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Published online: 18 Jul 2024.

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Health and social care integration: fixing a fixed service ecosystem for value co-creation

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ABSTRACT
In response to increasingly complex needs and tightening fiscal constraints, integration has led to changes in governance arrangements and joint service delivery. Applying a service ecosystem a holistic view is presented to discuss the interconnectedness between the domains of the health and social care ecosystem, including their unique and shared contexts and the various actors and institutions involved. However, our analysis also exposes important power dimensions regarding how the service ecosystem is framed and the actors acknowledged as involved in value co-creation. In response, three interdependent types of integration (structural, institutional, and relational) are proposed.

In the context of multiple and growing chronic health conditions and increasingly stretched budgets, health and social care integration has been proposed as a valid policy response across the Western World (Kaehne et al. 2017). To counter the limitations of the episodic model of healthcare, integration is typically associated with broad aims to relieve pressure on acute care, improve the efficiency and effectiveness of services and positively impact population health (Alonso and Andrews 2022; Damery, Flanagan, and Combes 2016; Pearson and Watson 2018). Rhetoric on integration also centralizes the service user through an inter-disciplinary approach to plan and deliver person-centred care and better contend with complex needs (Glasby 2017; Woolcott et al. 2019). This suggests a strategic 'user' orientation, where an external perspective of value for service users, communities and society (rather than only economic value) is fundamental (Alford 2016; Osborne et al. 2021). Despite integration's potential, there is a sustained gap between policy rhetoric and implementation (Finch, Wilson, and Bibby 2023). Indeed, there is evidence internationally that deep-seated factors (e.g. cultural and funding differences and power asymmetries) constrain collaborative working relationships and the personalized care approach

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associated with integration, with inconclusive outcomes often the result (Baxter et al. 2018; Steele Gray et al. 2020).

The lack of conceptual clarity regarding the idea of integration adds further complication. In practice, collaboration takes place to differing extents, at different levels of the system and includes multiple actors, evidenced by the various models of integrated delivery in operation across the international context (see Baxter et al. 2018). The academic literature adds insight by positioning integration as an alternative mechanism of governance and a form of inter-disciplinary working (Schot, Tummers, and Noordegraaf 2020) with a focus often on a specific thematic area, such as care for older people (Liljas et al. 2019). However, there has been less consideration of the complexity of the actors involved, their contexts, relationships and the institutions governing them, and the extent to which these enable a collaborative and person-centred approach (Burn and Needham 2023). These dimensions are important not only for the process of integration, but also for value co-creation for service users, communities and society.

Drawing on an illustrative example of Lanarkshire, Scotland, we explore health and social care as a complex nested service ecosystem which suggests overlap and inter-connection across various levels of the ecosystem (Vargo and Lusch 2016). Focusing on service delivery by statutory and third-sector providers, we consider the following research questions: *how is integration playing out in practice from a service ecosystems perspective; and how might integration better support value co-creation for service users and communities?* Drawing on service theory, our analysis suggests that integration cannot be understood as a linear model of collaboration, taking place at discrete levels or within a discrete system of processes, but rather takes place as an interconnected and complex set of interactions and institutions within and across a multi-layered context. Importantly, we further argue that power relations within the service ecosystem shape its boundaries, influencing interactions across levels and offering a narrower view of value, who is involved in its co-creation and ultimately impacting value for service users and communities.

We start with a discussion of the health and social care integration literature, examining how integration has been framed previously from managerial and systems perspectives. Drawing on service literature, we then introduce the service ecosystem and propose different domains for health and social care to frame the case of Lanarkshire. Through our analysis, we offer a nuanced account of the health and social care service ecosystem, emphasizing that in practice, the boundaries of the integrated service ecosystem are narrowed and overlook the contributions of essential actors. We then propose a typology of integration to explore how integration may better support value co-creation for service users and communities. In doing so, we contribute both to the literature on integration and the evolving literature on public service ecosystems (Osborne et al. 2022; Petrescu 2019; Trischler et al. 2023). Finally, we offer implications for practice and research.

Health and social care integration

Although integration has been discussed extensively in the academic literature over the past two decades, the concept remains relatively elusive (Baxter et al. 2018; Pearson and Watson 2018). The idea is rooted in contingency theory which suggests that the approach to organize, lead, and make decisions is dependent on

an organization's goals and its environment (Morgan 2006). Integration is therefore conditional on the internal capabilities of organizations to integrate resources, but also on the contextual backdrop. However, the goals, values and context of individual actors may be different, overlapping and even conflicting (Rossi and Tuurnas 2021). Indeed, healthcare is typically considered highly medicalized, evidence-based, and episodic, whereas social care tends to be personalized, long-term, and directed at different life-stages (Wolstenholme and McKelvie 2019). The discrete values-base and approaches associated with each can constrain the implementation of integration in practice and, given its diversity and its strong philanthropic values, the inclusion of the third sector adds further complexity.

Leutz (1999, 77/78) defines integration broadly 'as the search to connect the healthcare system (acute, primary medical, and skilled) with other human service systems (e.g. long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)'. The emphasis here is on a system of actors, with professional collaboration and connections within and across organizational boundaries, supported by specific models and techniques (Schot, Tummers, and Noordegraaf 2020). Indeed, integration can be operationalized at different parts of the public service production process and to varying extents, including any variation of the following: policy integration at a strategic level; financial integration of resources between service providers; integration of governance structures to create networks or new administrative entities; and clinical integration of professional expertise (Baxter et al. 2018; Mason et al. 2015; Schot, Tummers, and Noordegraaf 2020).

A strong managerial discourse is emphasized in early integration literature, which suggests that collaborative working through integration will improve access, quality, satisfaction and efficiency (Nolte and McKee 2009). Such aims are facilitated by various models of integrated delivery, including integrated plans, shared access to information, financial integration, shared guidelines/protocols and multi-disciplinary teams (Baxter et al. 2018; Liljas et al. 2019). However, health and social care is comprised of a highly fragmented landscape of actors, who are not confined to formal networks and who cannot access information. Social care in particular is offered by a complex set of informal, sometimes hidden actors, including families, friends, third sector (Burn and Needham 2023) and private sector organizations (Daly and Lewis 2018).

Systems perspectives have been proposed latterly, in response to calls for greater efficiency and to contend with complex needs, with two broad categorizations summarized here. First, systems have been examined from an operations perspective considering, for instance, how patients flow through and how bottlenecks may be reduced, particularly to contend with delayed discharges from hospitals (Wolstenholme and McKelvie 2019). Efficiency under the managerial discourse, therefore, remains a compelling focus. However, this arguably embraces a narrow conceptualization of value, stressing short-term financial savings above person-centredness and value outcomes. Second, systems perspectives have emphasized person-centredness (Woolcott et al. 2019). Here, integration centres on the individual service user and their complex needs which cross traditional service boundaries (e.g. the cost of living crisis, social isolation). Woolcott et al. (2019), for example, propose an ecological systems approach, emphasizing the relationships between service providers to bridge connections across fragmented services and towards the service user. An

associated argument is that integrated services should be designed and delivered locally, where community problems are better understood, and local leadership and partnership are best placed to respond (Sturmberg 2018).

Service ecosystem

The service ecosystem metaphor has been used recently to make sense of the complex assimilation of actors, resources and institutions contributing to value co-creation in public service contexts (Osborne et al. 2022; Trischler et al. 2023). A service ecosystem is defined by Vargo and Lusch (2016, 161) as a 'relatively self-contained self-adjusting system of resource integrating actors connected by shared institutional logics and mutual value creation through service exchange'. A fundamental dimension is the notion of service which is framed as the basis of exchange in all relationships and defined as 'the application of knowledge and skills for the benefit of another' (Akaka et al. 2015, 210). In other words, value is co-created (or constrained/destroyed) through various resource integrations across interconnected, loose levels (e.g. micro, meso and macro) of the ecosystem.

Across the levels and actors, a complex web of institutions is at play. Vargo and Lusch (2016) describe institutions as humanly devised rules, norms and beliefs which enable or constrain decision-making and implementation, and influence individuals' evaluation of value. These continually re-develop according to the socio-historic context and do not necessarily work in harmony (Vargo, Wieland, and Akaka 2015). The values-base of the third sector is, for instance, typically set apart from the managerial and traditional administrative underpinnings (e.g. accountability, transparency, objectivity) of the public sector; instead the third sector is regularly ideologically represented as 'an expression of individual freedom, a buffer against state power, a vehicle for citizen promotion of progressive policies, and a convenient excuse for resisting such policies' (Salamon and Sokolowski 2016, 1521).

Within any service ecosystem, actors can participate in various intersecting networks across levels, sharing resources for mutual value (Frow, McColl-Kennedy, and Payne 2016). Furthermore, the overlapping nature of the levels emphasizes interdependency, with interactions at one level potentially influencing value co-creation at another, suggesting emergent change (Frow, McColl-Kennedy, and Payne 2016; Trischler and Charles 2019). Value co-creation is therefore framed as a process of dynamic and iterative negotiation between various stakeholders, whose interdependence is a determining feature of the service ecosystem and its potential to foster value co-creation (Vargo, Wieland, and Akaka 2015). However, in a public service context, actors do not hold equal power in influencing and enabling value co-creation (Rossi and Tuurnas 2021) or in receiving mutual value. Indeed, value is phenomenologically determined and evaluated according to complex institutions, unique contexts, dynamic social structures and individual/professional/organizational/community/social values (Osborne et al. 2022; Vargo and Lusch 2016) which implies that the appraisal of value outcomes will be multifarious.

At each level, context is important in shaping value co-creation and evaluation (Chandler and Vargo 2011). The resources, capacity and infrastructure within a local system, for example, feed into value co-creation, along with an analysis of local needs. Resources available within a public service ecosystem are fluid and changing, especially in times of austerity, and that the 'rules of the game' at each level and of different actors are shaped, to some extent, by an overarching context, or what Chandler and Vargo (2011) refer to as the 'meta' level. For public services,

the social, historical, political, and economic context influences the resource integrations across the ecosystem. Importantly though, it is possible to zoom in or out on specific levels for the purpose of analysis to consider the unique contexts influencing resource integrations (Trischler et al. 2023). For example, individual service users and the interactions they have with frontline service staff across different services (Hardyman, Kitchener, and Daunt 2019) and their life context will shape value co-creation (Strokosch and Osborne 2020) as will their participation through co-production or co-design (Osborne and Strokosch 2022; Trischler, Dietrich, and Rundle-Thiele 2019). By contrast, a network of organizations may be the focal point, where intra and inter-organizational resource integration and interactions between managers and staff might be considered, as well as the different goals, values and working practices.

'Zooming out' further, individuals, networks and communities may share a meta level which provides the overarching context (Chandler and Vargo 2011). This might include societal expectations or shared values, which may be reproduced by the media, or the values espoused by the public sector or civil society. However, the meta level context is not undisputed. A shared strategic 'user' orientation among actors might, for example, place service users at the centre of decision-making (Osborne et al. 2021) but political motivations (Hodgkinson et al. 2017) and the institutional framework laid out in policies, legislation and performance measurement filter down to public service actors, influencing their actions. This will, for instance, shape the extent to which third sector and service users are involved in decision-making, and the extent to which service delivery is person-centred or efficient. Micro level interactions, contexts and values are important too; for example, embedded work practices and organizational/professional cultures will further shape the implementation of those participative processes in practice.

Illustrative example: health and social care in Lanarkshire

Context

Health and social care are devolved policy areas in Scotland, with 14 regional NHS Health Boards accountable to Scottish Ministers for the planning and provision of health care and 32 local authorities directly providing and commissioning various services, including social work and social care. In Scotland, legislation[1] established 31 Integrated Joint Boards (and one following a Lead Agency Model in Highland, where the Health Board takes responsibility) in 2016. Full structural integration was the aim (Pearson and Watson 2018) with Health and Social Care Partnerships (HSCPs) given joint delegated responsibility for planning, decision-making, commissioning, resourcing, and spending across primary, community, social and some aspects of hospital care. Although the intention was to dismantle financial barriers within the system, Donaldson et al. (2024) argue that the outcomes of integration have not been evidenced. Furthermore, the establishment of HSCPs and their Integration Joint Boards has not replaced Health Boards or the Local Authorities, with both remaining autonomous entities with distinct governance structures, cultures, and work practices. In Lanarkshire the set-up is especially complex, with one Health Board contributing to two partnerships as it spans the geographical boundaries of two Local Authority areas.

Table 1. Domains of the health and social care ecosystem.

Domain	Main actors	Role	Institutions
Government	Policy makers; legislators (e.g. Scottish and UK Governments)	Strategic decision-making	Legislation; current and legacy policies; policy goals; public values; funding arrangements; metrics; approaches
Health and social care system	Health Boards; Local Authorities; Health and Social Care Partnerships; Public Health; Third Sector Intermediary organisations.	Local decision-making and statutory sector service delivery to achieve predefined goals	Current and legacy policies; aims; local level funding arrangements; engagement structures; professional rules/standards
Community	Third Sector organisations (including network of organisations); service users; families; GPs; multi-disciplinary teams; independent care providers.	Define local needs and service delivery	Information sharing infrastructure; aims; approaches to service delivery; professional rules/standards; civil society values; community values and traditions; local history.

To discuss integration, we propose three domains (government; health and social care system; and community) which are explained in Table 1 and discussed further below to explain the Scottish context. We suggest that each domain is shaped by both discrete and shared institutions and contexts at different levels and by dynamic interactions among actors (Chandler and Vargo 2011; Osborne et al. 2022). In other words, each domain could be studied separately as a service ecosystem. We could also 'zoom in' on specific group of service users (e.g. people with learning disabilities) to examine the integrated care service ecosystem around them. However, with a focus on service delivery, our emphasis is on the community domain, and to offer a holistic view of value co-creation, we also need to 'zoom out' to understand interconnections with the other domains and their shared over-arching context.

In Scotland, integration is tied to diverse political goals, including reducing inequality and poverty and delivering efficient and effective public services (Scottish Government 2023). For over a decade, Scottish policy has emphasized early intervention and collaboration across professions and with the third sector to achieve outcomes (Christie 2011; Scottish Government 2017). However, progress on integration has been described as 'slow and piecemeal' with inequalities widening over the last decade (Hendry et al. 2021, 8). This may be linked partly to ideological legacy shaping strategic decision-making and practice. This reflects both the need for collaboration to contend with complex problems (Christie 2011) but also the pre-eminence of managerialism, efficiency and targets which are often focused on acute care (e.g. reduce waiting times or the number of people in hospital). In Scotland, UK-wide policies from Westminster also shape the context (e.g. austerity policy has been directly linked with widening health inequalities in Scotland – see Walsh, Wyper, and McCartney 2022).

The health and social care system also plays a decisive role in enabling/constraining value co-creation because it is here where national policy and local needs are interpreted alongside local policy and context. To target statutory and community resources accordingly, local decision makers and budget holders play an important role in steering the capacity of the system locally to ensure needs are met. Here, performance measures (e.g. the number of delayed discharges from

hospitals to the community; numbers on waiting lists) issued by the Scottish Government to guide public service planning and delivery. However, they should also take account of regional variations in context and needs and the local communities within.

Each local authority has different goals which should reflect the needs and context of the local area. North Lanarkshire, for instance, outlines 'ambitions' to deliver efficient services, support self-management and take an assets-based approach, emphasizing the contribution service users can make to individual and community wellbeing (North Lanarkshire HSCP 2023, 17). With regards to prevention and early intervention, and in line with Scottish Government policy (e.g. Scottish Government 2017) it focuses on empowering individuals and working with third sector organizations to support and develop local programmes. South Lanarkshire, by contrast, identifies strategic priorities for specific services such as housing (South Lanarkshire HSCP 2022b) but also includes broader aspirations around prevention, early intervention and inequalities in line with national policy (Scottish Government 2023). It further emphasizes statutory provision, integration and support and states that a 'whole system approach' is necessary, with public agencies working with communities to plan and deliver services (South Lanarkshire HSCP 2022b, 10).

Within the health and social care system, new governance arrangements have been established to join various actors, organizations and technologies in 'tightly coupled delivery mechanisms' which are supported by learning to achieve specific outcomes (Laitinen, Kinder, and Stenvall 2018, 847). In Lanarkshire, multi-disciplinary teams have been established but take different forms. In North Lanarkshire, six Integrated Rehabilitation Teams – one in each of the six locality areas – are co-located and comprise of both health and social care staff employed by the Health Board and Local Authority. In South Lanarkshire four Integrated Community Support Teams are in operation. They are different within each locality, set up according to the local environment; some include healthcare professionals only (i.e. nurses, Healthcare Occupational Therapists, physiotherapists and assistants) and others include carers from Local Authorities.

Both HSCPs have also developed strategies outlining how engagement with local communities will take place. Engagement forums include: Integration Joint Boards where local decision-making takes place and Third Sector Intermediary organizations are represented; Strategic Commissioning Groups which are responsible for developing strategic commissioning plans; Locality Planning Groups within each defined community area; community boards; and in North Lanarkshire, Community Solutions, which is a consortium where third sector anchor organizations meet to discuss community-led preventative activity and distribute a small annual fund to local groups (North Lanarkshire HSCP 2021; South Lanarkshire HSCP 2022a).

Emphasis on the community domain is essential to understand local needs, capacity/resources and service provision. Lanarkshire in west central Scotland is home to some 655,000 people or 12% of Scotland's population. With a strong industrial and mining heritage, the people of Lanarkshire have seen a challenging legacy of de-industrialization on their contemporary health and social care profiles (see NHS Lanarkshire 2023): life expectancy in Lanarkshire has decreased over the last 10 years for both males and females, and is 1.4 years below the Scottish level at 75 for males and 79.6 for females in 2021. This is in line with the poorest areas in the UK, who have suffered acutely from UK austerity policies since 2010 (Walsh, Wyper, and McCartney 2022).

The community comprises of resources from across public service providers and from communities and service users, each of which has discrete goals, values and work practices. Indeed, under marketization and the fragmentation of public services, significant resources are offered by third sector organizations (Osborne et al., 2015) which may be organized in loose networks, and by families, friends and service users themselves (Strokosch and Osborne 2020). Importantly though, how local needs are dealt with and resourced is influenced by the strategic orientation, goals and commissioning rules within the two other domains, as well as the overarching context.

Methodology

To explore integration in Lanarkshire, we conducted 26 interviews and two focus groups with respondents across Lanarkshire (see Table 2): eleven interviews in North Lanarkshire (NL); eleven interviews and one focus group in South Lanarkshire (SL); and four interviews and one focus group with respondents who offered a pan-Lanarkshire perspective and thus important contextual insights. A purposive sampling strategy was used initially to select respondents who had been involved in health and social care integration and would be well positioned to offer insights. This was guided by project team members who represented the public and third sectors. We then used a snowballing technique, asking for recommendations on additional potential respondents. The research was conducted according to the ethical guidelines of our institution, with ethical principles (e.g. avoidance of harm, informed consent, protection of privacy) adhered to throughout (Diener and Crandall 1978).

Table 2. Research respondents.

	Healthcare	Local Authority	Third Sector	Lived experience	Independent sector
Pan-Lanarkshire	Services Manager; Health Improvement Manager; Covid Rehab lead; GP Link Worker			Focus group (8 participants)	
North Lanarkshire	Health and Social Work Manager; Speech and Language Therapist	Integrated Rehabilitation team lead; Locality Social Work Manager; Social work – senior practitioner; Senior Manager	Third Sector organisation funded through Community Solutions x2; Third Sector organisation; TSIO senior manager		Independent Sector Lead for NL
South Lanarkshire	Integrated Community Support Teams Team Leader x2; District nurse; Health visitors focus group (4 participants)		Third sector organisation x5; TSIO Project worker	Lived experience participants x2	

Thematic analysis was used to code the data according to patterns of meaning emerging from what respondents said (Clarke and Braun 2017). An open coding process was conducted initially to assign data to categories. To manage the data and to allow for some flexibility to uncover similarities and nuances, the North, South and pan Lanarkshire areas were coded separately and organized in analysis tables. We looked for repetitions in the data, analogies used to represent respondents' thoughts, links between issues and similarities/differences in opinions across respondents (Bell, Harley, and Bryman 2022). After the open coding process, we developed sub themes. These were shared with respondents and the project team in a preliminary findings report and the analysis was refined to reflect comments and support validity (Lincoln and Guba 1985). Finally, three themes of integration were proposed: structural, relational and institutional. The data analysis process is shown in Figure 1 below, with a discussion presented thereafter.
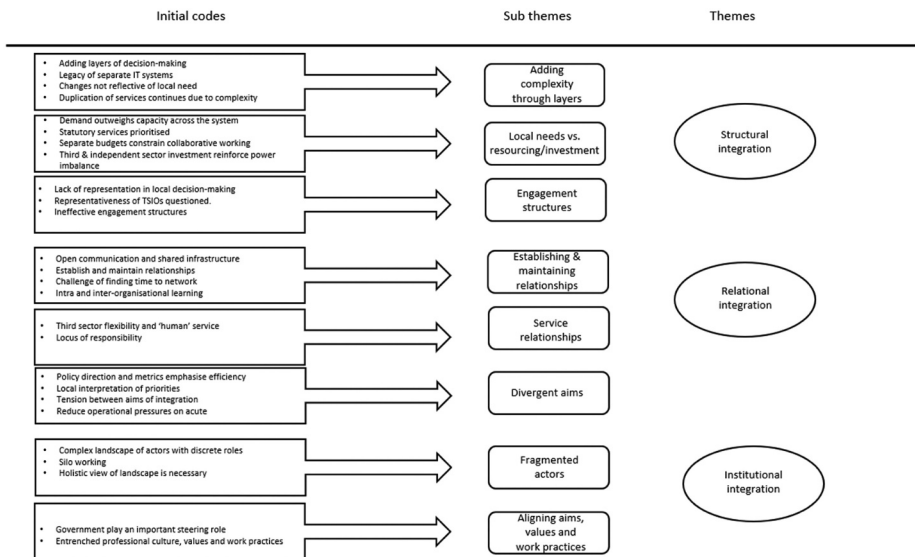

Figure 1. Thematic analysis.

Limitations

Although we endeavoured to take a rigorous approach to analysis, the sample is not representative of health and social care in Lanarkshire. Rather, it provides a snapshot with insights into the practice and impact of integration across Lanarkshire, with a specific focus on multi-disciplinary teams providing care and third sector service delivery and involvement. Our data come mainly from statutory front-line health and social care service staff (e.g. occupational therapists, physiotherapists and nurses) working in multi-disciplinary teams and third sector providers (see Table 2 above). Respondents with lived experience were recruited through third sector organizations, with the aim of providing insights from underrepresented groups and included a spread of age, gender

and geographical location; they had a broad range of experience of health and social care from across the statutory and third sectors. Insights from important stakeholders are not included (e.g. GPs, organizations from the independent sector) which is a clear limitation of the analysis presented here. However, given the context of de-industrialization and high levels of deprivation in Lanarkshire, we suggest that these insights may be relevant to similar contexts. Another limitation regarding the parameters of the study is that it does not explore the integration of service user/citizen resources in value co-creation which is recognized as an important dimension of value co-creation (Strokosch and Osborne 2020) but beyond the scope of this research.

Structural integration

Adding complexity through layers.
All respondents noted that integration has centred predominantly on structural changes. The establishment of HSCPs and Integration Joint Boards was regarded as adding extra layers of authority and decentralized decision-making, increasing the complexity of governance structures, strategic decision-making, employee relations and service delivery. Furthermore, sharing information was restricted because of separate information systems. Those working in multi-disciplinary teams across the two Partnerships spoke at length about the manual workarounds they encounter as a result and respondents with lived experience noted that this meant they had to tell their story multiple times, which did not feel person-centred.

Although decision-making is taking place at a decentralized level within Integration Joint Boards, respondents from the third sector and multi-disciplinary teams were critical of decisions made, arguing that they often fail to appreciate nuanced community needs or the realities of delivery, and highlighting the disconnect between the community and health and social care systems. Indeed, the changes implemented since integration were described as operational (e.g. working together to reduce duplication and free up hospital beds) rather than focused on improving outcomes. Respondents also said that the establishment of new service delivery teams with different structures in North and South Lanarkshire was confusing for those referring services users on and was likely to continue duplication.

> The Home First team was set up literally overnight ... Why not just put a wee bit more investment into [the multi-disciplinary team rather] than create another team that people then have to think ... is that who I refer to or is that who I refer to. (SL Healthcare multi-disciplinary team B)

Local needs vs. resourcing/investment.
All respondents discussed the various, individually complex, parts of health and social care (e.g. acute, primary healthcare, social care) all of which are working under extreme pressure where demand outweighs capacity. They reflected on the magnitude of the task in integrating these elements, which would take considerable time and would require transformative change within and across organizations: 'It's a huge it's a huge jigsaw that's just miles apart. All the pieces are miles apart. And they're moving further and further apart'. (NL Social Work). They also noted an imbalance, with statutory actors prioritized with regards to their operational pressures and funding.

> For me, the integrated joint order would involve public, private and third sector people of being able to work in that arena and all being paid fairly for it and being trusted and respected as professionals. The reality is, it's not. It's the Council and the NHS, working with budgets and funnelling it into their own services and a lot of the time that's not, they are not the answer to whatever the problem is. (SL Third Sector E)

Healthcare respondents with a pan-Lanarkshire perspective described separate budgets as an ongoing constraint on joint working. Some statutory sector respondents also warned that increasing demand and tightening budgets may lead to professional areas to protecting individual budgets which could hamper future collaborative working.

The commissioning model used to allocate contracts to the independent sector and third sector investment were each described as reinforcing power asymmetries and constraining outcomes. Although respondents said that the third sector was represented on Integrated Joint Boards, the sector's role was removed because it has different goals and a power imbalance exists through the commissioning model. At the same time, all respondents recognized the sector's importance in delivering services and in alleviating pressure on acute care.

Various third sector respondents noted the lack of investment from healthcare or Local Authorities, with an expectation that the third sector would deliver 'something for nothing'. Although the 'unique' funding model implemented in NL was received positively by some, there was also strong overall agreement that a 'bolder approach' to investment was required to adequately fund preventative and early intervention services. Respondents noted that this required transformative change to resource allocation by Partnerships, based on the equitable distribution of resources in accordance with local needs and to focus on prevention.

> It just takes that bravery to go, right, okay, we'll invest it now. Because see the time and the resource that they've saved by pumping them out quickly and not having that conversation, see when he bounces in three days later with an infection and he needs to be admitted and he needs surgery to amputate half his leg, how much is that going to cost? Because it would probably cost more than if they'd just invested the time the first time. (Lived Experience A)

Engagement structures. Third sector respondents across Lanarkshire expressed concerns over their lack of representation at a local strategic decision-making level on Integration Joint Boards. Despite engagement structures being in place, they were described as largely ineffective or tokenistic. For example, while Third Sector Intermediary Organisations are represented, respondents questioned the extent to which they were representative of the local third sector, communities or service users. Furthermore, third sector respondents in NL said communication with the Integration Joint Board was dependent upon having relationships with third sector anchor organizations and argued that current mechanisms in place to capture community insights were not fit for purpose. For some third sector respondents, the inefficacy of engagement structures was constraining the establishment and sustainability of relationships, with third sector organizations feeling left on the periphery of local decision-making.

> We're having the same conversations over and over again. So we don't know who actually makes the decisions, and presumably the Integrated Joint Board ... I don't know what the community input to that is it ... You know, are we being represented by a Third Sector Interface who don't speak to us?. (NL Third Sector B)

Relational integration

Governance. Respondents unanimously agreed that to enable integration, governance mechanisms should not be limited to rules, processes, and procedures designed by senior managers, but should foster and embed 'human relationships', through open communication and shared infrastructure.

Relationships were described as important at all levels, including those between members of the Integration Joint Boards, but also at the service level, within organizations and across agencies, and between service providers and service users: 'a lot of it is around the power of relationships and about knowing what's going on and how do you connect'. (NL Senior Manager). Respondents also said that establishing and maintaining relations across professional, organizational and sectoral boundaries would emphasize the contributions of different actors, helping to reduce power asymmetries: 'I think you know more relational. . . You know, working together as colleagues, part of the same team, equally weighted. I think that's where the solutions are'. (Healthcare A).

Inter and intra-organizational networking was described as important both for day-to-day team working to conduct screenings and ensure services users were allocated to the correct professionals; and for learning and knowledge exchange with those from the same profession to support development, and with other professionals and the third sector to help understanding of roles/remits and learning. Respondents from multi-disciplinary teams across Lanarkshire frequently mentioned misunderstanding as a barrier to joint working, especially with acute services where day-to-day working relationships remain largely disconnected. Furthermore, lived experience respondents reinforced how misunderstanding of roles impacted the advice they received, often resulting in them taking the wrong service pathway and thus impeding value co-creation.

With a strategic emphasis from government and partnerships on operational efficiency through structural change, building and sustaining relationships was deemed challenging. Statutory sector respondents across Lanarkshire said finding time to network and for knowledge exchange with the third sector was difficult. They thought being in the same building as collaborators from different professions/organizations/sectors would help to reduce barriers. Similarly, third sector respondents discussed at length the importance but difficulty of finding time to network within and across sectors; networking was not typically covered by funding agreements.

Service relationships. A few respondents said that integration referred primarily to the establishment of Integrated Joint Boards (IJBs) and the governance structures put in place to facilitate joint working between Health Boards and Local Authorities in Scotland. However, most offered a broader understanding of integration, suggesting it takes place at different levels of decision-making and service delivery and should include multiple actors, including the third sector. Respondents spoke unanimously of the third sector's 'low level' foundational role in the community and its ability to access and support vulnerable service users. Lived experience respondents reinforced this, discussing the 'more human element' advocated by the third sector and the flexibility with which it delivers services. Third sector respondents described their services as having less rules and were, therefore, more accessible to vulnerable service users who sometimes find it difficult to access statutory services.

> . . . we don't give up. It's not three strikes and we walk away . . . the door's always open. So we tap, tap, tap away and eventually they say, 'Oh yeah, OK'. We're not in a uniform . . . they trust [us]. . . (SL Third Sector A)

There was, however, some variation regarding where responsibility for maintaining health falls. Statutory service providers were clear that self-management by service users/patients. By contrast, third sector respondents and those with lived experience clearly articulated the vulnerability of some service users and their need for additional support, 'hand holding' or changing service provision to overcome the barriers to services and to help limit cycles of inequality.

Institutional integration

Divergent aims. Respondents noted the strategic orientation of Health and Social Care Partnerships was shaped by the national policy direction of the Scottish Government, as well as the leadership of the Partnership. Reflecting nuanced priorities at a local authority level, the intended outcomes have been interpreted differently in North and South Lanarkshire. Various respondents noted a shift in strategic positioning, with greater emphasis on resources within the community. The third sector, in particular, was described as well positioned to support goals around early intervention and prevention, especially in North Lanarkshire. Here, respondents mentioned the changed narrative towards a 'locality-based' approach, with local needs and assets within the community highlighted. In South Lanarkshire, by contrast, respondents said that while there was recognition of the importance of the third sector and some rhetoric around committing resources, this has not been reinforced with shifting budgets. Some statutory sector respondents said this reflected a difference between senior leaders' openness to risk-taking across the Partnerships.

Person-centredness was emphasized by all respondents delivering services, who agreed that concentrating on the individual service user could unite actors and support integrated goals and work practices. However, some respondents from across sectors also noted a tension between achieving person-centredness and efficiency. Statutory sector rules and bureaucracy were described by various respondents as shaping the goals of organizations.

> the other perspective of our users' experience with Social Work is poor . . . they've got so many, you know, risk assessments or protocols to follow to keep the population safe. The impact of that is the empathy, the understanding, the whole person approach . . . is missing. (NL Third Sector C)

Furthermore, respondents from across Lanarkshire said the emphasis was on achieving efficiency in line with Scottish Government performance indicators, and streamlining processes to reduce operational pressures on parts of the Health and Social Care system (e.g. discharging patients from hospital as early as possible to free beds). Thus, the uniting principle of person-centredness was typically side-lined for operational efficiency.

Fragmented actors. The analysis points to the complexity of actors from the public, private and third sectors, each playing important and discrete roles. The vast majority of respondents said the third sector plays a crucial part in improving population health and wellbeing and in supporting the objectives of early intervention and prevention. However, a few respondents from across sectors also

questioned its capability in providing services for complex needs, such as dementia, warning that cuts to statutory services put unrealistic pressure on the third sector to fill gaps. Related to this, all respondents emphasized the importance of viewing the health and social care in a holistic way and valuing the contributions made by different actors/sectors. They also discussed a domino effect, with understaffing in one part of the system resulting in poorer user experience and causing stress on other parts of health and social care.

> ... that's to do with the stresses and strains that are on home support, which then impacts on us because ... The situation just goes into crisis ... people's mental health goes down, so community mental health team are more under pressure for that. District nurses [are under pressure too] because people's physical health will be deteriorating. (NL Social Work)

Respondents discussed at length the legacy of silo working, especially within healthcare, where budgets are allocated to professional groups (e.g. physiotherapists or occupational therapists). Both intra- and inter-organizational working were therefore challenging. Although reducing pressures on hospitals was mentioned frequently as a goal of integration, respondents said acute was not integrated with primary care or the community. Across Lanarkshire, the focus had been on establishing multi-disciplinary teams which have been implemented in different ways (as discussed previously). Respondents in North Lanarkshire, where healthcare and Local Authority staff were integrated into teams, emphasized the challenges, including different work practices, and reluctance to change jobs/remits. Respondents from across Lanarkshire commented on poor support from senior leaders and the lack of co-working space, making day-to-day communications and relationship-building difficult.

There was general agreement that while inroads have been made in terms of statutory health and social care actors working together, the third sector is 'bolted on' and is used for onward referral rather than playing an integrated role in service delivery. Working with the third sector was described as especially challenging given its dynamic landscape, with local organizations often invisible to those working in multi-disciplinary teams or to people needing services. The independent sector was also described as detached, with very few respondents mentioning it, and those who did, saying it was not a core part of the rhetoric or practice of integration.

Aligning aims, values and work practices. Government has been described as playing an essential role, not only in steering integration through goals and metrics for measuring success, but also in aligning the various policy areas that impact on outcomes such as social inequalities (e.g. housing, planning, education). However, respondents emphasized the need to reflect different local needs and infrastructures, arguing that a one-size-fits-all, top-down approach was not appropriate to deliver health outcomes: ' ... the population of North Lanarkshire is not the same as the population in South Lanarkshire ... your health outcomes in certain areas they're hugely different'. (Healthcare C). They also noted the challenge in responding to need in an equitable way, reflecting local differences, while also considering the operational pressures across the health and social care system.

Enabling statutory actors to work together was constrained by separate governance structures and budgets, and change was slow due to organizational rules and bureaucracy. Entrenched cultures, mindsets and ways of working were also described as

a barrier to integration during service delivery, with negotiation and compromise important between professionals. In South Lanarkshire, respondents working in multi-disciplinary teams comprising only of healthcare professionals, described how the teams worked well because members shared a similar mindset, skillset, and practices: 'It was lovely working with the nurses and having physios. That all worked beautifully'. (SL Healthcare B).

Healthcare respondents also discussed the legacy professional groupings and said that groups wanted to retain their core skills and maintain their identities which integration may threaten. Furthermore, the rules and work processes structuring service interactions reinforced the emphasis on efficiency at the expense of person-centredness.

> . . . when it's all about efficiency and maximizing what we can get out of resources and when we know the system is under extreme pressure, I query how person-centred we can actually be. Because if I'm a physio and I've got ten-minute appointment for you. How much can I get into: how are you? How's this working for you? I'm immediately thinking right, we've got seven minutes left . . . stop the chit chat, I need to get on with this. (Healthcare B)

Third sector organizations were described as espousing strong person-centred values which better positioned them to cater for vulnerable groups. Third sector respondents, especially, reflected on the precedence of statutory rules and work practices which could be imposed on them to formalize approaches already implemented. Through this, there was a suggestion that learning and change were one-directional, emanating from and guided by the Health and Social Care Partnership and statutory sector organizations.

Discussion and contributions

Although our focus was on the community domain and the delivery of services, the analysis evidences the interconnectedness of the domains, with the influence of macro- and meso-level institutions and decision-making structures guiding value co-creation during delivery and impacting outcomes. For example, despite integration policy emphasizing an external view of value for service users and communities, service delivery is shaped by performance goals which emphasize efficiency. Value is, there-fore, translated primarily in economic terms (associated with the legacy of New Public Management) and takes precedence for decision-makers, commissioners and, to some extent, statutory service providers; front-line statutory service staff also emphasized that person-centredness underpinned their professional standards. Furthermore, per-formance indicators are designed to track statutory sector performance (typically on specific operational pressure points such as acute care) rather than the value added by the third sector, or indeed by more informal actors (e.g. service users, volunteers). They do not, therefore, fully capture the value co-created within the health and social care ecosystem.

There is strong sentiment that understanding the nuance within communities, including capacity/resources and needs, is necessary to shift from concerns over operational efficiency, towards person-centredness and collaboration. However, to support this, a strategic user orientation (Osborne et al. 2021) where community assets are valued as equal contributors, needs to be embedded throughout the service ecosystem. A crucial element of this is recognition of the complexity of the actors

within the service ecosystem, the unique roles they play and the value they add. However, the analysis highlights that the actors included, and the extent to which they are recognized as contributing, is restrained by a narrow view of the service ecosystem, with concentration primarily on statutory sector actors. For example, despite the third sector being a core resource in service delivery, contributing to goals of early intervention and prevention, it is positioned on the periphery of local decision-making and service delivery (e.g. filling gaps in statutory provision). Similarly, although staff in multi-disciplinary teams bring substantial knowledge and expertise, decisions around integration have largely been imposed upon them, leaving it to line managers to then negotiate differences. Somewhat in line with Vargo and Lusch (2016, 161) this suggests that the boundaries of the service ecosystem are 'self-contained', but purposefully so. Indeed, the complexity of the actors involved, the considerable resources they bring and the distinct roles they play in value co-creation are viewed too narrowly, or not recognized at all. Furthermore, the service ecosystem in this context is not fully 'self-adjusting' because those boundaries (i.e. who is recognized as being involved and whose value contributions count) are delimited by those in power. This inhibits the dynamism of the health and social care service ecosystem and especially the extent to which it can enact and optimize resource integrations of the community.

The focus of integration has been on changing governance structures to forge links between statutory sector decision makers and service providers, largely overlooking the complexity of actors involved in value co-creation and their role in working towards the broad policy goals of integration. Although structural integration is important in supporting exchange and relationships, concentrating purely on the statutory structures and the operational processes which might enable integration among certain actors and support efficient processes is not enough. Rather, we need to start with a broader view of the actors involved and consider how resource integrations across actors might be facilitated to profit from the dynamism of the service ecosystem. In response, we propose three interdependent types of integration which may be implemented to enable value co-creation and outcomes. A brief description of each is provided in Table 3 below, with detailed discussion thereafter.

Table 3. Typology of integration.

Types of integration to support service production and value co-creation		
Structural	Relational	Institutional
Connections between processes and organisational structures to enable joint working and information sharing (e.g. shared systems and IT infrastructure; location of staff; engagement and participation structures; funding arrangements; reporting requirements).	Inter-professional, -organisational and -sectoral relationships, as well as relationships with service users, which are influenced by expectations and values, and enabled by structural connections (e.g. working relationships; service relationships; networking; learning from other organisations/ professionals/ service users).	Rules/standards shared across the service ecosystem (e.g. social expectations, public values); professional values and standards, (e.g. social work professional standards); goals/ strategic orientation; and work practices.

Structural integration has been implemented through the addition of new governance mechanisms to support decentralized decision-making and joint service delivery (Schot, Tummers, and Noordegraaf 2020) primarily to achieve operational goals, including improved service coordination and reduced duplication. Top-down models of governance in the form of Health and Social Care Partnerships have, for example, been instituted on top of long-standing structures, with Integration Joint Boards positioned as problem locators and solvers. Indeed, the integration agenda has focused primarily on the health and social care domain and statutory sector actors, rather than third sector actors, and engagement structures in place to connect the two are largely ineffective. Furthermore, although new multi-disciplinary team structures have also been established to connect professionals and statutory organizations, with attempts to standardize procedures and share information, this has been constrained partly by the failure to connect infrastructures (e.g. IT systems; separate buildings) suggesting structural integration could go further (e.g. effective structures to draw on the lived experience of front-line staff and insights from the third sectors).

The analysis indicates that while structural integration is important, it is insufficient in supporting and embedding relationships to support value outcomes for service users and communities. *Relational integration* comprises the micro level interactions between various actors (Vargo and Lusch 2016) taking place across each domain and between domains. The emphasis here is on a complex system of human relationships rather than of organizations and processes, including actors from across sectors and service users. As discussed previously, this requires recognition of the various actors contributing to value co-creation and having structures in place to support learning across sectors and domains to appreciate nuances in local needs and capacity of community actors.

In connecting the community domain with decision makers, the third sector plays an important mediating role (Berger and Neuhaus 1978). However, third sector and service user involvement in decision-making can be facilitated (or constrained) by extrinsic structures of participation (Osborne and Strokosch 2022) such as representation on Integration Joint Boards . Ineffective engagement mechanisms and the sheer size and complexity of health and social care mean that local needs are not fully understood, pointing back to the importance of structural integration and innovative engagement mechanisms. Nevertheless, work practices, processes and rules can also enable or constrain relational integration between professions and sectors which is critical for day-to-day working, but also for learning, networking, and collaboration across actors and domains. They also enable (or constrain) value co-creation with service users during delivery where, for example, they emphasize efficiency over person-centredness.

Institutional integration refers to the extent to which aims, rules and values are loosely coupled within and across the service ecosystem to enable value co-creation. The disparate actors within health and social care draw on their different goals, approaches, values to play distinct roles and cater for different service needs (Rossi and Tuurnas 2021) which is something which should be maintained. Thus, the focus of institutional integration should not be standardization, but to facilitate the optimal blend of institutional arrangements across organizations and domains to enable value co-creation.

Importantly though, consensus in aims is necessary to achieve long-term outcomes for service users and communities. Government and policy makers thus play an important role in laying out and embedding a strategic user orientation (Lowe et al. 2021; Osborne et al. 2021) through, for example, measuring impact on service users/communities rather than simply economic value. Thus, while relational integration proposes a shift towards a service logic, institutional integration emphasizes a strategic orientation prioritizing communities and outcomes; one which weaves through the goals of all actors. The analysis presented above suggests that person-centredness is a potentially uniting dimension which links front-line service providers, but it is also a logic which may be more aligned with third sector organizations. However, systemic change in the field of health and social care is stifled by the legacy of institutions (e.g. New Public Management values) and enduring power asymmetries across the service ecosystem. Embedding relational integration to support learning, appreciating and trusting the roles, skills, and contributions of different actors are, therefore, likely to reinforce institutional integration. A precursor of this, as previously mentioned, is recognition by decision-makers of the contributions made by those various actors – especially the third sector, communities and services users – to value co-creation.

Implications for theory

Through the preceding discussion, we offer a more holistic view of health and social care integration, contributing to both the integration literature (Baxter et al. 2018; Woolcott et al. 2019) and to the evolving literature on public service ecosystems (Osborne et al. 2022; Trischler et al. 2023).

Our analysis presents a more comprehensive view of the health and social care ecosystem in three ways. First, by proposing three types of integration, we add clarity to the concept, suggesting it is not concerned simply with structural change but also with enabling relationships across a plurality of actors, including the third sector, and the shared and discrete rules, values and beliefs guiding them.

Second, we argue that a degree of alignment between domains and the actors within them is necessary to support the collaborative working and the 'user' orientation associated with and essential for value co-creation. An external view of value (Alford 2016) is a critical thread shaping service planning and delivery but is one which may get easily lost within the ecosystem's complexity and competing objectives. Indeed, reform is notoriously difficult in a public service context and implementing systemic change within the complex fields of health and social care is especially challenging (e.g. Greenhalgh and Papoutsi 2019). Thus, our analysis emphasizes the role of national and local decision-makers in steering reform and embedding person-centredness to support value co-creation for service users, communities and society.

Third, and we suggest especially important for the evolving public service ecosystem perspective, we reflect on Vargo and Lusch's (2016) definition of service ecosystems. Although the service ecosystem metaphor is useful in understanding the dynamism of value co-creation, the web of institutions at play and the importance of relationships, in neglecting considerations of power, it does not consider the enforced boundaries of

the public service ecosystem which may exclude important actors and impact what is valued and the potential for transformative outcomes.

Implications for practice

Our discussion suggests three implications for practice to support change. First, while questions of efficiency are important, they need to be framed as one factor in attaining outcomes for individuals/communities. Having a clear strategic user orientation, which emphasizes value outcomes, is necessary to understand need and resources (Osborne et al. 2021). Part of this involves ensuring performance indicators measure the value accrued by services users and communities beyond economic metrics for satisfaction and efficiency.

Second, that strategic orientation is guided by the complex institutional framework guiding the system. Thus, actors from the government, Health and Social Care system *and* communities play an important role in steering the service ecosystem, by embedding and aligning rules and processes which facilitate the achievement of outcomes (Lowe et al. 2021). Furthermore, to enable collaboration across professions, organizations and with service users, institutions and infrastructures need to be altered to support and invest in human relationships. The black box of collaboration for value co-creation is not simply concerned with altering working processes or adding new structures. It is dependent on agreeing and shaping shared values and enabling relationships.

Finally, in the complex landscape of health and social care, the focus should be both united and fragmented. United in the sense that all actors are aligned in their strategic user orientation to achieve value outcomes. But fragmented to understand nuances in local needs, including disparities between neighbourhoods and the roles, capacity and institutions of actors within the community and Health and Social Care system, which may require targeted investment.

Implications for research

The discussion presented here also suggests four avenues for future research. First, the influence of power asymmetries on value co-creation requires further exploration across a range of public service contexts, by asking questions such as: who decides what is of value? And how does the service ecosystem enable and constrain the involvement of various actors, including vulnerable service users? In the field of social care, the role and position of the independent sector would be particularly interesting to investigate.

Second, further examination of the institutional arrangements across the health and social care professions would offer important insight into where actors are aligned and what might be done to increase alignment. For example, person-centredness was described as a potentially unifying approach, but more understanding of the concept's application by different professions/sectors is required. Perhaps drawing on DiMaggio and Powell's (1983) concept of isomorphism would provide the framing to learn from the third sector to consider how the public sector might shift its strategic orientation.

Third, the values and beliefs operating at the sub-micro level (Osborne et al. 2022) and shaping different actors' willingness to engage in integration is necessary to explore potential for collaborative working. Finally, while service ecosystems are framed as dynamic (Vargo and Lusch 2016) more insight is necessary to understand how transformation might be instigated and steered on the ground to support

transformation to enable value co-creation and achieve outcomes for service users and communities. Understanding how those with lived experience feed into this will be crucial and, again, power is likely an important dimension in such analysis.

Note

1. Public Bodies (Joint Working) (Scotland) Act 2014.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

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