to the practices, and the phenomena that composed these practices, such as rules, understandings, and 'what is acceptable or prescribed in any practice', what Schatzki refers to as its 'teleoaffective structure' (Schatzki 2005, p. 475).

Since HealthOne was not a distinctive health service or program, practitioners did not grasp the model of care immediately. Similarly, as a researcher, the meaning of HealthOne evolved over time. By the end of the fieldwork I understood HealthOne and the organisational structures connected with it as being in 'a constant state of becoming' (Clegg, Kornberger, & Rhodes 2005, p. 158). The model of care was a work in progress, and an approach that was intended to (progressively and eventually) transform practice in community health and beyond.

The challenge of intelligibility: 'getting HealthOne'

Practitioners associated with HealthOne frequently said they felt challenged by trying to grasp what HealthOne meant in practice. This was colloquially referred to as 'getting HealthOne'. One experienced liaison nurse said that it took two years before HealthOne made sense to her. One senior manager told me in an interview that it took her 12 months to get her 'head around HealthOne'. Other senior managers expressed some excitement as they talked about staff finally 'getting' it (interview 1, March 2012; chronological record, June 2013). I heard that some senior managers still didn't 'get it'.

Some practitioners closely associated with HealthOne expressed the view that labeling the model of care as HealthOne had confused people. This was because this term did not immediately resonate with practitioners' understandings of primary health care or integrated care. Other factors may have added to the confusion, for instance, the implementation of seemingly similar national initiatives contemporaneously with the development of HealthOne, such as GP Superclinics, and Medicare Locals (interview, June 2013).

Ambiguity about the model of care was distracting for those working with HealthOne and meant that effort was required to explain the model. This was accompanied by the production of a stream of presentations and information artifacts. Developing a communication strategy to stabilise and capture in key messages the meaning of HealthOne became an ongoing activity for community health staff. Marketing experts were engaged by community health managers to find ways to encapsulate the meaning of HealthOne in a sentence. When this was achieved, it was hoped that everyone would 'get HealthOne' (Service Development and Implementation Group meeting June, 2013).

The challenge of making sense of HealthOne can be attributed in part to the nebulous nature of its material arrangements. HealthOne was not a discrete

provider or disease-specific health service. It did not have a unique or distinctive physical presence, usually being located in an office in the local community health centre or, at one site, in a suburban commercial building. Nor did it have staff, other than the GP liaison nurses, a position that existed in other settings. Furthermore, this pivotal role was not responsible for clinical treatment or case management. Instead, clients were enrolled in HealthOne by a range of practitioners. Clients could attend community health clinics (e.g. for women's health or wound care matters), and have contact with multiple health practitioners and services at various locations (in the home, in hospital and in the community), as could other community health clients not enrolled in HealthOne. HealthOne was not a program that offered a distinct number or range of services carried out by a particular group of practitioners.

Making sense of HealthOne may have also been a challenge because its practices seemed rarely different from those already occurring in other forms of healthcare. There was little to identify HealthOne as a model of care that might accomplish integrated care. HealthOne in reality operated as a distributed and often virtual network of activities traversing acute care, primary health care and community services. There were few practices that were distinctive to HealthOne. Those that were consisted of identifying a regular GP for clients, providing feedback to GPs, and holding case conferences with GPs. However, these practices were undertaken at a distance from clinical care. Many practices associated with HealthOne clients, such as case conferences and other activities identified in the model of care, such as care planning, and referral, were not unique to HealthOne. These were 'dispersed practices' (Schatzki 1996, 2002, p. 88), centred on a single activity that could be the practice of many healthcare practitioners, in healthcare arrangements other than HealthOne. Practitioners were accustomed to performing these activities during episodes of care. Hence

practitioners struggled to make sense of HealthOne's complex, scattered yet interwoven bundle of practices and arrangements.

Telos, rules and understandings underpinning practice

Making sense of HealthOne entailed grasping its teleoaffective structure, rules and practical and general understandings (Schatzki 2012). These were organising its practices and distinguishing HealthOne from other forms of care. The senior managers and clinicians in community health most closely associated with implementing HealthOne, recognised that its overall end-goal was to change service delivery towards comprehensive primary health care as articulated in the Alma Ata declaration (WHO 1978). These senior practitioners embraced this intention when explaining the model of care (Hanley et al 2014; interview 1, March 2012; chronological record, September 26 2012). The principles of comprehensive primary health care became part of HealthOne's teleoaffective structure as acceptable ends, shaping what made sense to do.

The senior community health manager who had led the development and planning of HealthOne was clear about how it should be practised. In an interview, she formulated this as explicit procedures or rules:

> what HealthOne should be able to say is they [a GP] can pick up the phone and say, 'Have I got an enrolment for HealthOne?' And then the GP liaison nurse can then set up a case review, all the players get around the table, we all look at what's going on, we all decide are there services that community health can contribute, are there other external services that can be brought to the table to help, what's the role of the GP, what's the role of community health, can we better manage this person's healthcare needs? That's what it's all about. (Interview 2, October 2011)

Making sense of HealthOne was a challenge for those who did not remember or appreciate the roots and the intent of the model, or who did not grasp the rules

underpinning practice. Although Schatzki holds that 'understanding an organisation as it happens requires a considerable grasp of its past' (Schatzki 2006, p. 1869), HealthOne's past was not shared beyond those practitioners and managers involved in its inception. Clinical staff newer to community health and HealthOne, who had trained in acute care, were unfamiliar with the principles of primary health care (chronological record, June 2013), although some may have learnt about these through postgraduate studies. Practical and general understandings only emerged through practice. However, practitioners who were resistant to following the practices of HealthOne and had not gained an appreciation of their worth, did not join in doing these practices, acquire a capacity to carry these out, or come to know their value. Thus the rules, goals and understandings by which HealthOne practice was organised were recognised by only some practitioners. Ongoing activity to create a communication strategy can be seen as an attempt to have all practitioners associated with HealthOne embrace its goals and procedures and participate as 'players … around the table' (Interview 2, October 2011) in workplace settings.

Meaning emerging through practice

In an early interview with the research team, a liaison nurse articulated some facets of HealthOne practice such as working together with GPs, communicating, coordinating services, strengthening relationships. In the interview extract below, she highlighted the formation of partnerships between community health and general practice, drawing out the sociality of new ways of working:

> Researcher: Can I just ask, in relation to that, in terms of what HealthOne and what the model is doing, how is it different from traditional community health, primary healthcare practice? What's it after that's different?

> HealthOne liaison nurse: For me—I don't want to speak for everybody—but for me anyway it's about integrating all those primary healthcare providers. Traditionally we've worked side by side, but not necessarily even communicating particularly well or coordinating services well. So what we're aiming to do is to try and do all of those as well as actually work as a team together. I know that creates problems in that they're privately funded and a different funding stream and that sort of thing, but the best that we can do that anyway. That's what we'll be aiming to do. I guess traditionally we haven't necessarily worked with the GPs so much - as much as we could. So it's a way of strengthening that relationship and definitely forming partnerships. (Interview 5, March 2012)

Because HealthOne's meaning was unclear initially, its actual meaning only emerged through and from practice. Speaking of one liaison nurse, one community health manager said:

> But Tina [the liaison nurse] is the embodiment of it isn't she? So if you didn't understand it you see what she's doing and then you get it and it's made a big difference. (Transcript, June 2013)

This shows how intelligibility related arrangements to practices, and arose from the practices. The practices created meaning for practitioners about what it made sense to do.

The liaison nurses were contributing to intelligibility, for they embodied the model of care for potential participants in its practices. Client enrolment was contingent not only on eligibility but also on the availability of a liaison nurse to instigate additional activity on the client's behalf, to carry out the practices of HealthOne as envisaged. HealthOne's operational base was community health. The liaison nurse created linkages for HealthOne clients to practitioners and organisations in general practice, allied health, mental health, disability services,

indigenous health, and social and support services, across the public, private and non-government sectors. HealthOne frequently operated as a virtual network of service providers. Its meaning was grasped often only through practices carried out by the liaison nurses, with various practitioners, organisations and clients.

Individual practitioners' grasp of HealthOne was shaped through their interactions with the liaison nurses who carried out the practices associated with the model of care. Having practised the model of care for over three years, one experienced liaison nurse was considered by other practitioners 'to somehow have a better understanding of it than a lot of the rest of us' (chronological record, June 2013). The HealthOne liaison nurses were regarded as embodying the practices, performing the actions that made up the practices.

As practitioners made sense of the model of care through practice, a form of integrated care emerged in practice. Community health practitioners gained new general understandings, for example, about the benefit to client care of identifying a client's regular GP and practical understandings about following rules to record all clients' GP's name on CHIME. In the process they also became engaged in carrying out the practices of the HealthOne model of care. Consequently, making sense of HealthOne through practice was central to practitioners enacting integrated care.

Meaning emerging over time

The continuous references across the data to 'getting HealthOne' show that the ways in which practitioners made sense of the model of care emerged over time. The struggles to grasp HealthOne were significant and point to often-unrecognised implications of introducing practice change such as new models of care. From a practice theory perspective, this is not surprising. Schatzki (2013) argues that the development of new practical understandings

accompanies change and is a requirement for the emergence of practice-arrangement bundles.

The arrangements and practices associated with the model of care were not immediately meaningful to practitioners. It was apparent that making sense of HealthOne was not a straightforward, immediate process. It involved a 'retrospective dimension' (Hager, Lee & Reich 2012, p. 5). Even for those liaison nurses and GPs who were involved directly in the practices of HealthOne, grasping HealthOne happened over time. Engagement with HealthOne was a slow and challenging process that called for more practical experiences of this new way of working, such as participation in HealthOne case conferences, rather than for more information brochures and presentations.

One liaison nurse with acute care experience recounted how it took her a while to 'get HealthOne', for it was not a return to a previous, known way of practising. Instead, practising HealthOne became 'a form of emergent coping guided by intelligibility' (Nicolini 2012, p. 166) as her experience and sense of the model of care grew. In an early interview, this was still forming, although she articulated some elements of HealthOne practice. She emphasised strengthened partnerships with GPs, but also mentioned care coordination, information sharing and patient empowerment for self-management. In later conversations she highlighted the importance of ongoing monitoring of clients as an element of the model of care, for by then she had come to realise that there were a number of components to carrying out the practices.

Making sense of the model of care also evolved for GPs. Community health managers stated in interviews that GPs were not generally regarded as understanding the concept of HealthOne (interview, November 2011; interview, June 2013). A GP who was actively supportive of HealthOne stated that many GPs did not yet perceive its benefits (chronological record, September 14 2012), despite HealthOne having had a presence in the local area for three years.

Participation was voluntary for GPs. However, one GP who took part in a HealthOne case conference reported later that the process was similar to hospital case conferences. This GP added that case conferences were more efficient than contacting individual practitioners about the patient and, as a billable Medicare item, HealthOne case conferences were also rewarding financially. First-hand experience of the practices of HealthOne, such as case conferences, gave the model of care meaning for some GPs.

Continuing activity led by community health managers to develop a HealthOne communication strategy also helped practitioners to show that they were grasping the meaning of HealthOne. Presentations at a HealthOne orientation in February 2013 initiating partnership with a non-government service for chronic disease and disability, encapsulated the later shift, both in articulating what HealthOne was, and how it was practised. The language was concrete, specific and focused on articulating acceptable 'ends' (Schatzki 2012, p. 16) as coordination of care, making linkages, and unblocking blockages. The work of the chronic, aged and complex care stream in community health was described as carrying out a number of practices from referral to discharge which included care planning, case management and case conferencing. Practical understandings organising a practice arise when participants in a practice reach consensus on what makes sense to do (Nicolini 2012, p. 165); from hearing the language of these more recent presentations, this point had arrived.

By the end of the fieldwork, the HealthOne model of care was emergent across community health in the local health district. The early struggles were to do with making sense of HealthOne, and grasping it as something tangible that health practitioners could practice together with eligible clients. Later, practitioners were clearer and HealthOne was becoming an approach they could apply to all community health clients, with the complexity of the client's needs determining the degree of involvement with clients and their GP.

HealthOne was becoming 'everybody's business' (interview, June 2013), for the rules, understandings and teleoaffective structure had in Schatzki's terms, disseminated and coalesced (Schatzki 2012, p. 23). Practising the model of care had become guided by intelligibility.

Practice has been the anchor to interpret the data about how integrated care was unfolding. Rather than operating as a distinctive health service or a discrete program, HealthOne was an approach to a way of working with others that was emergent. Making sense of HealthOne was made possible by the emergence of rules, teleoaffective structure and understandings, which organised the practices as a phenomenon that could be distinguished as HealthOne. It took time to make sense of the HealthOne model of care; grasping this was shaped through practice. This indicates that intelligibility was at the core of practice change, fostering engagement in the model of care. The centrality of intelligibility, of people struggling to make sense 'of what is going on' (Nicolini 2012, p. 163) and how HealthOne was practised, was a key feature of the unfolding of integrated care as practitioners gradually made sense of its practices, and thus became engaged in the practice of integrated care.

I turn now to explain the field of interwoven practices that together were shaping the practice changes I observed.

Practice change: an array of practices

Practice theory argues that stability and change are inherent to practice, and happen concurrently (Price, Scheeres & Boud 2009; Price 2013; Schatzki 2002, 2013). This section adopts Schatzkian practice theorisation to establish how organisational practices were simultaneously remaining stable and changing. I argue that integrated care in the making was an array of interwoven practices, both old and new, some stable and some changing. This array included new, altered, existing practices and revived practices. I argue that practice change co-existed uneasily with stability.

Whilst practice change was gradual, there was also an accompanying stability or continuity (Schatzki 2005, 2010). Stability can be seen in the way practitioners continued to work as part of the disciplinary streams of child and family health, or chronic, aged and complex care. Yet simultaneously the HealthOne model of care was slowly becoming part of everyday practice for all practitioners in community health. What Schatzki (2013, p. 40) describes as a 'stepwise, accumulating' round of change could be observed.

Integrated care was unfolding as a bundle of practices and arrangements. Besides 'the ebb and flow of established and new practices' and new and old arrangements, (Schatzki 2013, p. 37; see also Schatzki 2005), this study uncovered practices that happened for a time in the past that were reinstated, as part of the model of care. Thus I propose that the unfolding of integrated care encompassed an array of practices: embedded practices, remade practices, revived practices and emergent practices. The conceptualisation of existing, altered and new practices (Schatzki 2005 p. 476) has been reconfigured. As explained in chapter three, this reflects a deliberate engagement with Schatzkian notions of practice change and also a movement forward.

The elements of a typology for explaining how the model of care was reshaping care arose from an analysis of data associated with change, as explained in chapter Four. My definitions of these elements are as follows. Embedded practices have persisted over time and are established, existing practices. Remade practices are practices that have been reinvented, as a variation to existing practices. Revived practices have existed for a time in the past, and have been reintroduced. Emergent practices are new forms of practice. This section will explain my conceptualisation and how the practices were interwoven and related to arrangements.

This discussion is concerned with practices that I observed as practitioners carried out the HealthOne model of care. The practices explained below are tied

to the context in which HealthOne emerged, initially as a partnership between community health and general practice, which have traditionally operated as separate spheres of practice, with different funding and governance. In reality, clients enrolled in HealthOne received services from practitioners and organisations delivering client care in the public, private and non-government health and social care sectors. How integrated care was forming became interconnected with its context. Working autonomously was transforming into new ways of working with others, incorporating old and new arrangements, in general practice, community health and beyond.

Much healthcare practice did not change with the introduction of HealthOne. Some familiar, established practices identified as part of the model of care, such as client enrolment, care planning, and referral, involve activities indistinguishable from other forms of healthcare. However, emergent practices were distinctive of HealthOne as it was unfolding. The model of care also relied on existing practices that were revived and remade to promote integrated care, such as establishing partnerships with practitioners from a spectrum of services and organisations, sharing information among service partners and working together with GPs. In addition, the model of care entailed new and existing material arrangements or entities, both people, and services, and artifacts such as feedback and consent forms, that were familiar in other healthcare settings but now enjoining different purposes. Table 6.1 lists the interwoven array of practices through which integrated care was unfolding. Practices are categorised according to the typology outlined on page 169 that is elaborated in the following sections.

I maintain that new ways of working unfolded amidst practices that were concurrently reshaping care, advancing or co-existing uneasily with other embedded practices. I turn now to define and describe the different categories

of practices. My account draws out the interplay and tension between stability and change as practices were both maintained and evolving.

Practices	EMERGENT	EMBEDDED	REMADE	REVIVED
Protecting client confidentiality		✔		
Working in silos		✔		
Enrolling clients		✔		
Care planning		✔		
Referring clients		✔		
Sharing information			✔	
Participating in multidisciplinary case conferences			✔	
Establishing partnerships with practitioners				✔
Working with GPs				✔
Gaining client consent for disclosure of information to GP and community health for continuity of care	✔			
Identifying a regular GP for clients	✔			
Providing feedback to GPs	✔			
Participating in multidisciplinary case reviews in community health	✔			
Engaging clients	✔			

Table 6.1: An array of practices

Embedded practices

Embedded practices are practices that have been established and have remained in existence over time. They are organised by persistent rules and general understandings that are strongly held and prescribe how practice is enacted. Embedded practices are entrenched and resistant to change. In the HealthOne context, some embedded practices were sources of reaction to the model of integrated care because practitioners shared the understandings and rules of these practices and sought to uphold them. Practitioners worked in established discliplinary and organisational streams, and were accustomed to working autonomously and adhering to medico-legal requirements. These embedded practices co-existed uneasily with the changes presented by revived and remade practices (e.g. establishing working partnerships and sharing

information across disciplinary and sectorial boundaries). Two key embedded practices are working in silos and protecting the confidentiality of client information. Both these practices rubbed up against the unfolding of integrated care across sectors and disciplines.

Working in silos

Firmly held boundaries between healthcare disciplines, sectors and organisations have, historically, given rise to the embedded practice of working in silos, that is, as 'dispersed and independent services' (Keast, Brown & Mandell 2007, p. 12). This tendency has been consistently recognised across the literature (e.g. Keast, Brown & Mandell 2007; Mitchell, Tieman & Shelby-James 2008; Naylor, Alderwick & Honeyman 2015). The HealthOne model of care aimed to bring service providers together to collaboratively manage HealthOne clients' complex and multiple needs. Disrupting the silos was an integral step towards achieving integrated care. However, the organisations, disciplines and services associated with HealthOne clients in the study settings were structurally separate, with disparate and complex funding sources and governance arrangements. Mental health, drug and alcohol services, multicultural health and refugee health were discrete organisational streams; the traditional hierarchies of nursing and allied health in the community health sector remained separate. The silos remained, despite support for HealthOne from champions at the senior level in community health, general practice and the NSW Ministry of Health; the establishment of governance for oversight of HealthOne (NSW Health 2011d); and the establishment of formal partnership agreements in some HealthOne sites (transcript, October 2011).

One GP working with HealthOne highlights how the long-standing professional practice of working in silos was a challenge. This deeply embedded practice reflects both general understandings about historical divisions between

medical craft groups and differing rules about competencies and registration requirements:

> We're working in a context where there's I guess mistrust between various health professional groupings, both [at the] primary care level and between primary and hospital level[s]. Also I think we work in professions where there's a mistrust between profession[als] within the profession as well. So we're moving from … I guess it's moving from [an] individualistic model of practitioner care to a team-based model involving multiple people at multiple times, which is really what a hospital is. But the general practice really hasn't evolved yet to that position … [it] is historical and cultural, deep seated. I mean there's always been tensions, [and] territorial issues between doctors and nurses and then between hospitals and general practice … I've heard it said that Australia is probably more siloed than other places. (Interview 2, September 2011)

Health practitioners resisted stepping outside the silos. For example, one HealthOne liaison nurse based in community health commented during a discussion with other liaison nurses:

> When GPs are operating from their own practice they're not necessarily engaged with other health service providers and understanding of what is happening outside the GP practice realm. And it's the same with us. (Transcript, December 12, 2012)

General practice and community health were separate spheres of health care that co-existed. Individual practitioners retained a duty of care within their scope of practice, and organisations were structurally separate. They only intersected when individual practitioners were treating the same clients.

Distinctive material arrangements reinforced the silos. For instance, in the community health centre from where much of this study was conducted, the

child and family health nurses worked from a room on one floor, and the chronic, aged and complex care nurses were housed separately on another floor. HealthOne liaison nurses were attached to these different community health streams. Action plans, which were developed following HealthOne case conferences, replicated the disciplinary silos instead of becoming a set of shared goals and processes. Notably, GPs who participated in the case conference were not included in the action plans. Action plans enshrined the delineation of disciplines, implying that prospective services consisted of goals and tasks individually devised for the client, based on individual practitioners' resources.

Protecting client confidentiality

I also found that protection of client confidentiality was a well-entrenched practice, upheld in compliance with legislative requirements and generally understood as part of practitioners' duty of care. This worked against an acknowledgement of the benefit to the HealthOne model of care of sharing information, such as through instituting feedback letters for GPs and instigating multidisciplinary case reviews in community health (emergent practices discussed further below). The need for up-to-date information about a HealthOne client's health status so practitioners could plan future care rubbed up against the many instances where practitioners chose to protect client confidentiality. Health practitioners withheld certain personal information at times, as did practitioners from other organisations. This reflected the embedded practice of protecting client confidentiality for medico-legal reasons, and demonstrates the prominence of rules in organising practice.

Client consent to participate in HealthOne also authorised community health staff to disclose the client's health information to their GP. There were no signs of formal agreements for the sharing of information between organisations, or across sectors, other than the mechanism of this consent. Nevertheless, practitioners protected some client information from disclosure,

even to other community health practitioners, thereby observing rules and expressing general understandings about protection of client confidentiality.

For example, following a HealthOne case conference at a general practice involving a young Chinese woman whose baby had been admitted to the Children's Hospital for anaemia, the psychologist present divulged that the GP had talked with the client about her relationship. The client's English was poor, and she spoke with the GP and the psychologist in Mandarin at length. There was no translation of this conversation. However, other community health practitioners participating in the case conference were not given further information.

The protection of client confidentiality was an embedded practice, particularly in regard to sensitive information, for this is subject to more stringent rules restricting disclosure. For example, I attended a home visit to a HealthOne client, a new mother. The baby was the third baby born to this woman following the removal of her older children by a child protection agency. However, neither the mother, nor the agency, disclosed the reasons, or circumstances of this case, to the clinicians treating mother and baby in community health.

At times, practitioners made decisions, or advocated, on the client's behalf about which information should be protected. For example, an interpreter was not willing to interpret all the questions that a nurse was putting to a client, since the interpreter considered that the information requested regarding sexual health was too sensitive. Similarly, a liaison nurse expressed her concern about disclosing information about clients' mental health issues or sexual health history to GPs, questioning whether such sensitive information should be shared. Where practitioners from other organisations outside health participated in case reviews (e.g. in the Perinatal Working Party), the clients were de-identified to protect their confidentiality. One liaison nurse noted that

'GPs are very protective of their clients' confidentiality—they don't reveal much' (transcript, December 20 2012). There was therefore tension between the embedded practice of protecting client confidentiality and the importance to the HealthOne model of care of access to client information to support planning of a client's future services.

In summary, working in silos and protecting client confidentiality were embedded practices that challenged the precept of integrated care that called for practitioners to share care of HealthOne clients across organisational boundaries. These embedded practices were organised and maintained by rules and general understandings that upheld not only separate organisational structures but also principles of protection of client confidentiality and duty of care. Lacking formal shared care agreements to overcome this, the model of care relied on practitioners having embraced shared purpose and understandings to organise practices.

Remade practices

In practice theory, 'remaking' was initially conceptualised in relation to the practices of remaking 'one's job', as when workers 'reinvented themselves and their work' in response to the changing needs of their organisation (Price Boud & Scheeres 2012, p. 78; see also Price, Scheeres & Boud 2009). That conceptualisation related to workplace settings where employee-driven workplace innovation led workers to remake their jobs, by varying practices within their individual jobs, thereby also remaking organisational practices. The Australian Research Council project to which this doctoral study is linked was entitled 'Remaking practices'. The project used the term 'remaking practices' 'to signal the way the desired enactments of multi-disciplinary, interprofessional practices require different partnerships, relationships, activities, capabilities and identities including different engagements with patients' (Solomon et al 2010, p. 1).

In this study, the concept of remade practices has been expanded. Instead of varying individual jobs and practices so that organisational practices were remade, in the HealthOne setting practices were remade to incorporate multiple practitioners sharing care of clients in new material arrangements across disciplines, organisations and sectors. The practices of case conferences and sharing information were remade through a broader scope of arrangements. The practical understandings that formerly organised the practice became expanded. Thus existing practices were remade for a broader setting. This meant not only reinventing individual fields of work but also connecting a number of practitioners from multiple organisations in new ways of working with others across workplaces.

Remade practices for sharing information and case conferencing promoted integrated care. Case conferencing was a practice already used in the acute care setting, with health practitioners the usual participants. In the HealthOne setting, it was remade, by including GPs and clients where possible, as well as representatives from other social services, along with health practitioners. Thus in the HealthOne case conference, practices were remade across multiple organisations, beyond individual fields of work, to plan the future care of shared clients. The following chapter will explain how the case conference, a key feature of the HealthOne model of care, acted as a mechanism of integration.

Sharing information

The second remade practice I identified through my fieldwork is the sharing of information. Sharing information 'amongst health service providers for ongoing care' (NSW Health 2011d, p. 10) became a remade practice to support the HealthOne model of care. It was organised by general understandings about the benefit of reduced fragmentation of information to carrying out integrated

care and practical understandings about how to carry out actions to overcome the fragmentation.

HealthOne clients' health information was distributed temporally and spatially across the healthcare sector. Practitioners sharing care of HealthOne clients did not have shared access to comprehensive information about their client. There were no common summary electronic health records holding current information about HealthOne clients. Sharing information is generally understood as being vital to integrated care (e.g. Shaw, Rosen & Rumbold 2011; Wistow et al 2015). Yet arrangements to support this were absent. This led to interventions by individual liaison nurses to actively share information about HealthOne clients with practitioners treating them who were dispersed across disciplines and organisations.

Although community health practitioners had shared access to information about clients on CHIME, the community health information system, the HealthOne consent form authorised community health staff to share information with the client's GP without contravening privacy and confidentiality rules. With this official sanction the practice of sharing information about clients became remade and was extended beyond community health to encompass general practice as well as the multiple service providers associated with HealthOne clients.

HealthOne liaison nurses acted as the conduit of information, particularly with GPs, but also with other service providers. Liaison nurses physically shared information about HealthOne clients, for example, about hospital presentations, discharges, referrals, issues of concern. This practice was carried out through conversations with practitioners associated with HealthOne clients, and also by liaison nurses personally transporting material artifacts such as feedback letters, discharge summaries, and assessment forms, which were created during a HealthOne client's trajectory. Frequently, the liaison nurses

accessed multiple information systems to create an up-to-date account of the client's health status, which was then transported to another practitioner working with the client. This sharing was organised both by practical understandings to overcome the fragmented information held in multiple information systems and the lack of supportive technologies, and by general understandings about the benefits of shared information to support the care of HealthOne clients.

Revived practices

In this study, the conceptualisation of existing, altered and new practices (Schatzki 2005 p. 476) has been reconfigured to incorporate revived practices, as well as embedded, remade and emergent practices. Revived practices are those that existed for a time in the past, and have been reintroduced or resurrected. In the HealthOne context, revived practices co-existed uneasily at times with some embedded practices, such as working in disciplinary silos. However, the revived practices of working with GPs and establishing partnerships with practitioners promoted the emergent practices of integrated care through working with others in informal partnerships across health and social services.

Establishing partnerships

The particular arrangements and practices through which the HealthOne model of care unfolded were often advanced by the liaison nurses' efforts to establish partnerships that might facilitate future engagement in integrated care. The revived practice of establishing partnerships was not a formal component of the model of care. This practice was organised by general understandings that integrated care was enacted through a partnership between practitioners based on willingness to participate and professional duty of care rather than rules stipulating engagement in the model of care or mandated under formal agreements.

As noted in the first chapter of this thesis, 'integrated care' is a contemporary reframing of 'primary health care' that emphasises collaboration and coordination of services 'within and between the cure and care sectors' (Kodner & Spreeuwenberg 2002, p. 4). Participants in HealthOne recognised it as an intention to return to a more holistic approach to client care (interview, December 2012), by collectively tackling a client's spectrum of needs, instead of practitioners working autonomously, focused on task and condition (interview 1, March 2012). That view was expressed by senior community health managers in a meeting, as follows:

> It is a primary health model. It is not unique in its model approach. It is within the environment we are in now, and I acknowledge that. It is within that environment and it is a - the primary health model we've moved away from in community health services over, probably, a 10 year period. So from that perspective it looks new. What's different, I think, is the level of engagement with GPs. (discussion at HealthOne Service Development and Implementation Group meeting June 2013)

The various practitioners associated with HealthOne clients were from different discliplines and organisations, and possessed a range of competencies, resources and goals. Their individual fields of work were both interdependent and distributed. Thus, the practice of establishing partnerships was infused by a common general understanding that enacting a form of integrated care across organisational and disciplinary boundaries involved engaging with not only community health and GPs but also allied health, acute care and social services.

Hence the HealthOne liaison nurses worked at establishing informal partnerships that might induce integrated care. However, this work was not directly related to client management. The indeterminacy of future actions meant that the outcomes of this effort were uncertain. Nevertheless, liaison nurses encouraged participation with HealthOne by developing relationships

with practitioners distributed across disciplines, sectors and organisations, who were, or could be in future, involved in care and provision of services to HealthOne clients. The liaison nurses built connections with a wide range of individuals and organisations through numerous meetings, discussions and case conferences, thereby facilitating referrals to HealthOne and future access to services, and encouraging collaboration.

For example, the Perinatal Working Party that was convened by the child and family health liaison nurse included participants not only from health but other social services, although the group was not formally a multidisciplinary team. Client cases were reviewed, although those present were not usually involved in the current care of clients being discussed. Part of the purpose of the Perinatal Working Party seemed to be to seek advice about next steps in the care of complex clients. However, the working party was essentially a forum to establish informal partnerships with a range of health practitioners and service providers.

Engagement was a term that often surfaced in conversations and documentation about HealthOne. The liaison nurse relied on other health practitioners and services to refer clients to HealthOne, and needed the collaboration of the clients' GP as well as the client's consent for enrolment in HealthOne. A promotional flyer created by a liaison nurse and displayed on the door of one HealthOne office depicted a range of engagement activities (represented below in Figure 6.1). Although engagement was not explicitly formulated as a rule to be followed, it was generally understood as worthwhile activity to promote the HealthOne model of care and build partnerships.

Community Health and GPs working together

***E**mpowering community nurses*

***N**avigating the Medicare items*

***G**eneral practice (GP) consultations*

***A**ctively collaborating*

***G**etting to know local GPs*

***E**nhancing information exchange*

***M**aking time to get to know the community*

***E**valuating goals*

***N**etworking with other professionals working locally*

***T**argeting service providers*

Figure 6.1 'Community Health and GPs working together'

Establishing relationships and understanding how other practitioners and organisations worked was foundational to working in partnership. Enacting integrated care entailed building trust and willingness to work together co-operatively over time. These relationships could be drawn on to access services for HealthOne clients in the future. One liaison nurse describes the process:

> Partnership, it's really what HealthOne is. Instead of nurse to client, it's GP liaison nurse to services. Our role is to go out and understand what service providers do, to work with them from their space and to pool our information together … It's getting to know them. You just can't go and refer to someone. You need to know them, you've got to understand their service, build a relationship. And understand how their service works and the restraints on them. (Transcript, December 13, 2012)

In identifying partnership building as a practice, this study has uncovered a revived practice that was not formally part of the model of care. However, achieving practice change was contingent on the establishment of partnerships

with other practitioners, particularly those beyond the familiar workplaces of community health and adjacent hospitals. Building relationships with potential service partners through the liaison nurses' participation in various forums and their engagement with practitioners drew these practitioners into working with the model of care. Establishing partnerships with potential participants in joint work with HealthOne clients revived past practice, now reinstated as part of the model of care.

Working with GPs

Working with GPs was another revived practice. Improved partnership between community health and GPs was a key feature of the model of care (NSW Health 2011d, p. 9). Since participation in HealthOne was voluntary for GPs, establishing working relationships with GPs might encourage future collaboration. Although at the time of HealthOne's introduction, GPs and community health practitioners were accustomed to working autonomously, the practice of working with GPs and having ongoing dialogue about particular clients and families was familiar to practitioners who had entered community health some decades previously, as the following interviewee makes clear:

> Twenty years ago, I was a community nurse. I can quite clearly remember going out—you had your little geographic patch and you would visit the GPs and you would sit down and discuss their patients with them and what you were doing for them. You'd really work together. (Interview 1, March 2012)

A key element of HealthOne was the negotiation of effective working relationships with general practitioners. However, this sat uneasily with established practice. In the words of a senior GP, GPs had 'been ignoring the system for 20 years' (transcript, 19 November 2012). Beyond the core group of GPs who were leading the change, many GPs were disengaged and uncertain about HealthOne. The purpose of HealthOne was not commonly accepted

among GPs, and many were bewildered by it (chronological record, April 2013). Thus the degree of co-operation among these health professionals in working with the model of care varied. Some resisted passively until a complex case necessitated joint activities through HealthOne. In practice theory terms, GPs had not embraced the teleoaffective structure of performing actions for particular ends (Schatzki 2012, p. 16). There was little common acceptance or orchestration of established purpose helping to organise the practices. Despite responsibility for HealthOne clients being shared between community health and GPs, the revived practice of working with GPs co-existed uneasily with the embedded practice of working in silos as this HealthOne liaison nurse explained:

> they [community nurses] sometimes are really scared talking to GPs. … So part of what I do now is showing them that you don't need to be scared. They are normal people. All you need to do is understand their language … You can't imagine what it's like in GP land. (Interview 1, October 2011)

Although some GPs embraced the model of care for the sake of clients with complex problems who needed specialised assistance, rules and operating procedures served to preclude working together. Both community health and general practice were under pressure to meet the demand for services. The rate of consultations per person in Corymbia's local general practices was already the third highest in Australia, and 50% higher compared to other parts of Sydney (NSW Health 2012b). Many local practices refused to take new patients (transcript, December 2012). Additionally, GPs practised autonomously under fee-for-service arrangements, with prescribed rules for case conferences and length of consultation. One challenge for HealthOne was that according to the liaison nurses, under Medicare Australia's billing rules GPs could only claim for a case conference where two service providers and the client, in addition to

the GP, were present. However, HealthOne liaison nurses were not strictly service providers. Instead, they operated as clinical coordinators, while GPs worked under time limits in a commercial business model. The following discussion between liaison nurses highlights the challenges of working with GPs in integrated care:

> The GPs working in the big practices are trying to make money, in the commercial practices. … They would love to do this but they can't. They are under the strap as much as we are. It's their time. I have a new respect for them … If I don't take the information to them, they're not going to have time to look it up. Where do they get paid for that? They don't, we need to be working together to support them so that the client gets better care.
>
> They don't get paid for us if we don't have the client there for a case discussion. They're very gracious about it. It's not paid time when we go and talk to them, when we take the letter without the client. The receptionist will block you, and say, 'I'll get the doctor to ring you back.' The threat is access to the GPs. (transcript, December 13 2012)

According to one senior community health manager, GPs were keen to refer certain patient groups to HealthOne, especially non-compliant patients and those with complex problems. This manager stated in a presentation to a community health forum that GPs were reportedly cynical and misinformed about community health, lacked knowledge of services and referral processes, and were 'out of the feedback loop' and inexperienced in integrated care models (NSW Health 2010a, 2010b). Community health practitioners reportedly lacked knowledge about general practice issues, and focused on episodes of care rather than ongoing care (NSW Health 2010a, 2010b). From a practice theory perspective, practical and general understandings organising the practices of community health and primary care were not completely aligned.

The following scenario revealed the tensions around working with GPs. Although a liaison nurse had made an appointment with a GP to discuss a HealthOne client, the GP refused to speak to the liaison nurse without the client being present. However, the client was not interested in visiting the GP together with the liaison nurse. In the liaison nurse's view, it was unnecessary for the client to attend an initial discussion with the GP 'about how best we support the client' (chronological record, September 14 2012). Thus there was a dichotomy between the HealthOne approach and the general practice approach to care, which is shown in the extracts below:

> The prevailing wisdom of a decade ago … is that traditional general practice is dead and the relationship between an individual patient and a GP is not important, that in fact all you need is continuity of the service and continuity of the information. Both [are] untrue … They'll have a GP on the outside of their silo and communicate with them but not have them central. (Interview with senior GP, December, 2012)

> Kelly (liaison nurse): If there's been a long standing relationship with the GP, the GP has got all the evidence … If we need to get referrals happening, then we need that person in that circle to be inputting. The attitude is GPs are hard to get. Well, yes, they are. But then if you know that particular patients need to have that consistency and the GP needs to be involved and you make it happen, then they will follow on with that.

> Tina (liaison nurse): As you said, some will, some won't. That's it, isn't it? You deal with what you've got. (Transcript, December 12 2012)

Working with GPs was a case-by-case negotiation, calling on perseverance and adaptability, to create partnerships. Notwithstanding the resistance of some, not all GPs were unwilling to work together in the model of care. It is likely that the complexity of the client's case influenced the GP's collaboration, and

opened the communication between community health and GPs. A senior community health manager suggested that it was 'getting people used to having other players coming in and trusting' (transcript, November 19 2012) that disrupted the notion of 'my patient'. A GP on the HealthOne steering group suggested that it was about being 'invited to [a] case conference, stitching up the disconnections case by case, seeing it's possible to work with patients who are very complex' (transcript, November 19 2012). Thus, not all GPs were resistant to HealthOne. Working relationships had to be established, practice by practice.

A scenario recounted as a success story by one liaison nurse concerns a HealthOne client, Khoa, a young boy on the community health waiting list for speech therapy. A case conference was organised at the general practice with Khoa, his mother, the GP, the liaison nurse and a community services worker, to propose access to private speech therapy services through a chronic disease management plan to fund this service. The GP reportedly had difficulties submitting previous chronic disease management plans, but was willing to make another effort since the liaison nurse had renewed his involvement with the family. However, this scenario demonstrates how the model of care placed the onus on the GP to plan and coordinate Khoa's care, shifting the workload from community health to the GP, and perpetuating the prevailing medical model of care. Thus the revived practice of working with GPs was accompanied by some tension, which may account for its variable, uneven progress.

Building working relationships with GPs and establishing partnerships with other practitioners revived past practices of working collaboratively. These practices were not formally part of the model of care but were crucial in advancing integrated care. The practices were organised by general understandings that these relied on informal partnerships based on willingness

to participate and professional duty of care, rather than on rules prescribing engagement in the model of care.

Emergent practices

Enacting integrated care entailed creating new or emergent practices. These emergent practices differentiated the model of care from what had happened before, and were intended to promote integrated care. There were emergent practices about HealthOne clients, for example, gaining consent from clients to be enrolled in HealthOne. Patient consent authorised community health practitioners to contact HealthOne clients for continuing care and to share client information with GPs (NSW Health 2011d). Another emergent practice required the introduction of multidisciplinary case reviews for community health practitioners.

Some emergent practices introduced through HealthOne were constructed as discrete, singular actions in policy documentation, for instance, obtaining HealthOne client consent, identifying a client's GP and providing feedback to GPs (NSW Health 2011d). In practice, these were not concrete, or specific activities, but were more open-ended, being temporally and spatially dispersed (Schatzki 2012, p. 14). These practices were organised through HealthOne's teleoaffective structure (the end-goal being integrated care), practical understandings about how to search information systems and record information on CHIME, and rules about protocols for consent.

An example follows that illustrates how apparently simple tasks were organised as a new practice that promoted the emergence of integrated care across community health. A key requirement under the model of care was the emergent practice of identifying a community health client's regular GP, and recording this on CHIME, so that all practitioners could be aware of this information. There were rules attached to this practice, in that all community health practitioners had to follow this procedure. In practice theory terms, there

were teleoaffective structures related to beliefs about doctor shopping and the benefit to clients of contact with one GP; and general understandings that many clients lacked a regular GP and that many clients would only visit a GP from the same culture and gender. Locating and recording who was a client's regular GP involved an array of activities over time and space. Practitioners knowing how to carry out actions as elements of this practice created new practical understandings of what HealthOne entailed. This was an emergent practice introduced across community health through HealthOne, as rules, teleoaffective structure and practical and general understandings coalesced and governed practices carried out in common.

Providing feedback to GPs

Another emergent practice was concerned with sharing a HealthOne client's personal health information with GPs, by providing feedback letters to GPs about their clients enrolled in HealthOne. This was a seemingly simple activity, requiring the liaison nurse or community nurse to populate a template with information from CHIME and then fax or hand-deliver the letter to the GP. This practice was required under the model of care, and had been instituted to ensure that information provided from community health to GPs about HealthOne clients became a formal part of the general practice patient record. It was intended to reduce the risk that information provided verbally to GPs might be omitted from the patient's file. This practice adopted a broader set of purposes and activities about communication with GPs than had been previously imposed in community health. It enabled practitioners to build the partnership between community health and general practice, and ensured that the general practice was better informed about the HealthOne client's history and care.

However, providing feedback to GPs involved more than generating and sending a template form. During this study, hospital discharge summaries and

test results were still not routinely arriving in general practice information systems. For instance, in following up on a newborn baby with severe abnormalities, the liaison nurse mediated the transfer of discharge information from different inpatient episodes of care to the GP. The liaison nurse described this later:

> I gave the GP the discharge summary, she didn't have that, and the neonatal discharge summary from [another hospital] … She didn't know that the kid has all these other problems. (Transcript, September 14, 2012)

Another example follows of a perinatal patient whose mental health became of concern to the social worker and hospital nursing staff, who enrolled her in HealthOne. Information retrieved from the hospital including the discharge summary, was relayed by the liaison nurse to the client's GP. The liaison nurse then followed up with the hospital social worker:

> She [client's GP] didn't realise there were a whole lot of issues other than the fact that [the baby was due] … so I've explained that to her. Yeah that's right. And she does know that family well and they do see her regularly. And they didn't have any of that discharge summary or anything so I've given her all that stuff. (Transcript, September 14, 2012)

From a practice theory perspective, this emergent practice was organised by practitioners' practical understandings about providing comprehensive information to GPs about clients for the sake of improving follow-up care.

The emergent practice of providing feedback to GPs went some way to decrease the fragmentation of information about each client enrolled in HealthOne and involved additional activities beyond generating a form letter. However, the practice of protecting client confidentiality was common among GPs. This is an example of where an emergent practice can be in tension with an

embedded practice, for the flow of feedback information was typically unilateral from community health to general practice.

Carrying out the HealthOne model of care relied not only on the GP's collaboration but also on the client's willingness to be the subject of this care. At times, HealthOne clients demonstrated resistance and reluctance to engage, frustrating practitioners who were committed to the emergent practice of linking clients with a regular GP. The final section explores the emergent practice of engaging clients in the HealthOne model of care.

Engaging clients

HealthOne clients could be referred by GPs, other service providers or from community health. Although clients gave consent to be enrolled in HealthOne, their enrolment was not self-initiated. Typically, in primary health care, an interaction with a service is initiated through a referral from another practitioner. Alternatively, a client presents to a service as a self-referral. Enacting the HealthOne model of care relied on the client's willingness to be the subject of care, and yet a lack of shared understandings about the benefits of participation was apparent in some cases. Practitioners who carried out this practice of engaging clients in HealthOne reflected HealthOne's purpose of avoiding hospital admissions and improving or maintaining the health of clients through arranging access to a broader range of services. Hence engaging clients in HealthOne became an emergent practice, although it was not formally prescribed as part of the model of care. Nor was it part of usual practice in community health.

A GP closely involved with HealthOne described the liaison nurse as a 'hunter and gatherer', for the liaison nurse could be 'proactive about identifying people who need help accessing services' and engaging them with HealthOne (interview 2, September 2011). Rules about the allocation of time per patient did not apply under the model of care. Thus, HealthOne liaison nurses had the time

and licence to persevere with non-compliant patients, whereas many health services would have to move quickly to another client (chronological record, December 13, 2012). The liaison nurses understood that engaging clients in HealthOne involved prolonged activity with short periods of intense intervention. The value of this was a general understanding that infused how they practised with clients. 'This woman is going to be hard to engage. She's one of these ones who shut down the minute you start, so I am just going to tread lightly,' remarked a liaison nurse about a client, a twenty-year-old refugee diagnosed with human immunodeficiency virus (HIV), who had a newborn baby and a four-year-old child (transcript, October 25, 2012). Despite the dissonance that sometimes existed between health practitioners defining clients as in need of services and clients who were reluctant to accept offers of services, the perseverance of the liaison nurses continued. They considered that the client's health status warranted persistence to encourage participation in HealthOne.

However, HealthOne liaison nurses encountered instances where clients resisted offers of support or referrals. These instances where clients were unwilling to be the subject of care indicated that the local community had not all embraced the goals of HealthOne. The teleoaffective structure that was, over time, embraced by practitioners did not resonate with all clients. Some clients were reluctant to engage, sometimes only seeking assistance to negotiate with other services. On occasions, HealthOne clients rejected referrals, did not attend appointments, or refused to allow health practitioners to enter their home.

The efforts made by liaison nurses to engage clients are demonstrated by an example I observed on my fourth day of shadowing. This example concerns an African woman who had arrived in Australia a few years previously and who had two young sons. The liaison nurse had organised care plans for the children, and the older boy was booked in for his two-year development check

with a child and family health nurse, which the liaison nurse also attended as a means of monitoring the family's ongoing care. The liaison nurse, Tina, asked the client about 'the women's health nurse, did you manage to get there?' The client replied: 'No I haven't been there.' The client mentioned a women's health centre in Corymbia, where she saw a doctor. 'Not sure which one exactly] I will continue with, so let me take time again and ....' The liaison nurse also offered a counselling referral. The response from the reluctant client was:

> [now I'm] able to go some places, like to visit friends as well which is helpful. Sometimes you have stress but when you are with friends you talk [and] stress goes. Sometimes you think you have deep problems but when you talk to others yours are small than even others. You know. (Transcript, October 25, 2012)

But the client left the possibility of future help open: 'I'm strong cos I know if these things happen I've got Tina to get a solution. There's many things.' (transcript October 25, 2012). Although the woman resisted the proffered referrals for herself, she did accept a dental referral for one son, and returned some months after this consultation seeking the liaison nurse's assistance with her new home care application. The liaison nurse's light touch in encouraging her client to accept offers of support and referrals demonstrates the practical understandings that organised the liaison nurse's practice of engaging clients in HealthOne, which gave the client an avenue of further support when required.

Uncovering practice change

In this study, the Schatzkian conceptualisation of existing, altered and new practices has been reconfigured to incorporate revived practices, as well as embedded, remade and emergent practices. I have proposed that the practices enacting integrated care encompassed this interwoven array of embedded, revived, remade and emergent practices. This conceptualisation has allowed me to demonstrate how practice was concurrently stable and yet changing. It was

applied empirically in the context in which HealthOne was unfolding, which extended beyond individual workplaces and organisations, through informal partnerships across the health and social services sectors.

This conceptualisation illuminated revived practices, for instance, the efforts being undertaken to build collaborative working relationships between community health and general practice. This conceptualisation also helped explain the tension between stability and change. Emergent practices such as linking community health clients with a regular GP and providing feedback to GPs were in tension with embedded practices where individuals worked in disciplinary silos and were accustomed to protecting the client's confidentiality. In an interplay of co-existing practices, practitioners remade and revived other practices to encourage integrated care. This enabled multiple practitioners to share care of HealthOne clients in informal arrangements across disciplines, sectors and organisations.

Through an empirical application of Schatzkian practice theory, I have uncovered the array of practices unfolding as practice changed towards integrated care. Although the model instituted arrangements such as artefacts (consent and feedback forms) and people (GP liaison nurses), these were not particular to HealthOne, being used in other healthcare arrangements. While practice change was gradual, there was also an accompanying stability and some practices were maintained, remade or revived. A lack of shared purpose, or understandings, caused some participants to react against the model of care. Some embedded practices were at odds with other practices; these were interwoven with practices encouraging integrated care. Thus the model of care relied on teleoaffective structures, general and practical understandings, and rules, to organise the array of practices reshaping care through practice change. Conceptualising these practices as embedded, revived, remade and emergent

practices foregrounds the co-occurrence of stability and change, and the interplay and tension among practices.

Explaining the unfolding of integrated care through Schatzkian notions of practice

Evaluations of integrated care (e.g. Wistow et al 2015) continue to ask how change can be brought about in practice, finding that even multi-million dollar budgets to put integrated care into practice make limited progress and realise only modest changes in service delivery. This chapter has illuminated why it is so difficult to achieve service change on the ground in practice, and why evaluations of integrated care may fail to recognise progress in practice change. Schatzkian notions of practice recognise that practice can be simultaneously maintained and altered (Price, Scheeres & Boud, 2009; Schatzki 2002). This practice theorisation has provided a strong framework for uncovering how integrated care was unfolding through HealthOne.

In this chapter, I have drawn out the way in which there was an interplay and a tension between practices remaining stable and also changing. I have identified the array of practices as embedded, revived, remade and emergent. This description explains change not as a dualism of old and new but as an interwoven array of practices, allowing for attention to be directed to the activities practitioners perform in enacting integrated care. I have shown that some practices foster change and leave room for both maintained and altered practices. The persistence of embedded practices meant that emergent, remade and revived practices were enacted with slow and uneven progress. Such progress often went unnoticed, for these practices were not all formally recognised as part of the new model of care and were not measured as outcomes. Thus, conceptualising practice change as achieved through interwoven and co-existing dimensions explains how change was an uneasy,

continuous interplay between embedded, emergent, revived and remade practices.

The entrenchment of existing practices may also contribute to the challenge of making sense of new models of care until practitioners grasp, and then apply, practical and general understandings, rules and the purpose for which practices are enacted. Practitioners acquiring a grasp of how to do the practices was central to securing practice change. I have shown how intelligibility arose in practice over time. In the process of making sense of the HealthOne model of care, a form of integrated care came into existence.

Drawing on a Schatzkian practice theoretical analysis, I have explained that integrated care unfolded as a bundle of arrangements and practices that were emergent, embodied and relational. These practices were organised by rules, understandings and teleoaffective structures. I have shown that participants were configuring integrated care through an array of practices. These practices included those that were identified in the model of care, such as client enrolment, and case conferencing. In addition, integrated care in practice entailed engaging clients, and establishing partnerships among practitioners across a range of services and organisations and sharing information among service partners. Despite resistance from some practitioners and clients, this array of practices enacted a form of integrated care across professions and organisations. Although this enactment encountered challenges, my analysis shows that it did in fact develop as an unfolding approach to new ways of working together. Integrated care was enacted as an evolving process of practice change, rather than failing to achieve ambitious policy intentions. The following chapter analyses how integrated care was accomplished through particular mechanisms of integration. ■

Chapter seven

Two mechanisms of integration: liaison nurses and case conferences

Introduction

This chapter answers the research question: How was a model of integrated care accomplished in practice? In the previous chapter, I established how integrated care was unfolding through an interwoven array of embedded, revived, remade and emergent practices, accomplishing new ways of working together. This chapter explores this accomplishment with an ANT sensibility, drawing on empirical data I collected while shadowing HealthOne liaison nurses, during observation of case conferences, and from interviews with health professionals.

As the analysis showed in chapter five, a form of integrated care was enacted in multiple actor–networks associated with clients enrolled in HealthOne. In this chapter I explain how integrated care was accomplished in practice, by following two actors that act as 'mechanisms of integration'. The notion of accomplishment (Callon 1986) is used in the sense that enactment takes form as a 'set of actions with a series of effects' (Law 2000, p. 349). In acting, actors do something that has an effect (Mol 2010a), as explained in chapter three. I establish how two key actors held together shifting relations and emerging practices in an enactment of integrated care. To do so, I draw on ANT concepts of fluidity (de Laet & Mol 2000; Law 2007, 2012; Law & Mol 2011; Mol

& Law 1994) and relations (Latour 2005; Law 1999, 2007, 2010; Law & Singleton 2014) as elaborated in chapter three. The chapter shows how translation of a model of integrated care into practice was an ongoing process of negotiation and adaptation, with moments of relational stability (Latour 2005; Law 2008), rather than a completed achievement.

The two actors named as mechanisms of integration are HealthOne GP liaison nurses and case conferences, and my argument is that these actors were intrinsic to accomplishing integrated care. Being significant actors, they made a difference. They assembled and transformed multiple actor–networks within which they were entangled, and held together precarious relations and multiple practices. Both actors were flexible and adaptable. In this study, integrated care was accomplished in a fluid way, where care was adapted or attuned to HealthOne clients' circumstances and the local context. Thus, in practice, integrated care was not a clear-cut, singular, triumphant achievement. There were ''grades and shades of 'working' … adaptions and variants' (de Laet and Mol 2004, p. 225). Relations were central to enacting integrated care in practice.

I begin the chapter by introducing the HealthOne liaison nurses as the cornerstone of the model of care (NSW Health 2011d). I then explain how the liaison nurses orchestrated multiple practices and relations. I establish how the liaison nurses were accomplishing integrated care by holding relations together. In exploring my observations of case conferences, I then make the case for HealthOne case conferences as another mechanism of integration. I show how the practices connected disparate relations to realise fluid ways of working that accomplished integrated care as linkage (outlined in Table 2.1) across health and community workplaces.

HealthOne liaison nurses as a mechanism of integration

As indicated above, my argument is that two mechanisms of integration were key to the accomplishment of the HealthOne model of care - one of these was

the liaison nurse. In this section, I explain how the liaison nurses acted as mechanisms of integration. The discussion draws on data collected during 22 days that I spent shadowing the liaison nurses, over a nine-month period, on randomly selected days. I have also drawn on data from interviews with health professionals connected with HealthOne. This section begins by introducing the liaison nurses, who were central to the HealthOne approach.

The cornerstone of the model of care

> We didn't get anywhere with HealthOne—we went round and round in circles until we had hands and feet and it was the GP Liaison Nurse who was the hands and feet. … We went round in circles for two years until we got the GP Liaison Nurse and then we had the face of HealthOne out there. (Interview, November 2011)

Responsibility for operationalising the principles of the model of care rested with the liaison nurses. According to the HealthOne model of care, liaison nurses were 'the linchpin of this model, increasing the capacity of the workforce to more effectively identify clients needing care coordination and linking GPs, community health and other service providers to improve client management and health outcomes' (NSW Health 2011d, p.11). They were senior clinicians within the public community health sector appointed in a non-clinical role, whose origin and function is explained in the interview extract below:

> GP liaison nurses existed before HealthOne. They were part of a concept called Care Navigation. Care Navigation came out of hospital avoidance strategies that we [the local health district] were involved in developing many years ago … There were specific care navigators located within the hospitals. Their role was to understand when someone who fitted a certain algorithm, such as over 65 years of age [or], had more than three admissions in the last 12 months … turned up at the emergency department … They immediately went into the

> clinical information systems … [to get] a clear picture of that person and their history. They would bring it down to the ED and negotiate how the person got through the system. That's what that role was. The GP liaison nurse then was part of getting that person through the system early. So if they ended up being in a hospital ward … then the GP liaison nurses [would] try and facilitate them getting them out of the hospital, communicating with the GP, working those relationships. … It's the same principle upon which Health One is premised, because Health One as a concept grew out of the likes of Care Navigation. (Interview, December 2011)

As this quotation suggests, and, as I observed during shadowing, the position of HealthOne liaison nurse entailed liaison with a HealthOne client's GP and other service providers to organise services based on the client's health, and life circumstances. Their work did not usually include case management, clinical treatment, or formal assessments of HealthOne clients. Instead liaison nurses negotiated with practitioners and services involved in the client's trajectory. With the client's consent, the liaison nurses could consult with, or disclose the client's personal health information to, the client's GP or other services. In essence, the liaison nurses aimed to improve the health and care of community health clients enrolled in HealthOne, by linking clients with a GP and other services across the health and social services sectors, both public and private.

In the local government area where much of this research took place, there were about 170 service organisations, according to one liaison nurse. There were eighty general practitioners working in twenty-seven practices (NSW Health 2011c), some of which were large corporate practices but most were small private practices. Practitioners encountered during the shadowing represented hospitals, community health and general practice, and also other organisations. These included the Salvation Army, Barnardos Australia, Ageing Disability and Home Care, Corymbia Diversity Services, Aboriginal Medical Services, Sydney

in Home Care, Family and Community Services, Housing NSW, Corymbia Schools as Communities, MS Ltd, NSW Police, Western Sydney Medicare Local and Refugee Health. During this study, the Medicare Local (since disbanded) was playing an increasingly central role in primary health care across the region. The work of the liaison nurse responsible for chronic, aged and complex care also encompassed disability services, as this HealthOne stream of work was partnering with a non-government disability service.

As the cornerstone of the model of care, liaison nurses engaged practitioners in the practice of integrated care and held together the relations between practitioners. The community in which the model of care was enacted, was socially and materially heterogeneous, with multiple practitioners from various organisations working with the complex clients enrolled in HealthOne. Without liaison nurses in place, the form of integrated care unfolding through HealthOne could not be enacted. This was evidenced when the liaison nurse position in chronic, aged and complex care was vacant in one study setting for more than a year, and the work of HealthOne halted with those clients. The following sections explain how the accomplishment of integrated care was contingent on the practices and relations enacted by the HealthOne liaison nurses.

Acting with fluidity

The HealthOne model of care was neither fixed nor stable, as shown in the previous chapter. It was done in different ways and in various practices (Law & Singleton 2014). This chapter argues that attributes of fluidity and adaptability were significant in accomplishing integrated care. This variable way of enacting the model of care can be likened to 'tinkering', for it was a seemingly 'persistent activity done bit by bit, one step after another, without an overall plan' (Mol 2010a, p. 265; see also 2010b). In mid 2013, after my data collection was completed, the title of GP Liaison Nurse was changed to HealthOne Liaison

Nurse, signalling another tinkering with the model of care. As the discussion below demonstrates, the liaison nurses were able to act in a fluid way, tailoring care to immediate circumstances and the local context. In adapting to the messy and complex realities (Law 2004) of community-based care, the HealthOne case conference also distinguished its presence in the accomplishment of integrated care, as the second part of this chapter will establish.

Both the geographical location and the focus of liaison nurses' practices varied, depending on the nature of the client's health, psycho-social background and living circumstances. The adaptability and flexibility of the liaison nurses in responding to clients' vulnerabilities and issues of immediate concern meant that liaison nurses attended to a diversity of presenting problems, and there seemed few limitations on their field of work. Activity was reactive rather than systematic. Forward planning was impromptu or short-term. These 'fluid ways of working' (Law & Mol 2011, p. 14) were a feature of the liaison nurses' everyday practice.

Liaison nurses' practices

This section explores the various practices that liaison nurses were observed carrying out during the shadowing. However, documentation associated with HealthOne (e.g. NSW Health 2011d) described liaison nurses' practice in terms of specific actions. These actions were identified as: engaging clients with a regular GP; providing GPs and other service providers with regular feedback; and offering case conferences to service providers. This summary of actions is reflected in a screenshot taken in 2013, from CHIME (figure 7.1 below). The screenshot gives a limited view of the liaison nurses' practices as a list of categories that they could select from to record their activities.

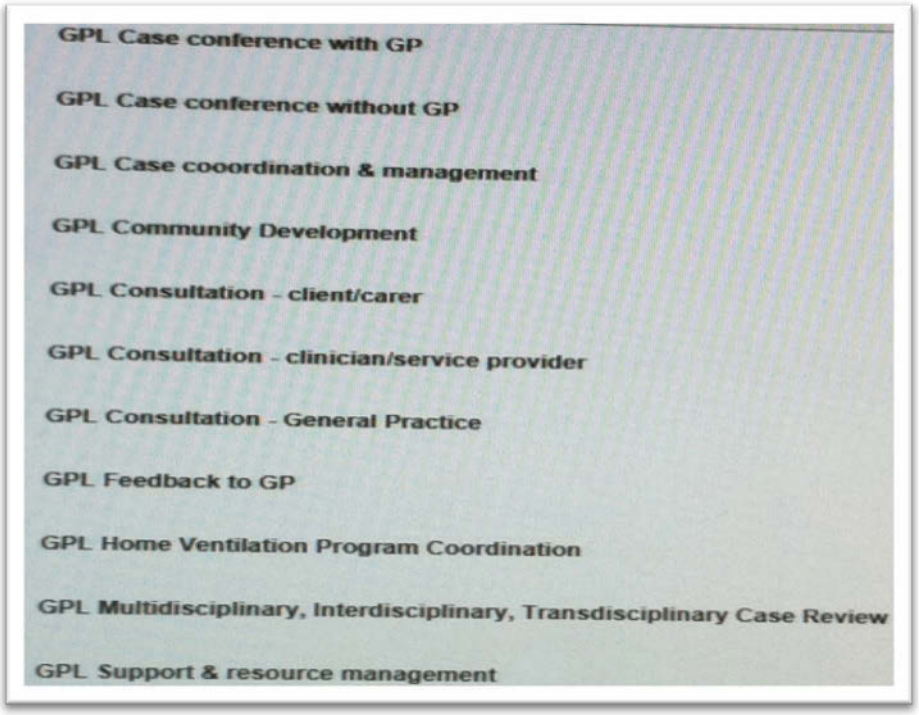

Figure 7.1 Liaison nurses' activities categorised on CHIME

As revealed during my shadowing of liaison nurses over several months, this categorisation of their practice did not capture all their work with and for clients. Indeed, CHIME was a source of frustration for liaison nurses. They were troubled by the processes provided within CHIME to record their activities. One concern was that information about HealthOne clients had to be attached to the most relevant service request (i.e. linked to the most relevant referral for the client), instead of being entered as a discrete set of information about HealthOne activity with that particular client. This made it difficult to search for liaison nurses' work with HealthOne clients more broadly across CHIME. One liaison nurse expressed her concern in a regional forum with other HealthOne liaison nurses: 'Do liaison nurses have an area to enter information about their interventions? The data is lost within CHIME as part of the clinician's notes' (transcript, September 26 2012). Liaison nurses were also not able to raise service requests on CHIME. If a service request had not yet been created for a client by the referring practitioner, there was no place on CHIME for the liaison nurses to note his or her activities with that client. As one

community health practitioner commented 'CHIME is probably only about a half of what actually happens, couldn't be a record of everything' (transcript, September 14 2012). The consequence for the liaison nurses was that their efforts on behalf of HealthOne clients might not be visible or recognised among the plethora of community health activity data.

This invisibility of HealthOne liaison nurses' work was compounded by the fact that relatively little of their work was undertaken in the community health centre. Their day-to-day work was generally carried out in conjunction with a broad range of practitioners who were sharing responsibility for HealthOne clients, or who might be in future. This took place in the varied workplaces of professionals associated with HealthOne clients, including hospitals, schools, community events at shopping centres, libraries, and the offices of GPs and community organisations. Accomplishing integrated care was a collective and mobile undertaking, despite the absence of multidisciplinary teams established through HealthOne.

The actors that I encountered on the first day of shadowing one liaison nurse indicate the range and focal points of the liaison nurses' activity. Actors included four allied health clinicians (two social workers, a psychologist, a speech pathologist), a senior child and family health nurse, four mental health clinicians and two GPs; various information systems (including eBluebook, the Personally Controlled Electronic Health Record, the Community Health Information System (CHIME), email); programs called Brighter Futures and Safestart; the Department of Family and Community Services; clinical records on paper and in electronic forms; and discussions between clinicians about fourteen current or future HealthOne clients. Activities varied from client advocacy, locating client records, arranging appointments, referrals, services, and case conferences, to attending consultations, meetings and case discussions.

At times, attention was also given to prevention and health promotion through activities for example, encouraging breastfeeding and supporting playgroups.

The actual practices carried out by HealthOne liaison nurses are outlined below in table 7.1, grouped by CHIME's typology of liaison nurses' activities. This table summarises the various practices observed during almost 160 hours that I spent shadowing two liaison nurses who worked at one particular HealthOne site. My account of the practices observed during this study may not comprise the entire range of their activity. However, the practices in table 7.1 occurred repeatedly. Practices were materially heterogenous, for these involved clients, GPs, other practitioners, consent forms, feedback forms, information systems, meeting papers, telephones, client files, and so on. Although most interactions were face-to-face, some were carried out through phone calls or email.

Nevertheless, CHIME's naming of categories did not adequately capture the relational aspects of liaison nurses' practices. Their relational effects (Law 2007; Law & Singleton 2014), as explained in chapter three, were obscured in the CHIME categorisation of activities. The following section demonstrates the relational character of the practices carried out by HealthOne liaison nurses.

HealthOne liaison nurses' activities categorised on CHIME	Practice
Case coordination and management	Meeting with practitioners about clients (present and future clients)
	Identifying a regular GP for clients
	Visiting GPs
	Meeting with clients and / or carers
	Gaining HealthOne client consent
	Referring clients
Consultation – clinician / service provider / GP	Attending client consultation with service provider
Case conference with/out GP	Participating in case conferences
Multidisciplinary, interdisciplinary, trans disciplinary case review	Participating in case reviews
	Participating in clinical working parties e.g. Perinatal Working Party
Feedback to GP	Sharing information about client with GP
Support and resource management	Recording notes of activity e.g. in CHIME or through progress reports
	Searching and using information systems
	Participating in planning meetings
	Participating in governance meetings
Community development	Meeting about HealthOne
	Convening workforce development meetings
	Participating in forums and conferences

Table 7.1 HealthOne liaison nurses' practices

Practice as relational

As the previous chapter illustrated, certain relational practices such as establishing partnerships with community-based and acute care services were not formally part of the HealthOne model of care, but were part of the array of practices unfolding through this model of care. From an ANT perspective, relations are central to practices, shaping and forming the actors caught up in various actor–networks (Law & Singleton 2014, p. 383). As Winance suggests:

> Care is a shared work, carried out jointly by the collective. It revolves around assembling and arranging the entities of a collective so that they fit together. To care is to tinker i.e. to meticulously explore,

> 'quibble', test, touch, adapt, adjust, pay attention to details and change them, until a suitable arrangement (material, emotional, relational) has been reached. The work of care involves a transformation of what these entities are, of their materiality and their sensations, of what they do, and above all, of the way in which they are linked to one another. (Winance 2010 p. 114)

Relations may shift (Law 2007), and holding these together in actor–networks is not easy work (Mol 2010a). Relations have to be negotiated, constructed, and maintained; this effort can be invisible (Singleton 2005). The following section elaborates on the importance of relations to the accomplishment of integrated care.

Much of HealthOne liaison nurses' day-to-day work consisted of meetings, as Table 7.1 indicates. Most were face-to-face interactions and consultations with practitioners about clients. Liaison with GPs was primarily undertaken through visits in person to the GP's rooms. Discussions with practitioners, clients, family members or carers frequently preceded case conferences or occurred as follow-up. The liaison nurses also attended a range of other meetings and forums. These included formally established governance committees such as the HealthOne Service Development and Implementation Group; community development forums for practitioners in the local area (e.g. the Local Community Partnership); and planning committees (e.g. the Paint It Read working group consisting of representatives of many local community service organisations organising a literacy event for local children). Other meetings were arranged for workforce development, for example, one liaison nurse organised a presentation by Medicare Local on electronic health records. Many of these activities were means of introducing HealthOne to, and building partnerships with, a range of practitioners.

Throughout my fieldwork, I observed how persistently liaison nurses worked to connect a broad range of practitioners and services from government, non-government or private health and social services sectors in order to support HealthOne clients. The liaison nurses assembled multiple practitioners through meetings, working parties, conversations, case conferences and case reviews. Little of this activity appeared to produce new care plans or to update existing ones. It usually entailed providing feedback and sharing information about clients and about services, getting everyone 'on the same page' (transcript, December 20 2012), and considering what to do next about provision of care and services for HealthOne clients. These gatherings had an important function in that they were opportunities for liaison nurses to establish relationships with practitioners and develop engagement with the model of care.

The liaison nurses' activities can be considered as relational effects (Law 2007) connecting actor–networks associated with HealthOne clients. As explained in chapter five, the HealthOne model of care approached integrated care as linkage (outlined in Table 2.1). This was an adapted response to enacting the vision of integrated care, where client care was individualised by proposing prospective services based on individual practitioners' resources and the client's immediate concerns. In transforming relations from non-existent or weak to more durable, the liaison nurses lessened the chaotic, disconnected nature of activities occurring in isolated pockets of the various health and community organisations working with HealthOne clients.

The composition of actor–networks linked with HealthOne clients was wide-ranging. In addition to working with practitioners from general practice, acute care, allied health, mental health and community health, liaison nurses also became involved with a range of other partnerships and organisations that were associated with the trajectory of a HealthOne client. Fragments of these complicated trajectories became visible during the shadowing, from observing

case conferences, discussions and emails between practitioners, and entries on CHIME. A typical trajectory could include a discharge from acute hospital care to the community, encounters with a range of government and non-government service providers across health and social services, including one or more general practitioners and other private sector practitioners, as well as multiple re-admissions to acute care.

Liaison nurses were the node or connecting element to disparate practitioners as they became engaged in working with others through the HealthOne model of care. There were multiple configurations of actors in networks of relations associated with HealthOne. During shadowing, one liaison nurse described her practice to me as resembling that of Phoebe, a character on a popular television show, who acted as the liaison between friends:

> If you were to map it, you could see who the linkages were that Phoebe had. She was the one that had all the liaison, she had all the connections all networked with these whole groups of people. (Transcript, October 25 2012)

Many of the liaison nurses' practices associated with HealthOne, such as the frequent meetings and phone calls about clients, were not clearly distinguishable as elements of this particular model of care. Yet these were intrinsic to its accomplishment. In particular, the emergent practices of establishing partnerships, engaging clients and working with GPs (discussed in chapter six) were underpinned by many of the liaison nurses' practices described above. For instance, meeting with multicultural health practitioners about HealthOne was an activity aimed at engaging them in joint visits to GPs. The practices generating change were therefore interconnected and interwoven with a range of activity instigated by liaison nurses who held various, precarious relations together. Health professionals responsible for

implementing HealthOne highlighted the importance of these relational aspects of the model of care:

> The HealthOne model was not built around clinical service delivery, like having GPs. It was built around relationship building. (Interview, November 2011)

> With GPs it's about relationships and they work better when they actually know people and know who they can pick up and ring and it's quick and they can say hello, it's me … and feel confident that something's going to happen. (Interview 2, October 2011)

As explained in chapter 6, the liaison nurses encountered resistance from some practitioners and clients, and engaging these actors in new ways of working through the model of care required case-by-case negotiation. The enactment of integrated care was thus contingent on the liaison nurses orchestrating practices to organise care of HealthOne clients, by connecting with a web of practitioners in multiple settings who shared a common interest in the wellbeing of their client. The negotiation of effective working relationships with general practitioners was a key element of the emergence of integrated care. In reality, GPs were only one link in the actor–network and often liaison nurses had to construct relations with other practitioners also. This work called for the liaison nurses to negotiate the diverse activities, projects, purposes and resources attached to practitioners in multiple workplaces. As a result of this negotiation, the array of practices associated with the model of care were held together in multiple, complex webs of interrelations.

The liaison nurses held together and adjusted networks of actors surrounding HealthOne clients, as scenarios outlined in chapter five regarding the new mother with severe mental health issues, or the mother of eight with injuries from a car accident, illustrate. This resonates with Latour's (2005) notion of actors as mediators who gather and transform the elements in an actor–

network. As both the client's point of connection to various services involved in their care in the community, and the conduit of information between practitioners, the liaison nurses acted as the mediator in many actor–networks. Thus HealthOne liaison nurses can be understood as a node at which the multiple actor–networks associated with HealthOne clients became modified, where connections were accomplished to generate transformations in the client's trajectory.

The HealthOne model of care was practised collectively. The liaison nurses gathered together various practitioners associated with HealthOne clients, and built partnerships and networks. By acting as the node through which activities and information flowed, liaison nurses facilitated and generated the enactment of integrated care, encouraging practitioners to participate in the model of care as envisaged. The liaison nurse as the point of connection and continuity between clients, practitioners and organisations acted as a mechanism of integration through which the model of integrated care was accomplished.

HealthOne case conferences as a mechanism of integration

Having explained how the HealthOne liaison nurses acted as mechanisms of integration, I turn now to the HealthOne case conference as another mechanism of integration in the model of care. The discussion in the following section demonstrates the fluidity (de Laet & Mol 2000) of both actors as they attuned and adapted themselves to the local context and each client's circumstances. The remainder of this chapter establishes how both actors were accomplishing integrated care as an ongoing process of assembling, holding together and transforming practices and relations in multiple, changeable actor–networks connected with HealthOne clients.

In exploring the effect of the HealthOne case conference as a mechanism of integration, this section draws on data collected while shadowing the liaison nurses and observing case conferences at various locations in the research

setting. From its inception, the HealthOne case conference was an important element of the model of care. This was in the context of enacting integrated care where the model of care was an approach to instilling collaborative coordinated care, rather than a service embodied by formally established multidisciplinary teams. Since the care of complex and vulnerable clients enrolled in HealthOne involved diverse organisations and service providers, the composition of a HealthOne case conference was broad and varied. The link between participants was the HealthOne client who was being treated or managed by the practitioners invited to the case conference by the liaison nurse. The remaking of practices beyond individual fields of work was an effect of the HealthOne case conference, as the next section explains.

Remaking practices across workplaces

The previous chapter argued that while 'remaking' was initially conceptualised with a Schatzkian practice theorisation in relation to the practices of remaking one's job, case conferencing can be understood as a remade practice under the HealthOne model of care. In this study, I extend the notion of remade practices that was applied to individual jobs within an individual organisation (Price, Scheeres & Boud 2009; Price, Boud & Scheeres 2012). I do so by suggesting with the analysis in this chapter, that the HealthOne case conference remade practices *across* workplaces for multiple participants from various health and social services, all of whom were sharing care of a HealthOne client.

The HealthOne case conference enacted a new way of working together that had flow-on effects in multiple jobs in multiple organisations. Case conferences are increasingly familiar devices in health care (Fitzpatrick & Ellingsen 2013) and are typically multidisciplinary, usually including a range of health practitioners, for example, an acute care team. In the HealthOne case conference, practices were remade beyond individual fields of work in one organisation, by participants collectively considering the client's health and psycho-social status,

and canvassing and allocating follow-up activities across workplaces. Not only individual jobs in individual organisations were remade. As an effect of the HealthOne case conference, the everyday practices of participating practitioners were remade, incorporating multiple practitioners in a sharing of care for a HealthOne client in new arrangements across sectors, disciplines and organisations.

One general practitioner working with HealthOne described how the model of care aimed to emulate the multidisciplinary approach of hospital case conferences that included nursing, medical and allied health practitioners.

> it's a ward meeting … run by the nursing unit manager. Junior doctors come in and they present each of the cases and then around the table you've got the social worker, the physio, the OT, the dietician … We'd like to replicate that at primary care level. (Interview 4, October 2011)

The HealthOne case conference was a loose gathering of practitioners sharing care of a HealthOne client. This was a multidisciplinary group where practitioners from health and social services might assemble to interact on a limited, transient basis. Practitioners gathered as a 'momentary association' (Latour 2005, p. 65), a temporary arrangement, a make-shift multidisciplinary team, depending on the actors present. Each case conference was focused on immediate interactions and interventions, and did not necessarily entail follow-up conferences or continued associations among all participants.

The HealthOne case conference enabled participants to enact a form of integrated care. Participants, who possessed a range of resources and competencies, were interdependent in that they shared responsibility for the client. They formulated the next steps in service delivery by collectively negotiating and assigning interwoven activities, that might otherwise be discrete, detached pieces of individual work. Rather than each practitioner holding fragments of the client's history, and multiple practitioners taking

individual responsibility for the HealthOne client's care, the HealthOne case conference introduced a shared understanding among those assembled, about upcoming services to be provided, by whom, how and when.

Such horizontal, ad hoc, informal relations being enacted across organisations and sectors were in contrast to the traditional discliplinary and organisational silos, which had formal and vertical hierarchies, with fixed boundaries. In the space of a HealthOne case conference, next steps in the client's care were adjusted and arranged, remaking practices across workplaces and also relations, as the following section explains.

Assembling actors

The actors at case conferences observed during the shadowing varied, depending on the client's health and circumstances. Usually the HealthOne case conference was a face-to-face meeting attended by various health professionals and service providers. Typically, a range of practitioners from community health, acute care, allied health, mental health, or social services organisations participated. The model of care aimed to have the GP present. However, HealthOne case conferences involved GPs only sometimes. On many occasions, the client and family members were also present. The liaison nurses facilitated this gathering of practitioners associated with the client.

> We draw them in—we need to know everything about this family [or client] … that's how you approach the client complexities. (Transcript, December 20 2012)

Thus the HealthOne case conference also assembled fragments of information about the client who was the subject of the case conference. The HealthOne case conference provided space for 'a discursive process that served to elucidate and stabilise what was deemed essential in a complex and messy whole' (Engeström et al 2003, p. 298). Participants both captured and elucidated what was already known about the client's past treatment and services, and formed future goals

in terms of care and services to be offered to the HealthOne client. Co-narration of the patient's history by both client and practitioners was rare. With their presence, or through advocacy on their behalf, clients gained some voice in the meeting.

The commentary below from an interview with a liaison nurse exemplifies how the HealthOne case conference gathered diverse practitioners together to support the client:

> I did one [case conference] last week. The GP said, I've never seen so many people. He turned to the client and said, 'Look how many people are trying to help you.' … For this particular woman—she was allied to the Cerebral Palsy Alliance so she had an issue there. She needed counselling, so she had counselling through Trans-cultural Mental Health. So we had the Cerebral Palsy Alliance there, the Trans-cultural Mental Health person, the Child and Family Health nurse who was involved in the newborn care, myself [liaison nurse], the interpreter and the GP. So they all have certain investments [in] that client, but they hadn't necessarily been able to come together … So I think it's valuable in that there's an opportunity for them to talk about what care is being provided. In this case there was a sibling, who had cerebral palsy and the newborn, and mum's stress levels were—you can imagine. It's about that joint [approach] having everyone from the different disciplines thinking about how we can best support that client. So someone will say, have you thought about this or have you thought about that? It actually makes a difference. (Interview 5, March 2012)

The forum of the HealthOne case conference activated a joint approach to considering how to manage a complex range of issues. Practitioners who were usually disconnected, formed informal associations by gathering together in person. The case conference described above gave participants not only an

opportunity to talk about the range of issues and conditions that the client's family presented with, but also an understanding of the extent of services already in place. As the liaison nurse pointed out, although many practitioners were working with the family, it was unusual for them to work through with other practitioners the options for support that might be provided in future. The HealthOne case conference assembled multiple, dispersed practitioners and enabled adjustments in care for the client in light of more complete information about the client and the joint discussion.

The extract below is from a discussion between liaison nurses about a case conference that was attended by two parents with intellectual disabilities, their baby (Keith), their GP, a liaison nurse, and clinicians from the acute care hospital where the baby had been admitted. The baby's admission to this tertiary hospital had brought the family to the attention of the child protection unit and an initial case conference was organised in hospital. That case conference had included the social worker and paediatrician but neither the liaison nurse nor the family GP. A second case conference that was the subject of this discussion, was subsequently organised by the liaison nurse. It also included the GP:

> You can't actually say in words some of that stuff. Like Keith on paper would look very different to when you actually walk in there and you meet mum and you go aaah, right … You just can't describe a relationship, particularly because we're all about relationships. You can't describe a relationship on paper. And you could see that [mum] was very connected … You could see her relationship with the GP … If we couldn't have bought that GP in and if the hospital wouldn't have been satisfied that that GP had such a good grasp, she could have lost that baby … if we couldn't have been there getting everyone on the same page, it was very borderline. (Transcript, December 20, 2012)

As this extract reveals, a disconnect between acute and primary care was patched temporarily by assembling practitioners from both sectors. This HealthOne case conference demonstrates how information and relations that are not noted on official records can have a significant impact on the client's trajectory when gathered in the forum of a case conference. Assembling practitioners including the GP, and making the relations visible between the parents and baby Keith, and between the parents and their GP had a significant effect. The hospital's child protection unit's concerns about parenting capability and ongoing support were relieved, and their work with the family was short-term. As a result of this case conference, care plans were developed with the family and the GP, setting future services in place.

Thus, the HealthOne case conference was a mechanism to retrieve information that was not available on paper, in information systems, or in other formal forums, thereby somewhat overcoming the propensity (observed during the research) amongst practitioners and clients to protect some personal or clinical information. Discussion about clients involved identifying the client's current health status, and current provision of services to the client; working out the client's needs for personal and support services, discussing possible future service options; and considering what to follow up. Participants concentrated on considering future services in response to the client's history and practitioners' immediate concerns about the health of the client. With this, efforts were made to initiate further activities and referrals that could benefit the client. In this way, by assembling a range of actors including the clients, the HealthOne case conference acted as a significant mechanism of integration in the model of care. However, this was an informal, cooperative arrangement, as the next section explains.

A cooperative arrangement

As explained in chapter five, the HealthOne model of care had emerged in practice as linkage, which is a relatively unstructured form of integrated care (outlined in Table 2.1). Enactments of integrated care as linkage were particularly visible through the mechanism of the case conference, where efforts were made to arrange service provision for individual HealthOne clients based on immediate concerns and the local context. This relied on co-operation among practitioners from disparate disciplines and organisations, in the absence of the formal arrangements, shared care agreements, and supportive systems that Leutz (1999) associated with fully integrated care.

The cooperative work arrangement arose in the case conference and often dissolved after the case conference. Individual practitioners returned to their individual fields of work, frequently in diverse organisations or disciplinary streams. The following example illustrates this transient, cooperative association.

Some weeks prior to this case conference, a HealthOne client's baby had been admitted to hospital for anemia, after attending the community health centre for a routine check-up. A case conference was then organised at the client's GP's office by the HealthOne liaison nurse for child and family health. This gave those present an opportunity to collectively discuss the infant's and mother's health issues with the mother, and to negotiate future plans. Participants present at this case conference were the client's GP, the liaison nurse, the mother and baby and three practitioners based at the community health centre: a child and family nurse, a psychologist and a speech pathologist.

The case conference began with discussion of the baby's eating and play behavior. The child and family health nurse and the speech pathologist provided advice to the mother, with the GP supporting the aim to move the baby onto solid foods. There was also some discussion with the mother about

her mood and sleep patterns and her interactions with the baby, for attachment was of concern to the psychologist. The GP spoke directly and at length with the mother and the psychologist in Mandarin, and requested that the liaison nurse forward a copy of the baby's hospital discharge summary. However, the GP made little comment, other than mentioning the baby's health briefly. The mother was not keen to pursue a referral to Karitane offered by community health. However, she requested that future appointments for the family at the community health centre be scheduled on the same day. This required some negotiation between practitioners about clinic schedules and further consultation with their manager. While potential follow-up services were identified, such as an immunisation at the GP's surgery for the baby, and a further appointment for the mother to receive psychological counselling, future joint activity was not planned. There was also little joint decision-making.

After this case conference, the liaison nurse independently developed an action plan, using a HealthOne template. The template proposed future activities focused on both mother and child. The action plan listed client issues, suggested goals and prospective services for mother and baby, and identified follow-up activities for individual practitioners, with the exception of the GP. Consequently, the mother returned to the child and family health clinic for check-ups. The mother later contacted the liaison nurse about a domestic violence concern. Indications of this issue had already emerged in the case conference, and the liaison nurse stepped in to organise emergency accommodation. By raising the matter of the client's relationship with her partner, during discussion between the mother, the GP and the psychologist, the GP gave the mother an active voice in the case conference about this issue. However, there were no follow-up case conferences arranged through HealthOne. Instead the practitioners continued in their individual fields of

work, with further individual communications with the liaison nurse as required.

With this multidisciplinary group of practitioners brought together by the liaison nurse for the case conference, the collaboration between practitioners was informal and transient. In this context, HealthOne case conferences became the physical gathering of individual practitioners working within their scope of practice, with ongoing interaction on a limited basis. Further referrals to services were created on an as needed basis. In a momentary point of stabilisation in the client trajectory, care was adapted in a cooperative arrangement to meet the client's current circumstances.

However, each case conference evolved differently as the contexts, participants, activities and intentions varied over time. Constructing and holding together precarious relations to enact improvements in care is not easy work (Mol 2010a). As the next section suggests, the effects of case conferences were not always or inevitably favourable for all actors.

Variable effects

This section will show that case conferences may not always achieve the anticipated effect. The lack of structure that enabled these loose cooperative arrangements also meant that effects could not be specified or decided prior to the case conference. Case conferences' successes and failures were a matter of degree. The focus of the case conference - the patient or client - did not always have a voice in the proceedings. While future activities and services might be proposed, joint decision-making was not always achieved. Proposals for the client's future care were often oriented towards services identified by practitioners, rather than by the client, and were not necessarily agreed collaboratively with the client. The following two examples demonstrate these equivocal effects.

One scenario was recounted by a liaison nurse who was new to her role and who was still establishing working relationships with the hospital staff. This case conference was the first that the liaison nurse had convened in the local hospital. She became involved when the hospital's discharge planner could not contact the patient's GP. The patient, who was paralysed on one side as the result of a stroke twenty years earlier, had had ten admissions to hospital and eighteen emergency presentations in the previous two years as well as numerous outpatient contacts. A nurse on the medical ward told the liaison nurse: 'they patch her up, fix her up and then she ends up going home and she comes back worse than before'…'she comes in, we fix her, she goes home, and nothing ever changes' (transcript, January 24 2013). Her husband, who was the patient's carer, had been advised by the GP and others to arrange home care services, but reportedly refused to pay for them. Although considered ready for discharge, the patient had a severe pressure injury, was malnourished, and taking antibiotics for an infection.

According to the liaison nurse, the hospital had not planned to hold a discharge case conference. Nonetheless, the acute care staff had taken action to contact the patient's GP and to consult with the community health nursing team. As a result of the hospital's discussion with the community health clinical coordinator, the liaison nurse organised a case conference at the patient's bedside, and arranged for a multicultural disability patient advocate to be present, as well as assembling numerous other practitioners from the hospital. These were the ward manager, two doctors (an intern and senior doctor), a social worker, an occupational therapist, a person from post acute care and the discharge planner. The patient's GP and her carer were not present.

Although the liaison nurse assembled the acute care team involved with the patient at the time of discharge, this case conference did not produce joint decisions. The case conference did not serve as a clinical handover from medical

staff to community health staff and the GP. However, some future services were proposed. At the case conference, the social worker offered personal care services that had previously been subject to a twelve-month waiting list. The family was now reportedly happy to pay for these. The post acute care service planned to do an assessment and contract services for personal and domestic support. The liaison nurse intended to contact the patient's GP as a follow-up from the case conference, and to arrange for a mental health assessment of the patient, while the client advocate planned to organise home visiting. Through the intervention of a HealthOne case conference, improved home and community care aimed to assist in management of the patient's health in the future. Despite this, the patient's preferences were not apparent from the liaison nurse's account of the case conference.

However, this case conference was not without complications. The liaison nurse was concerned about the hospital's response to the pressure injury and wanted to submit an incident report to trigger further investigation. And as a result, relations with the hospital, already precarious, soured during the case conference. The liaison nurse recognised that it would require a lot of effort to build effective working relations with the hospital, saying that: 'Its going to take some time before people really appreciate the benefits of having that linkage between community and hospital' (transcript, January 24 2013).

A second case conference example also demonstrates that the conferences could be more or less effective, depending on the circumstances at the time. This case conference was held with Nina, a community health client with a disability who had recently given birth. Nina's file on CHIME was voluminous; she was an 'elderly primigravida', and her newborn baby had been taken into temporary care under the Department of Family and Community Services. The case conference was convened by the accommodation manager of a disability service that could offer Nina temporary housing while she waited for permanent public

housing. This convenor had gathered the attendees together to deal with 'all the emails flying around' (log of enquiry, April 22 2013). It was clear that although those assembled were not on familiar terms with each other, they had shared responsibility for the client and her baby. While community health and several community services were represented at the meeting, which Nina also attended, health practitioners working with Nina were not present. For example, neither a mental health clinician, a case manager nor a general practitioner was present.

This case conference was primarily about securing accommodation for Nina and her baby, a solution that was offered on condition that Nina accept support services. According to the housing and community services agencies, this solution would address their concerns about the baby's safety. However, Nina was determined that she would not accept support services nor stay at this particular service. This case conference called for sensitive linkages among a broad range of service providers beyond the health sector. Subsequently, Nina declined the proffered housing solution. The lack of attention during the case conference to managing the health issues of Nina and her baby left the liaison nurses concerned.

These examples demonstrate that the planning of future services often focused on gaining access to other services for example, home visits, mental health assessments, allied health interventions, or home care services to support clients in the community, as recommended by the practitioners, rather than being instigated by the client. Referrals to services for clients were organised and clients were brought into contact with the services, rather than the client having a voice in his or her care. Although physically present, the client's preferences were sometimes unheard or were presented as obstacles.

Thus care risked being oriented towards service provision. One liaison nurse who had previously worked in the National Health Service remarked at a forum for HealthOne liaison nurses: 'It's not patient centred care, it's service

oriented care' (chronological record, September 26 2012). Similarly, a Victorian study of web-based care planning and coordination in primary care found from the analysis of consumer responses that 'client needs are framed from the perspective of what services the agencies offer, rather than from the perspective of what the client is needing and prioritising for their care' (Blacker 2011a, p. 12 in Walker et al 2013). As the last two examples showed, case conferences convened for complex clients also tended to frame future care in terms of available services rather than in terms of the client's preferences.

While I have argued that the HealthOne case conference acted as a mechanism of integration, the previous section showed that the effects of some case conferences were not always as anticipated. The following example demonstrates how the practices and relations held together at one HealthOne case conference. It was a momentary point of stabilisation in relations (Latour 2005; Law 2007, 2008) between disparate services operating across diverse locations and times.

Holding relations together

For this particular case conference, the liaison nurse gathered a number of clinicians who had previously worked in isolation with the client. The participants were diverse, and loosely associated by having the client in common. The client, who had been invited to attend but had declined, had been admitted to hospital five times in the previous year. He had had bilateral above-knee amputations and suffered from high blood pressure, heart problems and diabetes. The case conference participants were a dietician, an occupational therapist, the client's case manager who was from a community services organisation, the community health clinical coordinator for chronic, aged and complex care, and the clinical nurse consultant for wound care. However, the client's GP was not available as she was on leave at the time. Some participants, for example, the occupational therapist, had worked with

the client for some years. Others, for example, the wound care clinical nurse consultant, had only had one encounter with the client. The dietician had not been involved with the client for several months. The community health clinical coordinator had only recently begun home visits to the client, after re-allocating work loads among her team to offer extra support for this particular client, who presented with difficult behaviour such as refusing entry or becoming aggressive at times with practitioners and support services.

At this case conference, the practitioners were able to capture what was already known about the client, by meeting with other practitioners involved with the client's care. Until this case conference, some of the practitioners present had not been aware that the client could not read or write. The community services case manager's role with the client was time limited, and passing on details of the client's clinical history, relationships and living circumstances at the case conference was intended to assist with the client's future care and management. The participants assembled at the case conference were able to summarise and pool their information about the client, learning more about the client's background and health problems.

The case conference allowed participants to not only find out more about the client's history and other services, but also to envision their provision of future services for the client. Both the dietician and the wound specialist offered to provide services to the client in future when called upon by the client or other practitioners. A further home visit was planned by the occupational therapist to review the client's new air mattress. After negotiation with the community health clinical coordinator, it was agreed that the occupational therapist would also follow up by carrying out another comprehensive health assessment of the client. According to the community health clinical coordinator, the case conference would help the client to live sustainably in the community, if

practitioners could encourage the client to come to the community health wound clinics, since it was crucial to heal the amputation wound.

It emerged at the case conference that both the liaison nurse and the case manager were having difficulty contacting the client's GP. If contact could be achieved, participants suggested that it could be an opportunity to recommend that the GP prescribe a blister pack for medications so that the client could manage his medications more simply and follow the schedule. Thus, the case manager was keen to continue to rely on the liaison nurse to negotiate the problematic relationship with the GP by working with the GP's practice. The case manager pointed out at the case conference, 'the ground is really good, the whole business with the GP, you're picking up with this and really running with this' (transcript, January 25 2013).

Since the client's father identified as Aboriginal, the liaison nurse was keen to arrange that the client's GP registered the client with 'Closing the Gap', an Indigenous health program. Through this, there might be an opportunity in the future to link the client with the Aboriginal Medical Service, and the Connecting Care program, both organised from the Medicare Local office. The liaison nurse also suggested referring the client to another service, a Sydney wide Indigenous support service. However, the occupational therapist added the caution that the client identified as Aboriginal depending on who was present, advising that the client should be asked first before referrals were made to Indigenous services. Providing information so that future referrals could be made appropriately, demonstrated an important aspect of 'the basic linkage level of integration' (Leutz 1999, p. 93).

A follow-up case conference was suggested by the liaison nurse since she wanted to monitor activities 'to make sure we're all hitting our targets' (transcript, January 25 2013). If the client's wounds did not heal, further hospitalisation would be a possibility, and this was an event that the HealthOne

model of care was designed to prevent wherever possible. The liaison nurse's manager, the community health clinical coordinator, had recently become involved with the client and with HealthOne. She repeatedly encouraged the liaison nurse to coordinate the care of this complex client in the background, to become less involved in person. She suggested that this client would benefit from virtual collaboration, with the liaison nurse facilitating the connections between practitioners and referrals to services, and assembling practitioners for case conferences as required.

The HealthOne case conference exemplified above allowed participants to discuss past and future care. In addition, the patient-centred approach of the case manager at this conference allowed the absent client to have some voice in the meeting. The conference participants learnt that the case manager had talked with the client before the case conference and intended to develop a care plan jointly with the client afterwards. The case manager had also informed the client that, as well as supporting him, he would work in cooperation with the other professionals involved with the client. The mechanisms of the HealthOne case conference and the liaison nurse had now connected the case manager with the community health clinical coordinator as well as with other health practitioners, increasing his knowledge of local services. The case manager had also become aware of the range of other practitioners' support for the client. As the following quotation implies, the care plan was intended to be a person-centred one:

> What I was saying [to the client] was that I was anticipating we were going to have this case conference and was actually flagging issues. I was telling him that flagging issues, that would then connect to this plan, an [action] plan that could emerge from this case conference, and then taking that from this case conference, actually going back to him and doing a person centred care plan. (Transcript, January 25 2012)

However, in the case manager's view, the action plan developed at the case conference would be a tool for the service providers, rather than a patient-centred care plan. The case manager was adamant that the care plan should be developed with the client so that referrals were made and care was coordinated with the client's agreement. The case manager advised that suggestions from participants about options for future goals and treatment should be discussed with the client, not imposed on the client:

> And if he wants to go to car races or if he wants to hook up with people that are fellow amputees, you know, he should be supported and encouraged to do that. And if he wants to avail himself of certain services and if he doesn't know, then it's our job to help him to give him that information so he can make those decisions. If there's particular things that he likes eating and there are others things that he doesn't [then] it's really to come to a position for stuff to come from him rather than for it to be offered to him. (Transcript, January 25 2013)

The occupational therapist supported the case manager's patient-centred approach:

> He really thrives on the ownership that you have been giving him and encouraging him and motivating him to do things by himself and he's actually seeing results, so he's got the scooter that he was prescribed in hospital (Transcript, January 25 2013)

According to the occupational therapist who had been involved with the client prior to both amputations, the referral to HealthOne and the follow-up by the liaison nurse with the case manager, clinical coordinator, and the other practitioners involved with the client, had made a positive difference to the client's health status, living conditions and care. Before there had been a sense of 'we can't do anything more for you', since further surgery was not an option.

Now it was considered that the client was 'coming on in leaps and bounds' (transcript, January 25 2013).

This example demonstrates how the HealthOne case conference accomplished a moment of stabilisation in relations, whereby connections were made with diverse services across health and community sectors. During the case conference, the discussion centred on finding out more about the client; identifying multiple, uncoordinated, individual services provided to the client; allocating tasks; and planning future services. The action plan was an artifact that was intended to serve as a subsequent form of communication between practitioners from various organisations, by identifying client issues, and suggesting prospective services based on individual practitioners' resources and competencies. However, it was intended that a patient-centred care plan would also be created, following discussions between the client and his current case manager. Thus this example shows how the practice of a case conference — familiar to those in the acute care setting — was now remade within the HealthOne model of care to integrate and coordinate the contributions of multiple practitioners from different professions and organisations. In the next section I discuss the practitioners' perspectives on HealthOne case conferences.

Reflecting on practice

At the close of the case conference discussed in the previous section, the participants first confirmed the follow-up actions and how and when these would be done. They then reflected on participating in the case conference as a practice. Here is an extract from these unsolicited reflections:

> Kelly (liaison nurse): As we've been saying there's been so many different changes with the way with and Shane [the client] has been up and down. Just trying to start the year off on track being a little bit more consolidative of where we're heading with him
>
> Bill (Community services case manager): I think having a plan

Kelly: a plan

Bill: is key

Kelly: and not going off on different tangents

Bill: us all in the same room together at the same time

Cheryl (community health case manager): I'm just seeing a lot of clients and I've been flagging them with, you know I'm just saying in general, flagging them with Kelly to say look you really need to be involved with this one and we really need to link the services. I mean there's other case managers and things involved and we're kind of all in our own little silo you know and we really when it comes to, like you can see the benefit of everyone coming together, from what its done for Shane. And I mean you know it just shows the potential of you know what is possible when services do link up and you can't, they don't play one off against the other and you all know what is going on and you can all have a shared goal of care

Bill: yeah

Cheryl: so its certainly

Bill: and it doesn't conflict with your, as far as my experience to date and I've done a couple of these, it doesn't conflict with your professional autonomy

Cheryl: no

Bill: it doesn't conflict, in fact.

Cheryl: everyone's got their own their own little thing that they do

Bill: yeah

Cheryl: you can actually now you are comfortable to say. You know I could ring you up and say well, this is what's happening and next time you're there can you just bring it into conversation? Yeah you

> have that relationship and same with Barbara [occupational therapist] in our own health service
>
> Bill: and Joy [the wound specialist], she's only seen him once and she's got so much more information
>
> Kelly: yeah she has
>
> Bill: about finances, about how you handle certain things, and then you go in with a different picture of the client
>
> Cheryl: like I say just having the input that you gave me prior to my visit last time that helped so I kind of had, I didn't know the guy at all but I knew what Bill had come and told me and what Kelly had told me. I went in with that little bit of you know you have you just go in a little bit more aware of what you're dealing with and the psychological issues that are around. (Transcript, January 25 2013)

These reflections after a HealthOne case conference show how practitioners saw the benefit of these. Practitioners see themselves as continuing to work in individual professional fields of work, with future connections being arranged as required by the client's evolving circumstances. In fact, the reflection illustrates the practitioners' attachment to their professional autonomy. Despite this, there was a recognition that working with others could benefit both practitioners and the client. Information and goals for future care were now shared. New informal partnerships between practitioners were established. From the perspective of practitioners involved, provision of care was seen as interdependent and mutually supportive rather than conflicting, isolated or divergent. Furthermore, the client's health was being maintained.

The HealthOne case conference thus contributed to new ways of working together through remade practices across workplaces. It became a space for establishing cooperative work, sharing what was already known about the client, advocating on behalf of the client and joint planning for future service

delivery by various practitioners involved with the client. Deciding collectively what to do next called for cooperation, communication, and negotiation. As a mechanism of integration, the HealthOne case conference was a site of social activity that enabled practitioners to negotiate and collaboratively manage the interwoven activities that would unfold in individual fields of work for the benefit of the HealthOne client. It was a point of momentary stabilisation where practitioners could take stock of the messy and complex, absorb the multiple elements at play in the client's care, and adjust and arrange future steps in care.

Accomplishing fluid ways of working

This chapter has explained how a fluid form of integrated care was accomplished within the HealthOne model, principally through the HealthOne liaison nurse and case conference acting as mechanisms of integration. As explained in chapter three, fluidity meant that these actors were able to act in an adaptable and flexible way (Mol 2010a, 2010b; Mol & Law 1994), depending on the actor–network with which they were associated. This chapter followed the actors enacting a model of integrated care in practice, rather than considering the 'enablers' or mechanisms of integrated care as ''soft' skills …. such as 'leadership, vision, trust, values and continuity of relationships'' (Wistow et al 2015, p. 76), or as organisational features such as 'governance structures, financial arrangements, common care processes and an information sharing platform' (Curry et al 2013, p. 5). It has been shown how HealthOne liaison nurses and case conferences connected fragmented and disparate actors in relations that enacted integrated care on the ground without large budgets, comprehensive governance, structural arrangements, or linked information systems. The strength of the model of care was that it recognised the degree to which top-down solutions are a challenge to achieve, and instead realised 'fluid ways of working' (Law & Mol 2011, p. 14) that served to encourage clinical integration and linkage across health and community workplaces.

This chapter has demonstrated that the HealthOne model of care was contingent on the liaison nurse orchestrating practices to facilitate care of HealthOne clients and establish relations with evolving webs of practitioners across multiple settings who shared a common interest in the care of HealthOne clients. The liaison nurse as the point of connection and continuity between multiple, diverse, practices, practitioners and organisations, acted as the mechanism through which integrated care was accomplished as responsive and collective practices.

I have extended the notion of remade practices to explain how case conferences remade practices under the HealthOne model of care as cooperative work arrangements across workplaces. The HealthOne case conference accomplished integrated care by enacting temporary associations among diverse practitioners whose link was a shared client. This case conference acted as a mechanism of integration whereby flexible multidisciplinary gatherings of practitioners individualised care for the HealthOne client, by cooperatively assigning services in response to the client's health priorities and immediate concerns. It was a moment of stabilisation in the client trajectory, and a way of moving forward without guaranteeing effects.

Although this enactment of integrated care lacked formalised structures and processes, the 'mechanisms of integration' accomplished a form of integrated care in practice in the workplaces associated with HealthOne clients. Enacting integrated care in practice called for negotiation and adaptation. The HealthOne liaison nurses and case conferences show fluidity (de Laet & Mol 2000; Law 2007) in mediating and enacting relations and holding practices together by changing shape (Law 2007) according to the networks in which they acted. Thus, both actors were nothing without the practitioners and clients who were being drawn into this model of integrated care (as discussed in chapter six), in the same way that the Zimbabwe bush pump is 'nothing without the

community that it will serve' (de Laet and Mol 2000, pp. 234-5). Two key actors, HealthOne liaison nurses and case conferences, were holding the relations and practices of integrated care together in the presence of absences (as discussed in chapter five). Acknowledging that the accomplishment of integrated care is an ongoing process that is never completed, I have shown how as mechanisms of integration, HealthOne liaison nurses and case conferences accomplished integrated care in practice. In the final chapter of this thesis, I draw together my findings to summarise how integrated care was enacted in practice through the HealthOne model of care. ■

Chapter eight

Conclusion

Introduction

This final chapter describes the contributions that this doctoral study makes to the advancement of knowledge in the field of integrated care, by focusing on integrated primary health care at the practice level. It reframes conventional approaches to studying policy enactments that aim to achieve better health care through integrated service delivery. Through this reframing, the study contributes to better understandings of integrated care and how it can be accomplished, by exploring the translation of policy into practice. The study does this by the use of multiple theoretical resources that draw on empirical data collected through extended, multi-sited ethnographic fieldwork. In advancing knowledge about the complex phenomenon of integrated care and the realities of its enactment in community-based services, this study contributes innovative and nuanced perspectives on integrated care in practice.

The chapter begins with an outline of the area of concern and rationale for this study. The chapter then explains the findings from the three research questions introduced at the beginning of this thesis. While the focus is primarily on the empirical and methodological contributions in light of existing literature, contributions to integrated care in practice are also identified. The chapter closes with a critical reflection on the study and consideration of the study's implications for policy and future research.

The study was undertaken as part of a larger Australian Research Council (ARC) Linkage research project, with NSW Health as the industry partner. The

broad aim of that research was to contribute understandings of practice change in primary health care by 'producing rich descriptions' of health practices in local practice settings; by developing 'practice improvement resources'; and by developing 'new and more adequate theorisations' of professional practice and learning (Solomon et al 2010, p. 1). This doctoral study and its findings were developed independently from the broader ARC project yet contribute to this aim.

The ARC study and this doctoral study investigated HealthOne, a New South Wales (NSW) government healthcare initiative (NSW Health 2007), located in primary health care. The HealthOne model of care was a policy developed by NSW Health. HealthOne aimed to provide integrated care by bringing together general practitioners, community health and other health and social service providers to facilitate communication and access to services and to support care coordination across patient conditions, settings and services over time (McNab, Mallit & Gillespie 2013; NSW Health 2012b).

Drawing on theorisations of practice, this study explored everyday practice, in order to understand and explain how a model of integrated care was enacted on the ground in community-based services. The study examined how a model of integrated care evolved as an approach to caring for clients with complex health needs in western Sydney from 2011 to 2013. The study analysed how multiple practitioners from various services enacted integrated care in working with HealthOne clients. The focus was on work practices associated with care of HealthOne clients carried out by a wide range of health and social care professionals.

Rationale for study

Chapter one presented the context and aim for this study, showing that integrated care has been an ongoing goal for governments and policymakers in Australia and internationally in the quest to reduce healthcare costs and

improve quality of care (Ham & Walsh 2013; Goodwin et al 2014). Aspirations to 'achieve better outcomes at a lower cost' (Standing Council on Health 2013, p. 2) remain central in iterations of health policy. The logic of quality improvement underpins the policies (Leutz 2009; Valentijn et al 2015).

Although literature on integration and integrated care emerged in the 1980s, there has been little consensus on what integrated care is. It is still unclear whether integrated care is effective and how it can be achieved (Janse et al 2016; Stokes, Checkland & Kristensen 2016). Results of evaluations are inconclusive and the essential elements of models of care are still under examination (e.g. Minkman 2016b; Valentijn et al 2015a). Studies of integrated care have focused on measuring and evaluating outcomes and identifying challenges and strengths of various models of integrated care. Since evaluations and trials of integrated care have produced inconclusive results (Curry et al 2013; Minkman 2012; Suter et al 2009; Wistow & Dickinson 2012), some researchers argue that policy support is waning for integrated care as a serious reform initiative (Leutz 2009). Others continue to argue for overcoming the barriers to integrated care (e.g. Gilburt 2016; Naylor Alderwick & Honeyman 2015).

The literature review drew attention to the fact that integrated care is a complex and ambiguous aspiration that is poorly understood in practice. The review identified the need for more research on integrated care that was theorised and based on empirical data, 'to further unravel the concept of integrated care' (Van der Klauw et al 2014, p. 7). Relatively few empirical studies of integrated care have made explicit use of theorisations in the analysis and interpretation of data. In July 2016, an examination of the application of integrated care in England concluded that important research questions 'relating to how to best define, enable and enact integrated care' were still to be answered (Stokes Checkland and Kristensen 2016, p. 3).

The literature on integrated care has attended more to searching for improved outcomes, defining mechanisms and identifying challenges and success factors rather than examining the actual practice of integrated care. Scholars agree that integration involves multiple dimensions including system, organisational, professional and service (also termed clinical) (e.g. Kodner 2002; Shaw, Rosen & Rumbold 2011; van der Klauw et al 2014; Valentijn et al 2013; Valentijn et al 2015a). However, professional and organisational aspects of integration have been the major focus within the empirical literature (Valentijn et al 2015a). This leaves a gap in evidence about how integrated care is achieved in practice in service settings.

The research questions

Three research questions were posed in chapter one. Each of the findings chapters (chapters five to seven) took a different theoretical stance, with findings and discussion attending to the particular research question in focus for that chapter. Both actor–network theory (ANT) and Schatzkian practice theory offered theoretical resources to cast new light on practices. Two of the research questions were analysed and interpreted with ANT tools, and the other drew on Schatzkian practice theory. This analysis also drew on Leutz's classification of levels, or degrees, of integrated care, as an additional tool for analysing how integrated care was enacted through HealthOne. Although Leutz (1999) does not make any claims about following theories of practice, the Leutz classification attends to 'how' practitioners 'work', hence its applicability to this study of practice. The following section addresses each of the research questions, establishing the usefulness of the methodological approach to explore the complex phenomenon of integrated care.

What were the realities of enacting the HealthOne model of integrated care?

In chapter five, an ANT approach made visible the multiple realities that emerged in this enactment of integrated care. The realities that were enacted in

practices were 'historically, culturally and materially located' (Mol 1999, p. 75) as a heterogeneous combination that included clients' background and health status, resourcing issues and technology matters. The realities were located in, and distinctive of the study settings. The study does not claim that the realities enacted in this study are similar or universal to other enactments of the HealthOne model of care.

Attention was drawn to particular realities enacted as matters of concern in order to illuminate their effects on how the model of care was enacted. Absence and uncertainty were pervasive, the former present in many forms, while the latter was not unexpected. The data suggested that HealthOne lacked structural arrangements, supportive technologies, recurrent funding and administrative processes to support its intended capability.

Although the multiple realities of enacting the model of care included instances of absence and uncertainty, a form of integrated care was emerging. According to the classification by Leutz (1999), integration may occur in degrees, beginning with linkage, then coordination and lastly full integration (Kodner & Kyriacou 2000; Leutz 1999). A 'higher' degree of integration is not necessarily better, practical or appropriate for all clients and contexts (Leutz 1999; van der Klauw et al 2014), and this classification does not serve as a framework for evaluation. In this study, enactments of integrated care resembled the least structured level of integration. Integrated care in practice was oriented toward service delivery, through referring HealthOne clients to services after practitioners identified issues. Those elements of linkage identified by Leutz (1999) (outlined in chapter two in Table 2.1) were evident in this translation of policy into practice.

Enrolments in HealthOne and service referrals were usually initiated by service providers and not by clients. Enrolment gave consent for practitioners from community health and general practice to contact the client for 'continuity

of care', thus introducing the client to the notion that a number of practitioners would now be involved in their care through HealthOne. However, some form of resistance was apparent. At times during this study, clients rejected referrals or did not attend scheduled appointments, showing unwillingness to be part of the model of care. Nevertheless, based on information provided by practitioners, often in the forum of a case conference, appropriate referrals were made, demonstrating in practice an important aspect of the linkage level of integrated care enacted in this context.

The effects of multiple realities were that the HealthOne model of care was translated into practice as linkage. Integrated care was enacted through multiple networks of practices and practitioners traversing acute care, primary care, community health and social services. Care was individualised and adapted to the client's immediate needs and the realities of the local context.

How was integrated care unfolding?

In applying Schatzkian practice theorisation to an 'account of social unfolding' (Schatzki 2012, p. 21) in chapter six, the unfolding of integrated care was theorised as an evolving process of practice change. Enactment of policy into practice was not a linear or immediate process. The practices uncovered during this study both promoted new ways of working and reacted uneasily with the vision.

As a concept, the meaning of integrated care has been ambiguous and contested. The confusion in the literature about what integrated care is and how it is achieved was reflected among practitioners encountered in this study. Practitioners struggled to make sense of the model of care through policy documents and information artifacts. The challenge of making sense of HealthOne can be attributed in part to the nebulous nature of its material arrangements. Although HealthOne instituted arrangements such as artefacts (consent and feedback forms), and people (liaison nurses), these were not

distinctive of this model of care, being used in other healthcare arrangements. HealthOne was not a health service or program that offered a particular type or range of services carried out by a separate team of practitioners. In addition, there were few practices that were distinctive of HealthOne. Those that were consisted of identifying a regular GP for clients, providing feedback to GPs, and holding case conferences with GPs. However these were carried out at a distance from clinical care and reflected HealthOne's goal of building partnerships between community health and general practice. Making sense of the model of care was a challenge for practitioners associated with clients enrolled in HealthOne.

Healthcare transformation evolved over time as practitioners gained understandings of the model of care. Practitioners who lacked experience of HealthOne made sense of the model of care in and through practice. The meaning that HealthOne had for practitioners was related to the practices and phenomena composing HealthOne practice, such as its rules and intent, that organised the practices as a model that could be distinguished as HealthOne. Practitioners 'getting HealthOne' was the shift precipitating participation in the model. Intelligibility, the Schatzkian notion of acquiring meaning through the practices, was a central feature of the unfolding of integrated care as practitioners made sense of the practices, and became engaged in the practice of integrated care.

Integrated care in practice unfolded in gradual, uneven progress. Practice change was evolving, and there was an accompanying stability. From a Schatzkian perspective, the emergence of change comprises not only new and altered practices, but also existing practices (Schatzki 2002, 2005, 2013). I presented the coinciding dimensions of practice change in a new light as four types of practices. These were named as *embedded, revived, remade* and *emergent* practices. This nuanced interpretation of practice change demonstrated that

some practices fostered change, and some also overlapped uneasily with familiar practices. Since practices were both maintained and evolving, there was an interplay and tension between stability and change, as integrated care unfolded.

Practice change was not an immediate shift from old to new. Working autonomously was transformed over time into new ways of working together. However, enacting integrated care called for more practices than those identified in the model of care such as client enrolment, case conferences and referral. In this study, enacting integrated care demanded additional practices that were not formally recognised as elements of the model of care. These practices entailed engaging clients, establishing partnerships across a range of services and sharing information with service partners. The interplay between emergent, remade and revived practices fostered change. Thus integrated care unfolded as a distinct array of practices hanging together; these were interwoven, concurrently stable and changing.

How was a model of integrated care accomplished in practice?

Both the literature examined in chapter two and the findings that have been explored in answering the first two research questions illustrate that the challenges of enacting integrated care remain significant. In drawing on ANT concepts to answer the third research question in chapter seven, these allowed the study to explain how integrated care was accomplished in a fluid way, adapted and attuned to the local context, clients' health, practitioners' concerns and the cooperation of clients and practitioners.

Translation of a model of integrated care into practice was an ongoing process of negotiation and adaptation with moments of relational stability, rather than a completed achievement. This enactment of integrated care was accomplished through actors named as 'mechanisms of integration'. These actors, HealthOne liaison nurses and case conferences held together shifting

relations and emerging practices. Both actors accomplished ways of working fluidly with multiple, diverse practitioners and fragmented services, encouraging integrated care across the health and social care sectors.

This study foregrounded the relational practices that accomplished integrated care, often unnoticed in conceptualisations and assessments of integrated care from system or organisational perspectives. While a small number of recent studies of integrated care have noted the importance of relational practices in building 'social capital' (for example, Carswell 2015; Gilburt 2016; Valentijn et al 2015b; Wodchis et al 2015, p. 10), this study goes further in providing a theorised analysis. From an ANT perspective, relations are central to practices. Relations had to be established and maintained, holding these together was not easy work. Although clients consented to be enrolled in HealthOne, their enrolment was not self-initiated, and enacting integrated care relied on the client's willingness to be the subject of this model of care. Since participation in HealthOne was voluntary, practitioners were engaged in working together with HealthOne through liaison nurses and case conferences connecting precarious relations. This enactment of integrated care was an approach to new ways of working reliant on practices encouraging practitioners' and clients' engagement with the model of care.

Without liaison nurses facilitating care of clients enrolled in HealthOne and sustaining communication and collaboration between practitioners, the form of integrated care interpreted as linkage could not be enacted. Practices such as engaging clients with HealthOne and working with GPs were underpinned by many of the liaison nurses' activities and were intrinsic to the accomplishment of integrated care. The adaptability and flexibility of liaison nurses in responding to clients' vulnerabilities and issues of immediate concern meant that they attended to a range of matters, across a broad field of work. This work involved negotiation with a HealthOne client's GP and other service providers

to organise services intended to improve the client's health and care. Hence liaison nurses were active in developing informal partnerships with practitioners and services, conveying information, transitioning HealthOne clients to services as well as liaising with clients' GPs. Liaison nurses acted as the mechanism through which integrated care was accomplished as evolving, responsive and collective practices. The liaison nurses gathered diverse and fragmented practitioners into the practice of integrated care and held together various, precarious relations as networks of practitioners working with HealthOne clients.

HealthOne case conferences also acted as key mechanisms of integration in the HealthOne model of care. The link between participants was a shared duty of care. Practitioners assembled from a wide range of organisations, including health and social care public, private and third sector organisations. It was noted that HealthOne case conferences involved GPs only infrequently. However, clients were often present. The HealthOne case conference acted as a mechanism of integration in accomplishing a moment of stabilisation in relations between disparate services operating across diverse locations. Next steps in the client's care were adjusted and arranged in a remaking of practices across workplaces that might otherwise be discrete and fragmented. In this way, processes and relationships were established to respond to immediate circumstances, without the existence of formally established multidisciplinary teams and comprehensive case management.

Integrated care in practice was neither fixed nor stable. The realities of fragmented or absent systems and structures called for an adaptable response to enacting integrated care 'on the ground'. In adapting to the messy and complex realities of community-based care, HealthOne liaison nurses and case conferences acted in a fluid way. In this study, the enactment of integrated care as a relatively unstructured form was negotiated in a flexible, variable way,

underpinned by two key actors holding together unstable relations and evolving practices. Insofar as this enactment of integrated care encountered challenges in the form of uncertainty, absence, and instances of resistance from some clients and practitioners, a form of integrated care was actively and gradually accomplished in the study setting, as a fluid translation of the intent of the model of care.

Contributions to knowledge

This empirical study of the enactment of integrated care makes a number of original contributions to advancing knowledge in the field of integrated care. These are listed below and then each is discussed in detail.

Empirical contributions of the study:

- It reframes conventional approaches to interrogating the enactment of integrated care.
- It demonstrates how integrated care was achieved in practice.
- It reworks understandings of practice change in order to disrupt the conventional discourse on the challenges of integrated care.
- It explains how two key mechanisms of integration, HealthOne liaison nurses and case conferences, facilitated integrated care.

Methodological contribution of the study:

- It draws on multiple theoretical resources to provide innovative understandings of integrated care in practice.

Reframing the interrogation of the enactment of integrated care

This study reframes conventional approaches to inquiry in the field of integrated care by explaining the enactment of integrated care through the logic of 'translation'. It challenges assumptions that measuring the effectiveness of integrated care or demonstrating improvements in the desired objectives is

sufficient to understand integrated care. The quality improvement logic (Leutz 2009; Valentijn et al 2015a) underlying much of the policy and literature has resulted in many studies that report mixed results, as chapter two described. These results have shown that there is not a direct relationship between implementing the policy and achieving the intended outcomes. Therefore, unravelling the complex phenomenon of integrated care is not a simple matter of applying evaluative measures or defining strategies, mechanisms, challenges and strengths. As pointed out in chapter two, efforts to study 'what' policy implementations achieve might usefully turn to questions of 'how' integrated care is enacted.

Assumptions that achieving policy objectives will be straightforward remain central in iterations of integrated care policy. However, scholars recognise that integrated care entails complex interactions across the care and cure sectors (Kodner & Spreeuwenberg 2002; Leutz 1999; Valentijn et al 2013). Many evaluations have found that developing integrated care takes time (e.g. Bardsley et al 2013; Curry et al 2013; McNab, Mallit, & Gillespie 2013). Expert practitioners agree that the development of integrated care is characterised by unpredictable and non-linear progress (Minkman 2012).

By studying and interpreting integrated care with the 'logic of translation' (Law 2007, p. 6), this study challenges expectations about achieving integrated care as a triumphant, stable endpoint. Using the notion of 'accomplishment', Callon (1986) offers a way of creating a different set of expectations about integrated care, rather than appraising the implementation of policy in terms of failed/achieved, reduced/improved and so on. In this study, the enactment of integrated care was not evaluated, nor was it analysed with the expectation of reporting a resounding success. This study takes an alternate conceptual framing that recognises a continuum of achievement from modest to more encompassing, and one that acknowledges progress that may go unnoticed if

viewed from more conventional perspectives. The approach taken in this study allows a different perspective on assessing and understanding enactments of integrated care.

The HealthOne model of care was understood in this study as a policy approach to integrated care. This investigation of an enactment of integrated care policy in practice was framed in terms of exploring how the effects of practitioners' activities realise the intent of the policy. In recognising the indirect relationship between policy and practice, an ANT sensibility makes room for adaption to realities that are encountered in the work of translating policy into practice. Thus ANT can be employed as a 'critical sensibility' that troubles assumptions about policy in practice, as exemplified by Law and Singleton (2014, p. 379) and Singleton (2005).

Interpreting the enactment of policy reforms through this lens acknowledged that there were nuances of achieving integrated care through a shaky, gradual process. The effects of realities were not always as anticipated. This study has shown that multiple realities were shaped in multiple practices, and that practice was adapted and attuned to the local environment. Integrated care in practice became a fluid version of the vision. The findings from this study establish that the policy does not work in practice entirely as envisaged, and yet a form of integrated care was accomplished as new ways of working together.

Demonstrating how integrated care was achieved in practice

Few studies have investigated the practice of integrated care (Dickinson 2014; Evans et al 2014) or gone beyond examining outcomes to explore how multiple disciplines work together in practice to deliver integrated care (Liberati, Gorli, M., & Scaratti 2016). As Evans states:

> The extent to which the peer-reviewed academic literature accurately captures integration practices as they have unfolded over the years in real world contexts is debatable. (Evans et al 2014, p. 151)

There has been limited attention in the integrated care literature to studying in detail the practices of joint working and how groups of practitioners work collaboratively across sectors, organisations and services, as discussed in chapter two.

As the literature review showed, many studies of policy initiatives have focused on organisational and professional dimensions, aiming to demonstrate outcomes of effectiveness and improvement (e.g. Curry et al 2013; Katterl et al 2012; McNab, Mallit & Gillespie 2013; Rand, Ernst & Young 2012). Few studies of integrated care have analysed policy in practice by examining practices. Rare exceptions include the evaluation of the northwest London integrated care pilot which observed case conferences and meetings (Greaves et al 2013) and another UK study of integrated care whose methods included site visits (Lewis et al 2013). Consequently, while reporting mixed results, few analyses of policy initiatives are able to account for the nature of this incoherence. It is still not clear which approaches to integrated care work in what context and for whom (Sheaff et al 2015). Dickinson (2014, p. 195) suggested that 'we need to pay attention to the detail of what professionals do in practice', the various activities and the struggles. In recognising that achieving integration is difficult and involves investing time in relationships and communication, Dickinson's discussion paves the way for studies such as this, which take into account the realities of enacting work practices.

From the perspective of the theoretical approach taken in this study, the effects of activities were shaped by the local context, and practices evolved against a backdrop of challenge, upheaval and uncertainty. Enactment is interpreted as 'an occasion in a location, a set of actions with a series of effects'

(Law 2000, p. 349). The enactment of integrated care through HealthOne emerged as a less structured form of integration, understood in this study as linkage. This enactment of integrated care entailed connecting HealthOne clients to community-based health and social services, depending on the client's circumstances and practitioners' concerns. This form of integrated care was a flexible, adaptable approach to enacting the vision among the target population of clients with complex and chronic conditions and vulnerabilities.

Practices and relations were enacted across organisations and sectors, including general practice and community health, and more broadly with acute care and social care organisations. Practice is always situated, and it shapes and is shaped by context and material conditions (Green 2009; Kemmis 2009). In this study, services, professions and organisations involved with HealthOne clients were structurally separate, with disparate and complex funding sources and governance arrangements. Since there were no funding incentives, formal partnerships or shared care rules and principles organising HealthOne practice, enacting integrated care relied on creating flexible informal partnerships across professional and organisational silos with individual clinicians and services. This called for case-by-case negotiation with a web of practitioners and a co-operative approach to participation in the model of care. These practices created moments of stabilisation in relations between practitioners from various fields of work, who were aligned by a shared duty of care toward the HealthOne client.

The findings revealed how a degree of integrated care was enacted, as the vision was adapted for the realities of cooperative work with complex client groups and multiple practitioners from disparate disciplines, organisations and sectors. There are few ethnographic studies of integrated care to have spanned acute and primary health care services, encountering doctors and nurses, as well as allied health and social care professionals. The methodological approach

enabled in-depth analysis of practices that created variable responses from both practitioners and clients. It afforded the opportunity to uncover understandings of how practitioners worked together to achieve integrated care in practice when multiple realities reflected uneven, messy alignment with the envisioned features of policy.

Reworking understandings of practice change to disrupt conventional discourse on the challenges of integrated care

Drawing on Schatzkian theorisations of practice change, this study developed a new conceptual resource, which encapsulates four different types of practices that co-exist in the process of work practice change. Change was an uneven, ongoing process that unfolded through an array of practices, conceptualised in this study as *embedded*, *revived*, *remade* and *emergent* practices. The application of theory to explain an enactment of integrated care has produced innovative perspectives on practice change that will be pertinent more broadly.

This conceptualisation expands on Schatzkian theorisations of change, in particular, that of Schatzki (2012, 2013), Price (2013), and of Price, Boud and Scheeres (2012, p. 78), who conceived the concept of remaking practices as a practice of remaking 'one's job' through workers reinventing 'themselves and their work'. In this study, the notion of remaking practices has been extended. Instead of varying individual jobs, in this context, practices were remade to incorporate multiple practitioners sharing care of a HealthOne client in arrangements across professions, organisations and sectors. This study also identified revived practices that existed for a time in the past and were unfolding as part of the model of care. Thus, the conceptualisation of existing, altered and new practices (Schatzki 2005) has been reconfigured to incorporate embedded, revived, remade and emergent practices.

This fresh perspective on practice change suggests that in enacting new models of care, an acknowledgement of existing practices will support the

evolution of change. It is broadly accepted that integrated care is a challenge to implement (e.g. Evans et al 2014; Cumming 2011; Janssen et al 2015; Leutz 1999; Ling et al 2012; Wistow & Dickinson 2012). Studies of policy initiatives from the field of integrated care such as Ling (2012) and Cumming (2012) describe the challenges, however, the broader literature also recognises similar barriers to healthcare improvement (Ling et al 2012). Most studies follow the conventional approach in using the organisation, the model of care, or the health professionals as the unit of analysis to identify enablers and barriers, rather than analysing practices in the workplace. Thus the conventional discourse is shaped by the task of defining challenges, rather than exploring the relationship between vision and achieving this in practice.

The aim underpinning integrated care 'to create connectivity, alignment and collaboration within and between the cure and care sectors' (Kodner & Spreeuwenberg 2002, p. 4) seeks new ways of working together. An evaluation of HealthOne Mount Druitt found that 'community health embraced new ways of working' in partnership (McNab, Mallit & Gillespie 2013, p. 4). However, studies offer limited information about practices and arrangements or theorised discussion of factors that advance or hinder joint work (Cameron et al 2012). In confronting this gap in the literature, practice was the anchor. This study establishes empirically how integrated care unfolded through an array of practices, with detailed analysis and interpretation of enacting new ways of working together across organisations and professional silos.

This study shows through a Schatzkian analysis of particular practices that were unfolding through a model of integrated care, how some practices fostered change, and how some practices reacted to change, challenging the precept of integrated care. Policies promised change, however resources were scarce, boundaries were fixed and many clinicians privileged traditional medical models of care. These challenges were not dissimilar to those encountered in a

study of an enactment of public health policy in the United Kingdom (Singleton 2005). My study established how some practices promoted integrated care more readily, while other practices perpetuated existing forms of care.

Practitioners were accustomed to working autonomously in disciplinary silos and adhering to medico-legal requirements regarding patient confidentiality. These embedded practices co-existed uneasily with changes presented by revived practices, for example, establishing working partnerships; and remade practices, for example, sharing information across professional and organisational boundaries. The embedded practice of working in silos by and large remained in place during the study because there was little incentive to do otherwise. However, the revived practices of working with GPs and establishing partnerships were interpreted in this study as important practices that promoted the model's emergent practices by instilling new ways of working together. Practices were simultaneously remaining and altering, with tension and interplay between existing and emergent practices in an evolving process of change. Uncovering the continuous, uneasy relationship between stability and change is a move forward that creates new ways of understanding the challenges of integrated care in practice.

Explaining how two key mechanisms of integration facilitated integrated care

This study offers insights into ways that the policy worked to achieve better care for clients by understanding two key actors—liaison nurses and case conferences—in the HealthOne model of care as mechanisms of integration. The literature devotes considerable attention to defining various mechanisms of integration (e.g. Armitage et al 2009; Curry & Ham 2010; Kodner & Kyriacou 2000; Kodner & Spreeuwenberg 2002; Leichsenring 2004; MacAdam 2011; Minkman, Ahaus, & Huijsman 2009; van der Klauw et al 2014), as discussed in chapter two. However, a recent literature review aiming to understand which mechanisms achieve integrated care, questioned the methodological quality of

selected studies and found that few were based in empirical data (van der Klauw et al 2014). The various integration mechanisms defined in the literature remain theoretical and decontextualised. The literature is still unclear about what and how these mechanisms can be effective (Dickinson 2014; Martínez-González et al 2014; van der Klauw et al 2014) and how these improve health care (Valentijn 2016). This study explains how HealthOne liaison nurses and case conferences contributed to the enactment of integrated care.

As demonstrated in chapter two, there are few commonalities across the raft of mechanisms described in the literature. Those mechanisms encompass a range of processes, strategies and actors. While the evaluation of HealthOne, Mount Druitt NSW highlights the importance of the HealthOne liaison nurse and case conferences, that evaluation lacked detailed analysis of these factors, stating that 'there was a dearth of solid evidence on the mechanisms needed to improve coordination between fragmented services' (McNab, Mallit & Gillespie 2013, p. 1). Two recent studies (McNab et al 2016; Wilkes et al 2016) of the role of the HealthOne liaison nurse in improving integration and coordination of services relied on analysing practitioners' perceptions, rather than observation of practice. Neither provided a theorised interpretation. This study builds on the precedent set by Williams and Sullivan (2009), who used theoretical resources to analyse the role of key actors who shaped meaning and facilitated the process of integration.

In this study, two actors—the HealthOne liaison nurses and case conferences—were central to holding together shifting relations and emerging practices. Acknowledging that actors can also be actor–networks and that actors make a difference, the study established how both actors transformed multiple actor–networks associated with HealthOne clients by adapting and attuning care. HealthOne clients' health needs were diverse and complex. Plans for clients' future care were often oriented towards services recommended by

practitioners, adjusting future care in terms of available resources. HealthOne liaison nurses and case conferences were able to attend to a multiplicity of presenting problems and facilitate care across a spectrum of services and times.

This study provided close detailed description and theorised analysis of how two actors, named as mechanisms of integration, enacted integrated care. In so doing, this study builds on and extends a small body of work on factors contributing to integrated care (examined in chapter two). This analysis provided insights into how the two actors were effective and how the practices were important in accomplishing integrated care. This study is therefore of interest to those seeking better understanding of particular mechanisms and processes that can be replicated in other contexts.

Drawing on multiple theoretical resources to extend understandings of integrated care

This study has established how integrated care was enacted, by drawing on multiple theoretical resources. The definition of integrated care from Kodner & Spreeuwenberg (2002) has underpinned the study. The analysis and interpretation of findings began by exploring policy in practice with an ANT perspective (chapter five), turned to a Schatzkian exposition of practice change (chapter six), and then explored with ANT tools how integrated care was accomplished in practice (chapter seven). In addition, degrees and dimensions of integrated care as recognised in classifications by Leutz (1999) and Valentijn et al (2013) have informed the analysis. These resources have allowed the study to ask and answer different kinds of questions about integrated care in practice, as discussed in the previous sections. The study establishes how an integrated care policy was actually enacted by working with concepts that explain how practice was shaped, changed and achieved.

Empirical studies of integrated care have rarely taken a theoretical approach other than through the logic of quality improvement or by using the

classification by Leutz (1999) of degrees of integration. Instead, by drawing on practice, ANT and integrated care literatures to explain how integrated care was enacted, this study opens up new ground in the debate about the theory and practice of integrated care. Thus the study contributes to knowledge by enriching integrated care as a theoretical construct, but doing so in a way that remains closely grounded in practice.

Studies of integrated care that draw on theorisations of practice are lacking, as shown in chapter two. The use of complementary theoretical perspectives on practice in this study helps explain why conventional approaches to conceptualising integrated care have been ambiguous and contested. The struggles to grasp HealthOne were significant and point to often unrecognised implications of introducing practice change through models of integrated care. While abstract definitions and identification of elements of models offer a terminology for integrated care, this study has demonstrated that the meaning of integrated care arose over time in and through practice in service settings.

This study sheds new light on how the policy of integrated care was enacted. The study does so by acknowledging the realities of policy in practice, by valuing degrees and nuances of care work, and by uncovering the coinciding dimensions of stability and change and the hidden effort of negotiating relations. Placing practice at the heart of this study and interpreting the translation of policy with complementary but different conceptualisations has afforded the means of understanding how practitioners themselves make sense of and realise the policy of integrated care.

In summary, the empirical, analytical and theoretical have combined in this study to explain the practice of integrated care. By anwering different research questions, this study offers novel understandings of the enactment of integrated care policy and how it might achieve better care. This approach will inform the

design of future integrated care studies as well as contribute to the literature on integrated care and studies of practice.

Critical reflection

My interest in the focus of this study began with a project that I led in 2010–11 in a professional capacity. That project's objective was to develop a national set of quality and safety indicators (ACSQHC 2011) that would be applicable to any domain of practice or practitioner in primary health care in Australia. As a policy and standards maker and non-clinician, I therefore began this study with considerable knowledge of healthcare from a systems perspective and some understanding of clinical practices. It is possible that long-term experience in consultation and interaction with healthcare professionals may have reduced my capacity to undertake this study objectively. However, as explained in chapter four, with the lens of ANT, one refrains from privileging any particular viewpoint. Thus my aim was to not to privilege one reality over another, and not to judge practitioners' efforts through the narrow prism of success and failure. Instead, continuing the effort to maintain impartiality about what practitioners achieved, I sought to understand how it was achieved, while remaining sympathetic to the immense effort of everyday work 'at the coalface' of health care.

The study sites for this ethnographic study were determined by the terms of the ethics approval, which was received prior to my commencing doctoral studies. During this study, it was possible to implement the HealthOne model of care to suit the local environment and client population. A standard model of operation was a subsequent development. The two HealthOnes had different resources in terms of practitioners. The relationships with local general practitioners and health services were unique to each site. As a consequence some findings may reflect the nuances of different localisations of state government policy. It is acknowledged that various health districts have chosen

to operationalise the principles of HealthOne in various ways. Thus the realities of enacting the HealthOne model of care in this study, discussed in chapter five, may not be comparable to HealthOne in other settings.

The fieldwork extended from September 2011 to June 2013 and dates for data collection were randomly selected. However, my other commitments and those of the participants had some influence on the time and days chosen. A follow-up period of continuous shadowing to test the findings would have been valuable. However, this was not possible due to time constraints imposed by the duration of the candidature.

Policy documentation ambitiously positioned HealthOne as a different type of service that would encompass private primary care and public community health services, with integrated patient-centred care provided by multidisciplinary teams. As explained in chapters one and three, this study was neither evaluating how effectively HealthOne was implemented nor seeking to prove hypotheses and causal effects. Instead this study aimed to contribute to better understandings of integrated care. The data indicated that system (macro) and organisational and professional (meso) dimensions of integrated care were not put in place to support HealthOne's intended capability. HealthOne lacked adequate structural arrangements, supportive technologies or recurrent funding. However, by focusing on integrated primary health care at the practice level, the study does shed some light on whether an enactment of the HealthOne model of care changed service delivery towards its objectives.

Practices instituted in community health for identifying a client's regular GP and providing feedback to GPs, did not in themselves immediately improve clients' health outcomes. These supported HealthOne's goal of building partnerships between community health and general practice. However, formal shared care arrangements were not established between community health and general practice, setting out the terms of shared responsibility for clients who

had been enrolled in HealthOne. General practitioners were not routinely acting as case manager for HealthOne clients and care plans were not a regular feature of practice in this study. GPs were notably absent from most case conferences held for the 26 clients whose activity was recorded during the fieldwork. Developing effective working relationships between general practice and the public health sector were ongoing matters of concern.

Permanently organised multidisciplinary teams were also not a feature of the enactment of the HealthOne model of care in the study settings. Since structural arrangements were not established across all organisations and sectors associated with HealthOne clients, efforts were made to coordinate service provision for individual HealthOne clients through a relatively unstructured form of integrated care. In practice, informal partnerships connected multiple practitioners from health and social care organisations in the local community, depending on the client's circumstances and the availability of practitioners with relevant expertise. With this, loose associations of multiple practitioners sharing care of HealthOne clients formed and dissolved over time. Case management was absent or else this responsibility was distributed between community health and social care organisations. Funding of services to HealthOne clients remained the responsibility of separate organisations. Practitioners did not have access to a common information system to support shared management of HealthOne clients. Rather than formal multidisciplinary team care, the HealthOne approach to integrated care became cooperative care management facilitated through liaison nurses and case conferences acting as mechanisms of integration.

The adaptability and flexibility of the liaison nurses in meeting the immediate health needs of clients meant that a broad scope of care was offered. It was a marked strength of HealthOne that liaison nurses were able to attend a multiplicity of presenting problems across a spectrum of needs, in

circumstances where clients were willing to engage. Liaison nurses' field of practice encompassed client advocacy, mental health issues, child and family health, chronic illness, disability and home visits to patients, as well as arranging home care and interpreter services and locating discharge summaries and referrals. Attention was also given to prevention and health promotion through activities encouraging for example, immunisation and breastfeeding. The broad scope of care therefore expanded the range of professionals associated with HealthOne clients, including practitioners from allied health, mental health, acute care, general practice, refugee health, community services, community health, interpreter services and indigenous health.

Typically, HealthOne clients were characterised by complex health needs, their conditions were unstable and tended to be severe, chronic or terminal. The clients' needs for services were multi-faceted and often urgent. However, the clients' capacity for self-management was often constrained by literacy, mobility, developmental delays or other factors. The population group that was targeted by HealthOne's eligibility criteria were more akin to those appropriate for full integration, according to Leutz's classification (outlined in Table 2.1). Hence there was some discrepancy between the level of clients' health needs and the degree of integrated care that was accomplished through the HealthOne model of care. The data did not indicate whether preventable hospitalisations were reduced. Nevertheless, in the study settings, HealthOne achieved its objective to give clients greater access to a broad range of community-based services thereby reducing health disadvantage.

Since the object of inquiry for this study was practice, the study was not designed to elicit the clients' experience of integrated care. Although HealthOne clients encountered during the shadowing were asked to give informed consent before becoming part of the study, data was not collected directly from clients. Activity related to 26 clients appeared during the shadowing and has been used

to illustrate the empirical analysis. Fragments of clients' trajectories were clearly indicated in the data. Importantly, the analysis revealed that clients were in fact present at many case conferences, in person, or through the representations of a client advocate, and that case conferences or case reviews were held for many of the HealthOne clients who were encountered either in person, or indirectly, during the shadowing. However, health consumers were not part of governance committees, and community involvement was not an item on committee agendas. The study found no evidence to indicate that co-design of the model of care with clients and carers had occurred or was considered. The policy ambitions of working in partnership with clients seem somewhat inconsistent with the realities. Nevertheless, the clients were central to activity associated with the HealthOne model of care. This study has also argued in chapter six that engaging clients was an emergent practice carried out by liaison nurses although this was not formally part of the model of care.

The study settings, policy reforms, structural context and the cultural backgrounds and health status of HealthOne clients gave a particular character to the practices of integrated care observed during this research. By the end of the study, many of the organisations and practitioners who had championed the HealthOne model of care had disappeared or had changed into other structures and roles. Thus, upheaval and change were a continual backdrop to this study.

The particular time, location and policy context of this study are of course specific. But the sheer complexity of clients' conditions and backgrounds, the mess, the absence and the uncertainty of caring for vulnerable clients in community-based services are not unique to this study and are precisely why the policies have been so difficult to achieve. One value of this study lies in its close engagement with the concerns of the integrated care literature. This field of inquiry lacks evidence on the working practices of integrated care (Dickinson 2014). The model of care (NSW Health 2011d) referenced in this study was

developed in one study site to operationalise the principles of HealthOne that were applicable across the state of New South Wales (NSW Health 2011c). These principles and the key elements of the HealthOne model of care align with the principles of comprehensive primary health care and key features of integrated care strategies, as shown in chapter two. Therefore, in providing close detailed descriptions of the HealthOne model of care and its enactment in primary health care, the study fills important gaps in the knowledge base about integrated care.

Implications for policy

HealthOne was the means of developing new ways of working in primary health care through improved partnership between general practice and community health and collaboration with other service providers to provide care for community health clients with complex health needs. However, the state-funded community health sector was introducing a model of care that took place to a significant degree in health and social services that were separately funded and governed. HealthOne received in principle support from senior personnel in the general practice and community health sectors. However, the model of care concentrated on redesigning processes at the service delivery level, without establishing system, professional or organisational integration arrangements.

As Leutz's (1999) fourth law of integration recognises, differing funding models and organisational processes create a challenging environment in which to enact integrated care. Engagement of general practitioners was a key dependency, yet the policy was not accompanied by formal agreements with this body of private sector practitioners nor with other social care services. The planned benefits of integrated care might accrue to the clients and the acute sector, yet the burden was imposed on community-based services. There is a need for policy to establish formal partnerships that navigate the existing maze

of various, disparate funding and governance arrangements and sustain the vision of integrated care with appropriate funding and partnership agreements between private and public health and social care sectors.

Apart from the position of liaison nurse, the model of care was not supported with funding for practitioners' additional time spent working with HealthOne. Allocating the responsibility for case management of HealthOne clients to general practitioners and attributing the GP's attendance at HealthOne case conferences to existing billing arrangements and business models was unrealistic, given GPs' traditional way of working autonomously within strict time limits. Clinical integration should be supported by systems and structures to facilitate multidisciplinary care management and care planning. For example, funding each private provider through the Medicare benefits schedule for attendance at multidisciplinary case conferences to develop or review care plans could incentivise practice change toward integrated care. Case management for people with complex health needs takes additional time in primary care outside clinical consultations and should be resourced appropriately. Information systems that enable the sharing of care plans and tracking of clients' care, for example, follow-up of referrals, are essential.

Although a number of health outcomes were specified in the model of care that was a key actor in this study, practitioners relied on manual systems to collect and report process and outcomes data in the study settings. Accurate and timely data that supports continuous quality improvement and accountability is important. However, the collection of practice-level data for monitoring of outcomes and quality improvement remains a challenge in primary health care. Standard processes and information systems to collect and report health outcomes data should be established, data definitions should be used consistently and data should be feasible to collect across a range of care settings, conditions and populations.

However, the health needs of people enrolled in models such as HealthOne are heterogeneous and activities were tailored to meet individual circumstances. The health outcomes that may be important to one client may be irrelevant for another client or less significant for the treating practitioner. Health outcomes measures should be defined, understood and agreed by practioners, clients and health service providers working with clients and communities to deliver integrated care. Criteria for success should be agreed, taking into account the unpredictable, non-linear, and often unseen nature of integrated care in practice.

It is now recognised that system and organisational integration is insufficient to achieve integrated service delivery (Curry & Ham 2010; Evans et al 2014; Janse et al 2016). The role of the HealthOne liaison nurse was critical to encourage professional and clinical integration, engage clients and to build effective working relationships across professions and sectors. Funding to ensure sustainability of integrated care initiatives should be adequate to attract and retain skilled people in this role of care manager or care coordinator. Ideally the role is filled by senior health professionals with a range of competencies including health promotion, analytical skills, relationship building, clinical leadership, education, strategy, advocacy and collaborative working as well as a broad base of knowledge (Hanley et al 2014). The role should be a recognised step in health practitioners' career progression and allocated appropriate professional development and supervision. The flexibility and adaptability of HealthOne liaison nurses in managing clients' complex health needs by facilitating access to health and social care are features of their practice that should be acknowledged in future as key capabilities.

Strong leadership of integrated care initiatives is needed at all levels of the system. HealthOne accomplished integrated care case by case through informal partnerships established by liaison nurses based on horizontal, trust-based

relationships. However, in the absence of strong leadership and shared care agreements, as Dickinson and Glasby (2010) point out, partnership working can be fraught with confusion about responsibility and accountability. Leadership that formally articulates the aims of joint ways of working and endorses binding agreements between organisations should be first steps in enacting future integrated care policies. When the vision and organisational integration is established, senior leadership should focus on supporting those tasked with leading initiatives on the ground to enact the vision for new ways of working. Support should be established for practitioners enacting integrated care including profession supervision, advocacy training and definition of clinical responsibilities.

Implications for future research

The conceptual framework for this study was chosen after immersion in the data and was intended to support the aim of the overarching ARC project. The theoretical approach drew on complementary theories of practice, bringing particular perspectives on integrated care to the fore. Other theoretical tools may introduce new insights. In addition, studies of integrated care in different settings might usefully employ the dimensions of practice change identified in this study. This approach would contribute further to exploring the nuances, effects and challenges of enacting practice change.

HealthOne has been operating for another two years since the completion of data collection for this study. The opportunity to explore how the model has been embedded in practice and how it has further evolved would produce valuable and complementary findings to this study. A number of general practitioners participated in interviews and meetings, contributing data to this study. Developing working relationships between general practice and the public health sector, and protection of client confidentiality were both matters of

concern. Exploring the practices and experiences of general practitioners in enactments of integrated of care is an area for further research.

In this study, data about activity with clients was collected from the shadowing phase of fieldwork. Interviews were not conducted with clients. At one HealthOne site, the staff had recently carried out a client experience survey and findings were referenced in this study. However, a survey was not undertaken with clients at the second site. In general, there is limited evidence about clients' experiences with integrated care. Future studies are recommended that foreground the client's experience of integrated care and investigate how clients and practitioners work in partnership. Studies should also consider clients who resist engaging with models of integrated care. In addition, to address the needs of culturally and linguistically diverse patient population groups such as those encountered in this study further studies should explore culturally appropriate models of integrated care with clients.

Conclusion

Integrated care is a complex and ambiguous phenomenon. In policy documents and evaluation reports, the input is clear, namely clients with complex and chronic conditions making heavy demands of the health system. The output has also been clear in that the policy was expected to reduce the burden on acute care and improve health care. Between the input and the output, the achievement of integrated care in the words of Latour (1987, p. 4) has been a 'black box'. This means that the complexity faced by practitioners in everyday work, the uncertainties, the mess and the challenges have been secluded from close investigation. What constitutes integrated care and how it is achieved has proved difficult to unravel. However, this study of an enactment of integrated care opens up the practices of integrated care in a way that reveals the limitations, tensions and momentary accomplishments and also the persistence and adaptability of those charged with its enactment. Progressively and over

time, the vision of integrated care was made to work as a form of integrated care that accommodated the local context and clients' circumstances. Just as Latour opened the black box of 'science in the making' as a rich and fascinating picture (Latour 1987, pp. 4, 15), this ethnographic study of a model of care opened the black box of integrated care to present multilayered pictures of practice in the making. ■

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Appendix 1

'Remaking practices' information sheets

PO Box 123, Broadway, 2007

UTS HREC Ref No 2011-029R

CLINICIAN INFORMATION STATEMENT

Remaking practices: learning to meet the challenge of practice change in primary health care

You are invited to participate in a study about the development of an innovative primary health care service, *HealthOne NSW*, an initiative of the NSW Health Department. This Australian Research Council funded project will research the remaking of health service and professional practices in two *HealthOne NSW* sites. The research team will work closely with *HealthOne NSW* staff and stakeholders to develop new understandings and practical insights about how health professionals from different professional backgrounds work with each other, with patients, and with other stakeholders to achieve the aims of *HealthOne NSW*. The research will add significantly to understandings of how service innovation and change is accomplished in local workplace settings. The research findings will be useful in policy development, service redesign, workforce development and professional learning and development.

Research aims are:

1. To produce detailed descriptions and analysis of how innovation is negotiated and achieved in the two *HealthOne NSW sites*

2. To develop learning activities and service improvement resources that will be utilized during the research
3. To investigate the role and possibilities of existing and emerging technologies, in particular, information and communication technologies, in shaping professional practice and change
4. To contribute to the development of more adequate understandings of learning and change in the area of health service redesign.

There are a number of ways in which you can participate. You can nominate your areas of participation on the consent form:

1. Participate in an interview about your experiences in working within the *HealthOne NSW* initiave. In particular, you will be asked to reflect on key questions of interest, in particular how practices have changed and what learning has occurred.
2. Participate by being shadowed during parts of your working day. We are interested in understanding the daily practices of *HealthOne NSW* staff.
3. Participate in the recording of key staff meetings where clinical or service development matters are discussed.
4. Participate by recording key events using written or digital diaries.
5. Participate in the audio or video recording of some your consultations with patients.

Members of the research team will conduct the interviews, focus groups, recordings and collaborative review groups.

We cannot guarantee that you personally will receive any benefits from this study, but the study does aim to improve the safety and quality of patient care in the health system.

Voluntary participation:

It is important for you to know that your choice to participate is entirely a matter for you. You are not required to participate unless you wish to do so. You are free to withdraw your participation from this research at any time without giving a reason. Such withdrawal will not affect your current or future relationships with the health service. If you have any difficulty or concerns about the research you can contact Professor Nicky Solomon (9514 1334). Professor Solomon is the Chief Investigator in this research.

If you are being recorded and wish the recorder to be turned off, you can ask for this to happen without any reason being given.

Confidentiality:

Any information about you that is obtained in connection with this study will remain confidential. Data gathered from the interviews and from the recording of interactions will be used for publication, training, workforce, doctoral research purposes and professional development purposes. When such data is used it will be completely de-identified. The names of patients, clinicians and health services will be removed from all reports and publications.

All information obtained in the course of this research will be securely maintained in accordance with university data security policies, and will not be made available to anyone outside the research team, unless this is required by law.

Financial and in-kind support to cover the costs of carrying out this study is being provided by the Australian Research Council; the University of Technology, Sydney; and NSW Health.

You will be given a copy of this form to keep.

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or

complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0309.

The conduct of this study at HealthOne has been authorised by the Western Sydney Local Health Network. Any person with concerns or complaints about the conduct of this study may also contact The Secretary, WSLHN Human Research Ethics Committee (Westmead Campus) Telephone No 9845 8183 or email researchoffice@swahs.health.nsw.gov.au and quote SSA reference SSA/11/WMEAD/10

UNIVERSITY OF TECHNOLOGY SYDNEY
PO Box 123, Broadway, 2007
UTS HREC Ref No 2011-029R

PATIENT INFORMATION STATEMENT

Remaking practices: learning to meet the challenge of practice change in primary health care

You are invited to participate in a study about the development of an innovative primary health care service, *HealthOne NSW,* an initiative of the NSW Health Department.

HealthOne NSW aims to support different groups of health professionals – doctors, nurses and allied health professionals – to work more closely with each other and with patients to deliver high quality health care that is effective and sustainable. *HealthOne NSW* is particularly interested in delivering services in partnership with patients and the local community.

Talking to patients is a critical component of understanding how *HealthOne NSW* services are developing.

The purpose of the research is not to evaluate *HealthOne NSW*, rather we are interested in understanding how *HealthOne NSW* has developed and ways in which it is different from other health services. To hear about your views and experiences will help us in understanding these matters and will assist with the development of improved health care services in NSW and nationally.

Your participation in this research would be greatly appreciated.

There are three ways in which you can participate in the study – you can nominate one or more of these ways in the consent form:

1. Participating in an interview about your experiences in attending *HealthOne NSW* services. The interview will last approximately 30

minutes and will be conducted in a private space at *HealthOne NSW*. We will also ask if you are agreeable to having your interview recorded and transcribed.

2. Having your consultation with a HealthOne NSW clinician audio or video recorded.
3. Participating in a small focus group for patients discussing their experiences of HealthOne NSW.

Members of the research team will conduct the interviews and recordings. If you are being recorded and wish the recorder to be turned off, you can ask for this to happen without any reason being given.

We cannot guarantee that you personally will receive any benefits from this study, but the study does aim to improve the safety and quality of patient care in the health system.

Voluntary participation:

It is important for you to know that your choice to participate is entirely a matter for you. You are not required to participate unless you wish to do so. You are free to withdraw your participation from this research at any time without giving a reason. Such withdrawal will not affect your current or future relationships with the health service. If you have any difficulty or concerns about the research you can contact Professor Nicky Solomon (9514 1334). Professor Solomon is the Chief Investigator in this research.

Confidentiality:

Any information about you that is obtained in connection with this study will remain confidential. Data gathered from the interviews and from the recording of interactions will be used for publication, training, workforce, doctoral research purposes and professional development purposes. When such data is

used it will be completely de-identified. The names of patients, clinicians and health services will be removed from all reports and publications.

Financial and in-kind support to cover the costs of carrying out this study is being provided by the Australian Research Council; the University of Technology, Sydney; and NSW Health.

You will be given a copy of this form to keep.

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0309.

The conduct of this study at HealthOne has been authorised by the Western Sydney Local Health Network. Any person with concerns or complaints about the conduct of this study may also contact Ms Jillian Gwynne Lewis, Westmead Hospital Patient Representative, (Contact details: Telephone No 9845 7014 Email address: jillian.lewis@swahs.health.nsw.gov.au) and quote SSA reference SSA/11/WMEAD/105

Appendix 2

'Remaking practices' consent forms

PO Box 123, Broadway, 2007

UTS HREC Ref No 2011-029R

CLINICIAN CONSENT FORM

REMAKING PRACTICES: LEARNING TO MEET THE CHALLENGE OF PRACTICE CHANGE IN PRIMARY HEALTH CARE

I, ...*[name]*

of

.....*[address]*

have read and understood the Information for Participants on the above named research study

and have discussed the study with

.....

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

- I have agreed to be interviewed about my experiences in working within the *HealthOne NSW* initiave: Yes ☐ No ☐
- I have agreed to be shadowed during parts of my working day Yes ☐ No ☐
- I have agreed to participate in staff meetings that will be audio or video recorded Yes ☐ No ☐
- I have agreed to record key events using a written or digital diary Yes ☐ No ☐
- I have agreed to participate in audio or video recorded consultations

between *HealthOne NSW* clinicians and patients Yes ☐ No ☐

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

NAME: .....

SIGNATURE: .....

DATE: .....

NAME OF WITNESS: .....

SIGNATURE OF WITNESS:.....

PO Box 123, Broadway, 2007

UTS HREC Ref No 2011-029R

PATIENT CONSENT FORM

Remaking practices: learning to meet the challenge of practice change in primary health care

I, ... *[name]*

of

.....*[address]*

have read and understood the Information for Participants on the above named research study

and have discussed the study with .....

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

1. I have agreed to be interviewed and have recorded my views and experiences of attending *HealthOne NSW* services:

Yes ☐ No ☐

2. I have agreed to have my consultation with a *HealthOne NSW* staff member audio recorded:

Yes ☐ No ☐

video recorded: Yes ☐ No ☐

3. I have agreed to participate in a focus group for patients of *HealthOne NSW:* Yes ☐ No ☐

I understand that my participation in this study will allow members of the research team to access demographic information about me.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

NAME: .....

SIGNATURE: .....

DATE: .....

NAME OF WITNESS: .....

SIGNATURE OF WITNESS:

.....

Appendix 3

'Remaking Practices' interview questions for health professionals

1. Can you identify your position and your relationship to Corymbia HealthOne?
2. Could you tell us about the development of HealthOne at Corymbia and the ways in which HealthOne aims to be different from traditional primary health care practice?
3. What has been achieved at Corymbia to date – what does this look like?
4. How have these changes been achieved?
5. What stands out?
6. What factors have enabled and constrained the development of HealthOne at Corymbia?
7. What has been your role in this?
8. Much is happening in the broader health system, for example, Medicare Local. Can you tell us about these changes and their implications?
9. Can you identify the 3 most important factors related to the success of Corymbia HealthOne?
10. Looking to the future – what will HealthOne look like in three years time?

Appendix 4

Publications and conference presentations related to this thesis

Publication

Hanley, E, Doyle, T, Fagan, N, & Mulligan, J 2014, 'Facilitating integrated care: an approach to child and family health in primary health care', *Australian Journal of Child and Family Health Nursing*, vol. 11, no. 1, pp. 25-29.

Conference presentations

Dunston, R, Solomon, N, Robertson, T, Lee, A, Thistlethwaite, J, Sorensen, R, Hanley, E 2012, 'Learning from practice - getting close to service redesign in primary health care', 2012 *Primary Health Care Research Conference: Program & Abstracts*, Primary Health Care Research and Information Service, Australia, phcris.org.au/conference/abstract/7336.

Hanley, E, Robertson, T, & Solomon, N 2013, 'Integrating work in new models of primary health care', The 13th European Conference on Computer Supported Cooperative Work.

Hanley, E 2014, 'Practising primary health care with complex and vulnerable clients', *2014 Primary Health Care Research Conference: Program & Abstracts*, Primary Health Care Research and Information Service, Australia, phcris.org.au/conference/abstract/7958.

Hanley, E 2014, 'Producing integrated care: the vision and the realities', Faculty of Arts and Social Sciences Conference, University of Technology, Sydney.