Phenomenology of health and social care integration in Italy

Abstract

This article analyses how governance and organisational dynamics produce different forms of health and social care integration. The ethnographic study, carried out in two different Italian organisations, highlighted two forms of integration, which we termed *mechanical* and *cultural*. The first is characterised by the prevalence of codified and hierarchical forms of coordination and the substantial isolation of professional groups, with limited contact opportunities. Under these conditions, integration is mainly achieved in the final product through the independent and uncoordinated delivery of specific social and health services. In the second, codified tools occur alongside informal coordination activities, based on face-to-face interactions and the sharing of knowledge, values, and goals. Integration takes place in daily formal and informal interactions and in the development of professional intimacy. Our results suggest that public policies need to be clear about the form of integration at which they aim. The mechanical form is appropriate for product integration, while cultural integration is the preferred form for process and professional integration. In the latter case, ICTs are undoubtedly useful but not sufficient. To stimulate informal co-ordination, mutual trust, and professional reciprocity, analogic communicative patterns are needed to allow the emotive dimension to be expressed.

Keywords

Health and social care integration, Welfare policy, Ethnography, ICT, Community of practice.

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Introduction

Health and social care integration (HSCI) is a key public policy area to enable the transition from homogeneous health care systems, based on medical institutions to welfare systems comprising new forms of caring and treatment that entail increasingly heterogeneous, polycentric, and fragmented practices (Leipzig et al., 2014; Schubert, de Villota and Kuhlmann, 2016). HSCI is also referred to as integrated care (Stokes, Checkland and Kristensen, 2016), joint working (Cameron, 2016), partnership or inter-agency working (Hudson, 2002; Glasby and Dickinson, 2009), and interprofessional collaboration or teamwork (Fox and Reeves, 2015; Reeves et al., 2010). It is not exactly clear what HSCI is, and for some, perhaps it is a chimera. However, everyone agrees on the positive effects the integration of services, professions, and procedures have on organisational outcomes and on health benefits for citizens. Leutz (1999) stated that HSCI deals with the connection between health services

(hospitals and primary cares) and other "human services systems", including support for long-term care, educational, vocational, and housing support (most of them provided by social work services). HSCI comprises a wide, heterogeneous, and unstable universe, subject to technical-scientific and medical innovation, economic arrangements, public policies, and socio-demographic transformations (Glasby, 2017). The present article connects institutional narratives of integration to everyday practices in health and care settings to analyse how: (1) HSCI takes different forms according to specific organisational features; (2) ICT can (or cannot) facilitate the creation of integrated services and working groups; (3) HSCI also regards symbolic and interactional aspects usually neglected by health care public policies and much of the scientific literature. For these purposes, we examined everyday interactions between Italian municipalities and local health authorities in the field of adult service, studying professional practice in its natural settings.

The quest for the integration of health and social care

In a recent editorial in the BMJ, Glasby (2017, p. 1) summarised the current state of HSCI: "While progress has been made over time, health and social care remain separate entities with different legal frameworks, different budgets, different cultures, different geographical boundaries, different accountability mechanisms, and different approaches to whether services are free or means tested – all of which make joint working difficult at the best of times". Two considerations emerge from this editorial. First, HSCI still remains a priority for welfare public policies; in fact, in the title of his article, Glasby refers to it as the "holy grail". Second, though much has been done, much still remains to be done before we can put our hands on the desired "cup". In fact, 18 years have passed since Leutz (1999), analysing the integration efforts undertaken in the 1990s in the United States and the UK, formulated the so-called "5 laws" – which became 8 in 2005 – of HSCI. Leutz provided

recommendations for implementing integrated services, emphasising that integration is a medium/long-term phenomenon requiring the abandonment of the claim of universalism and implying conflicts and negotiation processes.

These guidelines became widespread in the following years, yet the state of implementation of HSCI remains unsatisfactory, as Glasby recently stated. Several studies, especially in the fields of health service research and medical education, have investigated the factors hindering the implementation of integrated services. Financial (an opaque funding mechanism and lack of dedicated funding), organisational (ambiguity and geographical distance), and professional (role conflicts, stereotypes, distrust, and different values) obstacles have been reported (Cameron, 2016; Glasby and Dickinson, 2009; Rämgård, Blomqvist and Petersson, 2015; Stokes, Checkland and Kristensen, 2016; Tousijn, 2012). These factors may affect the various levels of integration: policy, financial, management, and clinical (Leutz, 2005). Multi-professionalism is another keyword in this scientific debate (Fox and Reeves, 2015; Hudson, 2002). It has been shown that a significant number of health and social care managerial tasks and responsibilities have become incorporated in the healthcare professions and that this "new professionalism" affects the interprofessional teams that administer the health services and HSCI (Numerato, Salvatore and Fattore, 2012; Tousijn, 2012).

A significant limit to the existing literature on HSCI is the prevalence of quantitative studies, meta-analysis, and policy research. While effective in evaluating perceptions, attitudes, values, and infrastructural factors, such studies cannot grasp the interactional and symbolic dimensions of everyday life and practice. Moreover, focusing on institutional, organisational, and professional documents (such as rules, flowcharts, and protocols) allows us to draw the "formal map" of HSCI: that is, the set of possible interactions among the various actors (institutional, human, and technological) involved. Nevertheless, there will always be an irremediable gap between the abstract tools used to govern and

control these socio-technical systems and the interactions in everyday practice (Timmermans and Berg 2010). This article seeks to attempt to bridge this gap in the field of HSCI by focusing on the plan of situated action (Suchman, 1987), according to which symbolic objects (such as HSCI) and related artefacts (rules, protocols, guidelines, measurement tools, etc.) need to be analysed in relation to physical environments and contingent situations in everyday practice. As Gherardi (2008, p. 521) stated: "The materiality of situations enters into relations, objects can be conceived as materialisations of knowledge, as tangible knowledge which 'steers' and sustains a set of practices". Everyday practice represents the locus of constant problem solving in which public policy, organisational rules, and abstract guidelines interact with infrastructures, technologies, practitioners and patients, systems of knowledge, and meaning (Alby and Zucchermaglio, 2006; Lusardi, 2015; Weick, 1995). Greenhalgh and colleagues (2014) focused on the everyday practices of GPs and administrative personnel to uncover the symbolic and behavioural resistance that hinder the use of an ICT system for online outpatient referrals. In fact, there is widespread debate on whether ICT can facilitate inter-professional working groups (e.g., through data and knowledge sharing and remote working). Baar and colleagues (2017) discuss how the effectiveness of IT in enhancing communication depends on the existing social relations within which the technology is placed. We will therefore concentrate on the different forms that HSCI assumes in everyday practice, which depends on the system of relations composed of organisational elements, technologies and human actors, social interactions, symbols, and daily rituals.

Methodological notes

The present study investigates the social and organisational processes to implement HSCI in everyday practice. One of the authors (RL) conducted two qualitative case studies in two urban areas of Emilia Romagna, in Italy. He used ethnographic methods – shadowing and participant observation (Silverman,

2011) – and undertook fieldwork between October 2012 and December 2013. The cases were selected on a theoretical basis by identifying two empirical fields characterised by different forms of service governance (see Tab. 2).

Participant observation was the main method used, for a total of 80 hours (Tab. 1). At the beginning, participant observation was free and followed the ordinary activities in the two organisations. Later, it was used at relevant moments of the service activities, such as during team meetings and service assemblies.

The shadowing was effective in understanding the multi-situated and dynamic nature of the topic, allowing the researcher to observe integration practices even outside organisational settings (Silverman, 2011). The author devoted 64 hours to shadowing the following practitioners: community nurses, social workers, front-desk staff, and service managers.

Tab 1. Data collection activities

	Case 1	**Case 2**
Roles and numbers of subjects shadowed	Community nurse (2) Social worker (2) Front-desk operator (1)	Community nurse (2) Social worker (2) Care service head (2)
Total hours of shadowing	30	34
Places subject to participant observation	Premises of the Home Nursing Service and Social Bureau office Social workers' offices Health Board premises	Premises of Health and Social Care Access Centre
Hours of participant observation	40	40

The ethnographic data collected was digitally transcribed in the daily field notes. In addition, “casual” interviews, backtalk discussions, and occasional conversations were reconstructed in the notes. When drafting the ethnographic notes, a confidentiality protocol was applied to ensure the anonymity of the participants and to protect sensitive data collected during the observation. Empirical data was processed

using the MAXQDA software (Kuckartz, 2007). A two-step grounded approach (Charmaz, 2006) was used for data analysis: "(1) an initial phase involving naming each word, line, or segment of data followed by (2) a focused, selective phase that uses the most significant or frequent initial codes to sort, synthesise, integrate and organise large amounts of data" (p. 46). These are the categories that emerged as relevant properties: spatial disposals, communicative patterns, responsibility chain, coordination processes, and social cohesion (see Tab. 2).

The field

HSCI has been among the foundational principles of the Italian National Health System since 1978, although initially applied more as a general premise than an effective practice (Brugnoli and Colombo, 2013). Since then, the crucial need for effective reciprocal integration between the health and social entities has made HSCI a key factor in the implementation of welfare services. Emilia Romagna, Lombardy, Piemonte, Tuscany, and Veneto are the most active regions experimenting with new organisational service architectures and technological innovation (Lluch and Abadie, 2013). Scholars have investigated how local implementations are varyingly defined in regulatory terms according to the national and regional area of application, mainly due to the decentralisation process underway since the mid-1990s (France, Taroni and Donatini, 2005; Pavolini and Vicarelli, 2012).

The empirical study was carried out in two cities in Emilia Romagna, a region in northern Italy. The regional welfare system is traditionally based on the role of public institutions – health care authorities in particular – and may involve a third sector or private partners (France, Taroni and Donatini, 2005). The regional welfare programme is contained in the *Piano sociale e sanitario* (Social and health care plan). This document – issued in 2008, extended in 2013, and still valid – serves to orient regional welfare policy. It states: "HSCI is a prime value and, at the same time, a strategic objective of the

regional welfare system" (Regione Emilia Romagna, 2008, p. 21). The institutional setting for the two cases analysed in the present study adopts specific forms to promote, implement, and develop HSCI at the institutional, community, professional, and managerial levels. The selected cases present different forms of governance, including different political-institutional relationships between local health authorities (LHAs) and municipalities. In the first case, the municipality completely delegated HSCI governance to the LHA, only retaining the management of social assistance services (delivered by executive public/private organisations). In the second case, the municipal Department of Health and Social Care acted jointly with the LHA to manage and deliver health and social care services.

Case 1

We are in an urban district of about 70,000 inhabitants within a large city, where the organisational and professional actors engaged in HSCI are mainly community nurses and social workers from city hospitals that were part of the Protected Discharges (PD)[1] operational protocol and from other participating facilities, e.g., the Hospital and Community Unit (HCU), the Community Nursing Service (CNS), the Social Bureau (SB), and the Community Social Service (CSS). Other practitioners involved are: general practitioners (GPs), geriatricians, and specialists belonging to the Geriatric Assessment Unit (GAU) and health care assistants, employees of cooperatives delivering home care services through an additional public organisation. This description includes only some of the actors involved and indicates the complexity of the health and social care system. Participant observation took place at the CNS and the CSS. The former provides home medical and nursing services, while the latter provides social and assistive support.

Located in the main public medical centre of the district, the CNS has a team of 13 nurses and a manager and contains three rooms with different functions: operating room, front office, and

warehouse. The CSS is instead located within municipal institutional structures and serves two functions, each with different locations, responsibilities, and competencies: the SB and the social service. Located on the ground floor of the building, the SB represents the access point to the service and consists of administrative staff with front office functions. The second function is provided by the municipal social workers, who devise and implement social intervention services. At the time of the ethnographic research, the service included two social assistants for the elderly, one deputy for minors, and one manager.

Case 2

In the city centre of a town of around 200,000 inhabitants, the *Health and Social Care Access Centre* (HSAC), which is the organisational link between the health and social entities of the city's welfare services, mainly provides the HSCI. The HSAC comprises 8 community nurses, 5 social workers, 10 health care workers, 2 health care managers, and 4 operators with administrative functions. The service is coordinated by a physician with a managerial role and by two managers from the nursing and social area. The service headquarters is in the city centre on the top floor of the old city hospital. Most of the nurses, social workers, care workers, managers, and administrative staff work here. All the offices are off a corridor. There are also two offices in the new city hospital, located outside the city, with an assigned nurse and social worker introduced to coordinate the care pathways that contain hospital internships.

Two forms of integration: mechanical and cultural

Different connections between health care and social services have been identified, leading to two distinct phenomenologies of integration, which we named *mechanical* and *cultural*[2]. *Mechanical integration* deploys social and health practices on parallel tracks, interconnected through technical tools (procedures or ICTs). *Cultural integration* consists of a physical and symbolic container that jointly coordinates social and health practices. The following table summarises the properties that characterise the two forms, which are described below.

Tab 2. The two forms of integration and their properties

	Mechanical integration	**Cultural integration**
Governance	Municipality delegates the management of social care to LHA	Partnership between municipality and LHA
Funding system	Social services are funded by municipality; health services by LHA	Social services are funded by municipality; health services by LHA
Spatial disposal	De-location	Co-presence
Responsibility chain	Internal to each group	Internal and diffuse
Communicative patterns	Digital	Analogue
Coordination form	Bureaucracy	Informal
Social cohesion	Inter-group	Trans-group

The first two properties (governance and funding) derive from sampling choices; the others emerge from the analysis of empirical material.

Mechanical integration

HSCI involves a complex array of organisational and professional actors; we illustrate this using the *railway lines* metaphor. Health and social entities work independently along parallel tracks but heading in the same direction, identified in advance by the PD protocol. The "departure station" is the HCU of the LHA. Every integration process begins here, where the supports necessary to meet the needs of patients are selected and implemented. Once the pathway is initiated, the protocol formally provides for

an “intermediate junction” (where the social and health entities intersect) at the GAU, which provides further indications about the direction of the process: the health and social care services needed, the facility to which the person will be discharged, access to day care centres, or the care allowance granted. Finally, the “arrival station” is defined: the patient’s home or the residential facility in which s/he will go after discharge and receive the health and social services foreseen by the treatment plan. Therefore, it is the operational procedure (the PD protocol) that identifies the specific and circumscribed occasions for the integration of the services provided by the two entities.

From the start of fieldwork in their respective workplaces, community nurses and social workers stressed the difficulty of the research task. Both groups emphasised the separation between the health and social sectors, each of which has its own institutional arrangements, organisational spaces, and operational methods, which are largely unknown to the other. The physical separation between the two entities has been addressed in organisational terms through the development and implementation of a specific ICT infrastructure. The composite list of facilities and services presented above reflects an equal number of micro-organisational worlds scattered around the city and connected (at least virtually) by a technological platform designed to act as a “bridge” between the social and health entities to disseminate information and coordinate activities.

But what happened in practice? Starting from the healthcare side, Paola and Francesca were the community nurses who usually managed the PD at the CNS office. When the researcher asked for the HSCI, they laughed and pointed to the computer on the main desk. The ethnographic excerpt below provides an example of everyday HSCI at the CNS.

> Francesca comes into the office and asks Paola if Mrs. Antonella is still waiting to be discharged [is still being processed by the software] because they are waiting for a telephone call from the woman’s daughter. She explains that the lady should have been discharged during the day, but the date of the

last blood sample for the Coumadin [anticoagulant drug] is missing, and so they must know if she has been discharged and obtain the date of the sample to plan the next blood test. Francesca says she has already called the two telephone numbers listed in the software, but in vain. […] She enters the woman's file in the software and notes that the contact has been forwarded to the Social Service and that the "social needs" box has been ticked. She says that she knows the lady, who lives alone in a small attic. The woman is sprightly enough, she says. In fact, she wonders who activated the request for social services: "Who told the HCU?" She calls the cellphone number listed, thinking that she will speak to the daughter, but soon realises that she is talking to the woman herself. She asks if she is still in hospital and if she knows when she will be discharged. "I don't know, maybe tomorrow, they told me," the woman replies. Paola tells her that she will call Villa Magnolia [the private clinic where Antonella was admitted] directly. She says goodbye and hangs up. She leafs through the phone book next to the computer, finds the hospital's number, and calls. After ten minutes she can talk to the nursing manager of the long-term care ward, after having introduced herself four times and spoken to five different people in different departments. She asks to confirm that the woman has been discharged, but the manager instead tells her that the discharge has been postponed to the following Monday. [...] She also informs Paola that the hospital will give the anticoagulant therapy. Paola asks why social services had been activated. The manager describes the woman as being "a bit at risk" because she has only recently started walking again and moves with difficulty. Considering that she lives alone, they decided to ask for the support of social services. They end the call, postponing everything until Monday, when they will speak to confirm the woman's discharge. (Note 21/11/2012)

The main task of the two nurses was to convert the digital data into instructions for the nurses who would provide in-home care to the patients. A ticked box on a software page alerted the community nurses that the social service had been activated. There were no further details, which led the nurse to ask for the reason for the activation, since she personally knew the patient's condition and considered

her to be relatively autonomous. Due to the structure of the service (and to the PD protocol), the social intervention had been defined at the "departure station" by the HCU. In the CNS, which entered the protocol at a later phase, the presence of the social services was noted based on the small amount of information in the software. In this case, a greater degree of HSCI was achieved through the information Paola obtained from the clinic manager by phone. Therefore, the telephone call, in addition to collating the needs and health care information from the different services, enabled a greater degree of HSCI, albeit without any contact with social workers.

The software permitted further convergence between the health and social entities by means of a screen containing a field for additional comments. When Francesca explained how the software worked, she stressed the importance of this field, since it often contained essential information for implementing the real intervention, which could not be provided in the predefined fields, as in the following case:

> The patient is currently a guest at Villa Rosa [private clinic], but after an interview today with her sister and niece, we've learned that they will go to the district social workers to better define a discharge pathway by putting her on a list for the residential care home. (Note 19/11/2012)

The CNS learned about the social workers involvement only from this annotation. The CNS acquired further details about the members of the household and their degree of involvement in their relative's illness. It was also informed about plans for the patient and the possibility of moving her to a residential care home. This kind of information was available because of the scrupulousness with which the hospital ward staff and later the HCU staff compiled the clinical documentation and the software fields.

These accounts show how communicative interactions between the social and health entities are mediated by the ICT platform. Communicative patterns are mainly *digital*: the emphasis is on the

informational content, and the semantic structures are codified, hierarchically arranged, and spatially and temporally delimited (Watzlawick et al., 1967). The above excerpts illustrate how the digital information needs to be decodified and adapted to the patient's specific circumstances. They also point out some practices to fill in the gaps in the organisational and technological infrastructures through informal activities and channels.

This form of integration is also revealed in the following "standard" exchange involving Maria, the SB operator in charge of "pre-processing" discharges that include social needs. The service is activated by email, and the "standard" exchange is as follows:

> Dear operators, I have to send a GAU (for Mrs. R. G. born in XXXXX (XX) on 12.03.1934 and resident in Via Roma, XXX. The contact person is the daughter, S.R., cell. 332-23232323. The individual care plan is open for sheltered housing. Please let me know, and thanks. Antonella Paoletti at Central. (Note 20/11/2012)

Maria's reply was:

> Good morning. The file has already been forwarded to social worker Rossi cc. to social worker Filippini. Best regards. (Note 20/11/2012)

This brief email conversation triggers the PD pathway on the social side. The social worker at the HCU has reported the woman's social needs to the competent CSS based on her address. The email from the HCU social worker is a product of the "departure station". In fact, the GAU request alerts operators to the presence of both health and social needs, even if SB staff is not allowed to know the specific nature of these needs. The task in this phase is to sort communications from hospitals that have adhered to the

PD protocol and transfer them to the CSS software. Although the same company that provided the CNS produced this software, the two systems were not compatible and cannot communicate with each other. It is therefore necessary to translate and adapt information so that the necessary data can be entered according to the functionality of each system.

The GAU is the "intermediate junction". It is here where the social and health entities meet to decide the pathway best suited for a patient according to his/her needs. The GAU consists of an interprofessional team that meets at the patient's home (or hospital or residential facility) and includes a geriatrician, a nurse from the CNS, and the social worker in charge of the case. The role of the GAU is to assess the specific case by combining the different skills of the professionals involved to gain a multi-dimensional perspective. It is a crucial stage in allocating health and social resources. Nevertheless, during the period in which the observation took place, it was the cause of the main flaws in the system because of the delay in convening the meetings – leading to significantly fewer meetings and, as a result, a decline in the total number of cases that could be assessed. According to information provided by the social workers, the last GAU (convened in November) dealt with cases opened in September, generating a sort of temporal limbo for patients until the outcome of the GAU evaluation, which redirected the patient's pathway to the "arrival station". The main outcome of the GAU committee was the score of the Breve Indice Non Autosufficienza (Brief Index of Non-Self-Sufficiency) test, consisting of a disability scale particularly suited to the elderly population that analyses 10 items, each containing 4 ordered modalities and a score (min 10, max 100), which yields a numerical indicator of the severity of the person's disability. The items relate to both social and health aspects. This card completes the documentation compiled during the GAU, representing its main output as well as one of the main integration tools envisaged by the *mechanical* form.

The last phase of integration is the "destination station", where, once the procedures are established and the activities necessary to convert them into care actions have been fulfilled, health and social interventions become effective on the patients' bodies. The nursing component attends to the body's suffering: sores, blood samples, medication, and anything connected to these, including the education of family members and caregivers in providing specific kinds of care. The social component is responsible for: personal hygiene, cleaning the patient's home, and everyday activities (doing the shopping, going to the doctor, etc.). The two lines of action are independent of each other, just like the *parallel railway lines* that end at the "destination station", i.e., the body. Following the procedure, the care recipient (the patient and his/her needs) multiplies: the health and social side know and act on different objects, though the sick person remains the same. Only by assuming the sick person's point of view, or that of a family member, can one understand the non-synchronised movements of the two entities at the arrival station. This form of HSCI clearly reproduces what Mol (2002) has shown to occur in medical practice, with the proliferation of specialisations and ontologies around what she named "the body multiple". From an organisational point of view, emphasis is placed on the rationalisation of procedures and on formal accountability systems, both common features of the standardisation process in healthcare organisations (Timmermans and Berg, 2010). Morgan (1998) noted how this can hinder joint working: "High degrees of specialization can create myopic views because there is no overall grasp of the situation facing the enterprise as a whole; and mechanistic definition of job responsibilities can encourage many members to adopt mindless, unquestioning attitudes" (p. 33). In the *mechanical* form, integration clearly emerges only in the final step of a process coordinated by bureaucratic and technological systems while remaining thin between services and professions.

Cultural integration

The HSAC includes all the actors involved in HSCI: community nurses, social workers, health care assistants, care service heads, and administrative staff. The two entities coexist both institutionally and physically within the same service, whose mandate is defined by organisational protocols developed jointly by the LHA and the municipality. The workers belonging to the two entities follow adjacent paths delimited by their specific professional fields – the boundaries of which are not, however, always sharply defined but which routine interaction has made familiar to both groups. Integration takes place through constant "exposure" to the other professional group amid the unfolding of everyday practices and the constant problem solving that characterises situated work (Alby and Zucchermaglio, 2006), thereby encouraging organisational sense making (Weick, 1995).

The HSAC achieves HSCI through two main elements: specific infrastructural conditions and collaborative rituals. The former concerns the co-presence of the two entities and specific organisational devices, such as the Local Operational Unit (LOU), which brings about reciprocal coordination. The latter concerns both formal and informal rituals that increase interdependence among professionals and promote identification within the service, thus acting positively on social cohesion, not only within the same professional group, as occurs more frequently, but also among all the practitioners involved (Friedkin, 2004).

Infrastructural conditions. The co-presence within the same organisational space of all components plays a significant role in achieving integration. The following excerpt illustrates how the everyday routine of the service operators is strewn with opportunities for integration.

> I am shadowing Stefania, the nurse who works in the reception office, while she is entering data into the computer. Gisella, a health care assistant, comes into the room, approaching

> Stefania's desk without saying anything. Stefania looks up from the computer, smiles, greets her, and asks if she needs something. Gisella returns the greeting and says that she has a question. Stefania tells her to sit down. She shows the nurse a discharge letter for a patient, containing the acronym "UTI". Gisella wants to know what this means, since they must activate the Home Care Service. Stefania takes the letter and reads it, admitting she doesn't know the meaning either. She repeats it out loud with a quizzical tone of voice. To find the meaning, the nurse searches for information in the electronic health records. Stefania also asks if she can make a photocopy of the document, since she has not received it and wants to keep it on file. Gisella is reluctant because she does not know the procedure and does not want administrative or privacy problems. Stefania insists, reassuring Gisella at the same time. On reading the information contained in the computerized clinical file, Stefania discovers the meaning of the acronym: urinary tract infection. We all burst out laughing, given the simplicity of the meaning. Stefania hands the document back to Gisella, after making a photocopy. Gisella gets up, thanks the nurse, says goodbye, and leaves the office. (Note 10/02/2013)

This episode exemplifies how logistical proximity and informality foster integration of the health and social entities. The materiality of the infrastructural framework facilitates discussion and comparison between the social and health components. Professionals are involved in practices embedded in physical places with shared symbolic references and informal rituals developed around a common domain (the continuity of care), which helps to develop a *community of practice* of HSAC practitioners (Wenger, 1998). Communicative interactions between health and social professionals are mainly *analogic*. They occur uninterruptedly through a dynamic in which the emotional component plays the primary role (Watzlawick et al., 1967). The informal coordination involves channels that are not immediately apparent and consciously governable, such as non-verbal communication and common

symbolic references. The development of reciprocal trust and shared values is essential to overcoming professional barriers that usually hinder HSCI (Glabsy, 2017). Shared language and symbolic repertoires also facilitate the building of a common identity and a greater sense of belonging to the interprofessional group (Reeves et al., 2010).

The HSAC also provides specific operating devices that facilitate integration, such as the LOU, which are meetings to evaluate the social and health needs at the patient's home. Below is an extract that deals specifically with one of these meetings in the home of an elderly lady.

> Along with Federica (care service head) in the room are Angela (community nurse), Giovanna (health care assistant), Graziella (GP) and Karina, the elderly lady's live-in professional caregiver. We are all standing, except for the GP, who is sitting at the table in the middle of the room with papers and documents spread out in front of her. On entering, we introduce ourselves to the doctor, who does not pay us much attention. It is Angela who handles the situation. She first asks the caregiver where the family members are, and if they will be coming to the meeting. The woman replies that they have commitments in the city where they live and cannot come. Federica explains that there has been an emergency activation of the HSAC to assist the caregiver in taking the lady home. The doctor appears to be concentrating on filling out the forms and seems a little concerned by what is happening around her. Angela asks the caregiver why the woman was hospitalized. Before she can answer, the doctor intervenes by saying that there were fears of a stroke because the woman had become aphasic and unable to walk. […] The doctor stresses that the woman's elimination of urine must be monitored. The nurse notices that the anti-decubitus mattress is turned off and points this out to the caregiver. She says that the mattress must always be turned on and shows her how to adjust it to the person's weight. The caregiver nods and apologizes, saying that no one had explained to her how it worked. Both the nurse and the

> doctor reassure her by saying that nothing has happened and that she will gradually learn. Angela says: “Just as you have taught me something about the lady, I’ll teach you something, if I can”. The doctor asks about other types of mattresses, and the nurse replies that the mattress is already anti-decubitus. The doctor had never seen that model. The care service head suggests that Angela bring a urine evacuation card and explain how it works to Karina. (Note 04/10/2013)

The LOU is a genuine occasion for discussion and situated learning for the different practitioners, each of whom offers the information that s/he possesses and, at the same time, completes his/her own knowledge by drawing on the common repertoire created during the meeting. The discursive register is pragmatic, oriented towards solving the problems related to the specific case. In the above excerpt, for example, the GP is not particularly open in her interactions with the others. She is isolated from them in performing her role, remaining within her institutional mandate, which mainly consists of fulfilling administrative requirements (she never approached the patient except to show a bedsore to the nurse). However, despite her reluctance to listen and discuss (generally considered “standard” prerequisites for collaboration), integration emerges from the succession of interactions: the informational picture of the patient is gradually completed, like a jigsaw puzzle, as the various professionals add pieces of different shapes. The need to resolve situated problems forces those present to share the same focus, centred on the condition of the elderly patient, whose home is “neutral terrain” for the professionals involved, all of whom are distant from their usual work environment characterised by symbols and rituals that convey status and power relations to themselves and others (Hudson, 2002). The uprooting produced by the neutrality “throws” the practitioners into a new environment they cannot control on their own, thus causing them to redefine role boundaries. This may lead to alliances being formed with the other professionals in an attempt to curb the natural anxiety caused by new sources of uncertainty and

produce a shared narrative that conveys to each of them the sense of what is happening amid the critical complexity of everyday situations (Weick, 1995).

Collaborative rituals. The second set of elements that facilitates cultural integration is collaborative rituals. For reasons of space, ethnographic excerpts are not presented; instead, their distinctive features are outlined. The clearest example is the coffee ritual.

Each morning someone went to Maria Luisa's (the social manager) office to make coffee. Near her office were a sink, a small table with a hot plate, and everything needed to make coffee. Though there were no set times or a specific person responsible for this task, it frequently fell to Stefania, the nurse at the reception desk, who everyone considers a true coffee connoisseur, not least because of her Sicilian origins. Nor were there specific "partakers". As the aroma wafted through the office areas, other workers were attracted, joking about if there was a cup for them; some would go around asking if anyone wanted coffee. It was not rare for two coffee makers to be filled to satisfy all. There were usually biscuits or cakes brought by a staff member or donated by users to nurses or social workers. This ritual was important to all the nurses and social workers in the head office, who, together with the administrative staff at the HSAC, could step out of their professional roles without interrupting the workflow.

The coffee ritual was often the occasion for exchanging views on recent or pending organisational issues, though in an informal and relaxed atmosphere removed from the participants' professional roles. Moreover, the professional dimension often overlapped the personal one, where personal anecdotes or experiences were shared.

Another collaborative ritual was the monthly team meeting called by the HSAC manager (a physician) and organised together with the social and nursing managers. The service operators at the head office

and those working at the city hospitals attended these meetings. Normally, around twenty people met in the early afternoon, when as many operators as possible could attend, given their different service hours. The health care assistants were the most penalised, since it was difficult for them to return to the office in time. Their managers, the care service heads, represented them. The agenda involved issues noted by the managers in the current month, along with organisational or service communications. The participants sat around the two central tables or moved their chairs against the walls so as not to turn their backs on those present. During these meetings, someone would brew coffee while waiting for all the operators to arrive. The communicative register combined the formal requirements of service management with informal conviviality. The turns of speech were managed in a relaxed but orderly way by the physician, who repeatedly demonstrated an ability to understand the points of view of both services and whose leadership both health and social practitioners recognised.

The discussion centred mainly on two themes: changes in the organisation of services and an analysis of problem cases. The nurses and social workers took turns asking each other questions about the progress of certain specific cases and for clarification of technical terms or procedures. For example, social workers often employ the term “contract” to refer to their activities, and during a meeting a nurse asked for clarification of the meaning, because she suspected it was different from what nurses normally give to the same word. The subsequent explanation enabled the nurses to learn more about the specific tasks of the social workers and their working practices.

Collaborative rituals contributed to *cultural* integration in the HSAC. The informal climate and possibility to share one’s private life strengthened social cohesion within the working group and generated reciprocal trust and familiarity regarding professional relationships, thereby reinforcing integration between the different service entities (Sennett, 2012). This produces “professional intimacy” between the health and social actors – that is, a mixture of intense interactions aimed at

solving shared problems and a sense of belonging and a diffusion of responsibility through which communities of practice are maintained (Wenger et al., 2002). These rituals are related, albeit with different nuances, to the identity of the service through participation in a shared experience constantly produced and reproduced in the everyday unfolding of workplace relationships (Reeves et al., 2010).

Concluding remarks

This article discusses how the form taken by HSCI depends on the underlying dynamics. While HSCI health policies and organisational procedures are well defined, the situation is different in daily practices. The ethnographic study of the two different organisational contexts highlighted two forms of integration labels, which we named *mechanical* and *cultural*, that refer to Morgan's organisational metaphors and highlight their distinctive features and radical diversity. *Mechanical integration* is characterised by the prevalence of codified and hierarchical forms of coordination and the substantial isolation of the various professional groups, with limited pre-existing contact opportunities. Under these conditions, integration is mainly achieved in the final product, through the independent and uncoordinated delivery of specific social and health services. In *cultural integration*, codified tools combine with informal coordination activities based on face-to-face interactions and the sharing of knowledge, values, and goals. Integration takes place in daily formal and informal interactions between the two entities and in the development of professional intimacy (Wenger et al., 2002). The former refers to analyses in recent decades on the standardisation process in health organisations, which warned of the risk of a fragmentation of work practices and professional hyper-specialisation (Mol, 2002; Timmermans and Berg, 2010). The latter refers to Wenger's (1998) concept of "community of practice", which describes the community of skilled professionals as having a common interest in the same objective – the continuity of care – and with shared values and knowledge. This is not risk free,

either. In fact, integration is the achievement of a cohesive community, and the strong internal cohesion on which the efficacy of the service is based may create a strong attachment to the service culture, thereby hindering organisational innovation or further integration with other services.

Our work did not intend to benchmark or assess these two forms, a shortcoming that future research might address by assessing organisational outcomes or user satisfaction. However, the results of the study point out the effect of the governance system and organisational properties on the form of HSCI. If social institutions (e.g., municipalities) fully delegate the responsibility of social services to health institutions, as described in the first case, then it is very likely these services will conform to the latter's goals and standards. Our results suggest that public policies need to be clear about the form of integration they seek to achieve. If they look for product integration, the mechanical form is the most appropriate; however, if they want process and professional integration, then cultural integration is preferable. In this case, ICTs are undoubtedly useful but not enough. Our study confirms the need to manage interactive contexts in which technologies are involved (Barr et al., 2017). To stimulate informal co-ordination, mutual trust, and professional reciprocity, contexts involving analogic communicative patterns are needed, in which the emotional dimension of the healthcare professionals is also expressed. In the first case study, where ICT is considered the main connection between the two entities, process or professional integration is not achieved. In the second, where ICT is complementary to other socio-organisational factors, such as co-presence and collaborative rituals, the result is a cohesive community of practice, which does not depend upon technology itself but upon the context of use (Greenhalgh, Stones and Swinglehurst, 2014).

Our study also suggests that managers act as intermediaries between the social and health worlds, like the physician manager of the HSCI service in the second case. This figure clearly derives from the "new professionalism", according to the established trend that sees managerial functions more and

more held by medical professionals. As Tousijn (2012) indicated, this figure must play an operative role in the field by considering the needs of both entities, not just by interpreting the health side. Finally, we concur with Glasby (2017) that it is necessary to further develop our ability to build social and health integration settings. However, our work shows that, in everyday reality, different forms of HSCI are achieved to help people with their medical and social needs. We must understand what kind of integration we desire for the welfare of the third millennium, and then act accordingly.

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Appendix I - List of abbreviations

CNS: Community Nursing Service
CSS: Community Social Service
GAU: Geriatric Assessment Unit
GP: General practitioner
HCU: Hospital-Community Unit
HSAC: Health and Social Care Access Centre
HSCI: Health and Social Care Integration
LHA: Local Health Authority
LOU: Local Operational Unit
PD: Protected Discharges
SB: Social Bureau

Notes

1 Due to the complex organisational structure, extensive use of acronyms is employed in what follows. Appendix I contains a list of the abbreviations used in the text.

2 These terms are inspired by Morgan's work on metaphors of organisational life (1998).

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