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Changing organisational practices through the integration of health and social care: Implications for boundary work and identity tactics

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Abstract: In response to well-documented pressures on healthcare systems, many countries have explored new 'integrated' models for the provision of health and care. However, integration presents deep challenges to professional practices in both health and care, reflecting enduring and hierarchical boundaries of expertise, remit, budget and practices. Through a qualitative evaluation of the integration of health and social care services in an English city, this chapter investigates the impact of integration on professional identity and boundaries for health and social work staff and the implications for organisational change. Our analysis shows how the top-down reconfiguration of services generated a degree of competitive boundary work. Where collaboration took place, however, this was not the result of breaking down boundaries but rather a reiteration and acknowledgment of them.

Introduction

Healthcare faces well-documented pressures due to ageing populations, a shrinking fiscal base, new technologies and the rising cost of treatment (Exworthy 2015; Dixon-Woods et al. 2011). In response to these pressures, many countries have explored new 'integrated' models for the provision of health and care. In England, integration has long been the direction of travel for health and care policy, in the expectation that integrated models will break down barriers between the health and social care systems, delivering joined-up and personalised services designed around population needs which can be made financially sustainable into the long-term.

However, efforts to integrate health and social care present deep challenges to professional and organisational practices in both health and care. Well documented enduring and hierarchical boundaries of professional expertise and practices between health and social care present a risk of unwillingness to integrate while, separate budgets for each sector, different statutory responsibilities and delivery distribution by differing geographical territories limit integration possibilities. In this chapter we seek to answer the question *how can work be fully integrated when each sector is funded to do different work, its workforces on different contracts with different legal obligations and required to deliver services for geographical areas which do not match up?* Indeed, it might be argued that integration could only succeed by disrupting or transforming the kinds of professional institutions upon which both health and care are founded. Integrated care therefore presents an ideal opportunity to examine organisational attempts to transcend professional boundaries, jurisdictions and career paths for professions in search of economies and innovation, and the enduring barriers posed by professional identity. This chapter adds to understandings of boundary work by considering boundary work in terms of interactions and not as a simple 'mix' of different modes. In taking this approach we are able to for example see how forms of competitive boundary work can be mirrored across professionals to create solidarity and enable collaboration and integration achieved through the reiteration of boundaries rather than the breaking down of them.

In the following sections, we examine policy driving the integration of health and care and discuss the way in which boundary work has been conceptualised and studied, with particular focus on the fields of health and care.

The drive to integrate health and care

An 'integrated' approach to health and social care has been advocated as a model which can harness new forms of collaboration and connectivity to better respond to the needs of contemporary societies by politicians and some professionals. Integration, it is asserted at a policy level, is a means to enhance patient centred care, reduce admissions to hospital care, facilitate faster and effective discharge from hospital and, in doing so, reduce costs while improving quality (Briggs et al. 2020). 'Integration' remains a health and care policy cornerstone driven in England through various initiatives including the Integrated Care Pioneers Programme, the Better Care Fund, Integrated Care Systems (ICSs) and, most recently, the formation of Sustainability and Transformation Partnerships (STPs) across England (Briggs et al. 2020). Strategic policy initiatives such as the NHS Five Year Forward View (2014) have brought new emphasis to breaking down barriers between 'family doctors and hospitals, between physical and mental health, between health and social care' in England (Shortell et al. 2015). This represents a significant move in the English context where health and

social care services have historically existed in separate systems since the divide created by the 1948 creation of the NHS. Health and care have different budgets and administration, are accessed in different ways and are managed separately with different resources, governance structures, statutory responsibilities and service delivery boundaries. In addition, the professions that make up the health and social care work forces have been educated and socialised in very different ways, impacting on work conduct, ideology and necessarily informing relationships between professions (Finn et al. 2010; Exworthy 2015).

This policy direction has endured despite claims that the evidence to back up many of these assertions is often tenuous (Cameron et al. 2014; Cameron 2016; Humphries 2015; Lewis et al. 2013). Indeed, even the definition of integration in this context is subject to extended debate. There are multiple ways to classify models of integrated care, looking at breadth, type, process and focus of integration, and definitions alternate between outcome-based (patient/service user perspective and person-centred coordinated care) or process-based (health system adaptations to deliver complex care) understandings (Stokes et al. 2016). It has also been observed that the integration of care can be understood to take place at different levels, such as team, service, profession or organisation (Robertson 2011). Other researchers distinguish approaches to integration in terms of their focus and form, differentiating between structural, functional, normative, interpersonal, and process integration (Singer et al. 2018).

Integration is thus multifaceted but by definition it implies changes to the boundaries of work in health and social care. It may therefore be argued that the resilience of professional boundaries and identities presents the most substantial obstacle to such integration initiatives (Martin et al. 2009). Understanding integration demands a close interrogation of professional boundaries and the kinds of boundary and identity work which takes place when organisational change disrupts such boundaries.

Professions and boundary work

The definition of a profession predominantly refers to established occupations that are recognised as experts within a given jurisdiction, often requiring a specific qualification (Abbott 1988; Freidson 2001). Through institutionalisation, such professionals are permitted to regulate themselves and their field of practice, generating professional autonomy alongside professional responsibility and discipline (Muzio et al. 2008; Muzio and Kirkpatrick 2011; Adams 2015). Anteby et al. (2016) suggest that occupations and professions can be understood through lenses of “becoming”, “doing”, and “relating” – that is by looking at “how occupational members learn to be part of the collective, what activities they engage in, and how they relate to others outside their group” (188). Key to understanding professionalism, then, is a consideration of jurisdiction, in terms of the boundaries of professional identity and practice, the relationship of the profession to those outside of it, and thus the boundary work which professionals engage in on a day-to-day basis.

Boundaries serve to distinguish categories and regulate the interactions between them (Lamont& Molnár 2002; Zietsma & Lawrence 2010; Bucher et al. 2016), and professional boundaries distinguish professions from each other, typically on the basis of the jurisdiction of expert knowledge and practice. Boundaries are important both for identity formation but also because they define a profession’s access to material and non-material resources such as power, status, and remuneration. Significantly, professional boundaries are not static but continuously evolving and require ongoing

identity and boundary work in order for their parameters to be maintained, changed and defended (Abbott 1988; Bucher et al. 2016; Lam 2019).

Boundary work, then, encompasses the strategies used by individuals and collectives to 'influence the social, symbolic, material or temporal boundaries, demarcations and distinctions affecting groups, occupations and organizations' (Langley et al. 2019: 3). Different forms of boundary work have been identified and theorised in the literature on this topic (Gieryn 1996; Bucher et al. 2016; Langley et al. 2019). These categorisations have tended to focus on the purpose of boundary. Gieryn (1996), for example, identifies three forms of boundary work: *expulsion* (attempts to exclude others), *expansion* (trying to control a new area), and *protection* of a given autonomy (defensive moves to protect existing boundaries).

Similarly, Langley et al. (2019) in a review of boundary work literature identify three main forms of boundary work, each with three sub categories: *competitive* (how people defend, contest and create boundaries to distinguish themselves from others to achieve some kind of advantage); *collaborative* (inter-occupational or inter-organisational practices of negotiation and accommodation 'where groups cannot achieve collective goals alone'); and *configurational* (where 'managers, institutional entrepreneurs, or leaders work to reshape the boundary landscape of others to orient emerging patterns of competition and collaboration, often combining elements of both') (Langley et al. 2019). Policy initiatives to integrate health and social care may be seen to represent instances of configurational boundary work, with boundary changes being reshaped from above to meet policy demands through changes to existing jurisdictional boundaries for those working in each sector, and thus imply both competitive and collaborative boundary work by professionals.

Understanding whether collaborative or competitive boundary work takes place requires a consideration of how such negotiations are framed. Bucher et al. (2016) identify four framing foci used when professions discursively negotiate their boundary claims: framing the issue of interprofessional collaboration; framing of justifications for favoured solutions; framing the profession's own identity, and framing other professions' identities. Importantly, these four foci are employed differently depending on power relations, defined they argue by field position, centrality and status within the profession - reflecting earlier work which suggests, for example, that higher status professions are more likely to defend existing boundaries while lower status professions strive to change them (Abbott 1988; Battilana, 2011). Allen (2000) found this for example when examining nurse managers attempts to accommodate jurisdictional change to medical-nursing and nursing support worker interfaces with doctors in hospital settings. Similarly, Burri (2008), when looking at how radiologists reacted to the introduction of new technology found attempts to maintain existing jurisdiction and regain professional authority alongside attempts to improve professional status by this group. Thus status and inter-/intra-professional power relations influence the strategies adopted in boundary work and outcomes. Recognising the range of possible boundary work is therefore critical for an understanding of how professions change and evolve in interaction with other professions.

Boundary work in the field of health

The significance of boundary work in healthcare settings has long been acknowledged (Liberati 2017; Powell 2012), healthcare being a sector where professional demarcations are well-established, with medical professionals enjoying dominance (Currie et al. 2009) but where numerous professions are constantly working to maintain or extend jurisdictions (Abbott 1988; Finn 2008; Bucher et al. 2016;

Bach, Kessler, & Heron 2012; Hazgui & Gendron 2015). Focusing on operating theatres, Finn (2008) for example examined the ongoing boundary and relationship work between surgeons, anaesthetics, nurses and operating department practitioners during team work – noting the significance of professional hierarchies in this setting. Similarly Burcher et al. (2016) explored how the existing boundaries and position of five health professions (Physicians, Registered Nurses and Psychologists together with their junior professions of Registered Practical Nurses and Psychological Associates) in Ontario, Canada, responded to a new government initiative.

Research on professional competition in healthcare has primarily focused on relationships within the medical hierarchy (Liberati et al. 2016) or between the medical profession and management/employers/regulators (Bryce et al. 2018). Such research has shown the significance of professional identity for how those in different health professions behave in organisations and how they conduct themselves in relation to other professions and occupations, shaping the way in which work is carried out (Hall 2005; Nancarrow and Borthwick 2005; Currie et al. 2008, 2009; Martin et al. 2009; Finn et al. 2010). Relative professional status impacts on who is able to voice opinions within team work and speak out and the distribution of tasks for example (Satterstrom et al. 2020; Finn and Waring 2006; Atwal and Caldwell 2005; Glendinning 2003). These hierarchical relationships are shown to potentially make team work harder and impact on patient safety and care. Indeed, multidisciplinary work has been found in some cases to reinforce professional boundaries rather than break them down (Finn et al. 2010; Liberati et al. 2016).

Policy initiatives to integrate health and care are not the only efforts to overcome professional boundaries and introduce greater collaboration in healthcare bureaucracies. Other initiatives include the encouragement of non-hierarchical collaboration (typically through networks) (Ferlie et al. 2012) and the creation of hybrid roles (Spyridonidis et al. 2015). Work in these areas have typically focused on individual boundaries in isolation (clinician-manager, for instance, or doctor-nurse) but have rarely compared different organisational responses to the same boundary changes. Advances in our understanding of boundary work (Langley et al. 2019; Singer et al. 2018; Bucher et al. 2016) present the opportunity to explore the intersection of different kinds of boundaries, including jurisdictional boundaries over tasks and knowledge, and the relationship between different professions and occupations as well as multiple group negotiations around boundaries in the context of policy-driven configurational boundary work.

In this chapter we draw on the existing theoretical literature to inform our analysis of the integration of health and social care in an English city. We seek to identify the different kinds of boundary work generated by top-down efforts to integrate health and social care, the implications for professional identities and collaboration, and explore the implications for the viability of such efforts to integrate health and social care.

Methodology

In this case study, the integration of health and social care was attempted via the establishment of a local care partnership which was tasked with ensuring the co-location of two main providers, community health and social care services, to form 12 community 'neighbourhood teams', four in each of the three localities that the city in question had been divided into (Mitchell et al. 2020). Each of these teams would include social care and nursing professionals as well as a team leader, with additional collaboration with GP and third sector partnerships. Staff however continued to be employed by either the council or their NHS trust, which means a lack of parity in employment

conditions. This approach to integration could be understood as process based (Stokes et al. 2016), taking place at the multiple levels – notably at an organisation and service delivery level (Robertson 2011) and in form structural and interpersonal (Singer et al. 2019).

Face-to-face semi-structured interviews were conducted with 24 practitioners involved in the integration of health and social care across a range of levels. Six interviewees were at a strategic level and 18 in operational roles; including team leader, managers, frontline health clinicians and social care staff. Equal numbers of health and social care professionals were interviewed covering all three localities. Interviews are thus classified by sector (health/care) and level (strategic/operational). We used a combination of purposive and snowball sampling for maximum variation and balance. All interviews were carried out in 2018 by a combination of three experienced qualitative researchers. Most interviews were carried out by a single interviewer, with a small number being carried out in pairs. The interviews lasted between 45 minutes and 1 hour 30 minutes, with most being approximately 1 hour long.

Data collection was informed by a rapid scoping review of the literature on the integration of health and social care, as well as policy and planning documents and grey literature related to integration (Munn et al. 2018; Tricco 2016). The search terms 'integrated health and social care', 'multidisciplinary teams' and 'interdisciplinary teams' were used for this scoping review. We focused on studies conducted in the UK and published in English between 2000 and 2018. Additional snowball searching was also conducted with bibliography searches of articles found and recommendations from colleagues with expert knowledge on the topic. In total 116 texts were deemed suitable for inclusion. Further methodological details of this study can be found in the projects report (Mitchell at al. 2019).

The interviews focused on the context in which integration was taking place, factors affecting the implementation of integration and the impact of integration on service delivery and care provided. All interviews were recorded, transcribed verbatim, anonymised, organised in NVivo 11 and subjected to thematic analysis. The research team developed an initial coding framework through team discussion, trial and revision based on our collective interpretation of the data. We used NVivo 11 to enable blind coding and verification of code application to check consistency of analysis. Coding and interpretations were discussed at regular intervals throughout the analysis phase of the study. As well as the established initial codes (e.g. clinical, informational, organisational, financial, and administrative) we added further codes (e.g. boundaries, relationships, identity and leadership) to the framework inductively as appropriate through an iterative process and then coded across all transcripts (for a previous example see Fereday and Muir-Cochrane 2006). We focused our analysis on the analytical framework, moving between the data and the literature in order to refine and situate our findings in relation to integration within wider discussions about shifts in professional and organisational identities and boundaries – this is in line with (Braun and Clarke (2006).

Our methodological choices meant that we accessed the experiences of people working at strategic and operational levels within the integrated partnership but recognise the views of these 24 participants are in a specific location and context. This study did not capture service user experiences or views, nor did it utilise observational data which could potentially have provided another dimension of understanding such changes in practice; these are a limitation of the current study and would be of interest in future research.

Findings

The integration of health and social care within this case study was found to have resulted in extensive and varied boundary work by those involved across professions, organisations and geography. Different forms of competitive, collaborative and configurational boundary work were all present across a multiplicity of interconnected boundaries. In this section the forms and strategies of boundary work undertaken are considered alongside an examination of the multiplicity of boundaries.

Motivations for boundary work

The integration of health and social care services was described as a 'top down' initiative by interviewees. They perceived limited efforts to consult or engage. Although many seemed to agree with the direction of travel (towards greater integration), several described experiencing disempowerment and some frustration as a result of this.

> *No one really seems to be asking us how do we think it should work… decisions have been made around how things are going to be and how things will work, and that our voices aren't really going to be listened to… feeling helpless in the process, really, feeling insignificant in the process is obviously very negative and it is frustrating.*
>
> (Interviewee 13 social care/operational)

The integration of health and social care services occurred then as a result of a "configurational" boundary shift (Langley et al. 2019), based on a regional policy initiative.

While the change itself was described as enforced, the practical boundary work needed to make such a significant shift work was described as being left up to those on the front line, with an expectation that those affected would work collaboratively to achieve the aims of integration, with a strong reliance on local 'champions' and local 'adaptation';

> *There will be people who will do something that makes a team feel like a team… I think some of it is around your champion… But then it's also then, being able to replicate something similar, in other parts of the city. So while I've got a natural champion in X in locality 3, it's then trying to find the equivalent of X in locality 3, in locality 5 and locality 4, to make that happen (…) So it's really important that it comes from those who are doing it, really, on the frontline.*
>
> (Interviewee 1 social care/strategic)

Many described integration as a threat to their professional identity, heightened by the strategically driven nature of reorganisation. There was concern among many neighbourhood team-members that team leads could be from another profession. Framing their opposition, individuals frequently began from a position of being personally against such a move, then highlighted that this was not only shared by their fellow professionals but by the 'other' professionals, and cemented this argument by discussing the difficulty of overcoming professional boundaries in the abstract, as exemplified in the following quote from a health professional;

> *There's a very rose-tinted view of how important people feel their professional registration is, and I would be an example of that. Because as a neighbourhood lead, there was no requirement to have a professional qualification. But (...) I have been very*

clear, as have my social work colleagues, there are a couple of social work colleagues who have got professional registrations, and they feel exactly the same way as I do. There is absolutely no way I would give up my professional qualification and identity, and that's how the people within these integrated teams will feel … I think the vision is, we can sit them all down, and they'll all be really friendly, and they'll go, 'oh yeah, let's do that together'. But, those professional boundaries, will be really, really difficult to overcome.

(Interviewee 20 health care/operational)

Competitive boundary work here is reinforced by the expectation that 'competing' professions will also fight to defend professional boundaries - ironically, generating a kind of perceived solidarity between competing professionals, that both health and care professionals would want to maintain professional boundaries.

Despite this, some collaboration did however take place. Collaboration was found to occur most frequently and successfully when existing professional boundaries were reconfirmed and a process of arbitrage was agreed.

We set the stall out that these are the roles, and this is what I can do, and this is outside of my scope of practice… So triage is predominantly undertaken by a health or a social care colleague and once those staff were familiar with some of the health components and the health staff were familiar with the care components, there's now only one person, as opposed to two.

(Interviewee 19 social care/operational)

Here, then, it was the respect of established boundaries that enabled collaborative boundary work.

Framing of boundary work

Multiple existing jurisdictional boundaries were defended, often on the basis of professional identity, specialist knowledge and the regulatory requirements of a given profession. The assumption by senior managers that professional boundaries would be easily broken down to enable integration and collaboration was seen as unrealistic by many professionals. This drive to break down professional boundaries was framed by some as not only challenging but also dangerous.

There was a concern from operational staff on both sides that changes to boundaries might result in additional work without additional support or resources. Both health and social care staff asserted that their 'side' would be most likely to carry the burden of the extra work. At the same time, it was argued by staff (on both sides) that an expectation for the workforce to work across professional boundaries would leave them and those they care for at risk.

All this conflict between the social workers in my areas that are coming through, and the medical model and the health professional, there will always be a conflict... It's like me, a social worker, and a district nurse come and report to me about a dressing and the wound that she's done. I haven't got a clue, I don't know.

(Interviewee 22 social care/operational)

Both health and care professionals identified a lack of inter-professional understanding on the part of their counterpart professionals - healthcare professionals believing that 'social care' could not understand healthcare, and social care professionals believing the same of healthcare. For example, the importance of technical knowledge (and regulation) was repeatedly stated as being needed for safe and effective working, and something which was held by those only within a given profession;

> *It's a bit ludicrous … that 'you don't need to be a social worker to manage social workers'. Well, I kind of disagree with that a little bit 'cause you're not going to have a lot of respect if you haven't done the job …you know if I said, you don't have to be a nurse to manage nurses, how far would that get you? Or a brain surgeon to manage brain surgeons. You'd just be laughed out of the place, wouldn't you? … what you end up with is the technical knowledge is all based at the bottom and then above it you're asking people to make decisions about things they have absolutely no knowledge about.*
>
> (Interviewee 18 social care/operational)

The importance of support and supervision from those within one's own profession, at peer and management level, was asserted to ensure both career progression and appropriate advice on care and conduct.

> *I'm quite worried about, you know, the idea of being managed either long-arm, by somebody who's not based where I'm based, either that, or be managed by somebody who's not a social work professional, somebody who's maybe a health professional or something. And there are issues around professional identity, supervision ...the important stuff really. So the informal supervision and the kind of daily chats and checking in and bouncing ideas … we do have differing priorities and different agendas. We do have very different kind of ideologies.*
>
> (Interviewee 13 social care/operational)

This perceived lack of understanding on the part of others pertained not just about the specifics of role remit and specialist knowledge but also in regards to legal requirements and philosophical approaches to care.

> *You're bringing those professions together, and expecting them to have a mutual appreciation of what's important to each. And actually, their core values are completely different.*
>
> (Interviewee 20 health care/operational)

Such arguments suggested that the values and approaches of health and social care were not just different but at times in conflict.

Multiple boundaries

It was also clear that multiple boundaries co-existed, and were in fact interrelated, with work on one boundary impacting others. A hierarchy of boundaries was evident, with certain boundaries situated as more important or requiring more defence or establishment than others.

Unsurprisingly the boundary between health and social care featured strongly, reinforced by historical feelings in social care that their sector was under-resourced and neglected.

Health is kind of like the big brother and we're the kind of the poor relation (…) everything's around Health and the conversations that have taken place. …. the Health budget is bigger, they've got more of the pie, they've got more of the work, so they are the kind of the main part of it, but that doesn't mean that the Adult Social Care stuff isn't important.

(Interviewee 13 social care/operational)

Competitive boundary work between health and care was however not the only line of tension; the boundary between professionals based in the community and those based in the acute hospital was often invoked frequently.

I think what's played out is that my opinion is that systems, the community health services as less important than acute staff. They're always a bit second-rate, really. And I think there's a great lack of understanding in acute-centric circles and hospitals around actually what a difference an investment in community services could make, and that's just a personal view.

(Interviewee 6 health/strategic)

Both health and social care workers saw the inequity between hospital and out-of-hospital funding as more problematic for resource access, and most felt that those professionals in hospitals had even less of an understanding of their role, irrespective of profession.

Over time in area 2 what's happened is the scale is weighted much more at the high end of acute care, mental health and in physical health. So we've got to balance those scales with some transformation money and over time try and put some of the balance back into primary care community services that are very much more joined up with social care so that we get the neighbourhoods to function very effectively from a provision of service perspective.

(Interviewee 3 social care/strategic)

Beyond the shared suspicion of hospital services, health and care professionals in the neighbourhood teams were also unified in their shared commitment to professionalism of any kind, particularly given the prospect of supervision by non-professionals, So, for instance, while nurses felt it was important to be supervised by a fellow nurse, and social workers by fellow social workers, both groups agreed that supervision by any kind of professional was preferable to supervision by a non-professional;

The neighbourhood leads will be a mix, so it could be that it's a voluntary (sector) person sat in this seat, managing one of those services, yeah…. It sends a shiver down my spine…. And as one organisation, as a nurse, I feel that that's dangerous.

(Interviewee 20 health care/operational)

Discussion: mirrored boundary work and interprofessional solidarity.

The integration of health and social care presents considerable challenge to existing professional practices in both fields, institutionalised as they are around enduring and hierarchical boundaries of professional expertise and practice. Integration represents a significant change to previous ways of

working, working remit and intra-professional collaboration and exploring the dynamics of boundary work reveal various dimensions of tension, but also solidarity and grounds for collaboration.

The original drive for integration was top-down, driven by decisions at the policy and strategic level, representing a case of configurational boundary work as described by Langley et al. (2016), involving the coalescing of boundaries. This integration initiative used policy change, resource allocation and restructuring of organisations at the level of teams, including the appointment of leads for integrated neighbourhood teams i.e. a formal set of change levers acting on those professionals in operational positions. However, the practical boundary work needed to bring together separate domains and deliver new ways of working relied on the willingness of the operational workforce in both health and social care to engage in collaborative, rather than competitive, boundary work.

Given the long history of tension and direct/indirect competition between the health and social care sectors and professions in England, it is unsurprising that the response to this integration initiative was a significant amount of competitive boundary work, intensified by national and regional policy drives towards integration, and reflecting previous work (Allen, 2000; Bach, Kessler, & Heron 2012; Burri 2008; Hazgui & Gendron 2015). The competitive boundary work was a defensive reaction to policy change that altered their roles and remit (as also seen in the work of Allen, 2000; Martin et al. 2009).

Notably, each profession mirrored the other in the kind of boundary work they undertook; framing the issue as one of interprofessional collaboration but making references to the importance of effective regulation and the obligations of legal duty and safe care to justify maintaining boundaries and asserting their own profession identity and remit (Bucher et al. 2016). Both professions agreed on the problem, adopted the same tactics, and both were more concerned about non-professionals encroaching on their remit than the challenge from other professional groups – generating a consistency in opposition, particularly to the notion of being managed by someone outside their own profession. There was little evidence that the experience of working together was dissolving the boundaries between health professionals and care professionals (at this point), or replacing competing professional identities with, for instance, a place-based concept of identity; instead, the proximity of working appeared to be clarifying inter-professional differences.

While most research into boundaries still focuses on competition, recent research has begun to identify forms of collaborative boundary work, where competition is downplayed and boundaries are dismantled in pursuit of mutual gain (Barrett et al. 2012; Liberati 2017; Rodriquez 2015). And indeed, despite the competitive stance described above, collaborative work did occur in this case. Much of this was around the practical need to get work done on a day-to-day basis. A substantial degree of collaborative work relied on individuals embodying boundaries, being individual champions of the cause, with this work occurring in different silos in different forms across the city (Langley et al. 2019; Azambuja & Islam, 2019). Notably, and in contrast to much of the aforementioned work which has identified collaboration, much of the 'successful' collaborative work started by reaffirming existing boundaries, specifically recognising existing profession identities and remits.

A degree of inter-professional solidarity also emerged due to collective resentment of other parts of the sector, such as secondary care or indeed non-professionals. The process of integration generated a renewed focus on other professional and sector boundaries, such as the boundary between in hospital and out of hospital care, and the difficulties health and care professionals sometimes

encountered working with non-professionals. This opened up shared space between health and social care to collaborate based on shared challenges - the shared concern about the prospect of non-professionals assuming managerial positions within integrated teams, and the broader tension between professionals working in neighbourhoods and the historically prioritised acute sector. This, and the shared foundational belief that in some way, integration in principle is the correct way forward, maintained the prospect of a degree of effective collaboration based on a mutual recognition of professional commitments and identities.

Conclusion

In this chapter we have examined the different kinds of boundary work generated by a top-down initiative to integrate health and social care in a major city in the north of England and examined the implications for professional identities in health and social care.

Drawing on Langley et al.'s (2019) typology, we have interpreted the integration initiative studied here as a form of configurational boundary work, and in keeping with other research in this field, we witnessed this top-down approach increasing competitive boundary work between health and care professionals, each deploying markedly similar but opposing arguments to frame their respective defence of boundaries. We also found evidence of a degree of collaborative boundary work, in response to day-to-day pressures of work and shaped in places by local leadership.

This was not, however, a simple 'mix' of modes of boundary work and the study suggested a more complex relationship between these modes. So, as noted, a more surprising result of integration and the imposed boundary changes was how the response of both health and social care professionals mirrored each other, and their shared resistance to the principle of being supervised by someone outside their profession, - or worse, a non-professional - generated a degree of solidarity. In a similar manner, shared resentment of the dominance of the hospital sector over primary and community health and care offered another source of unity against common perceived threats. Furthermore, where collaboration was identified, this was not the result of a blurring, ignoring or breaking down of boundaries but rather collaboration was facilitated through a reiteration and acknowledgment of them. In practice, then, our findings question the value, and the feasibility, of 'breaking down' professional boundaries. Instead, we suggest that a more viable route for 'integration' may be to protect professional boundaries and, potentially, look to supersede these divisions by invoking commonalities between professionals and importantly shared challenges and threats.

This study thus highlights how modes of boundary work need to be considered in terms of their interaction, such that competitive boundary work may paradoxically support collaboration in the longer term as professional boundaries are reaffirmed and recognised, turning attention of shared challenges – here, the potential infringement of non-professional leadership and the dominance of (professionals within) the acute sector. For researchers of health and care, we would therefore seek to underline the need to attend to multiple and inter-related boundaries in analyses of integration and inter-professional work.

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