Journal of Critical Public Health, **Volume 3 (2026), No. 1, pp. 57-72**

Research Paper

Negotiating the dilemmas of health system governance: A decentred analysis of integrating care systems

Justin Waring[1*], Simon Bishop[2], and Bridget Roe[3]

[1] School of Social Sciences and Humanities, Loughborough University, Loughborough, UK; [2] Nottingham University Business School, University of Nottingham, Nottingham, UK; [3] Health Services Management Centre, University of Birmingham, Birmingham, UK.
* Corresponding author: Justin Waring, j.waring@lboro.ac.uk

Across high income countries, policy makers seek to reform their health systems to promote public health, address long-term care needs, and reduce the burden on acute care. Policy narratives articulate a model of health system governance premised on multi-agency collaboration and service integration. Combining decentred theory with the negotiated order thesis, this paper examines how local policy actors interpret and negotiate the dilemmas presented by such reform in the context of their customary ways of working. Reporting on the findings of a three-year study of the introduction of Sustainability and Transformation Partnerships in the English health and care system, we focus on how policy actors negotiate the dilemmas manifest around the vision and priorities for, and the governance of, health system change. In each area, we show that structural interests and governing traditions shape actors' orientation towards system change. This results in tensions that are resolved (or not) through localised negotiations between policy actors, which vary according to whether they were open or closed, structured or emergent, and whether they had a significant or limited impact on system governance. The paper shows that health systems reform is contingent upon how local policy actors translate and negotiate policy narratives.

Introduction

Across high income countries, policymakers are facing multiple challenges associated, for example, with aging populations, technological change, and resource contraints (McKee et al. 2021). In response, policymakers increasingly seek to reconfigure national and regional health systems to promote public health and provide more integrated person-centred care (Goodwin et al. 2021, World Health Organization 2016). In many high income countries, these ideas are expressed in the narratives of 'population health management' and 'integrated care systems' and tend to articulate a model of governance in which multiple agencies work together to redesign care services around the long-term

needs of local communities (Buck et al. 2018). Locating this narrative in the literature on public governance, there is emphasis on the role of collaboration as a basis of consensus-based decision-making (Ansell & Gash 2008, 2012). In this paper we develop a decentred analysis of this policy, focusing on the introduction of integrated care systems in the English health and care system. Taking a decentred approach (Bevir & Richards 2009, Bevir & Waring 2017a, 2017b), we examine how local policy actors give meaning to contemporary policies in light of their particular traditions, and interact to shape the emerging patterns of governance in the formulation and implementation of integrated care systems. Recognising that actors perceive the opportunities and threats of change in different ways, according to their distinct traditions and interests, we seek to understand how these differences play out in their negotiations. To this end, we engage critically with the 'negotiated order' thesis to offer complementary insight into the way public governance narratives are negotiated (Strauss et al. 1963). The negotiated order thesis has its roots in symbolic interactionism and, like decentred theory, offers a critical alternative to more structural or institutional explanations of social organisation by focusing on the micro-level interactions through which social order is contested and settled.

Towards Integration in the English Health System

Over the course of the twentieth century, Western health systems had typically prioritised the delivery of specialised hospital services to the neglect of primary, community or public health services. Since at least the 1970s, there have been growing calls for the development of more integrated health and care services (Glasby 2017, Goodwin et al. 2021). Although there remain debates around the definition of integration, with the term often used interchangeably with coordinated or person-centred care (Goodwin et al. 2021, Glasby & Miller 2020, Valentijn et al. 2013), we are interested in the way it is used to describe a model of care in which multiple agencies work together to better address the complex health and care needs of populations, which might involve sharing of knowledge, resources and facilities, new overlapping management arrangements, and/or inter-professional working. These agencies could include health care services (primary, secondary and community), social care providers, housing, education, transport and employment services.

In England, the contemporary integration agenda emerged in the 1990s with New Labour's efforts to modernise public services through more collaborative multi-agency working (Ferlie et al.,2012, Newman 2001). Since this time, a plethora of policy initiatives have promoted the integration of English care services, including Integrated Care Pilots (later 'Pioneers'), New Care Models ('Vanguards'), Sustainability and Transformation Partnership (STPs), and now Integrated Care Systems (ICSs) (NHS England 2019). It is important to make two contextual observations about the English integration agenda. First, service reforms have unfolded in the context of sustained financial austerity and cuts in public funding, especially in the social care sector, and so integration policies are often aimed at making efficiencies as much as joined-up working. Second, many integration initiatives were introduced as remedial solutions to the re-introduction of market mechanisms in the 2010s that fragmented care services in the Health and Social Care Act 2012.

The narrative of the 'integrated care system' represents a step-change in policy in which the geographic area becomes the primary object of governance (Bishop 2020). Integrated care systems (covering approximately 1-2 million people) are typically configured to align with county or municipal boundaries, or in some cases encompassing two or more districts or municipalities that form part of a larger metropolitan conurbation; for example, within cities such as London or Birmingham. Integrated care systems are further sub-divided into 'place' (250-500k people) and 'neighbourhood' levels (30-50k people), to which reconfigured services across acute, primary and community care could be aligned (Kings Fund 2022). As of 2024, the English National Health Service (NHS) is organised into 42 Integrated Care Systems meaning that each usually includes one or two local authorities and their social

services functions, one or more NHS secondary hospitals located in significant towns or cities, associated primary care services, and then a range of other public and private agencies involved in the provision of care.

These reforms initially took the form of 'Sustainable Transformation Partnerships' (STPs) introduced in 2016 to bring together key health and care agencies to develop plans for preventative and integrated 'place-based' care (NHS England 2019). Initial policy priorities for STPs included primary care, prevention, early intervention, mental health, maternity and early years, productivity, and workforce development. Each involved the creation of new governance structures wirh representatives from constituent care organisations brought together to collaborate in the formulation and implementation of a portfolio of transformation projects. Of relevance to this paper, STP leaders lacked formal statutory authority and so efforts to hold care organisations to account were difficult (Moran et al. 2021), with actors collaborating on the basis of goodwill and persuasion (Waring et al. 2023). The subsequent *NHS Long Term Plan* proposed that STPs would become the foundations for new Integrated Care Systems (ICSs) (NHS 2019). Other than nomenclature, a major change was the creation of Integrated Care Boards (ICBs) as statutory bodies with responsibility for planning and commissioning care within the geographic boundaries.

Locating the English integration agenda within public policy literature, it reflects a broader shift away from bureaucratic planning and market competition towards a more collaborative model of public governance (Klijn & Koppenjan 2012, Osborne 2006). The argument for integration is underpinned, for example, by the idea that the complex health problems facing communities can only be addressed through multiple policy actors working together in joined-up way, sharing resources and developing innovative policy solutions (Newman 2001).

Notwithstanding the rhetoric of collaboration, there remain significant challenges to engendering integration. Kaehne (2018) suggests integration is complicated by the incompatibilities between professional values, governance arrangements, and funding systems that distinguish the health and social care sectors. Waring and Crompton (2020) describe dilemmas faced by system leaders when confronted with the competing interests and the authority of dominant groups. Such research demonstrates that there is a gap between the policy narrative of integration and the plurality of competing interests (Bevir & Waring 2017b). The specific controversies that complicate health system change relate to the reallocation of *roles* (who does what), *relationships* (who works with whom), *responsibilities* (who is in charge) and *resources* (money, people, infrastructure) (Waring et al. 2023). How then, do local policy actors interact to shape that patterns of governance that form in the formulation and implementation of integrated care systems?

Towards a Negotiated Dilemmas Perspective

To answer the above question, we develop a decentred analysis of the governance of integrated care systems (Bevir & Richards 2009, Bevir & Waring 2017a, 2017b). Decentred theory suggests that patterns of governance cannot be explained with reference to mid-level theories of bureaucracy, market or network, rather governance arrangements are realised through the meaningful actions of policy actors who interact on the basis of their diverse beliefs and histories. Here, meaningful action foregrounds actors' interpretation of prevailing or preferred arrangements and how these interpretations are anchored in particular systems of meaning that reflect history, position and ideology. A decentred approach deploys the concepts of tradition and dilemma to account for the way policy actors respond to changing govrnance arrangements or narratives. Tradition is understood as the acquired meanings, values and interests that guide social action, albeit in a non-deterministic way. Actors engage in governance arrangements on the basis of their beliefs and value systems that provide a normative guide to what is appropriate and desirable. Decentred theory recognises the plurality of traditions and the potential for conflict to arise from actors diverse values and interest. The concept of dilemma is used to understand

how changing social, environmental or political circumstances call into question social actors' beliefs and traditions, requiring them to both enact *and* adapt their traditions in light of novel circumstances. This includes, for example, responding to policy narratives that call for new forms of governance, which might disrupt establish customs and practices. Such dilemmas call for actors to engage with, contest and re-construct policy narratives on the basis of their particular traditions, which in turn, (re-) create patterns of governance. In the case of integrated care systems, policies introduce a radically different model of care that presents almost all actors with dilemmas in terms of how they fit in and work within the new system, and in this context these actors will adapt both themselves and the governance landscape in ways not always anticipated by policy.

With its emphasis on the meaningful actions of policy actors, decentred theory shares many ideas found within the field of symbolic interactionism. Symbolic interactionism focuses on the idea that social life is ordered through the everyday interactions between social actors who recursively make sense of and react to their world through their interactions with others. We draw, in particular, on the negotiated order thesis to enrich the decentred approach and provide additional insight into how public governance arrangements are constructed through the negotiations of policy actors. The negotiated order thesis was developed by Strauss and colleagues (1963) through their research on the social organisation of hospital work. They argued that hospital work was organised, less on the basis of formal rules and structures, and more through the situated negotiations of healthcare actors. In a vast array of different circumstances (what we might consider micro-dilemmas), the everyday routines and patterns of care work were ordered through micro-interactive forms of persuasion, bargaining, and uncooperative behaviours. These dilemmas related, for example, to the timing and distribution of work; accepted values and goals; inter-group relations; and demarcations between professional groups, and all were resolved through face-to-face negotiation.

In light of criticism that the thesis neglected structural and historical influences, Strauss (1978) later developed the idea that negotiations are framed by a 'structural context' comprising the established hierarchies, rules and relationships within the given setting, and the specific 'negotiation context' that comprises the range of actors, the basis of disagreement, and the opportunities for interaction (Maines & Charlton 1985). However, the negotiated order thesis continues to be criticised for its inattention to the socio-historical context of negotiations, the structures of power that contextualize actors' involvement, and the vested interests that frame negotiation (Allen 1997, Day & Day 1977, Hall & Spencer-Hall 1982). That said, it offers an important lens for analysing the micro-level interactions through with social order is contested, negotiated and settled, with a rich literature describing trade-offs, deals and pacts, compromises, exchanges and silent bargains (Day & Day 1977, Maines & Charlton 1985, Mesler 1989, O'Toole & O'Toole 1981).

We suggest there is analytical benefit in bringing together decentred theory and the negotiated order thesis to examine how changing patterns of public governance (or order) are constructed through the negotiations of multiple policy actors acting on the basis of their particular traditions. In complementary ways, both perspectives attend to how influence and power play out through the meaningful actions of actors in the shaping of social order. Symbolic interactionism foregrounds how meanings and patterns of social organisation are constructed through micro-level negotiation, but not always with consideration to the broader traditions and positions of actors. Decentred theory provides additional understanding of how meaningful interactions are framed by actors' particular histories and traditions, as well as their social positions, which together shape how their make sense of and react to dilemmas. Bringing together these ideas, policy narratives around integration create dilemmas around the reallocation of roles, resources, relationships and responsibilities that become the contexts for negotiation, and where the negotiation and resolution of these dilemmas shapes the emerging patterns of governance, albeit where actors interact from unequal social positions.

Study Context and Methods

Our paper draws on a qualitative study carried out between 2018 and 2021 on the governance and organisation of three STPs within the English NHS. The study received favourable ethical review by the University Nottingham Research Ethics Committee. Following a desk-review of all 44 STPs, three sites were recruited taking into consideration the number, size and range of health and social care organisations, wider demographic variations in terms of population size and diversity, and the thematic priorities for change (see Table 1). The rationale for selection was to examine differences related to the configuration of local NHS services, especially the presence of large or prominent teaching hospitals, the concentration of associated community care services, and the configuration of local authority services.

	Case 1	**Case 2**	**Case 3**
Population	1.2 million	1.1 million	1 million
Geographical footprint	Three medium sized towns (c150,000 people) and villages, on edge of Greater London.	One medium sized city (c350,000), several towns and rural villages.	One medium-sized city (c250,000), several towns, large settlements (c100,000) and numerous smaller villages.
NHS Trusts (N)	6 incl. ambulance	4 incl. ambulance	5 incl. ambulance
Other Care Services	Community health social enterprise	Community health social enterprise	Private Community Interest Company
Local Authorities (N)	1	2	2

Table 1. Summary of STP characteristics

Semi-structured interviews were the primary method of data collection. Recruitment was based on a participant's involvement in the governance of each STP, broadly defined. Participants were identified through a review of public documentation that identified STP leaders and other prominent roles; with further participants identified through snowball sampling with gatekeepers and through field observations. In total, 72 people participated in 83 interviews across the three STPs (Case 1=26, Case 2=32, Case 3=14) (See Table 2). Interviews followed a topic guide that enquired about participants' experiences and understanding of the evolving organisation and governance of the STP including the development of strategic plans, leadership and governance arrangements, plans for resource sharing, the prioritisation of activities, and examples of service change. The interviews focused on the controversies or disagreements experienced in formulating and implementing system changes, and how these were resolved (or not). Interviews ranged from between 30 and 120 minutes with an average of around 60 minutes, and several senior leaders in each STP participated in multiple interviews to examine change over time. All study participants provided written consent before taking part in the research.

	Case 1	**Case 2**	**Case 3**
STP Leadership	• STP Chair • Transformation Lead • NHS Snr Mgmt (2) • Local Authority Lead	• STP Director • Local Authority Lead • Commissioners (2) • Medical Director (2) • Transformation Lead	• STP Director (2) • STP Deputy Director • Workforce lead • Facilities lead • Programme Mgmt

	• Women & Children's Lead • Medical Director	• Community volunteer	Plus 2 Focus Groups with Senior leadership team
Themes Leads and Projects Teams	• Acute care Managers • Commissioners (2) • Project managers (3) • Primary Care Managers • Medical Directors (2) • Patient/Public Reps. (2) • Medicines Lead • Pharmacy Lead • General Practitioner (GP) Representatives (2) • Community Care Lead • Quality Lead • Integrated Maternity Lead • Early Years Lead	• Acute Med. Director (2) • Programme lead (2) • Project Managers (2) • Communication Leads (2) • Commissioners (3) • Police rep • Urgent care Leads • Adult Social Care • Mental Health Lead • GP reps (9)	• STP manager • STP finance • STP strategy lead • Talent Manager • Project manager (2) • Cancer Care lead • Commissioner
Total N	26	32	14

Table 2: Summary of study participants

Field researchers also carried out non-participant observations of senior leadership meetings, committee meetings and project team meetings, which were recorded in field journals. The observations aimed to understand how disagreements and negotiations played out amongst different actors, in different settings and around different issues, informed by Strauss' (1978) negotiated order thesis (see below). In total, 28 senior-level or thematic meetings were observed over 49 hours (Case 1: 22 hours, Case 2: 22 hours, Case 3: 5 hours) dealing with matters of broad STP governance, strategic planning and project level governance. Many people also participated in informal 'in situ' conversations to clarify observations. As a result of the pandemic, almost all observations with Case 3 were carried out online, and two focus groups were carried out with staff in place of interviews. A large volume of documentary sources was collected for each STP to provide contextual understanding and inform sampling including: strategy documents, public online information, organograms, and information videos.

Analytical case summaries were produced for each STP, including: i) a narrative account of each case; ii) a summary of governance arrangement; and iii) a summary of key points of disagreement and controversy. Cross-case analysis focused on understanding the manifestation and resolution ofdisagreements (dilemmas) through the situated agency of local actors. Following Strauss (1978) this considered:

- The number and complexity of the *issues* being negotiated
- The options to *avoid* or discontinue negotiation
- The number of *negotiators* and their experience and the interests they represented
- The *occurrence and* significance of negotiation, e.g. one-shot, repeated, linked

- The relative balance of *power*, in terms of formal authority and informal influence
- The *interests* at stake, e.g. roles, resources, relationships, responsibilities
- The *visibility* of interaction (overt or covert)

Following this approach, the paper focuses on the dilemmas manifest around the *purpose*, *governance* and *priorities* for system change. *Purpose* relates to how actors provided differing narratives about what an integrated care system should aim to do, in terms of its purpose, the value of 'integration' and the meaning of 'the system' as a bounded place; and then how these were negotiated in the construction of an overarching narrative for change. *Governance* relates to the challenges faced in configuring, introducing and operationalising new accountabilities structures, and the negotiations that occurred around the allocation and enactment of leadership roles. *Priorities* relates to the debates and disagreements that unfolded around what each STP should aim to do in realising system change, in terms of a programme of work.

Findings

Negotiating the Purpose

Each STP had a high-level Partnership Board comprising senior executives from the NHS care providers, commissioning bodies, primary and community care providers, local authority social services, public health, and third sector representatives. Collectively they were responsible for the strategic leadership of each STP. Alongside the Board, each had a 'core' Senior Leadership Team responsible for translating the overarching strategy into a programme of transformation. In the early period, system actors made sense of the rationale for change in ways that provided the foundations for ongoing disagreement in the subsequent development of system reform 'plans', especially when leaders periodically called for a 're-boot' or 'refresh' of their strategy. As noted above, significant contextual factors were ongoing financial pressures, which were felt disproportionately by some sectors (e.g. social care), the prevailing governance expectations faced by individual organisations, and status disparities between care organisations, which together seemed to shape how groups interpreted the rationale for change in different ways accordingly their particular traditions, priorities and pressures.

Although senior leaders ostensibly supported the principle of a more integrated care system, there were underlying differences in how they conceived: a) the health priorities and needs of local communities; b) what constituted a local community or 'care system'; c) their assessment of deficiencies within the current system; and d) how a reconfigured system might address these needs. In short, actors interpreted both the nature of the problem and the possibilities of the solution in different ways.

To illustrate, it was common for commissioners, public health leaders and local authority representatives to see integration as addressing persistent health disparities that stemmed from a complex range of socio-economic and demographic factors. For this group, problems with the current care system stemmed from an overriding focus on curative medicine, rather preventive wellbeing. For a small number of public health and social care service leaders, this required a radical shift in service prioritisation towards more public health and community prevention, whereas for those in commissioning roles it was expressed as a more subtle re-balancing of care away from hospitals to primary care services. Those in the hospital sector recognised the importance of addressing the drivers of long-term health problems, but this seemed guided by a different understanding of deficiencies in primary and community services that resulted in inappropriate demands for hospital care, and so integration should be about ensuring 'the right patients were treated in the right places'. With their different readings of the problems, stakeholders held dissimilar views about the purpose and scale of integration, from more radical transformations to more targeted integration projects.

> In some areas it just seems like we are doing integration for the sake of it, I am not sure it is really needed (NHS hospital representative)

> You can't really argue against trying to make [county name] healthier but I am not really sure we are addressing the deeper problems…it's just a collection of improvement projects (Community care representative)

Such divergence seemed to condition the relationship between STP 'partners' especially about whose visions should prevail. These differences highlighted underlying disparities in status between local actors. The representatives from the community care organisations and local authorities often argued that leaders from specialist hospitals dominated thinking about systems working. Although leaders were committed to partnership working, they also remained responsible for the on-going functioning of their individual services, and so the idea of crafting a shared vision for system change seemed secondary to dealing with the day-to-day realities of their individual organisations.

Focusing on the experiences of one STP, the 'core' senior leadership team crafted a shared vision by consulting with the senior executives and other representatives of the main care organisations to better understand their distinct preferences. In parallel, they convened workshops with professional and managerial representatives to understand the overarching priorities for change. They also contracted external consultancies to carry out stakeholder analysis.

Across all three STPs, the visions for health system change were articulated as a series of statements that were so all-encompassing that no group could disagree, but also lacking in specific detail about what change might entail. These included, for example, a range of statements and principles that in different ways combined the terms '*joined-up'*, '*working together*', '*working better together'*, with '*for our communities'*, and '*healthier communities*' in combination with the name of the locality (these statements have been edited to preserve the confidentiality of participants). Although senior leaders questioned the meaningfulness of such statements, they seemed sufficient to articulate to wider stakeholders that the STPs had a purpose around which they could align. Arguably the crafting of these overarching master-narratives at the local level served to conceal or downplay the underlying differences between partners.

> It's about being inclusive… so people can feel engaged and inspired….I know how difficult it can be to try to force people, doctors, to accept change and it has to feel that it is driven by the community (Field interview with STP Director)

> We have discussed the possibilities…openly with many organisations, groups and individuals…but no decisions have yet been made and we remain open to the views of key stakeholders (STP Proposal documentation)

Negotiating Governance Arrangements

We next look at the dilemmas associated with each STP's governance arrangements, or what was termed 'system architecture'. Here, we identified disagreements relating to: a) the position of the 'core' leadership team; b) the formation and constitution of new committee structures and leadership roles; c) the introduction of new performance management channels; and d) the allocation of resources.

For each STP, the position of the core senior leadership team remained a consistent issue of controversy. This stemmed less from the Partnership Boards who delegated tasks to these groups, and more from middle-managers and professional leaders from across each system's care organisations who perceived this new groups as having significant influence, but without the corresponding legitimacy to wield influence. What made their position especially precarious was that, at this time, they had no formal authority in the prevailing systems of health care governance and so their position was openly questioned.

> We are in a precarious position. We are a small team and we don't really fit anywhere, but we are responsible for making sure the plans are taken forward (Field notes: STP Leader)

Such tensions were intensified in two of the STPs following the introduction of new performance management procedures that monitored the timelines and deliverables of transformation projects. Although project teams acknowledged the importance of oversight to ensure progress, they often questioned the position of STP leaders to use this information to overseer and hold to account individual projects:

> They have a role in providing that kind of high-level view, providing support and opening doors, but they shouldn't start using that kind of information to tell us what to do or how to do it…that seems like they are overstepping (Field notes: STP Project Team meeting)

Hospital managers criticised the burden of STP performance monitoring which were see as adding to or at odds with prevailing governance requirements in line with national policy and regulation. This again seemed to highlight the structural position of hospital leaders to more openly question and challenge the emerging governance plans.

> I am not sure what benefit this extra layer of governance is really having? They [STP leaders] can bring us together to work on shared issues, but they really can't tell us what to do, and they shouldn't be then trying to performance manage us (Hospital manager)

And yet, these core leadership groups easily weathered such criticism and rarely, if ever, needed to publicly justify their position. In one STP, efforts were made to present the core Senior Leadership team as facilitators of change, thereby downplaying their oversight role. It seemed that these groups were provided with a degree of 'air cover' by the senior-level STP Board members who comprised the executives from individual care organisations. That said, the lack of formal authority meant that the core teams had few formal levers with which to influence system change and so relied on more informal influence, deal-making and negotiation (as we describe below).

In other aspects of system governance, negotiation became more explicit during the composition of committees and projects teams. To illustrate, one STP established a group to coordinate a programme of change around 'urgent care' (covering unplanned care and emergency hospital admissions). The membership of this group was subject to negotiation because leaders from primary care, mental health service, and first responder services perceived the committee to be dominated by managers and clinicians from the acute hospitals. They argued that transformation efforts continued to focus on reducing the demands on emergency departments, rather than dealing with other urgent care needs. In such cases, senior STP leaders needed to intervene to reconstitute committees in more inclusive ways, but as noted above, lacked the formal authority to mandate membership, leading to heated disagreement.

> It's about being inclusive… so people can feel engaged and inspired … I know how difficult it can be to try to force people, doctors, to accept change and it has feel that it is driven by the community (Field notes: interview)

> It's so important to find the things that will keep them interested, it doesn't always have to be more resource or pandering to their egos, it is better when it's about the issues that really matter to the service and communities. (Theme lead)

Another focus for negotiation was found with the proposals for pooling and re-allocating financial and human resources. This featured at almost all levels of STP governance, from the Partnership Boards to individual Transformation Projects. We illustrate with an observation of the interaction between local commissioners and care provider organisations:.

> The cancer services lead describes a proposed project to expand community diagnosis and referral for cancers with long waits. This new pathway will need securing additional community locations, access to diagnostic equipment, and nursing and medical oncologist support. The commissioner emphasises that the business plan must be clear that change is cost-neutral overall and to be clear on longer term financial and clinical benefits. The STP manager asks about the anticipated stumbling blocks. The commissioning manager and cancer services lead both talked about the current demands in the Trust (large hospital) and the anticipated opposition of specialists to changing the currently funding model as this would risk existing services. The cancer lead talks about findings charitable funding. The STP lead then suggests thinking of non-financial inducements that might encourage hospital specialists to move some of their work to community locations: 'they go to the work, rather than the work going to them' and then they can be directly involved in setting up and overseeing the new diagnostic and referral pathway (Fieldnotes: Observation of meeting between commissioning lead, STP manager and cancer services lead)

From the perspective of the commissioners, finding ways to pool and share resources (finances, staffing and estates) was essential to supporting new models of integrated care. Proposals included, for example, moving specialist resources out of hospitals into community settings, repurposing clinics intended for one patient group to be used by others, or bringing together different care teams into new 'combined services'. From the perspective of many care providers, such resource sharing could prevent them delivering existing services, and there were common concerns about who would benefit and who would lose.

> Clinical, strategical and vision it is absolutely the right thing to do. … But internally, I haven't got the Trust to identify any funding, something has come via the [commissioners] for a small number of patients. Whilst the money seems to be the block, I don't really think it is, I think it is the resource in terms of capacity and frontline [NHS] staff to engage with it. We want to try it as proof of concept. (Medical Representative)

> [We're] supposed to be working together, but there will still be the financial directors of organisations that will want to maintain their books and balance the books. So, there is still that financial tension which has an impact, as well as workload issues that get passed across. So that integrating primary, secondary - the politics is to do with finance, their contracts, workload, and negotiating with drug pharma companies. (GP Lead)

In these quotes, money is emphasised as an underpinning reality to which all negotiations return, but the fixedness of money is also questioned, especially when considered in light of actors' relative position and influence within these system: in the first quote the medical representative directly challenges arguments focused on money, and in the second quote the GP attributes financial concerns to financial directors' wish to balance the books.

System leaders worked closely with Partnership Board members in closed backstage meetings to audit the profile of resources and to identify opportunities for resource sharing that might gain favourable to system partners. This involved a series of negotiations with the commissioners and project leaders to develop convincing business cases that any re-allocation of resources would have longer term benefits for these partners, even if it meant a relatively short-term reduction in resources.

Negotiating Transformation Priorities

We next look at the dilemmas that emerged in the context of formulating and implementing individual transformation projects. We focus on two common areas of dispute, the first relating to determining the

priorities for change within the broad thematic areas, and the second to managing individual project activities.

With regards to the dilemmas experienced in determining the thematic priorities, we focus on the negotiations observed with one STP's Mental Health Theme. Our observations of the thematic committee found that, whilst there was broad agreement about the need to reconfigure mental health services, there were different views about the priorities for change, which broadly reflected the tensions identified with the overarching vision for system change. To illustrate, clinical leaders from the large teaching hospital prioritised reducing demand on hospital admissions for people experiencing mental health problems; community mental health services advocated for the expansion of crisis intervention services; other third sector providers and patient representatives called for projects that expanded patient choice to support independent wellbeing and recovery; and police services called for interventions that reduced the demand of emergency services. Although these different perspectives could potentially be aligned as a coherent programme of work, there was little agreement about the priorities of change. This is because the capacity to expand community services was premised on releasing resources from other parts of the system, especially the hospital sector, but these resources were already committed to maintain the functioning of existing services. This created a type of 'Catch-22' dilemma in which the diversion of resources could only be made once demand was reduced, but demand could not be reduced until resources were diverted. The situation became something of a stand-off in which no one party was willing to invest or dis-invest without corresponding commitments from other partners. Over a series of meetings, the negotiations between partners became circular, where demands made by one organisation could not be fulfilled and at subsequent meetings other organisations would make similar demands of another partner to adjust their position. In seeking to resolve this stalemate, the thematic programme leader intervened in the negotiation process by introducing clear structures and expectations for individual partners. This involved, for example, requesting that those with broadly similar agendas work together to develop their business case for change, and at subsequent meetings these cases were subject to group analysis. By taking this approach to conflict resolution, the programme leader worked to displace the focus of attention on partners' different interests, and onto the specific cases for change.

> It's so important to find the things that will keep them interested, it doesn't always have to be more resource or pandering to their egos, it is better when it's about the issues that really matter to the service and communities. (Programme Lead)

Turning to another STP, we observed negotiations that took place around the merger of commissioning functions into one overarching agency to better coordinate resource allocation. Under NHS governance rules, such a change required consultation with local stakeholders. We found, however, that leaders started planning for the merger long before the consultation strategy was considered. Commissioning managers then faced the dilemma of needing to engage with primary care actors, but without first inviting these stakeholders to participate in the co-design of change. A formal post-hoc engagement strategy was enacted which involved the dissemination of proposal documentation; a website and communication campaign; and an online survey with public and professional representations. GPs were openly critical of this approach as it offered little opportunity for meaningful engagement. As such, a further series of engagement activities were arranged involving public engagement events or 'town hall' meetings, a series of focus groups with stakeholder, and a 'listening exercise' with GP representatives. This seemed to give the impression of an inclusive, democratic and legitimate decision-making process, but again, GPs questioned key procedural aspects of the overall decision-making process in public meetings. For example, a number argued that senior commissioning managers had agreed the proposal long before the consultation was planned and the majority of the GPs we interviewed described the decision as 'top-down' and the consultation processes as '*tokenistic'* and a '*rubber-stamping exercise*'.

> If they had done [the consultation exercise] before they merged the governing bodies it would have looked more like a consultation and less like a foregone event (GP1)

> It's been too little too late. We've been told that it's happening but we're not told that we could have a vote on it till very recently (GP4)

> They haven't … the consultations were a couple evenings … most GPs are too busy to attend in the evenings … anything you put on in an evening is not going to engage people (GP5)

Notwithstanding such criticism, and the limited scope for engagement, the STP leadership team pressed on with the planned merger and the voices of these groups remained marginal to the decision-making process. In this instance, claims to consultation or engagement were used to legitimise and push through a proposal that had already been devised.

Discussion

Our study examines how the governance of evolving integrated care systems is realised through the interactive negotiations of multiple local policy actors. The patterns of governing observed were not formulated by policy, but negotiated through the meaningful interactions of policy actors. The study focused on controversies related to the visions and purpose for system change, the governance of integrated care systems, and the priorities for system transformation, each of which highlights deeper tensions inherent to large-scale system change associated with the reallocation of roles, responsibilities, relationships and resources (Waring & Crompton 2020). The study shows that, for some, the prospect of health system change was viewed optimistically, in part because prevailing models of care constrained their role and so change was an opportunity to expand their role and status. For others, change was viewed as a threat to their established ways of working and associated privileges. Taking a decentred approach, policy actors' perception of and reactions to change were shaped by their distinct traditions, beliefs systems, structural interests and competing ideologies (Kaehne 2018). In particular, it is important to note the relative power and structural influence of these groups, with the former more often being marginal and less influence actors and the latter more central and dominant actors. This highlights the paradox of embedded agency, namely that those with more capacity for agency or influence are often least inclined to use it to bring about change, because they are privileged by the status quo.

We complement a decentred approach by engaging with Strauss' negotiated order thesis (Strauss et al. 1963) to examine the interactive tactics used by local actors trying to advance their preferences and interests, and how these negotiations shaped local governance arrangements. Our study echoes Toole and Toole's (1981) research on the negotiation of inter-organisational relationships, which are shaped by multiple overlapping contextual drivers found amongst differing societal, community, organisational and inter-personal preferences, and how negotiations were often settled through the inter-connected work of multiple skilled negotiators who worked across multilateral forms of influence. We found the dilemmas of change involved constellations of interacting actors and the structural position of these actors afforded enhanced scope for dealing with conflict, even where conflict stemmed from their own community or related to their own position. For example, professional elites in the form of medical directors and clinical elites continued to hold an influential position based upon their expertise and symbolic leadership (Waring et al. 2020), whilst commissioning managers retained authority over the allocation of financial and spatial resources (Waring et al. 2023). Returning to the above observation, it seems that marginal or less prominent actors engage in negotiation tactics through more formal or procedural means, such as developing business plans or project management. In contrast, more established or dominant actors engage in negotiation through more discursive representation and hidden channels. It might be suggested that those with less structural authority need to rely upon formal governance systems to 'prove' or

demonstrate their position, whereas those with incumbent influence are not compelled to engage in such 'due process', and instead engage in more limited activities.

By linking decentred theory and the negotiated order thesis, our study offers additional understanding of the types of negotiations that occur in the changing governance of health and care systems, and perhaps in other fields of policy activity. Such a typology is defined by whether negotiations are:

i) inclusive or exclusive;
ii) planned or organic; and
iii) have a significant or limited impact on governance.

Based on these dimensions we elaborate our study findings to propose four distinct types of negotiations, thereby adding to the literature on negotiated order.

The first type of negotiation is inclusive and planned, but the consequences are limited or incremental. For our study, such negotiations were observed with the scheduling of thematic programme committee meetings, where actors routinely discussed their different points of view, but where the significance of these debates was limited. These were manifest as '*staged managed negotiations*' whereby key actors steered the overarching structure and processes of deliberation, determined the parameters for negotiation, and sanctioned the outcomes of deliberation.

The second type of negotiation is more exclusive and organic, and also impactful. This could be seen when a relatively small group of senior system actors engage in closed deliberation and decision-making, often in backstage settings, to resolve major issues, such as the pooling of resources. These matters were generally not seen as amenable to open negotiation because the matters were of fundamental significance. As such, these resembled a type of '*exclusive negotiation'* amongst dominant elites.

Leading on from this, the third type of negotiation is inclusive and planned and presented as having a significant impact on resolving disputes, but in actual fact they have a marginal or negligible impact of system working (because the major decisions has been reached in exclusive negotiations as outlined above). This could be seen with the engagement processes around the changes in commissioning in which GPs were given the impression of engagement and shared decision-making. We conceptualise these as '*false negotiation'* where participants are likely to believe they have been influential and see the outcomes as more legitimate, but in actual fact the decisions were already made.

The fourth type of negotiation is where key actors consider an issue either not amenable to or worthy of deliberation, and so they refrain from engaging in negotiation with relevant actors. This type of '*non-negotiation'* occurs where an issue is either viewed as too significant or conversely as relatively insignificant. Both false negotiations and non-negotiations could be related to what Allen (1997) identified as a limitation of the negotiated order perspective; in that it tends to focus on explicit face-to-face negotiations, but giving less attention to other forms of action and interaction that aim to limit or avoid negotiation or giving the impression of negotiation. Combining negotiated order with the decentred thesis helps to overcome the criticism noted by Allen (1997), that questions the primacy of explicit negotiations above other forms of ongoing symbolic interaction. Instances of non-negotiation could be seen to illustrate the way in which existing power relations were already established within the discourse available to all actors.

Our paper sheds light on the way dilemmas in public governance are manifest and resolved through the interactive negotiations between policy actors. Bringing together the negotiated order thesis with decentred theory offers complementary benefits to each perspective. The negotiated order thesis benefits from closer attention to the role of history and tradition in shaping the negotiated context and the variable role of actors within the field of play. For example, it highlights the need to look to the wider ideological and economic context, the longer-term processes or histories of change, and in particular their relative status and power in the system of care. The decentred thesis benefits from closer attention to the situated interactions between policy actors as a form of negotiated exchange with variable settlements. In particular, it offers a framework for thinking about the way different histories and interests play out

through the ebbs and flows of on-going interaction and negotiation. Together, both perspectives help understand how the formulation and implementation of policies for integrated population health systems is contingent on the way change produces dilemmas for local actors and how these actors negotiate to resolve dilemmas, resulting in the particular forms of system governance.

By focusing on the negotiated dilemmas of health system reform, we also pose some broader questions of contemporary public governance. Health policy narratives continue to promote a model of governance based on collaboration and inter-agency working (Ansell & Gash 2008), often alongside or as an alternative to other narratives based on competition or bureaucratic planning. And yet, our study suggests such a model of public governance is, at best, difficult to realise or, at worst, utopian idealism. This is because the plurality of traditions and interests within the health and care system render notions of consensus and collaboration problematic. Those leading health system change are faced with the dilemmas how to foster power sharing, when the structures of power are institutionalised in the traditions and positions of social groups, or how to foster collaboration when social groups hold opposed preferences and interests. As argued by Mouffe (2011), the emphasis on consensus can downplay the irreconcilable ideological differences that define the way social groups engage or disengage in democratic decision-making, and which can be potentially productive of more radical social change.

Acknowledgments

The authors acknowledge Georgia Black, Jenelle Clarke, Mark Exworthy, Naomi Fulop, Jean Hartley and Angus Ramsay who contributed to the design and conduct of the wider National Institute for Health and Care Research (NIHR) study from which this paper is drawn.

Funding

This study was funded by the UK National Institute for Health Research (NIHR) (Health Services and Delivery Research) [NIHR 16/52/04]. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

References

Allen, D. (1997) The nursing-medical boundary: a negotiated order? *Sociology of Health & Illness*, *19*(4), 498–520. https://doi.org/10.1111/j.1467-9566.1997.tb00415.x

Ansell, C., & Gash, A. (2012) Stewards, mediators, and catalysts: Toward a model of collaborative leadership. *The Innovation Journal: The Public Sector Innovation Journal*, *17*(1), 2012, article 7.

Ansell, C., & Gash, A. (2008) Collaborative governance in theory and practice. *Journal of Public Administration Research and Theory, 18*(4), 543–571.

Bevir, M., & Richards, D. (2009) Decentring policy networks: A theoretical agenda. *Public Administration 87*(1), 3–14. https://doi.org/10.1111/j.1467-9299.2008.01736.x

Bevir, M., & Waring, J. (2017). Decentring health policy: traditions, narratives, dilemmas. In M. Bevir & J. Waring (Eds.), *Decentring health policy: Learning from the British experience in healthcare governance*. Routledge.

Bevir, M., & Waring, J. (2017) *Decentring health policy*. Routledge.

Bishop, S. (2020) Space and place in network governance: Putting integrated care into place. In M. Bevir & J. Waring (Eds.), *Decentring Health and Care Networks: Reshaping the Organization and Delivery of Healthcare* (pp. 95-120). Palgrave. https://doi.org/10.1007/978-3-030-40889-3

Buck, D., Baylis, A., Dougall, D., & Robertson, R. (2018) *A vision for population health*. King's Fund.

Day, R., & Day, J. V. (1977) A review of the current state of negotiated order theory: an appreciation and a critique. *The Sociological Quarterly*, *18*(1), 126–142.

Ferlie, E., Mcgivern, G., & FitzGerald, L. (2012) A new mode of organizing in health care? Governmentality and managed networks in cancer services in England. *Social Science & Medicine*, *74*(3), 340–347. https://doi.org/10.1016/j.socscimed.2011.03.021

Glasby, J. (2017) The holy grail of health and social care integration. *BMJ, 356*, j8-1. https://doi.org/10.1136/bmj.j801

Glasby, J., & Miller, R. (2020) Ten lessons for integrated care research and policy – a personal reflection. *Journal of Integrated Care*, *28*(1), 41–46. https://doi.org/10.1108/JICA-11-2019-0047

Goodwin, N., Stein, V., & Amelung, V. (2021) What is Integrated Care? In A. Volker, V. Stein, E. Suter, N. Goodwin, E. Nolte, & R. Balicer (Eds.), *Handbook of integrated care* (pp. 3-25). Springer.

Hall, P.M., & Spencer-Hall, D.A. (1982) The social conditions of the negotiated order. *Urban Life, 11*(3), 328–349. https://doi.org/10.1177/089124168201100305

Kaehne, A. (2018) Values, interests and power: the politics of integrating services. *Journal of Integrated Care, 26*(2), 158–168. doi 10.1108/JICA-01-2018-0007

Klijn, E.H., & Koppenjan, J. (2012) Governance network theory: Past, present and future. *Policy & Politics 40(*4), 587–606. doi.org/10.1332/030557312X655431

Maines, D., & Charlton, J. (1985) The negotiated order approach to the analysis of social organization. *Studies in Symbolic Interaction, Suppl 1*, 271–308.

McKee, M., Dunnell, K., Anderson, M., Brayne, C., Charlesworth, A., Johnston-Webber, C., … & Watt, R.G. (2021) The changing health needs of the UK population. *The Lancet,* 397(10288), 1979-1991. https://doi.org/10.1016/S0140-6736(21)00229-4

Mesler, M.A. (1989) Negotiated order and the clinical pharmacist: the ongoing process of structure. *Symbolic Interacteraction, 12*(1), 139–157. https://doi.org/10.1525/si.1989.12.1.139

Moran, V., Allen, P., Sanderson, M., McDermott, I., & Osipovic, D. (2021) Challenges of maintaining accountability in networks of health and care organisations: A study of developing Sustainability and Transformation Partnerships in the English National Health Service. *Social Science & Medicine*, *268*, 113512. https://doi.org/10.1016/j.socscimed.2020.113512

Mouffe, C. (2011) *On the political.* Routledge.

Newman, J. (2001) *Modernising governance: New Labour, policy and society*. Sage.

NHS England (2019) *The NHS Long Term Plan*. NHS England.

Osborne, S.P. (2006) The new public governance? *Public Management Review*. *8*(3), 377-387. DOI: 10.1080/14719030600853022

O'Toole, R., & O'Toole, A.W. (1981) Negotiating interorganizational orders. *Sociological Quarterly, 22*(1), 29–41. https://doi.org/10.1111/j.1533-8525.1981.tb02206.x

Strauss, A. L. (1978) *Negotiations: Varieties, contexts, processes, and social order*. Jossey-Bass

Strauss, A., Schatzman, L., Bucher, R., Ehrlich, D., &. Sabshin, M. (1963). The hospital and its negotiated order. In E. Freidson (Ed.), *The hospital in modern society* (pp. 147-69). Free Press.

Valentijn, P.P., Schepman, S.M., Opheij, W., & Bruijnzeels, M.A. (2013) Understanding integrated care: A comprehensive conceptual framework based on the integrative functions of primary care. *International Journal of Integrated Care*, *13*. e010. doi: 10.5334/ijic.886

Waring, J., Bishop, S., Black, G., Clarke, J. M., Exworthy, M., Fulop, N. J., ... & Roe, B. (2023) Navigating the micro-politics of major system change: The implementation of Sustainability Transformation Partnerships in the English health and care system. *Journal of Health Services Research & Policy*, *28*(4), 233-243. https://doi.org/10.1177/13558196221142237

Waring, J., & Crompton, A. (2020) The struggles for (and of) network management: an ethnographic study of non-dominant policy actors in the English healthcare system. *Public Management Review, 22*(2), 297–315. https://doi.org/10.1080/14719037.2019.1588360

Waring, J., Roe, B., Crompton, A., & Bishop, S. (2020) The contingencies of medical restratification across inter-organisational care networks. *Social Science & Medicine*, *263*, 113277. https://doi.org/10.1016/j.socscimed.2020.113277

World Health Organization (2016) *Health system transformation: Making it happen*. World Health Organization.