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Research Paper

Disrupted rituals and relational ruptures: A decentered approach to integrated working in the English National Health Service

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The implementation of Integrated Care Systems as statutory in the English National Health Service represented a significant shift away from service competition to service collaboration and 'disrupted' how services were organised and how different organisations interacted. Challenges of integrated working are well known, including differences in service organisation, funding, IT systems, and organisational cultures, and good communication with high levels of trust is essential for successful collaboration. The COVID-19 pandemic placed additional pressures on integrated working through the introduction of remote working for interactions traditionally performed face-to-face. Using the findings of two related qualitative studies conducted within integrated care systems, this paper combines a decentred theoretical approach with interaction ritual chain theory to understand how senior and front-line staff navigate the complexity of change and evolving relational dynamics. Service disruptions due to change can cause ruptures in relationships that, in turn, can give way to new traditions and modes of working. A focus on interaction rituals extends decentred theory by looking at the interactions that underpin the dilemmas and traditions during a service change. Working collaboratively through disruptions can strengthen social bonds through the re-alignment of the social order.

Introduction

The implementation of Integrated Care Systems (ICSs) in the English National Health Service (NHS) represents a significant health and social care policy that seeks to provide coordinated patient care. Services, including NHS organisations, local authorities, police departments and charitable organisations, are meant to work together at the local level to plan for local health and social care needs, improve health outcomes and reduce health and care inequalities in local communities. Whilst ICSs have been operating for several years, they became statutory in 2022. Studies have focused on implementing integrated care (Waring et al. 2022a), the challenges of integrated working (Fraser 2019, Lilo & Vose 2016, Tsasis et al. 2012), and the organisational politics of such a major system change (Waring et al. 2022b). The main findings of these studies highlight that there are several tensions and challenges present within integrated

working, not least the different ways in which services are organised and funded, the different IT systems that make sharing data challenging, and the different organisational cultures and expectations that often clash when multiple services come together to provide care. Positive working relationships, underpinned by trust, mutual respect, and good communication, is paramount to successful integration (Tsasis et al. 2012, Woodbridge-Dodd 2018). Negative feelings, miscommunication and misalignment of shared values can often lead to the breakdown of inter-team and inter-organisational working (Brennan 2018). Notwithstanding these challenges, policy makers continue to prioritise local integration of services, often resulting in service changes and re-organisation. The COVID-19 pandemic, and subsequent pressures such as the cost-of-living crisis, have further highlighted the tensions that exist within integrated working and system change, and the importance of 'good' relational dynamics within and between teams. Additionally, the pandemic ushered in new modes, or 'rituals', of practice, particularly remote and hybrid meetings, resulting in changed ways of communication and a reliance on electronic forms of communication and problem solving. It is not well understood how individuals establish and sustain the relational work to enable service change and integration, both at the senior level of integrated care and on the ground at the front line, particularly post pandemic.

A decentred approach is particularly suited to understanding the complexity of how individual actors use their relationships to enact and manage policy initiatives such as integrated care. Decentred theory accepts the messiness of enacted governance and does not seek to impose order on the process, but rather explains how individuals work through complexity (Bevir & Richards 2009). This paper explores two levels of relational work: that of senior staff within integrated care systems and how they manage the 'relational' ruptures of service changes; and that of how front-line staff navigate new remote rituals and changed relational dynamics. The paper extends decentred theory through a combined analysis of interaction ritual chain theory, which emphasises the importance of expectations, emotions and the sense of belonging, and highlights how individuals build collaborative relationships through everyday interactions during a period of disruptive change.

Integrated Care Systems

To explore the relational challenges of integrated working, it is first necessary to contextualise the approach to integrated care within the English NHS. Implementing an integrated approach to health and social care represented a major system change and two fundamental shifts in culture and values. Firstly, prior to the introduction of ICSs, health services were organised around the New Public Management principles of competition and bidding for contracts (Millar et al. 2020), which reinforced silo working and organisations prioritising their own interests (Bevir & Waring 2020). The arrival of ICSs required organisations to move from an organisational, self-interest approach, to system working and acting based on what is best for the system, even if that is not best for them as an organisation. During such instances of major change, there can be resistance and reluctance of organisations, and their staff members, to work as a collective system, as system winners and losers emerge. For example, Waring et al. (2017) followed the reconfiguration of a major trauma centre that meant decommissioning services from some organisations to create a central 'hub' that served the entire locality. These 'losses' can be powerful sources of resistance as professionals' identities and reputations are often intertwined with their services (Black et al. 2022), making collaborative work difficult. Managing the relational dynamics of creating and sustaining integrated care is vital to system success.

Secondly, ICSs changed how services organise their care pathways. Instead of care organised around a diagnosis, teams are required to organise care around patient need. At the time of writing, there are 42 ICSs within England, each consisting of several NHS Trusts and networks, including mental health, primary care, acute care, community care, police services, local authorities, and charitable and voluntary organisations. They are managed by an Integrated Care Board (ICB) which is tasked with setting local policy to address health and social care needs through pooling financial and staffing resources, and

coordinating services at the micro, meso and macro levels within the system. Teams are being designed to take account of the complex and the idiosyncratic ways that patients access care in practice, not just in theory. For example, a mental health Trust might join up with a community health Trust to provide a reconfigured dementia service that captures how patients are referred in for assessment and care, such as by care homes, primary care, or informal carers, and then followed up for care within the community in a more coordinated way. Integrated Neighbourhood Teams (INTs) also provide a system approach to care at the primary care level that also links with services in the wider ICS.

Due to the ongoing impact of the COVID-19 pandemic and the current cost of living crisis, there is unprecedented demand on public services. Health and mental health care teams are working to clear long waiting lists that have been exacerbated, and in some cases created, by lockdowns. Staff shortages, burnout, lack of resources and ongoing industrial action within multiple levels of health, have posed further challenges for providing integrated working. On the social care front, some local authorities in England are going bankrupt due to increased financial demand within local areas. As local authorities cannot stop providing essential services, injection of funds from central government is required in exchange for top-down government control of running the organisation (Pearce & Mayor 2023). Any integrated approach to patient care, already known to be a challenge to deliver, now operates within this wider post-pandemic context of high waiting lists, lack of staff resources and financial strain, alongside changed ways of working with the introduction of remote and hybrid meetings and appointments.

Whilst the origins of these situations are distinct, as service re-organisation was planned and COVID-19 was unexpected, they nonetheless share traits of service disruption and changed ways of working. They also represent two of the largest disruptions to integrated working within the last five years. Comparing these disruptions on the macro and micro level offers insight into how teams and systems work to achieve new traditions and collaborative ways of working.

Decentred Theory and Rituals

Against the backdrop of pressures on ICSs, effective interpersonal relationships are essential. ICSs are given de-centralised control to respond to local priorities, and this can mean services are regularly reconfigured and 'tweaked' to keep up with demand, changing patient needs and increase efficiency within the system. On paper, this approach provides a flexible system that is responsive in real time, reduces duplication of effort and resources, and provides patients with enhanced services. In practice, this process is messy, sometimes confusing for staff and patients, and can generate feelings of frustration, anxiety and loss. For example, Black et al. (2022) highlight the emotional loss that occurs for some individuals during major system change and reconfiguration, including loss of status, influence and power. Relational dynamics within integrated teams are often complex as team members navigate differences between organisational cultures and values, financial structures, statutory requirements, data sharing, and availability of resources (Raus et al. 2020, Tsasis et al. 2012, Woodbridge-Dodd 2018).

A decentred approach to the complexity of integrated working attends to individuals' interactions and practices when enacting governance policies (Bevir 2011). Practice is underpinned by contextual beliefs and traditions that can be disrupted through 'dilemmas' of contradictory views and values. Traditions in this sense are 'the way things are done'. During periods of change traditions are deliberately displaced to create new modes of working. Major system re-organisation and changed ways of working due to COVID represent significant disruptions to traditions. However, these disruptions are not linear, and one reconfigured system or team does not seamlessly replace the old model. Periods of transition create dilemmas that individuals must navigate and involve interactions of negotiation, resistance, and trial and error until eventually the new beliefs, values and practice solidify into a new tradition. System changes represent disruptions to traditional practice for organisations and on the ground ways of working for front line staff.

The focus of decentred theory on individuals' everyday practice has overlaps with interaction ritual chain (IRC) theory. IRC theory has a sociological underpinning of attention to those everyday interactions that draw together individuals with shared attention and emotion, which are conceptualised as 'rituals' (Goffman 1967, Collins 2004, 2020); these are distinct from routines. There is a rich tradition in business and organisational studies on 'rituals' and 'routines', sometimes referred to as 'rites' and 'ceremonies' (c.f. Trice & Beyer 1984), that often focuses on bounded moments that further the needs of organisation (e.g. Smith & Stewart 2011, Islam 2015). Whilst there are overlaps between the study of ritual traditions within organisational studies and sociology, particularly the focus on everyday interactions and group cohesiveness, the two vary in terms of their purpose. Organisational rituals are often episodic and goal orientated. IRC theory focuses on rituals that are linked across time, rather than those in one moment in time, to build social connection. Goffman and Collins highlight how individuals are working towards cohesion, or the 'veneer of consensus' (Goffman 1959, p.9), and generating a sense of belonging in interactions with others. For example, Goss (2007, 2008) applied IRC theory to entrepreneurship to highlight that rituals go beyond rationality and goal orientation as they are full of emotion that shapes entrepreneurial identity and meaning. Rituals in this sense include macro rituals such as religious or sporting events, and micro rituals of greetings, formal and informal meetings, and smoking breaks. Crucially, and similarly to decentred theory, IRC holds that ritualised interactions over time give rise to social expectations that are tied to emotions and form the culture and value system of a group or community. Successful rituals are defined as those interactions that leave individuals feeling confident with a sense of belonging and inclusivity and that motivate individuals to repeat similar types of interactions. Failed rituals are interactions where individuals are depressed, alienated and avoidant of those future interactions. Upsetting the expectations, or the 'tradition', is to break the moral code, which then requires the group to re-form their sense of belonging and inclusivity. Tavory and Fine (2020, p. 367) argue that disrupted interactions, or interaction rituals, 'potentially give rise to new, deeper modes of intersubjectivity and social coordination', a notion very similar to decentred theory's approach to new traditions. Sometimes this reformation involves expelling or resisting the disrupter and at other times, it involves incorporating changed rituals and their accompanying values and priorities.

This paper expands decentred theory with the use of IRC theory to focus on the emotional component of traditions, particularly during times of disruption.

The Studies

Drawing on the findings of two related qualitative studies within integrated care systems, this paper explores how change is navigated. The first was a multi-site, three-year study looking at the micro-politics of implementing system wide integrated working. Important findings of this study related to senior leaders' relational work as they sought to address policy and wider system pressures alongside staff resistance to change. The second study is an ongoing multi-site study exploring how integrated care teams build and sustain interpersonal relationships through everyday practices, particularly post-COVID.

Study 1: Navigating Micro-Politics within Integrated Healthcare Systems

To implement ICSs, a major health system change, senior health and social care leaders must navigate organisational politics and tensions around competing inter-organisational values, beliefs, and professional power interests (Waring et al. 2022c). Study 1 aimed to understand how leaders engaged in micro-political interactions to address resistance to change and build collaboration amongst competing interest groups to facilitate integration (Waring et al. 2022b). Purposive sampling was used, following a desk review of 44 Sustainable Transformation Plans (STPs) in England, to select three case studies to account for variations in structure and urban and rural provision (Waring et al. 2022d). All three sites had

approximately the same population of 1 million. Site 1 was larger in terms of service provision with hospitals, two community hospitals, and one ambulance service and local authority. Site 2 had one hospital, a teaching hospital, a large mental health and community provider, and two local authorities. Site 3 was more rural and had two community hospitals, one city-based hospital, one ambulance provider and one merged commissioner and one local authority. Interviewees consisted of leaders across different levels of the 'system', including service leads, Trust leads, Non-Executive Directors, and emerging leaders. Participants were from a range of specialities including medics, nurses, managers, local authority leaders and health and care senior advisors. Detail about the study methods, participants and sites is available in Waring et al. (2022d). The study used a narrative ethnographic approach, with 83 narrative interviews with 72 senior health and social care leaders and 49 hours of observations of 28 ICS meetings. Data analysis centred on the tensions, barriers and disagreements that senior leaders encountered and, drawing from Ferris et al. (2005), the various political skills they employed to reach collaboration (Waring et al. 2022d).

Study 2: The Rituals of Integrated Working

To explore how teams use their interactions to build relationships that generate trust and belong, this study involves four linked work packages, and is informed by narrative ethnography to analyse and explore experiences of social actors within their wider social contexts (Gubrium & Holstein 2008). The study used a case study approach (Yin 2018) to identify integrated healthcare teams. Multiple teams who provide care for patients requiring a high level of service integration were contacted across England to be part of the study, including those focused on the needs of older adults. Three teams have been selected to date based upon their different specialities, including teams in mental health and community services focused on clinical issues such as dementia and frailty. Two of the three teams are embedded across different services and all work closely with local authorities. Study participants are from a range of professions and include medics, nurses, community health workers, pharmacists, pharmacy technicians, managers and administrative stuff. This study is ongoing, with data collection including observations of team meetings and interviews. Whilst meetings are often online, in-person observation of teams are also underway. Ethical approval was granted by the NHS Health Research Authority (REC Ref: 22/WM/0003), including Confidential Advisory Group (CAG) approval (CAG Ref: 24/CAG/0144). Data collection has completed with one integrated mental health team, consisting of six team member interviews and 11 hours of observation of team meetings. Though findings are at an early phase of analysis, emerging patterns indicate the importance of collaboration and 'good feeling' within the teams but also the impact of COVID-19 on changed ways of working.

Data analysis for the two combined studies was thematic (Braun & Clarke 2019), focusing on areas of similarity of integrated working during moments of transition between the senior level and front-line. Moving between the senior level of ICSs to the front-line similar highlights their similar responses to disruptions in practice through policy change and service improvements. The two different levels do not represent the macro and micro level of change, but rather that the relational work that underpins change occurs within both groups, albeit taking different forms. For both groups, disrupted traditions, or disrupted rituals, cause relational ruptures that leaders and teams must manage to enact service change.

Findings

Relational Working within Integrated Care

Individuals from both studies are consistently united on the importance of good relational working within ICSs. One Study 1 participant explained how a network approach to health is 'reliant' on collaborative

relationships:

> [W]ithout the relationships you don't have a network. We have to create an environment where those clinicians want to come to the table. […] It's about listening to them and bringing their ideas and formulating what's best for our patients in each of our specialities really (Study 1, WP2-3).

Senior leaders within Study 1 highlighted that implementing major health system change, such as merging services, pooling resources and introducing change behaviour within professional groups, occurs through these relational networks. These changes often necessitate services taking on increased and/or changed responsibilities. It is how leaders use their relationships to enact change that can determine the success of a policy change. There is no 'one size fits all model' as relational working requires leaders to be agile and responsive to individuals and groups they seek to influence:

> [T]he relational skills that go with the technical skills of being a leader or a manager in the NHS is so critical and actually what works in a relationship with one person doesn't work with another'. […] I think inevitably to do a job effectively you have to nuance your style a bit dependant on who you're working with (Study 1, WP2-35).

> I think just the way this incredibly complex organisation works. The way people cooperate in it to find what enables change and feeds […] it. So even when you understand it, you do have to keep your ear to the ground because it's dynamic, it's organic, it's changing, its challenge has changed. And people's response to them therefore changes. But if you start from knowing the context, the base of it, you've probably a pretty good chance of getting to know what's changing (Study 1, WP2-24).

Part of the agility and 'know-how' of system working is leaders' strategic use of relationships to enact organisational and system change. This approach goes beyond listening and responding to individuals within a system and is a deliberate strategy of connections and interactions to maximise their influence. One leader describes this process of specifically seeking out 'partnerships' that would enable them to be best placed to learn about changing priorities and strategies, and then reflecting upon this knowledge with individuals within their own organisation:

> I think what I learnt working at a national level is working horizontally, making good relationships with people at the same level as you in the, those other organisations becomes critical, so you become a, you seek partnerships and networks beyond your own organisation in order to tune into some of that soft intelligence and you also take time, you probably do it more than I probably did it in a local place. I think at a national level you probably take more time reflecting on what's going on, noticing some of those political things, talking about it actually to probably some of your senior team and your immediate direct reports (Study 1, WP2-35).

Strategy is not reserved for the system or organisational level as front-line staff also use their relationships and connections to advance their priorities. For example, Study 2 participants explained how inviting neurology professionals to attend their multi-disciplinary team meetings once a month resulted in better communication and a reduction in time from assessment to diagnosis. These results improved for both teams and attendance from neurology remains consistent, despite their own ongoing pressures and demands.

The Relational Ruptures of Disrupted Traditions and Rituals

Implementing ICSs and service improvements to meet patient need involves interrupting services and teams' way of doing things to replace them with new forms of practice. Resistance to these changes is

common and can cause a rupture in working dynamics, often with an emotional component. For instance, one clinical director shared the feeling of fear and loss of during a merger:

> I think there was some fear in the trauma units that some of the services would be lost or some of the skill set might be lost. Even just forming a network […], there's a fear that things will move to the centre and that therefore the periphery hospitals might not, not that they're as important but they might just have a fear really. […] It's helping people to see all the time that what we're doing is the best for the patients and the pathways and that actually it's not around shifting services, moving services, stopping services, it's around pulling those services to work together in one system (Study 1, WP2-3-D).

The same clinical director explained that managing the transition required '*smoothing the ruffled feathers'* to help staff see '*the bigger picture'*. Repairing the rupture, and securing collaboration involved helping staff through the emotions of the transition.

To help staff and patients with a sense of loss at service reconfiguration, other leaders brought in strategic partners. A head of service described the anticipated resistance to changing an emergency department to an urgent care centre, which would be seen as a 'downgrade' by patient advocacy groups, such as Healthwatch, an independent charitable organisation that represents the views of patients and carers. Instead of seeing Healthwatch as an adversary, the head of service brought them in as a project partner to gather patient feedback:

> Because it was thinking actually they, they're there to seek out, that's exactly what Health Watch are there for and if we actually can work with them, we would probably have a better outcome than working against them (Study 1, WP2-16).

In this instance, the leader anticipated the resistance and worked to prevent a rupture in the relationship even though the tradition, in this case the emergency department, was being disrupted.

New ways of working can also increase anxiety about increased workloads. A CEO discussed the relational tensions that can come with changed work allocations:

> [B]ecause the pressures on both tend to mean that each side is trying to push responsibility onto the other. So, why should they take the responsibility that I want them to take when it means it'll just overwhelm them? And why should I, when it'll overwhelm me? So again, some of that is about mutual understanding and not completely screwing each other (Study 1, WP2-24).

Here, the dilemma facing both sides was a fear of being stuck with more responsibility than any service can manage. Whilst the resolution may involve some extra responsibility and potentially unhappiness, the CEO implies there is a balance that must be struck through understanding the limits of their own and the other service so that neither service is inundated.

Blame and shame are other powerful emotive forces that can accompany service improvements and lead to a breakdown of relational working, which in turn can result in resistance to service change. After discovering some procedural errors, a director of services discussed how the 'individual fear of being blamed' or judged on their performance led to disengagement and created resistance to improving processes. Their workaround for this problem involved creating a 'coalition':

> So by building some peer based coalitions and then tactically thinking okay who else could I bring into this conversation beyond the individual that's blocking this and doesn't want to acknowledge the scale of the problem, but being quite thoughtful about how you do that rather than, not in a big front stage way of standing up in a meeting and going this place is rotten and you're rotten and all this sort of thing, but actually just gently building that coalition to move it from an individual problem to an organisational one (Study 1, WP2-47).

Combating the alienation brought about by a fear of blame and shame was overcome through collaboration and shifting the 'problem', and therefore the blame, away from the individual to the organisation. This shift enabled staff members to fully participate in finding the solution to problem that led to the error.

Whilst some change brought about large disruptions in tradition, such as the move from emergency to urgent care services, other traditions were more micro, but no less emotive and causing ruptures in working relationships. For example, one clinical lead described the sticking point with a group of nurses during a merger of two hospitals as the colour of their uniforms. One colour meant a certain rank in one organisation, whereas the same uniform indicated a different rank in the other organisation. Each group was protective of their status through the symbol of the uniform. As neither group could agree on what the original colour of uniforms would now signify, the clinical lead had to purchase a whole new nursing uniform to gain their collaboration.

Changed Relational System Working – Post COVID-19

COVID-19 has brought about lasting disruptions in how people work together within and between organisations, specifically remote and hybrid meetings. At the time of writing, these 'disruptions' are solidifying into new traditions. There are clear benefits to remote meetings. One of the teams in Study 2 highlighted that pre-COVID, finding a room to fit all staff was a challenge. As the team covers a wide geographical area, team members spent a significant portion of their day traveling to and from weekly meetings, at the expense of doing other duties, including clinic time. Moving to remote meetings for the majority of their weekly business meetings and multi-disciplinary team (MDT) meetings has increased attendance, and therefore professional group representation. In other words, as at least one person from the five main clinical specialities is present, meaning more can be addressed in the meeting rather than tabling an item to await a response, and there is a wider disciplinary approach within the service. For example, MDT meetings have too many patients to discuss within the time limits and the team frequently explore strategies to streamline this work:

> Psychology says that having a feedback slot on MDT meeting would make it easier to organise their work in advance. Occupational therapy highlights that MDTs are so busy with a significant number of scans to discuss and they are not getting through each case and discussing clinical feedback. It is agreed that the assessment feedback needs to be separate from 'other feedback' to make it easier for everyone to follow. Psychology and nursing professionals agree (Study 2, fieldnote, May 2023).

At the time of data collection, nearly all this team's meetings, including MDT meetings, continued to occur online. The team trialled a face-to-face meeting and asked team members their preferences. Most of the team cited the benefits above, and the administrator noted that transcribing Teams meetings is much easier as the room in a face-to-face meeting has more of an echo and it is less clear who is speaking. Colleagues also highlighted that it is easier for their neurology colleagues to come and go, making their representation at the meetings consistent.

However, during interviews, staff painted a slightly different picture as to the relational impact of remote working. Staff who were more established and been with the service for longer noted that they missed the interactions and recognised that the team dynamics are different, less personal, and potentially more procedural than relational.

> So, when people join, if someone's late, for example, there's a little bit of small talk, but there's nothing like there used to be when it was face-to-face, especially at the end, everybody's bye, and leave. There's no there's no hanging back. Which is a shame. Now that's what was a good thing about face-to-face. The networking, catching up with people you've not seen for a while (Study 2, P5).

Newer members of staff told a similar narrative. Two members of their team started during just after lockdowns and their opportunities to build rapport and experience a sense of belonging within team occur primarily through remote meetings.

> I think the fact that we can't meet up very often with, you know, we can't all be in the same room very often and I think it means that you don't get that kind of, more sort of, you know, sort of friendly conversation with each other. And you know, you don't get that team bonding and that way, you know. Yeah, so I think I think that can be that can be a bit of a shame (Study 2, P4).

When asked about the difficulties of working within an integrated team, the second newer member of staff commented:

> I think the first one is the fact that we all work remotely. I think because […] we're all based on different bases. Um, it's kind of hard to build a bit of a bond, a bit of a relationship with the other professionals (Study 2, P6).

The same participant went on to describe that the lack of a relational bond means there is a reluctance to raise issues within the team and that trust is harder to build:

> [I]t is a lot harder just because it is remote. Everybody's just so busy. Everybody's split within the different teams and people's like people have different priorities like in different teams and within [our team] as well [...] So because everybody's so busy it can be quite, it can be very difficult to build that trust. So, for example if there's an issue or anything. Personally, it will be harder for me to approach that person with that issue (Study 2, P6).

In addition, because P6 does not know members of the team well, there is also a hesitation to follow up items with specific team members. In previous roles that were more face-to-face, it was easier to take '5-minutes' for a brief ad-hoc conversation, whereas now, those ad-hoc conversations do not happen.

Despite the difficulties in forming deeper connections to team members, the team is finding new rituals emerge within remote working. P4 described how it can be difficult to jump in with a question online so will '*just do the little raise hand thing and just quietly wait'* for a turn to speak. The chair of the meeting will always bring in those with raised hands and provide them with space to ask questions or comment during the meeting. The downside is that questions and comments can often be out of synch and the flow can be disjointed.

Discussion

Changes within healthcare systems, such as a move to integrated working and changed ways of working due to COVID-19, disrupt interaction rituals and how individuals and organisations work, often causing ruptures in relational working. This paper explores these disruptions on two different levels: the move to integrated working at the system level and the impact of COVID-19 on the front line. The introduction of Integrated Care Systems in England formalised the transition away from siloed, competitive, market-driven service organisation to collaborative systems where resources are pooled, sometimes at individual organisational or service cost levels. Clinical care pathways are now (re)configured around patient need rather than diagnosis. These changes have brought disruptions to services in the form of mergers and service reconfigurations. COVID-19, and the aftermath of the pandemic, has put a significant amount of pressure and change within the health service and these new integrated partnerships. In particular, the pandemic has changed the way some integrated and multi-professional teams work, with many teams now utilising remote or hybrid methods of meeting and interacting. Whilst immediate changes to social

interaction were temporary, such as always wearing masks in all public spaces, other changes have been more lasting, such as the increase in remote team meetings. This changed mode of interaction has changed the relational dynamics of some teams as the social exchanges have become more focused on specific forms of work and more transactional, rather than the interactions that helped build interpersonal team relationships.

Decentred theory looks at how individuals manage and navigate change, including on an everyday basis. Disruptions to established patterns of working cause dilemmas for individuals as the traditional way of working and relating changes. IRC theory adds to decentred theory by looking at the interactions that underpin the dilemmas and traditions during a service change. In particular, decentred theory's emphasis on 'tradition' is similar to IRC's importance of expectation. Everyday social interactions within teams or organisations build a pattern of relating that individuals come to expect from the interaction. For example, for a face-to-face team meeting, individuals may expect pre-meeting conversations in the corridors and in the meeting room, a way for individuals to interject with a perspective or question during the meeting, and there may be post-meeting conversation for reflection or raising other business with colleagues. Individuals will also develop expectations around how disagreements are managed and how failure and success are addressed. If a team works together well, with high levels of trust and respect, the expectation will be that however difficult a discussion, it will be enacted in a way that continues to build a sense of team solidarity and belonging. Disagreements can be present, but it is how they are worked through that matters.

In contrast, if it is a negative working dynamic, the expectation may be one of blame, judgement, alienation and isolation. Interactions in this sense may be charged with high levels of difficult emotion or may lack emotion and generate feelings of boredom or a sense of 'going through the motions' in a routine rather than a ritual. These types of interactions result in low emotional energy (Collins 2004) which can lead to avoidance of certain types of social interaction and a lack of motivation to work as a team. Expectations through rituals such as meetings solidify into tradition and becomes part of the value and moral code of a group and/or organisation. Successful rituals generate symbols that embody the group's identity, values and moral codes. They can be the colour of a nursing uniforms, logos, coffee cups, lanyards, ideas, beliefs, and even a whole service. These symbols are charged with emotional meaning and attachment that are linked to personal, professional and organisational identities. Change both disrupts these traditions as the usual expectations for how things are done no longer hold, and reveals the values, morals and symbols that underpin groups and their personal and collective identities. Disrupting these traditions is personally disruptive, and personal and collective resistance can build and fester. Decentred theory's acceptance of this disruption provides an opportunity to explore how individuals use their rituals to generate new expectations and potentially even new rituals. This disruption acceptance has echoes to Tavory and Fine's (2020) analysis of disruptions being a necessary component of interactions so that new forms of relating can emerge. Disruptions from this sense are not distractions from cohesion to be overcome, although overcoming disruptions is part of it, but working through disruptions can strengthen social bonds through the re-alignment of the social order.

Social stratification is an important component within ritual theory, and transitions often highlight the 'winners' and the 'losers' of change. Importantly, the social stratification within ritual theory has an emotional emphasis with those experiencing high levels of confidence and group solidarity emerging as the winners. In the example given of the major trauma configuration, some organisations lost their trauma centre as the service became centralised. The clinical leader recognised the perceived sense of loss of individuals who were losing their service and worked to manage the relational dynamics so that the loss could be a palpable gain for the system and for patients. In this case, the leader drew on the shared sense of patient benefit, itself a sacred value and symbol, and in doing so, established solidarity with the 'losers' to provide a narrative they could support. The social stratification may have been unchanged in terms of the organisational structure as some organisations still lost their service, but they were provided a more equal footing relationally and emotionally because those struggling were able to save face by transforming their narrative into a patient gain rather than a personal loss. This example highlights the importance of

how leaders and teams can still generate a sense of inclusivity and collaboration through their interaction rituals even during moments of service cuts and service reconfiguration. It also helps highlight how disruptions can be temporary, or, if not handled well, can result in relational ruptures where no new traditions emerge because the social actors cease to interact.

Conversely, the change brought about by COVID-19 to remote forms of working have highlighted the differences at the front line between established and newer members of the team. Remote working is preventing newer members from obtaining the same level of emotional capital within the team. The usual expectations for having a personal and professional attachment to a team have been disrupted and continue to frustrate efforts of newer members to fully integrate within the team. Here, there is less of a relational rupture, as newer members struggle to build the relationship to the team in the first place, and overall, the team is not growing their collective bonds and sense of trust that are essential for integrated working. Interactions that occur before and after a face-to-face meeting, including the walk from an office to a meeting room, making a cup of tea or coffee with colleagues, are integral components can enhance emotions at work (Methot et al. 2021). However, these are lost in remote working and the new ritual of a quick catch up with muted colleagues or even blank screens, is not enough to produce and reproduce the same feelings of inclusivity and belonging. The result is that some colleagues do not have the confidence to speak up, to ask questions or to challenge more senior leads. These senior leaders have no way of knowing what their team are thinking and feeling if team members do not verbalise their perspectives. In this scenario, interactions risk becoming more routine and less of a ritual without building collaboration. Whilst the divisions between team members may be subtle, it does increase the risk for problematic dynamics such as lack of trust and difficulties navigating team challenges. The team may have a 'surface' level of trust at a professional level but may struggle to develop a deeper relational level of trust that is essential for successful integrated working. In other words, Goffman's (1959, p.9) 'veneer of consensus' that is required for social cohesion is not enough for developing deeper bonds of trust and inclusion that can withstand disruptions and transform through them. A team that never disagrees is just as much of a concern as teams that never seem to resolve tension.

Healthcare research has long written about change and transformation in relation to organisational change. In particular, disruptions in decentred theory have links with concepts of liminality in healthcare whereby an individual's identity is altered as they move from state to another, such as undergoing cancer treatment (Willis et al. 2021). Applied to healthcare change, Willis et al. (2021) have highlighted how healthcare staff negotiate bureaucratic changes whilst also providing high quality patient care. At worst, the stress of these changes can contribute to burnout, though changes can also be moments of creativity and innovation. These findings are similar to Kaehne (2022) who sees liminality in integrated care as spaces where old ways of working have ceased but the new forms of work are not yet solid. In these spaces are opportunities for reflection and new definitions of roles and professional identities. From this perspective, healthcare change is not simply structural, it is also relational. This study extends those findings to highlight the importance of solidarity between individuals whilst undergoing change and disruption that can make innovation and creativity possible. True solidarity is not the absence of disagreement, but the acceptance of disruption, including the difficult emotions and relational ruptures that change brings, and finding a new form of solidarity in the change process.

At the time of publication, the NHS is embarking on another moment of significant transition with the abolishment of NHS England, the central organisation that oversees the delivery of healthcare, and changing the size and scope of Integrated Care Systems. The task of the leader and of the team is to not ignore symbols and emotional attachments, but to work with them, otherwise they risk alienation and the type of social stratification within an organisation, for example one professional group pitted against the management group, that makes change impossible. Embracing disruption and attending to the everyday changing nature of interactions, symbols and sense of inclusion within a group and/or organisation, is essential to creating new traditions.

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Conflicts of interest

There are no conflicts of interest to declare.

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