The institutional logic of integrated care: an ethnography of patient transitions

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Abstract

Purpose – The purpose of this paper is to use theories of institutional logics and institutional entrepreneurship to examine how and why macro-, meso-, and micro-level influences inter-relate in the implementation of integrated transitional care out of hospital in the English National Health Service.

Design/methodology/approach – The authors conducted an ethnographic case study of a hospital and surrounding services within a large urban centre in England. Specific methods included qualitative interviews with patients/caregivers, health/social care providers, and organizational leaders; observations of hospital transition planning meetings, community "hub" meetings, and other instances of transition planning; reviews of patient records; and analysis of key policy documents. Analysis was iterative and informed by theory on institutional logics and institutional entrepreneurship.

Findings – Organizational leaders at the meso-level of health and social care promoted a partnership logic of integrated care in response to conflicting institutional ideas found within a key macro-level policy enacted in 2003 (The Community Care (Delayed Discharges) Act). Through institutional entrepreneurship at the micro-level, the partnership logic became manifest in the form of relationship work among health and social care providers; they sought to build strong interpersonal relationships to enact more integrated transitional care.

Originality/value – This study has three key implications. First, efforts to promote integrated care should strategically include institutional entrepreneurs at the organizational and clinical levels. Second, integrated care initiatives should emphasize relationship-building among health and social care providers. Finally, theoretical development on institutional logics should further examine the role of interpersonal relationships in facilitating the "spread" of logics between macro-, meso-, and micro-level influences on inter-organizational change.

Keywords Government policy, Implementation, Hospital management, Integration, Organizational theory, Home care

Paper type Research paper

Integrated care is a complex social process influenced by macro-level circumstances such as legislative mandates, meso-level features such as organizational leadership, and micro-level interactions between health/social care providers and patients. However, research on

integrated care has for the most part examined one of these levels individually, neglecting the complex interrelationship between them Valentijn *et al.* (2013). Consequently, how the macro, meso and micro are intertwined, and in what ways the relationship between them serves to enable and/or constrain integrated care remains poorly theorized and understood. Responding to the call to bring an organization studies perspective to bear on interdisciplinary work in health policy and medical sociology (Currie *et al.*, 2012) our paper draws on theoretical developments in organization studies to examine the interrelationships between these levels and their influence on the process of implementing integrated care.

Given the conceptual challenges regarding the interrelationships between macro, meso, and micro-levels of integrated care, the theory of institutional logics has enormous potential for advancing understandings of the development and implementation of integrated care. This perspective captures how broad institutional ideas, such as those often embedded in policy, become manifest in the actions of organizations and individuals; institutional logics provide a theoretical link between the various conceptual levels of institutional and organizational change (Thornton *et al.*, 2012). Beyond a simple re-statement of structuralism, institutional logics specify how institutional ideas, organizational mandates (both explicit and implicit), and individual thoughts and actions work upon one another, attending to the reciprocal influence between them as new institutional practices such as integrated care emerge (institutional logics are explained in greater detail below) (Thornton *et al.*, 2012; Friendland, 2013). With an interest in further exploring the relationships between these macro, meso, and micro-level influences on implementing integrated care, we conducted an ethnographic case study of how certain institutional ideas embedded in health policy at the macro-level in England helped to form a dominant institutional logic of integrated care across organizations in one region of London.

Our paper proceeds as follows: first, we explicate the theory of institutional logics as a way to conceptualize the links between macro, meso, and micro-level influences on organizational action and institutional change (Thornton *et al.*, 2012). We then describe the methodology for our ethnographic case study, and present our analysis of the interrelationships between macro-level ideas in the English national health policy context, meso-level strategies of organizational leaders, and micro-level practices of integrated care in the region. Specifically, we describe an institutional logic of partnerships, which fostered relationship-building practices of key institutional entrepreneurs in their efforts to implement a more integrated approach to transitional care. We then discuss the implications of this work for conceptualizing the integration of health and social care across the care continuum.

Theory of institutional logics for integrated care
The institutional logics perspective arose from research and theory development in the study of organizations, focussing on how salient features of macro-level institutions exert their influence on micro-level actions, while mediated by meso-level realities of organizational life (Thornton *et al.*, 2012; Friedland and Alford, 1991; Thornton and Ocasio, 2008). According to Friendland (2013), an originator of the institutional logics perspective, the term "institution" refers to a distinct set of ideas that influence our way of theorizing, framing, and narrating our experiences, and therefore helps to give structure and meaning to our everyday actions (Friendland, 2013). Institutional ideas are often embedded in governmental and organizational policies, for example, where democratic ideas are built into government efforts to promote patient engagement in health policy, health research, and direct service delivery (Klein, 2013; Carman *et al.*, 2013). However, as Friendland (2013) notes, "it is only when theories, frames and narratives are 'embodied in practices' that [institutional] ideas become logics" (Friendland, 2013); institutional logics are the manifestations of macro-level institutional ideas, interpreted and transformed into the micro-level realities of health care practice as they are enacted by reflexive and interested individuals. Health care providers bring institutional ideas into being

as institutional logics, when for example, providers enact the institution of democracy (macro-level) by more fully empowering patients to participate in their own health care (micro-level) (Carman *et al.*, 2013).

Institutional logics are sometimes mistakenly thought of as referring solely to the ways in which macro-level institutional ideas affect micro-level practices (Klein, 2013). However, macro-level ideas only become manifest through the actions of reflexive, self-aware practitioners (Maguire *et al.*, 2004; Reay and Hinings, 2009). This means that practitioners can purposefully weave elements of different institutional logics together in their actions, holding the potential to change which logics are most dominant in particular organizations through their decisions, discourses, and practices. Moreover, institutional logics often compete for dominance in a given institutional field, as certain organizations or professional groups formally or informally adopt particular institutional practices and their associated logics at the expense of others (Reay and Hinings, 2009). This may lead to different institutional circumstances, where either a single logic becomes dominant in an institutional field or various logics cohere or compete to create an environment of "institutional complexity" (Greenwood *et al.*, 2010).

An example of competing institutional logics is where health care providers actively empower patients to make informed decisions about their own care, helping to shift institutional logics away from historically dominant models of professional-centred care towards person-centred care. Here health and social care providers must integrate different macro-level ideas into their micro-level practices, drawing on discourses of person-centeredness over and above other potentially conflicting professional goals. In this way, "individual and organizational actors have some hand in shaping and changing institutional logics" (Thornton and Ocasio, 2008). This observation provides a key insight into the link between macro-, meso-, and micro-level efforts to implement integrated care, illustrating the role of broad institutional ideas and policy directions while simultaneously considering the important role played by organizations and individual actors in making those ideas manifest in the delivery of health and social care.

The role of individuals, specifically "institutional entrepreneurs", is critical to consider in efforts to understand changes to dominant logics in health care (Maguire *et al.*, 2004; Battilana *et al.*, 2009). Institutional entrepreneurs are individuals who "break with existing rules and practices associated with the dominant institutional logic(s) and institutionalize the alternative rules, practices or logic they are championing" (Garud *et al.*, 2007). The capability to act as an institutional entrepreneur depends on two conditions in particular: the actor's social position relative to others in the field of practice, and the enabling conditions of the organizational field (Battilana *et al.*, 2009). In terms of social position, individuals who hold substantial power (or social capital) are more likely to win the support of other key organizational actors in their efforts to initiate and sustain changes to the practices that represent institutional logics (Maguire *et al.*, 2004). In terms of the conditions of the organizational field, changes to important contextual features such as organizational leadership or new policy developments might either enable or constrain individual action to promote institutional change (Battilana *et al.*, 2009).

We address each of these enabling features of institutional entrepreneurship in our analysis of how specific individuals were effective in shifting the dominant logic of integrated care in our case study of transitions from hospital to home. Although the institutional logics perspective has been applied to the study of leadership and conflict between clinical/managerial logics in health care (Reay and Hinings, 2009; Currie and Lockett, 2011) ours is the first study to our knowledge to apply institutional logics to help interpret the implementation of integrated care. One final important note is that our study was not initiated with the institutional logics perspective in mind; instead, a variety of theoretical perspectives were sought after to help make sense of the data. The institutional

logics approach provided the most coherent explanation of our data set, and thus helped to guide our interpretations and conclusions. Reiterating the purpose of the study from our introduction, the key research questions driving this study were:

RQ1. How are the macro, meso and micro intertwined in transitions from hospital to home?

RQ2. In what ways does the relationship between these levels serve to enable and/or constrain integrated care?

Methods
Study setting: policy context
In 2003, a policy was implemented in England's National Health Service (NHS) called The Community Care (Delayed Discharges) Act (hereafter referred to as "The Act"). This policy is a central contextual element of our empirical study; participants cited its implementation as an important motivator for the shifting logic of integrated care in the region. The Act has been subject to much evaluation and critique (McCoy *et al.*, 2007; Bryan, 2010; Manzano-Santaella, 2010; Glasby *et al.*, 2006) in part because of its aggressive approach to improving transitions out of hospital. The Act mandates that where a patient is medically ready to be discharged from hospital but is delayed for reasons deemed to be caused by social services (e.g. because the social worker has not yet assessed the patient for discharge), the local social services are fined £100/day as a "hotel cost" of the hospital bed (£120/day in London due to higher cost of living) (Bryan, 2010). That fine is to be submitted from social service departments to the hospital in order to offset the costs of the patient's stay (Bryan, 2010).

Understanding the impact of the Act requires an appreciation of the historical context within which it was introduced. The Act was implemented into existing inter-organizational arrangements between health and social care that were quite isolated and, in some cases, even combative (see Webster, 1998 for a comprehensive historical review) (Manzano-Santaella, 2010; Glasby *et al.*, 2006). The Act had consequences for the complex relationship between health and social care by adding mandatory processes of collaboration to the more aggressive policy lever of fines just described. For example, the Act mandated that hospitals and social service departments collaborate on the weekly preparation of a list of reasons for delayed transfers of care in their region, thus bringing the two sides together to agree on common problems and their impact on delayed discharges (Manzano-Santaella, 2010). These mandatory collaborative processes were intended to promote the building of partnerships between health and social care despite the potential for conflict arising from the newly instituted financial penalties to social care (Manzano-Santaella, 2010).

In a document published by the national Department of Health that was intended to act as national guidance for organizations responsible for implementing the Act, the importance of partnerships between health and social care was clearly emphasized:

> [The fines] are a way of reflecting where costs are borne across the different parts of the health and social care system. It is about incentives to improve services, and developing capacity *in partnership* across the whole of health and social care, not shifting money around […] In fact it is desirable for [Social Service] Councils to act to minimise reimbursement payments. The focus should be on developing capacity *in partnership* with the NHS (England Department of Health, 2003, pp. 5-6, emphasis added).

The Act thus contained conflicting messages: on the one hand, social service departments were being financially coerced into taking greater responsibility for patient discharge, to the benefit of hospitals. On the other hand, social service departments and hospitals were being instructed to build partnerships and collaborate on transitioning patients out of hospital care (Bryan, 2010; Manzano-Santaella, 2010). These conflicting messages represent

polarized institutional ideas about how to best promote more integrated care. According to the institutional logics perspective, these conflicting ideas can compete to determine which will assume dominance in driving the practice of patient transitions out of hospital (Reay and Hinings, 2009; Besharov and Smith, 2014). Depending on the institutional entrepreneurship of particular individuals or organizations, the dominant logic might shift towards a new, more collaborative ethos or remain focussed on the historical isolation between the two sectors. It is in the context of these competing institutional ideas of the Delayed Discharges Act 2003, and the historical context of isolation between health and social care, that we present our case study findings.

Study setting: case study site
The initial setting for our ethnographic case study was a single ward specializing in the care of older people with complex needs within a large, urban acute care hospital in London, England. The hospital had demonstrated consistently low rates of delayed transfers and was considered by many in the local health services community to be a source of best practices regarding more integrated transitional care. This site therefore made for an ideal case study because of its success and reputation as an organization driving best practices in patient transitions and integrated care, enabling unique insight into how and why such high-performing practices were accomplished (Baker, 2011; Siggelkow, 2007; Yin, 2013). The emergent case study design, wherein our fieldwork directed us to other sites and participants as we followed patients transitioning out of hospital (Yin, 2013; Flyvbjerg, 2006) enabled us to expand the settings in which our research took place over time. Specifically, our ethnographic fieldwork eventually took place within a community primary care clinic, a local social services office, patients' homes (interviews only), and the leadership offices of both the hospital and social services in the borough/neighbourhood where the study took place.

Data collection and participants
We conducted a total of 65 hours of observations over a ten-week time frame across the following settings: transition planning meetings on the hospital ward among health and social care practitioners (30 hours); community-based transition/case management meetings in a community health centre among health and social care practitioners (20 hours); and ad hoc observations of practice in the hospital and community health centre related to transitions occurring outside of formal transition planning meetings (15 hours). All observations were conducted by the Principal Investigator (XX) and focussed on describing practices involved in integrated care, particularly how practitioners interacted with others involved in the process of transitioning patients from hospital to home. The investigator conducting the observations was a non-participant in the scenarios observed, and observations were written in an open-ended narrative style in order to capture the interactions and flow of discussion.

We also interviewed three patients/families, 16 health and social care practitioners, and 11 leaders across health and social care. Interviews focussed on participants' experiences, thoughts, and feelings related to transitions out of inpatient hospital care and the development of more integrated transitional care. We also analysed two key policy documents related to the process of patient transitions in the study region (The Community Care (Delayed Discharges) Act and the related Guidance Document described previously). All references to participants are pseudonyms. See Table I for details of participants whose data is reported in this study. Although all data were analysed to inform the study findings presented here, our focus is on the perspectives of organizational leaders and formal care providers in order to emphasize their strategies and techniques regarding the implementation of more integrated care.

Participant name (Pseudonym)	Job title	Professional designation	Organization	Years of experience in health and social care	
Emma	Assistant Director, Joint Programmes (Social Services and NHS)	Social Worker	Social Services Department	32	
Martin	Manager of Discharge	Registered Nurse	Acute Hospital	12	
Carol	Director of Integrated Care	Registered Nurse	Acute Hospital	16	
Sharon	Head of Integrated Care	Chiropody	Acute Hospital	21	
Dr David Aitkin	Senior Consultant Physician	Physician	Hospital	26	
Anne	Manager of Hospital-Based Social Services	Social Worker	Social Services Department	8	
Evelyn	District Nurse Consultant	Registered Nurse	District Nursing	24	
Dr Samuel Porter	Staff Psychologist	Psychologist	Acute Hospital	30	
Sara	Social Worker	Social Worker	Social Services Department	5	
Julia	Mental Health Nurse	Registered Nurse	District Nursing	22	

Data analysis
Our analysis followed an iterative process wherein the research team read fieldnotes early in the fieldwork process, informing the interview questions, which in turn informed subsequent observations. We then completed more detailed thematic analysis across all data sources (Yin, 2013; Braun and Clarke, 2006) assigning descriptive codes to identify thematic categories, examining these categories for interrelationships, and then progressing to higher order themes as the analysis proceeded. We then compared these higher order themes with multiple theoretical perspectives to establish robust and coherent explanations of the data. Theory on institutional logics and institutional entrepreneurship provided the most robust explanations of our findings, informing a detailed and convincing account of how macro-, meso-, and micro-level issues relate to one another in the implementation of integrated care. By following this analytic process, we were able to gain substantial insight into the links between macro- and meso-level efforts to bring about more integrated care and the micro-level practices by which transitions were enacted.

Findings
We present our findings in three sections, each illustrating the characteristics and actions of our case study participants as they worked to implement integrated transitional care. The first discusses the actions of organizational leaders reacting to the Delayed Discharges Act, focussing on the institutional ideas they prioritized in their leadership practices at the meso-level to promote more integrated care. The second describes the concrete actions leaders took to support the efforts of health and social care providers in enacting more integrated transitional care. The third discusses one key institutional entrepreneur in particular at the clinical level (Dr Aitkin), illustrating his role in developing the collaborative model of care that was regarded as best practice for integrated care in the region, and the relationship work that was fundamental to the success of an integrated model of transitional care.

Creating a partnership logic at the meso-level: the actions of organizational leaders
In reaction to the conflicting institutional ideas about integrated care embedded in the Delayed Discharges Act, leaders of key organizations across health and social care in our case study acted as institutional entrepreneurs at the meso, organizational level.

Specifically, organizational leaders sought to respond collaboratively to the demands of the Delayed Discharges Act (2003) despite the history of isolation across health and social care sectors. They were responding to what Manzano-Santaella (2010) referred to as a "partnership *ethos*" underlying the Act, embracing the institutional ideas embedded in the policy that promoted partnerships across sectors for more integrated care (Manzano-Santaella, 2010). By making the partnership ethos manifest in their inter-organizational activities, they enacted their roles as institutional entrepreneurs and actively contributed to making an institutional logic of partnerships dominant at the meso-level of health and social care; we refer to this dominant logic as the partnership logic. It is important to emphasize that not all leaders in similar circumstances would act to change institutional arrangements and thus earn the title of "institutional entrepreneur". The unique commitment to work together in this new policy context motivated institutional entrepreneurship among these specific leaders in particular.

Upon the introduction of the Act in 2003, leaders came together quickly to establish new processes and local policies that would encourage partnerships for integrated care in the local area. They chose to find ways to work around the central macro-level policy directive of fines in the Delayed Discharges Act (Debono *et al.*, 2010) by relying on trust in their newly developed relationships across sectors to find mutually beneficial solutions at the meso-level of organizational leadership. In so doing, they advanced the partnership logic at the meso-level. Emma, an Assistant Director at the social services department explained the reaction of senior leaders across health and social care as follows:

> Yes, so we were obliged to sort of, toss up fines, but we got around actually taking money away from each other by getting a Section 31 Agreement, saying we won't fine people, but we'll pool any fines into a fund that will pay for our delayed transfer process people […] [Our] strategy says if people need this sort of care, we will jointly fund it […] You trust us. We're partners. We're not going to run off with the money. We're all spending it on the right people.

A Section 31 Agreement was a policy that enabled local regional authorities in England to legitimately alter meso-level funding arrangements in cases where there was a new potential arrangement deemed more beneficial for local population health (England Department of Health, 1999). Leaders thus came together with a shared understanding of the potentially damaging effects of simply enacting the hierarchical institutional idea of cross-sector fines embedded in the Delayed Discharges Act, and established an alternative process that was more consistent with their partnership ethos. As Martin, a manager of hospital discharge reflects, improved discharge was attributed to the leaders' creative workaround and not to the cross-sector fines mandated by the Delayed Discharges Act:

> Pre-2003, before the Act came into effect, the relationship between the NHS and social care was quite bad, it was really a blame culture. The NHS would blame social services for many issues, including delayed discharges, and social services would say it's the NHS's fault. The Delayed Discharges Act has improved the working relationships between health and social care by forcing them to work together for discharge planning. So it's not actually the fines that improved the discharge process, but just health and social care working more together.

One key mechanism by which regional leaders implemented this shared commitment to making the partnership logic dominant was by creating a new local guidance document stating the implications of the Delayed Discharges Act, to be followed by providers and organizations in the local region (different from the national guidance document quoted previously). In so doing, they jointly "translated" the macro-level institutional idea of partnerships for integrated care into descriptions of specific practices that could be implemented by health care providers – thereby using a key communicative strategy to advance the partnership logic in the local field (Ocasio *et al.*, 2015). However, the development of policies and procedures as organizational structures at the meso-level is

alone not sufficient to enhance collaboration among health and social care providers at the micro-level (Baillie *et al.*, 2014). Organizational leaders thus sought additional practical ways to promote more integrated working across health and social care in which the partnership logic could become manifest.

Establishing a forum for relationship-building to promote integrated care
In order to promote actual collaborative practice among care providers, leaders in our case study created forums in which providers could work more collaboratively on transitional care. As Sharon, the Head of Integrated Care at the study hospital rhetorically asked, "How do we get this [patient] flow going across [sectors], which works with what it says in the policy? [It's] the relationships and how we work with other providers, that is probably the most important bit for me". Bringing providers together who had previously never worked in an explicitly collaborative manner was the key means by which leaders sought to build those relationships and support a change in the dominant institutional logic at the clinical level. Carol, the Director of Integrated Care at the hospital, explained:

> So, I think the reason why we've been able to move so quickly, is because we haven't done [structural] integration, and we've majored massively on relationships. So, when you're talking about collaboration, you know, people come here thinking we've got some sort of secret formula, if they just apply it, they can deliver the same results as we have. But actually, the biggest single success factor, I think, we've had for our integrated care program is the time and investment we've made in [supporting] relationships [among providers].

By creating shared forums for providers across health and social care sectors, organizational leaders provided opportunities to foster interpersonal relationships among health care providers. One such example was by providing resources to develop a community-based "hub" model of care, wherein providers can meet weekly to discuss the needs of shared patients as they transition out of hospital. Yet even these shared forums do not guarantee that more collaborative, integrated clinical practice at the micro-level will occur. The work of establishing actual collaborative relationships at the micro, clinical level was dependent upon the efforts of care providers themselves.

The community hub model of care: implementing the partnership logic at the micro-level
As a consultant physician with over 25 years of experience in the NHS, Dr Aitkin was uniquely positioned in a number of ways to act as an institutional entrepreneur in implementing the partnership logic for integrated care in clinical practice. Dr Aitkin was well respected by his colleagues both professionally and personally, he was considered to have a strong understanding of the challenges faced by social care, and had a role spanning direct clinical care (micro-level) and clinical leadership (meso-level). In these ways, he demonstrated the characteristics (and the relative social power) deemed optimal for successful institutional entrepreneurship (Battilana *et al.*, 2009).

One of the key ways in which Dr Aitkin acted as an institutional entrepreneur was by responding to the opportunity to contribute to the development of the new community "hub" suggested by leaders of the hospital and social services in the region. This new forum for collaboration during patient transitions was proposed by organizational leaders as one means to bring providers together across the continuum to work more collaboratively on patient care; the hub represented organizational leaders' investment in creating the conditions in which partnerships among providers could form across sectors. The hub involved weekly meetings wherein the care of the most challenging patients transitioning out of the hospital could be discussed among a multi-disciplinary team, and a commitment among the participating health and social care providers to communicate regularly

regarding the care of these patients. Dr Aitkin commented on how he embraced the new task of leading the hub:

> [I] thought, "yes this is good care. I want to be a part of that." So [I] very much put ourselves at the forefront, you know […] put some consultant time in and invest a bit of time and try to make this [hub] work […].

Dr Aitkin invested substantial amounts of his own time networking and garnering support for the hub, encouraging other care providers to buy in to the partnership logic that formed the foundation of this new approach to care. The hub became a manifestation of the partnership logic, as Dr Aitkin worked to encourage new participants in the hub to understand and engage with the relationship-oriented approach to more integrated care:

> You've got to make sure they understand the ethos of how we work, what are the standards we expect, you know the sort of contributions to meetings [and such] […] there's already a good core of people that understand the system, so the new ones quickly learn off the ones who are already [there].

The success of the hub and the presence of the partnership logic at the micro, clinical level was contingent upon the buy-in of these other health care providers. Evelyn, a clinical nurse leader explained the importance of these relationships:

> [The Hub] is [about] sharing information, developing the relationships and the networking. Any sort of joint working that might be possible on discharge pathways and service improvement, that sort of thing […] I think those forums are ideal for actually maintaining those good working relationships, and actually I think, you know, improving the whole sort of discharge pathway for patients really.

Good working relationships among practitioners were central to the hub as a means of advancing the partnership logic for integrated care. Dr Aitkin took specific steps to ensure that relationship-building constituted the central manifestation of the partnership logic at the micro, clinical level. One of these ways was by engaging in "relationship work", taking specific actions to build or maintain partnerships among collaborating health care providers even in the face of conflict. However, despite the focus on building interpersonal relationships that accompanied the partnership logic, conflict did occur. This conflict challenged the partnership logic at the micro-level, further emphasizing the need for dedicated effort to maintain collaborative relationships among providers participating in the hub.

A notable example of this relationship work is an interaction that occurred at a community hub meeting wherein the care plan for an older woman with particularly complex needs was being discussed. The woman had a Urinary Tract Infection (UTI) and severe mental health issues, and had frequently been arriving at the Accident and Emergency department with many subsequent admissions to the hospital ward overseen by Dr Aitkin. The hub team struggled to reach consensus regarding the care plan for the woman: Dr Aitkin and a hospital psychologist (Dr Porter) supported admitting her into a long-term care institution, believing that to be the best solution for the patient; and the social worker (Sara) and community psychiatric nurse (Julia) thought it best to help her manage at home. The following is the observation of the hub meeting:

> Dr Porter says in an assertive tone, "Yes, the UTI is clouding the picture, but I really think the infection is a consequence of the anxiety and the broader situation, not the cause." Julia very quickly replies to Dr Porter's comment, "you're right, Samuel [Dr Porter's first name], we need to establish a baseline to understand why these deviations are occurring. But we also need to act in her best interests, especially now that she doesn't have capacity. I think we need to ask if a package of care can sustain her at home." Julia's expression is calm and she speaks with a calm, non-confrontational tone.

Dr Aitkin raises his naturally loud voice, and with a frustrated chuckle loudly says, "No!" [He had already voiced this opinion a number of times]. He shakes his head and looks down at the notes in front of him. Sara then joins the debate from against the back wall, leaning forward on her seat and agreeing with Julia: "we need to at least attempt to manage her at home-" Dr Aitkin interrupted again, saying in a loud and urgent tone "but even with 24 hour care at home, she's still going to call the ambulance!" Sara then repeated, quietly now and with less conviction, "we should still try to manage her at home".

The chair of the Hub (a General Practitioner) decided to give social services the opportunity to manage the patient at home. Dr Aitkin conceded after this decision had been made and offered his support to social care in the end, asking how he could help to make it happen. After the meeting had adjourned and the team was leaving the meeting room, the following was observed:

Dr Aitkin approaches Sara sitting at a computer against the far wall, pulling up a chair slightly to her right but facing her. Dr Aitkin says with a chuckle, "So, quite a case we have here!" Sara laughs quietly as well, nodding her head. Dr Aitkin smiles as they speak quietly about the woman's case. After a few minutes he gets up and says, "Right, well good luck! I look forward to hearing what you get up to." He smiles and leaves the room.

This interaction highlights that the partnership logic does not mean avoiding conflict at all costs. On the contrary, it means recognizing that conflict is an inevitable part of relationships and that work is required to maintain those relationships in the face of conflict. This is aptly captured in Dr Aitkin's reflections on his exchange with Sara:

If you have got a bit of conflict you don't want it to sort of, spread into a grudge and I don't think it will [in the case with Sara], so I'm very careful actually if something like that happens, I'll go and have a bit of a [friendly] chat and just take it easily. I'm usually careful that I do, if I feel there's a bit of a conflict to go and talk to the team member afterwards to make sure there's no lingering sort of, feelings of hurt.

Central to the manifestation of the partnership logic of integrated care at the clinical level was Dr Aitkin's leadership of the new hub model of care and his own interactions with other professionals involved in jointly caring for patients. Although organizational leaders at the meso-level acted as institutional entrepreneurs to support relationship-building practices as a strategy to enact the partnership logic, it was the actions of Dr Aitkin and other health and social care providers that actually brought the partnership logic to fruition at the micro, clinical level.

Discussion
In this ethnographic case study we drew upon the theory of institutional logics to examine the implementation of integrated transitional care by organizations and care providers in a particular area of London, England. This theoretical approach enabled us to identify a partnership logic arising from the institutional ideas embedded in England's Community Care (Delayed Discharges) Act, which became dominant in the local case study region to enable more integrated care. In a general sense, our study supports the value of identifying the institutional ideas that constitute the central elements of a particular policy, as the individuals responsible for implementing policy mandates will selectively draw upon (or actively ignore) these institutional ideas as they structure their actions and reactions within their everyday work contexts. Our findings provide insight into both practical developments in the effort to implement integrated care, and theoretical developments in literature on institutional logics. We will address each of these in our discussion.

Strategies to promote the implementation of integrated care in defined regions within health systems have included a variety of approaches (Nolte and McKee, 2008) including the

"organizational integration" of, for example, organizational leadership or health information systems (Baillie *et al.*, 2014). In this way, organizational structures are brought together across the continuum of care with the assumption that integrating these broad structural features will eventually result in more integrated practice at the micro-level among health and social care providers. However, some commentators on integrated care have suggested that such organizational integration at the meso-level is itself not sufficient to promote enhanced integration at the clinical level of health and social care provider interaction (Curry and Ham, 2010; Burns and Pauly, 2002). Our study provides insight into why this might be the case, specifying additional efforts that might also be necessary to support the actual implementation of integrated care at the clinical level.

Our findings suggest that of critical importance to integration at the clinical level were the actions of meso- and micro-level leaders acting as institutional entrepreneurs, selectively integrating institutional ideas embedded in the Community Care (Delayed Discharges Act) (2003) into organizational opportunities for interaction (i.e. developing the community hub) and practical efforts to build and maintain interpersonal relationships (i.e. engaging in relationship work). Our study thus advances the work of commentators such as Curry and Ham (2010) by suggesting that successful integration might require both: specific opportunities for health and social care provider interaction (e.g. the hub); and an emphasis on relationship work.

The practical implications of these findings are two-fold. First, efforts to facilitate organizational change towards the achievement of more integrated transitional care out of hospital should include an explicit focus on the recruitment of institutional entrepreneurs to support the necessary changes. Although a growing body of literature has explored the tasks and demands of health care leaders seeking to implement integrated care (Curry and Ham, 2010) the ways in which those leaders might be equipped to foster changes to historically entrenched modes of isolated practice between health and social care has not been sufficiently addressed. Martin and Waring (2013) suggest that health care is a particularly challenging context for leadership among health and social care providers, as "policy imperatives, professional divisions and bureaucratic structures may interfere with the ability of staff to lead across boundaries and up hierarchies" (p. 359). Institutional entrepreneurs are precisely those individuals who have the requisite status both professionally and personally to take on meaningful leadership roles that can disrupt such boundaries and hierarchies (Battilana *et al.*, 2009). So central is the role of institutional entrepreneurs in implementing integrated care, a domain that is replete with historical sectorial divisions and professional hierarchy, that without active recruitment of such individuals a lack of meaningful engagement across traditionally isolated health and social care sectors is likely to persist. This lack of meaningful engagement in turn will thwart the micro-level relationship work that we found to be essential for the success of integrated care.

Second, our study identified relationship work, including the reflexive acknowledgement by participants that relationships are both personal and emotional, as key to the functioning of the hub. Recent research has begun to identify strategies to promote interpersonal relationships for more integrated care, such as the creation of task-focussed shared workspaces that support informal interaction (McEvoy *et al.*, 2011). However, both theoretical and empirical work remains to be done. Relational Coordination Theory (RCT) of collaboration in work settings (Gittell, 2009, 2012; Gittell *et al.*, 2010) is a notable example of a popular theory examining the role of interpersonal relationships in organizational settings that has been used to guide empirical work on integrated care. RCT claims that strong work relationships exist between roles as opposed to between individuals. However, our findings point to the importance of interpersonal relationships in ways that acknowledge their emotional nature, attending to the personal connections and conflicts that occur in the course of professional work such as integrated care. Future research should thus expand upon the tenets of

relationship-centred care (Beach and Inui, 2006) acknowledging the personal nature of professional interaction and identifying practical strategies to promote positive relationships among health and social care providers to achieve more integrated care.

Our case study findings also have implications for the theory of institutional logics, specifically in relation to the ways in which logics "spread" between macro-, meso-, and micro-levels of organizational practice. Ocasio *et al.* (2015) argue that streams of communication constitute the key mechanisms by which institutional logics are reproduced and changed: conversations, organizational newsletters, conference presentations, e-mails, etc. build parameters around the kinds of institutional logics that become manifest in the talk and actions of organizational members (Ocasio *et al.*, 2015). However, the findings of our study emphasize that these acts of communication occur within the bounds of ongoing interpersonal relationships, and these relationships are consequential for the ways in which communication occurs. In our study, the existing relationships between organizational leaders and Dr Aitkin enabled their dialogue regarding the hub model of care, facilitating the links between meso- and micro-levels of health and social care. Links between the conceptual categories of macro-, meso-, and micro-levels of health care are thus not immaterial and abstract, but are in large part the actual interpersonal relationships between people who represent these levels ("policymakers", "organizational leaders", and "care providers", respectively). Without the relationships between those representing the meso-level and those representing the micro-level in our case study, the partnership logic would never have spread to influence the actions of the health and social care providers participating in the hub model of care. Given the significance of these relationships, further exploration of how they actually work to "transmit" logics between levels of organizations and systems is an important direction for future research and theory on institutional logics.

Our study focussed specifically on a single case of integrated care during transitions out of an acute hospital ward for older people with complex needs, and thus applications of the key insights derived from the study should be made judiciously (Eisenhardt and Graebner, 2007). The purpose of the study was not to identify practices of integrated care that could apply across contexts, but to identify mechanisms that account for the success of this particular case regarding transitional care. Given how significant these mechanisms proved to be in our case study, it will be critical that these be explored in different settings and policy contexts in future research. Building on the value of the institutional logics approach to understanding implementation, such work will help to advance the fields of implementation science and health systems change.

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