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Understanding inter-organizational trust among integrated care service provider networks: a perspective on organizational asymmetries

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Accepted Version

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Li, W. ORCID: https://orcid.org/0000-0003-2878-3185, Islam, A., Johnson, K., Lauchande, P., Shang, X. and Shen, X. (2018) Understanding inter-organizational trust among integrated care service provider networks: a perspective on organizational asymmetries. Health Policy, 122 (12). pp. 1356-1363. ISSN 0168-8510 doi: https://doi.org/10.1016/j.healthpol.2018.09.003 Available at https://centaur.reading.ac.uk/78981/

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To link to this article DOI: http://dx.doi.org/10.1016/j.healthpol.2018.09.003

Publisher: Elsevier

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Understanding inter-organizational trust among integrated care service provider networks: a perspective on organizational asymmetries

Abstract:

Objective. To explore the factors that influence trust among the integrated healthcare service provider network in the context of seeking combined health and care services in the UK.

Data Sources/Study Setting. Primary data were collected from three regional integrated care service provider networks from March 2016 to October 2017.

Study Design. Explorative qualitative study and inductive methods from emerging findings.

Data Collection/Extraction Methods. We conducted qualitative semi-structured interviews in three care networks and collected organizational documents from local integration boards from 2016 to 2017. Thematic analysis was performed in three large care networks with hospital staff, local councils, integration boards, and community and voluntary organizations under the NHS England Better Care Fund.

Principal findings. Our findings reveal that trust among integrated care service provider networks is influenced by the following factors on various asymmetries: 1) recognition and knowledge asymmetries among care service partners of each other's skills, expertise and capabilities; 2) capacity and financial imbalances within the network; and 3) organizational differences in management, culture and attitudes toward change.

Conclusion. There is a need to improve competence recognition and capacity imbalances and to foster open minds toward change within networks to build trust to overcome divisions and facilitate integrated services among health and care organizations.

Keywords. Trust, integration policy, service provider network, health and social care, joining up

Introduction

An ongoing challenge for the National Health System (NHS) in the UK is to keep pace with the extra demands and to meet patient needs; therefore, integration of the health and care system has become a key element of the future of the NHS. Over the past three decades, broad changes in integration practices between health and social care services have been occurring across North America, Europe and elsewhere (Campbell., 1998; Kodner and Spreeuwenberg., 2002; Ouwens et al., 2005) to provide better and more cost-effective health and social care. As a result, a considerable amount of published research on integrated care has focused on identifying factors that influence integration, such as service sectors, professions, settings, organizations and care types (Ahgren and Axelsson., 2005; Busse and Stahl., 2014; Kodner and Kyriacou., 2000; Valentijn et al., 2013). Inter-agency cooperation is fundamental to successful integrated care however low levels of trust in inter-organizational relationships among health and care players is perceived to undermine the collaborative good will toward a successful integration (Ham, 2012; Williams, et al., 2013). For example, existing study on social care find considerable effort was still needed to build relationships and develop trust between agencies (Jacob et al's 2009). Wistow (2011) suggest trust and mutual confidence are important lubricants but are undermined by organisational restructuring in NHS reform. Furthermore, the leaders are advised to develop 'strong relationships' 'built on trust and experience' (Ham & Walsh, 2013).

Despite the literature highlights the importance of trust, the loss of trust surrounding health, local government and care organizations has not been fully captured empirically. Existing research into trust in the health and social care focuses on the changing nature of relational interactions between health professionals and patient (Anderson, L.A. and Dedrick, R.F., 1990; Thom, D.H. and Campbell, B., 1997; Andreassen, H.K. et al, 2006; Meyer, S.B. and Ward, P.R., 2008; Ridd, M. et al, 2009) or between professional autonomy and managerial imperatives (Brown & Calnan, 2012, Alaszewski & Brown, 2007) but not specifically to

problems of integration across the organisations. Although some studies consider perspectives such as leadership (Firth-Cozens, J., 2004; Vogus, T.J. and Sutcliffe, K.M., 2007; Wong, C.A. and Cummings, G.G., 2009), there is a scarcity of literature about inter-organizational trust in health and care organizations, which is essential for effective cross-cutting partnerships.

To understand the factors that lead to the loss of inter-organizational trust in health and social care services, we conducted a qualitative exploratory research with local integrated care service provider networks in England under the National Integrated Care and Support Programme – the Better Care Fund (BCF). This study aims to explore the factors that influence trust among integrated healthcare service provider networks in the context of seeking to combine health and care services in the UK. This work was undertaken as part of ongoing integration programs under the BCF (Department of Health, 2016). This study will investigate the following research questions:1) what are the factors that cause the loss of trust surrounding health, local government and care organizations; 2) how does the trust loss affect integrated care and how to build the trust for effective cross-cutting partnerships? We studied healthcare challenges, existing integrated care schemes, and inter-organizational trust in collaborations within integrated care service provider networks.

Methods

We adopted a qualitative-exploratory approach to understand how people make sense of the trust and the experiences they have in the care networks. A detailed qualitative investigation was therefore appropriate for our purpose because 1) qualitative inquiry can improve the description and explanation of complex, real-world phenomena pertinent to health services research (Bradley, 2007); 2) the factors that lead to the loss of inter-organizational trust in the context of integration are not well understood; and 3) we were interested in the worldviews of key stakeholders involved in integrated care, including health, social care and local authorities' experiences of the loss of inter-organizational trust. The reason why an explorative approach was used because there is very limited research on trust between health and social care

organizations and exploratory research is often used to tackle new problems on which little or no previous research has been done. We chose to study inter-organizational trust by focusing on the BCF program in the United Kingdom. The BCF spans both the NHS and the local government and seeks to combine health and care services. The BCF was created to improve the lives of some of our society's most vulnerable populations, placing them at the center of their care and support and providing them with integrated health and social care services, resulting in an improved experience and better quality of life, which aligns with the vision outlined in the NHS' five-year plan (NHS England, 2012). We selected the BCF in this research project for several reasons. First, the BCF is recognized as one of the most ambitious programs ever introduced across the NHS and local government, providing the largest financial incentive ever (Department of Health, 2016). Second, the BCF represents a unique collaboration between NHS England, Department for Communities and Local Government, Department of health and Local Government Association. The BCF requires cross-cutting partnerships to support local areas to plan and implement integrated health and social care services across England. Preliminary research of BCF revealed a problem with inter-agency relationships resulting in or generating low levels of trust relations, which was believed to be undermining the progress, with older people 'falling through gaps' between services (Williams, et al., 2013).

Data collection

We collected data over an 18-month period from March 2016 to October 2017 from three health and care networks. Each network covers a population of approximately 120,000 to 170,000. We interviewed 41 subjects, including healthcare professionals, nurses, integration managers, and community and voluntary organizations (Table 1). Individual interviewees were selected based on guidance provided by BCF integration program managers from local councils and levels of involvement with local integrated care pilots and initiatives. In addition, local integrated care plan and pilots' documents were collected and notes and diagrams were created by the interviewer on site to document additional contextual data about each interview. The

narratives used in this research paper were generated from these interview transcripts. Each interview session lasted an hour on average and included subjects from different backgrounds offering rich perspectives on trust-based relationships.

Insert table 1 here

Our semi-structured interview questions consisted of two parts. The first part focused on the interviewee’s experience in delivering integrated services and working in cross-cutting partnerships. A flowchart describing the architectural view of the integrated care process and interaction among stakeholders was used to engage participants throughout these discussions (Appendix 1 shows an example flowchart for one local network). Consequently, the flowchart acted as a living document that evolved in each interview to facilitate the data collection process. Furthermore, specific questions were created based on each participant’s background, because they possessed vastly different knowledge, experience, and perspectives. The second part of the interview questions focused on factors that influence inter-organizational trust and their impact on integrated care. Moreover, we supplemented our interview with local integrated care plan and pilots’ reports.

Data analysis

The data analysis involves three stages. In the first stage, all interviews were transcribed. We thoroughly examined what was said in each interview and iteratively converted the stories and thoughts into a written document. In the second stage, the transcripts were coded using thematic analysis and Nvivo 10. Once the data were collected, we attempted to identify and highlight passages in which interviewees referred to their thoughts and stories regarding the current integration of health and care services and inter-organizational trust. As our focus was on inter-organizational trust, we drew on existing work in this area through systematic literature review (Table 2) to establish a framework for the deductive coding process, extracting excerpts from

our qualitative data that related to inter-organizational trust. This process identified important factors influencing inter-organizational trust. The first, second and fourth authors were involved in interview data analysis process including theme analysis and coding. The third, fifth and sixth author were involved in member checking. We inductively identified emerging themes surrounding the notion of trust in integrated care service provider networks. Codes were created to depict the frequency of occurrence of words and phrases to denote a theme. Subsequently, these themes were reviewed, defined, and named according to their content and organized into a taxonomy.

Insert table 2 here

Next, we independently examined and identified tentative descriptions of each of these areas and how they formed a basis for inter-organizational trust; furthermore, we assessed the factors that lead to the loss of inter-organizational trust among professional groups and organizations. The third stage focused the interpretive analysis on quotations from narratives. As we improved our appreciation and knowledge of integrated care network and trust dimensions, we developed a better understanding and continuously revisited trust factors in integrated care partnership until they encompassed all our findings. In addition local integrated care plan and pilots' documents includes evidence base of challenges in care network, existing BCF schemes review and BCF plans in next two years. Especially BCF scheme review and plan includes existing inter-organisational collaboration projects such as discharge to access, social prescribing, living well partnership. The interview further complements the local plans with trust and organizational asymmetry issues that causes challenges of existing schemes. As a result, this analysis identified various types of loss of inter-organizational trust that interviewees expressed as having an impact on integrated care networks (Appendix 2).

Findings

Our findings relate specifically to local integrated care service provider networks, but some of the themes uncovered are likely to have broader applicability to similar care service networks. We found that perceptions of capability, recognition of competence and differences in capacity, funding, power and culture were the factors most mentioned as having implications for trust and care service integration processes among provider networks (Table 3).

Insert table 3 here

Capability perception and competence recognition

A key factor affecting trust in the integration processes was the perception and recognition of the capabilities and competences of care service providers in the network. The inability to identify, monitor and review partners' expertise was found to lead to the loss of inter-organizational trust in a partner's competence. This finding can be seen as a knowledge asymmetry within the network that influences referral processes (awareness to refer, longer assessment processes) and care model development (e.g., overlapping models). For example, knowledge asymmetry regarding partners' expertise also frequently involved a sense that the health organization was not referring individuals to the voluntary sector because they were unable to identify partners with the necessary skills to support their care strategy. By identifying and capitalizing on partners' expertise, service providers can enhance trust and continuity of care. This process can affect the perception of organizational boundaries and "closeness" between partner relations as shown in the comment below and *quotation 1* and *2* in Appendix 2.

> "The sector is made up of independent organizations, so the difficulty at the moment is anybody, anywhere within the system can't know everything about the sector" (Integration program manager, Local council, N3)

Similarly, the health organization staff mentioned a trust issue below that affected assessment processes. Similar comment can be found in *quotation 3 of Appendix 2.*

> "They will not trust our assessment. Either take them (the patients) straight away or give us a decision and say we can't cope with them and it's time for them to move, perhaps" (Professional lead OT, NHS hospital, N3)

Not being able to ascertain a partner's (both health and social care organisations) inherent skills caused overlapping care models in the community. For example, participants from health reported below and other voluntary sector interviewees reported similarly in *quotation 4 of Appendix 2*.

> "There are similarities between the different models in our area, and if you think about it, the local authority works with people over 60 years old like we do, and some of what they are doing overlaps with us. So, I would say, there is overlap." (Discharge service manager, Healthcare foundation trust/Integrated discharge team, N2)

Some staff indicated a loss of confidence in service quality from partner organizations because of the varying levels of quality inspections as below and *quotation 5 of Appendix 2*:

> "How can we develop confidence in GPs and the secondary sector to refer to us? The confidence that their patients will get a quality service, because I think that's not there for some people at the moment."
> (Specialist Care Practitioner, Care home, N3)

In other words, the hesitation to refer individuals and the overlapping developed models were partly related to the knowledge of and confidence in quality of care of partner organisations. A strong perception exists that an organization's ability to easily gain information about a partner's expertise in a multidisciplinary integrated care setting can affect the willingness to rely on each other with confidence that the other will reliably fulfill their expectations.

Capacity and financial imbalance

Capacity challenges exist in care service provider networks in the context of wider challenges in local economies, such as the increasing population (particularly in those over the age of 65 years). This challenge has led to capacity pressures for hospitals including increasing growth in non-elective care, A and E attendance, and pressure on urgent and emergency capacity. The capacity challenges in social care outside the hospital lead to delayed transfers of care and bed days lost, which in turn influence the trust and expectations of positive outcomes in the health and social service integration processes (see *quotation 6, 7 and 8 in Appendix 2*). The community and social care services also encountered similar capacity pressures, including increasing pressures on adult social care for community packages and care homes and increasing demand for planned (elective) care, which affect the expectation of service integration outcomes in the network:

> "The other problem with social services is that there is a great deal of human resources lacking. Carers are especially lacking. They have different mechanisms for hiring carers, and because they have different mechanisms, they buy it from the private sector. And the private sector will say either buy it for this length of stay, length or duration or don't buy it. It's a very tricky situation there, that's where we need to start figuring out how we commission those carers" (Chair, CCG, N3)

In addition to capacity challenges, the trust-related challenge was heightened with all organizations within local economies, including acute and community providers, CCGs, ambulance trusts and the local authorities, experiencing significant financial challenges. The participants from social service organizations felt that the financing provided to the health organizations was far less likely to be questioned when resources were allocated:

> "I think people see the council as taking children away from their families, putting old people in horrible, cheap homes, and emptying their bins. It's a shame. It's not right. I think it's our job to correct that. I can't

blame the public for thinking that. And it does mean that the NHS budget will be protected, and the social care budget clearly isn't protected at all" (Partnership manager, Local council, N1)

In many instances of care service networks, participants indicated that huge financial and operational pressures were driving the health organization and social care apart. Accordingly, they opted to draw strict liability boundaries to protect their vested interests (see below and *quotation 9 in Appendix 2*)

> "I don't believe we have been given enough money to run our statutory services. We are trying our very best to come in within budget here, but ultimately, I believe we don't have enough money. Sixty percent of the overall budget is allocated to health and 40% to social services, but we are scrutinized far more severely than health [services]" (Lead social worker, Hospice, N2)

We also found that although financial pressure had restricted all partners' capabilities and their financial interactions in the care service providers' network, it was not always appreciated by all the organizations. For example, we found that some social and community organizations felt less supported and far from integration as below and *quotation 10 in Appendix 2*:

> "I've been here for 8 years and prior to that, it was always known that health didn't fund continuing healthcare funding to the level it should, and we have always had many arguments with them about it. But it's always been accepted as, well, we can't get that sorted. In terms of integration, stuff like that needs to be sorted out; it needs to be much more spelled out. If the health organization here is one of the lowest funders of continuing healthcare funding in the country, which I am told is right, how can that disparity happen and not be questioned by someone bigger than us? We can't integrate if we are fighting over something as basic as this" (Trained Carer, Community Reablement team, N1)

Given the capacity and financial challenges within care service provider networks, commissioning across the health organization and social care involves a fear of cost shifting between purchasers, nurturing a belief that protective structures are not in place for situational success. This fear led to a decrease in beliefs and intentions that partners will act fairly to create

positive outcomes for the good of the relationship, eventually leading to a loss of trust between health and social care because of capacity imbalances.

Attitude toward change and cultural differences

We observed some fears of change, identity loss and reduced operational and financial autonomy in the integration process from participants, given the differences in operations and financial size among healthcare providers' networks:

> "I think one of the fears from our side is that one will take over the other. And there is certainly a fear, I know, in social care generally that the government appears to be pushing for the NHS to take over social care rather than social care to take over the NHS. That is worrying for us in terms of our professional identity, social work profession standards can get lost in the NHS profession standards. So I can understand there is a fear there of being taken over by a more powerful organization" (Partnership manager, Voluntary action, N1)

Some interviewees in social care organizations reported that their role was not perceived as equally important as health-employed individuals. Others indicated that although they were working closely with the health organization, certain organizations were dominating inter-organizational initiatives and communications (also see *quotation 11 and 12 in Appendix 2*):

> "After that you know, it's just been email contact and whatever discussions have been had through the CCG and the GP council, which we haven't been part of. So at one level we are quite removed" (Personal independence coordinator, local Age UK, N1)

In each of these cases, participants suggested that control is maintained by one or more organizations over others through operational or financial means. Accordingly, the perception of loyalty, satisfaction and equality in the partnership was compromised by fears of reduced operational and financial autonomy and identity. In contrast, participants from care service

provider networks where regular communications occur together among all organizations had a more positive attitude for the integration processes (also see *quotation 13 in Appendix 2*):

> "We have regular meetings, we all work together, within that [work there are] representatives from social services, community matrons, mental health nurse, OTs. So that is very integrated, and the way I get my referrals from NHS it's much more joined up" (Area manager, Social care service, N3)

Some participants in social care organizations identified that organizational or cultural differences with the health organization led to questions regarding the value of the "partnership" in their organization. The presence of these questions in the back of their minds meant that individuals began to shift their emphasis from collaborative activity to protecting their professional identities, positions and self-interests. Importantly, those emphasis shifts were narrated as responses to the lower perceived value of the social care organization, which prompted them to re-evaluate the relationship. After establishing their perceived value, collaboration no longer seemed as important, and the individuals realized that despite actively wanting to work toward joining up, they were discouraged by how they were seen and by a lack of mutual understanding. After working in both health and social care organizations, some participants realized that developing a mutual understanding was key to successful collaboration:

> "Social care works to a social care model; health works to a medical model. I have worked in health in joint social care teams... and I think the difference in thinking, values… and models… is what causes integration issues. I think once you build a relationship and understand each other, then collaboration works well. I think the key issue is people don't understand each other" (Assessment team, Elderly & frail ward at hospital, N1)

Some participants from local council integration boards indicated that these cultural differences impeded the smooth conflict resolution between health and social care managers;

this situation was identified as “people not wanting to change their way of working or behaviors”.

> “Some managers are quite set in their ways. It’s very difficult to change the way they do things because they don’t act on feedback, and they don’t want to interact with others in an “integrated” manner. I really don’t know what to do with them” (Integration program manager, local council, N3)

When participants described loss of trust in terms of organizational or cultural differences, they reported feeling as though they were outsiders in the health organization, causing them to rethink the relationship. This realization led them to decide that investing further in the relationship was no longer a priority for them and that they should be concentrating on other aspects of their own organizations. Thus, a lack of commonality across organizational boundaries impeded trust, causing considerable difficulty in health and social care collaboration, because parties were not able to predict with confidence others’ actions, and this affected the ways in which they made sense of the exchange process. However, an open attitude was indicated as an important factor for successful combined services:

> “I visited a health hub and it looked very good. The director there was health employed. He was sitting in a health office with council workers, working with council workers all the time. He was so open to developing something together, and that’s one of the first times I have seen that in a person. Now, I could work with him and I could feel that the social care element was respected and brought into the system, just as much as the NHS’s views and vision were brought into the system. He was somebody who could work across the two, and I absolutely respected that. It’s rare to find that in a person, and we need more people like that who are open to both cultures and visions and are willing to incorporate them both into the overall system” (Area manager, social care service, N2)

Discussion

Conceptualizing the salience of trust to integrated care and the notion of a more collaborative whole-system model could provide useful insights to individuals and organizations trying to

achieve full integration. As services are continually challenged with growing uncertainty and complexity, the relationships we found between loss-of-trust narratives and integrated care partnerships could help individuals and organizations anticipate potential issues related to health and social care services integration. Our research findings align with existing literatures where similar factors affecting inter-organisational trust are identified in other domains other than healthcare (as shown in table 2). It also aligns with “information asymmetry” in economics where of perceptions of value of goods and services is the basis of trade but the asymmetry creates an imbalance of power in transactions. Implications such as transactions going awry, adverse selection, moral hazard, and monopolies of knowledge can also happen in care providers’ network. Drawing from various aspects from different care service providers, we can see that a clear view about the whole care network can have substantial implication for reducing organisation level asymmetry and hence building trust. Local government with a clear overview and strong history of integrated care initiatives are more inclined to trust and are better able to construct and share it, both individually and collectively in a whole-system model. Furthermore, modest and achievable trust building and integrated care model can lead to wider success in the care network. For instance, the discharge-to-assess scheme at Sheffield’s Frailty Unit is highly regarded within the NHS as successfully merging health and social services to deliver care to frail and elderly individuals. Therefore, others have sought to follow this model, and in doing so, they have begun to respect the social care element as much as the health one.

Conclusions

This research has underscored the point that inter-organizational trust is an essential element in the integration of health and care services, and it has also offered insights into different facets of trust in the integrated care service provider networks. Our work indicates that care network organizations working together and making the most efficient use of available resources could be facilitated by adequate competence recognition, capacity and financial support, mutual understanding and an open attitude toward an integrated approach. Our study provides an

important empirical investigation into the continual loss of inter-organisational trust following an integrated care initiative. Our findings emphasise the importance of asymmetry-based factors in relation to the loss of inter-organisational trust. Our analysis reveals that competence-based trust and sense of partner's credibility can be reduced due to knowledge asymmetry regarding lack of knowledge on partner's skills and expertise. In the situation of asymmetric power between organisations, imbalanced capacity. It can lead to a reduced feeling of fairness and equality; sometimes it can even increase the fear of losing identity, which in turn can affect successful inter-agency planning and budgeting among health and social care organisations. The intrinsic culture and structural asymmetries that lie in different organisations, especially different perceptions and priorities on developing and maintaining inter-organisational relationships, can impede confidence and predictability in exchanging behaviours such as jointly managed programmes or services between health and care. As shown in table 4, trust in integrated care service provider network can be built in the following ways: 1) inter-organisation learning of mutual competence and differences among partners in care network; 2) set up organisation and individual spanners to facilitate services joining and involve personnel who have both health and social care experience for mutual understanding; 3) resource and leadership to balance the power, capacity and funding among organizations in the care network with clear commitment; 4) start from modest and achievable outcomes in trust building and integrated care model and gradually develop a trust building loop at all levels of the care network. We advance existing research by identifying empirical insights into asymmetries associated trust factors specifically to problem of integration across health and social care organisations.

The limitation of this research is that the majority of participants were only selected from provider organisations but only a few of them from NHS England team, local CCGs and health & wellbeing board. Involving more of such participants would have a unique and overall perspective on the functioning of local care networks, the relationships between the organisations and the impact on the local BCF plans. Based on findings of this study, future research priorities will be impact of trust and

asymmetry in the whole network, wider integrated care systems (ICS) and partnerships for integrated care across UK. The findings can also inform integrated care research in other countries such as China and Europe where similar health care system reform is happening and further research will explore different trust aspect in different county and policy context.

References

Ahgren, B. and Axelsson, R. (2005). Evaluating integrated health care: a model for measurement. International journal of integrated care, **5**, 1–9.

Ariño, A., Abramov, M., Skorobogatykh, I., Rykounina, I. and Vila, J. (1997). Partner selection and trust building in west European–Russian joint ventures: a western perspective. International Studies of Management & Organization, **27**, 19–37.

Ariño, A., De la Torre, J. and Ring, P.S. (2001). Relational quality: Managing trust in corporate alliances. California Management Review, **44**, 109–31.

Bachmann, R. (2001). Trust, power and control in trans-organizational relations. Organization studies, **22**, 337–65.

Bachmann, R. and Inkpen, A.C. (2011). Understanding institutional-based trust building processes in inter-organizational relationships. Organization Studies, **32**, 281–301.

Bartels, S.J. (2004). Caring for the whole person: Integrated health care for older adults with severe mental illness and medical comorbidity. Journal of the American Geriatrics Society, **52**, 249–57.

Bousquet, J., Anto, J.M., Sterk, P.J., Adcock, I.M., Chung, K.F., Roca, J., Agusti, A., Brightling, C., Cambon-Thomsen, A., Cesario, A. and Abdelhak, S. (2011). Systems medicine and integrated care to combat chronic noncommunicable diseases. Genome medicine, 3, 1–12.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health services research*, *42*(4), 1758-1772.

Bryman, A. and Bell, E. (2015). *Business research methods*. New York: Oxford University Press.

Busetto, K. Luijkx, H. Johannes, M. Vrijhoef Development of the COMIC Model for the comprehensive evaluation of integrated care interventions. International Journal of Care Coordination, 0 (0) (2016), pp. 1-12

Busse, R. and Stahl, J. (2014). Integrated care experiences and outcomes in Germany, the Netherlands, and England. Health Affairs, **33**, 1549–58.

Campbell, H., Hotchkiss, R., Bradshaw, N. and Porteous, M. (1998). Integrated care pathways. BMJ: British Medical Journal, **316**, 133–7.

Casas, A., Troosters, T., Garcia-Aymerich, J., Roca, J., Hernández, C., Alonso, A., del Pozo, F., de Toledo, P., Antó, J.M., Rodríguez-Roisín, R. and Decramer, M. (2006). Integrated care prevents hospitalisations for exacerbations in COPD patients. European Respiratory Journal, 28, 123–30.

Chen, S., Awan, S., Rajji, T., Abdool, P., George, T.P., Collins, A. and Kidd, S.A. (2016). Integrated care pathways for schizophrenia: a scoping review. Administration and Policy in Mental Health and Mental Health Services Research, **43**, 760–67.

Das, T.K. and Teng, B.S. (2001). Trust, control, and risk in strategic alliances: An integrated framework. Organization studies, **22**, 251–83.

Department of Health (2016). 2016/17 Better Care Fund Policy Framework. Available at: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017 (accessed 30 August 2017).

Eisenhardt, K.M. (1989). Building theories from case study research. Academy of management review, **14**, 532–550.

Exworthy, M., Powell, M., & Glasby, J. (2017). The governance of integrated health and social care in England since 2010: great expectations not met once again?. *Health Policy*, *121*(11), 1124-1130.

Grimshaw, D., Willmott, H. and Rubery, J. (2005). Inter-organizational networks: Trust, power, and the employment relationship. Fragmenting work. Blurring organizational boundaries and disordering hierarchies, Oxford: Oxford University Press.

Ham, C. (2012). Leadership and engagement for improvement in the NHS: Together we can. *Report from the King's Fund on Leadership Review*.

Ham. C., & Walsh, N., (2013), Making Integrated Care Happen at Scale and Pace, London, *The King's Fund*, 2013

Jacobs, S., Xie, C., Reilly, S., Hughes, J. & Challis, D., (2009). Modernising social care services for older people: scoping the United Kingdom evidence base. *Ageing and society*, 29(4), pp. 497-538

Kodner, D.L. and Kyriacou, C.K. (2000). Fully integrated care for frail elderly: two American models. International journal of integrated care, **1,** 1–19.

Kodner, D.L. and Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications–a discussion paper. International journal of integrated care, **2**, 1–6.

Lambeek, L.C., van Mechelen, W., Knol, D.L., Loisel, P. and Anema, J.R. (2010). Randomised controlled trial of integrated care to reduce disability from chronic low back pain in working and private life. Bmj, 340, Available at http://www.bmj.com/content/340/bmj.c1035.short (accessed 30 August 2017).

Lee, O. (1999). Science knowledge, world views, and information sources in social and cultural contexts: Making sense after a natural disaster. American Educational Research Journal, **36**, 187–219.

Li, F. (2003). Implementing E-Government strategy in Scotland: current situation and emerging issues. Journal of Electronic Commerce in Organizations (JECO), **1**, 44–65.

A. Mason, M. Goddard, H. Weatherly. Financial mechanisms for integrating funds for health and social care: an evidence review. University of York, Centre for Health Economics, New York (2014) CHE Research Paper No. 97

MacDuffie, J.P. 2011. Inter-organizational trust and the dynamics of distrust. Journal of International Business Studies, **42**, 35–47.

Marshall C. & Rossman G.B. (1995) Designing Qualitative Research. London: Sage Publications.

Merriam, S.B. (2009). Qualitative case study research. Qualitative research: A guide to design and implementation. San Francisco, CA: Jossey-Bass.

NHS England (2012). Five year forward view. Available at: http://www.england.nhs.uk/ourwork/futurenhs/ (accessed 30 August 2017).

Nooteboom, B., Berger, H. and Noorderhaven, N.G. (1997). Effects of trust and governance on relational risk. Academy of management journal, **40**, 308–38.

Nooteboom, B., Berger, H., & Noorderhaven, N. G. (1997). Effects of trust and governance on relational risk. Academy of Management Journal, **40**, 308–38.

Ouwens, M., Wollersheim, H., Hermens, R., Hulscher, M. and Grol, R. (2005). Integrated care programmes for chronically ill patients: a review of systematic reviews. International journal for quality in health care, **17**, 141–46.

Ring, P.S. and Van de Ven, A.H. (1994). Developmental processes of cooperative interorganizational relationships. Academy of management review, **19**, 90–118.

Rousseau, D.M., Sitkin, S.B., Burt, R.S. and Camerer, C. (1998). Not so different after all: A cross-discipline view of trust. Academy of management review, **23**, 393–404.

Sako, M. and Helper, S. (1998). Determinants of trust in supplier relations: Evidence from the automotive industry in Japan and the United States. Journal of Economic Behavior & Organization, **34**, 387-417.

Slembrouck, S. (2007). Transcription—the extended directions of data histories: a response to M. Bucholtz's' Variation in Transcription'. Discourse Studies, **9**, 822–27.

Smith, J.B. and Barclay, D.W. (1997). The effects of organizational differences and trust on the effectiveness of selling partner relationships. the Journal of Marketing, **61**, 3–21.

Stahl, G.K., Larsson, R., Kremershof, I. and Sitkin, S.B. (2011). Trust dynamics in acquisitions: A case survey. Human resource management, **50**, 575–603.

S. Greer, M. Wismar, J. Figueras, C. McKee Governance: a framework in S (2016)

Valentijn, P.P., Schepman, S.M., Opheij, W. and Bruijnzeels, M.A. (2013). Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. International journal of integrated care, 13, 1–12.

Van Dam, K., Oreg, S. and Schyns, B. (2008). Daily work contexts and resistance to organisational change: The role of leader–member exchange, development climate, and change process characteristics. Applied psychology, **57**, 313–34.

Wang, D.S. and Hsieh, C.C. (2013). The effect of authentic leadership on employee trust and employee engagement. Social Behavior and Personality: an international journal, **41**, 613–24.

Williams, K.E., Calnan, M. and Stephen Peckham, S. (2013) Trust matters for integrated care? *The King's Fund* .

Wistow, G., (2011), Emerald Article: Integration and the NHS Reforms, *Journal of Integrated Care*, Vol.19 Iss:4 pp.5

Yin, R.K. (2013). Case study research: Design and methods. London: Sage publications.

Tables in the manuscript

Table 1 List of participants, organizations, and involvement in integrated care and service provider networks

Local care service provider network number	**Organization**	**Role**	**Involvement in Integrated Care Program (Better Care Fund in England)**
Network 1 (N1)	GP Practice 1	General Practitioner	Working with community healthcare e.g., matron partners, developing shared care plans to support care coordination for care for frail older people
Network 1	Local NHS Hospital 1	Occupational Therapist	Working in partnership with family and social care to promote mental and physical wellbeing
Network 1	Voluntary Action	Partnership manager	Working in partnership with council, CCGs and community to deliver a Social Prescribing Pilot Project; supports individuals to access services and activities delivered by the voluntary organization
Network 1	NHS Local South CCG	General Practitioner	Regularly engage with local authority to guide service redesign, maintain quality and safety, and inform commissioning intentions.
Network 1	Local Age UK	Personal Independence coordinator	Engaging with CCGs and reducing non-electives to hospitals; integrated care pathway design to help older people with multiple long-term conditions
Network 1	Care home	Geriatrician Consultant	Train care staff and participate in reach team to provide care service outside the hospital (reduce non-electives)
Network 1	A&E Ward at NHS hospital	Operational Manager	Admission avoidance, assessment and get people home or to a community service
Network 1	Elderly & Frail Ward at NHS hospital	Assessment team	Care transitions of frail older people from hospital wards to other non-acute community healthcare services.

Network 1	Short Stay Unit at hospital	Nurse	Admission avoidance/get people home; provides care for patients who are admitted and are either expected to be discharged within three days or who require assessment before being transferred to another ward.
Network 1	Community Hospital	Care Transition Coordinator	Discharge referrals, coordinate with integrated discharge team, community reablement teams (CRT) and health hub to facilitate patient flow in the hospital.
Network 1	Community Reablement Team (CRT)	Trusted assessors/trained carer	Community Reablement Teams rehabilitating patients outside the hospital setting for 6 weeks. Community Reablement (6 Weeks)
Network1	Healthcare Foundation Trust/Integrated Discharge Team	Head of Physiotherapy Services	Facilitates patient flow in hospital by working with community hospitals, community reablement teams (CRT), and care homes
Network 1	Health hub	Hub manager	Sending and receiving communications to social services and community referrals, acting as the signposting system for ensuring referrals get to the right healthcare organizations from the hospital's front end.
Network 1	Social care service	General manager	Set standards and processes, within the context of the service priorities and principles of increasing user choice and control over the support they receive
Network 1	Local government/ council	Partnership manager	To manage Adult Health and Social Care Services and manage the Health & Social Care Partnership
Network 2 (N2)	Local NHS foundation trust hospital	Nurses	Involved with general Non-Elective Admissions Situation (Outpatients)
Network 2	Hospice	Lead Social Worker	Working in partnership with healthcare organization, CCGs and nursing team to provide end-of-life and palliative care.

Network 2	Care home	Trained Nurses	Reach team to provide care service outside the hospital (reduce non-electives) The interviewee is trying to train care staff out in the community slightly more to reduce the likelihood of patients becoming non-electives.
Network 2	Orthopedics & Surgery Ward at NHS hospital	Surgeons	Integrated care pathway design and hospital at home
Network 2	Neurology & Stroke Ward at hospital	Staff nurse	The stroke team liaises with community team for stroke care
Network 2	Rapid Response Team at hospitals	Occupational Therapist	Carry out admission avoidance, build a care package, coordinate with social services and bring the required care into the hospital to handle non-electives.
Network 2	Voluntary Action	Partnership manager	Support the social prescribing project to improve patient well-being and health by putting them in contact with voluntary and community services, thereby reducing GP appointments and non-electives.
Network 2	Healthcare Foundation Trust/Integrated Discharge Team	Occupational Therapy Professional Lead	Facilitates the patient flow in hospital by working with community hospitals, community reablement teams (CRT), and care homes
Network 2	Service Navigation team at NHS hospital	Nurse	Provide expertise and collate information that drives discharge; liaising with community hospital, patient families, friends, and social services.
Network 2	Local Age UK	Personal Independence coordinator	Supports the project that enables elderly and frail individuals to carry on living independently at home, prevents them from unnecessarily being admitted to hospital, and reduces the number of GP appointments, NHS 111/999 calls, walk-in centers, and urgent care services they are likely to use.

Network 2	Rapid response team at hospital	Social worker	Carry out admission avoidance, in the hospital's front end rapidly building care packages
Network 2	Local clinical commission group	CCG Chair	Coordinate with general practices to establish agreements for service provision
Network 2	Social care service	Area manager, social care	Working with GP and community services for integrated patient journey
Network 2	Social care service	Community project manager	Integrating community teams by integrating health and care professions to provide more person-centered care and reduce the need for admission to hospital
Network 3 (N3)	Local Healthcare Foundation Trust	Community Psychiatric Nurse	Networks of practices continue MDGs, care planning, care navigators, coordination and working with local providers to provide care (e.g., community and/or mental health)
Network 3	Service Navigation team in local NHS foundation trust hospital 2	Nurse	Support admission avoidance and assess people in their own environment as opposed to a hospital setting, as there is a 20/80 ratio of individuals treated in their own homes, with individuals staying home 80% of the time.
Network 3	Local government/ council	Local integrated care program manager	Regularly engage with CCGs, residents, service users and carers to guide service redesign, maintain quality and safety, and inform commissioning intentions. Coordinating local integration board
Network 3	Acute Medical Ward at hospital	Doctor	Offers rapid access to adult inpatient and diagnostic services and transfers to relevant wards
Network 3	Care home	Specialist Care Practitioner	Provides patients with an extended period, i.e., 6 weeks, to recover and prevent them from going into care homes, with Reablement Social Care Package
Network 3	NHS hospitals	Care crew	Discharge support, go around the hospital and get people out, washed, and dressed and into the discharge lounge from the ward

Network 3	GP surgeries	General Practice	GP surgeries contact everyone over 70 years to be proactive and preventative for health status.
Network 3	Service Navigation team at NHS hospital	Nurse	Provide medically fit list of individuals who are medically fit and ready for discharge but are unable to be accommodated by social services for some reason, e.g., a lack of capacity or arrangement for delayed transfer.
Network 3	Local Age UK	Personal Independence Coordinator	Support the management of frail older individuals within the community and prevent acute hospital admission
Network 3	Voluntary action	Partnership Manager	Interacts with community and voluntary organizations and supports them to prioritize statutory agencies
Network 3	Local clinical commission group	CCG Chair	Work with Council alongside partners from health, social care and the voluntary sector to better integrate health and social care services
Network 3	Social care service	Area manager	Manage a multidisciplinary team delivering specialist social care and enablement services for older people and physically disabled people

Table 2. Factors affecting inter-organizational trust

Factors	***Sources***
Perceived value of knowledge, expertise and capabilities of less dominant organizations	Sako and Helper (1998)
History of interactions among organizations	MacDuffie (2011)
Cultural differences between organizations	Ariño et al. (1997)
Levels of information sharing, knowledge and learning among organizations	Das and Teng, (2001)
Organizational/individual attitudes to change	Van Dam et al. (2008)
Perception of the psychological contract i.e., expectations both between individuals and organizations	Grimshaw et al. (2005)
Perceptions of organizational justice i.e., fairness	Zahheer et al. (1998)
Job security or other similar reward	Stahl et al. (2011)
Broader social, economic and demographic context	Rousseau et al. (1998)
Levels of organizational independence	Nooteboom (1997)
Funding streams and budgets, financial responsibility and accountability	Smith and Barclay (1997)
Restrictive/conflicting laws and regulations	Ring and Van de Ven (1994)
Controlling power differences among organizations	Bachmann (2001)
Staff engagement and leadership	The King's Fund (2012)

Table 3 Summary of Themes and Subthemes Emerging from the Finding

Asymmetry in capability perception and competence recognition

- Knowledge and trust of partners' skills, expertise and capabilities in service network influence the referrals and service joining up processes
- Perception of voluntary service quality varies at different levels
- A top-down recognition of social services as a valuable commodity drives the collaboration
- Creation of overlapping care models without considering existing community care models
- Contractual safeguards help to set expectations for roles and responsibilities for collaboration
- There is a lack of recognition on partners' competence and trusted assessors will be helpful to avoid duplicated assessment (e.g., care home and hospitals)

Capacity and financial imbalance lead to less willingness in service joining

- Individuals in less dominant organizations such as social services are uncertain about partners' future actions/behaviors. There is an imbalance in that health organizations are financially favored where there are cuts to valued services
- Capacity in both health, community and social services is important to build up trust for joining up

Cultural differences and attitudes to change

- Feeling of being part of the integration program is helpful for service integration
- Regular meetings with all service providers drives the integrated approach
- Fear of change, identity loss and reduced operational and financial autonomy in the care service integration
- Organizational priority differences between health and social services e.g., different levels of importance are given to the partnership in different organizations.
- Management style and culture sometimes are conflicting, different performance regimes and reporting requirements, low tolerance to change.
- Openness in staff attitude is indicated as an important factor for successful joint services

Table 4 Building Trust at Care Provider's Network

- Regular inter-organization learning of mutual competence and differences among the integrated care service providers network. Inter-organization workshops and seminars can be organized, where health and social care parties in the network present and work in teams to increase mutual understanding of partners' competences and improve perceptions of quality/value of service qualities (lesson stereotype impressions, negatively experienced dissimilarity and overlapping models)

- Involving personnel who has personal experiences of other partners in the care network, e.g. health staff who has previously worked at social care organization and vice versa can enhance mutual understanding of competences and tolerance of organizational and cultural differences in the network. At an individual level the ability to tolerate dissimilarity is needed in order to be able to enjoy the benefits of complementary (by definition dissimilar) actors.

- Resource and leadership to balance the power, capacity and funding among organizations in the care network is needed as the underpinning support to build the trust in the care network. Leadership and resource planning must be developed in ways that break down rather than reinforce silos between structural and interpersonal exchanges for cross-boundary management in integrated care. Inter-organization adaptation such as transfer of key personnel in the integrated care network could be a sign of commitment enhancing trust, increase the motivation for collaboration and potentially enables some consideration for learning and best practices.

- Organizational and individual boundary-spanners with knowledge of both health and social care organisations need to be assigned as a "translator" in order to gain understanding on competence and issues such as capacity, structure changes and finance. Organisational/individual boundary-spanners and network principles (e.g. integrated care system) should converge in order to meet the expectations set for partners and network.

- Information of organisations related to integrated care services should be given promptly and frequently and also some negative aspects should be revealed to partners or through boundary spanners. In addition to fact-based information also information on feelings, intentions and opinions could be communicated, to build a trusting relationship and openness at personal level.

- Clear commitment between health and social care partners could materialize in the relation-specific investments (e.g. time and responsibility of organizational and individual boundary spanners) to set expectations for roles and responsibilities for collaboration. At individual level the role clarity brings predictability and role stretching creates a feeling of adjustment to needs. In order to create a sufficient feeling of openness and security necessary for trust, organizational boundary-spanners should be made clear to potential partners in the care network.

- Instead of trust building at all levels among the network, a pragmatics way forward is to aim for modest and achievable outcomes in the first instance and gradually develop a trust building loop to nurture and sustain the trust. Individuals and organizations can adopt small win approach by identify partners and staring with modest but joint actions for integrated care service. The success of integrated care services through small wins can breeds a greater level of trust across the care provider network