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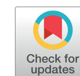
Austerity and the shaping of the 'waste watching' health professional: A governmentality perspective on integrated care policy



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ABSTRACT

Discussion related to the boundary between health and social care has existed in the United Kingdom (UK) since the inception of the English National Health Service (NHS), with successive governments outlining a desire to 'integrate' care. Globally, high-income, and low- and middle-income countries, are increasingly advocating integrated care (IC) as a solution to financial and quality issues. Recent research has argued that IC policy works discursively to manage tensions between competing policy aims, facilitating the continuation of austerity measures and the fragmentation of health and social care services. This paper extends this debate by moving beyond the discursive realisation of IC policy in official governmental texts to instead investigate its reception among practitioners 'on the ground'. By complementing the perspective of governmentality with Fairclough's (2008) Dialectical Relational Approach (DRA), our paper exposes shifting articulations and enactments of IC policy discourse as it moves through implementation in a community based integrated care service (CBIC) in England. Faced with the material reality of funding cuts to the service, integrated care is reformulated from '*transformational change*' to the responsibilisation of '*ideal integrated workers*' tasked with eliminating '*waste*'. Whilst frontline staff strongly resisted these subjectivities, they were ultimately subject to the harmful material effects of austerity politics with little in the way of positive change for patient care.

1. Introduction

Since the inception of the English National Health Service (NHS) debate has centred around how to tackle increasing complexity in how services are commissioned, funded and provided (Glendinning & Means, 2004). Fragmentation in service provision, it is claimed, leads to poor experiences for patients with complex needs receiving care from multiple providers (Humphries, 2015). Between 1997 and 2010, the New Labour government attempted to foster greater integration between health and social care through a variety of initiatives including multidisciplinary teams, pooled budgets, joint assessments and commissioning (Carey, 2018; Miller & Glasby, 2016). More recently, integrated care policy advanced by the Coalition government (2010–2015) and the incumbent Conservative government (2015-present) has centred around flagship interventions, including the Better Care Fund (BCF), Integrated Pioneers Programme, New Care Models (NCM), Sustainability Transformation Projects (STPs) and Integrated Care Systems (ICSs). Although taking shape under different UK government policy backgrounds these programmes hold in common the stated aim of pooling budgets and encouraging integration between social, primary, community and secondary care (Coleman et al., 2020; Hammond et al., 2017; Humphries, 2015).

Since the 1980s economic liberalisation initiated in the Thatcher period, and later through the 'third way' policies of New Labour, paved the way for the marketisation of UK health and social care, often addressed as the 'New Public Management' administrative regime of privatisation, contracting-out and performance management (Glynos et al., 2015; Ferlie, 2017). Broadly speaking, these reforms exhibited 'neoliberalism': a discursive and material mode of rule advocating private sector and market-based solutions to public sector problems, often aiming to dissolve the distinction between them. While New Labour advocated quality and continuity of care coupled with a focus on efficiency savings, the 2010 Conservative-Liberal Democrat coalition further embedded competition as a definitive organising principle through the notion of "any willing provider". Glynos et al. (2015) argue that, as a political logic, more recent iterations of IC policy operate to side-line

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criticism of pro-competition reforms within the Health and Social care Act (HSCA) 2012, and to depoliticise debates on austerity, privatisation and fragmentation. They argue that the increasing dominance of integrated care discourse is reflected in its "'empty' oppositional status" (p. 56): meaning that whilst it is purportedly against the fragmentation of services, this remains opaque in practice.

The widespread propagation of integrated care (IC) policy discourse in policy documents, academic literature, think tank reports, and professional practice renders it the cure to the health service's ills, through which both problems and solutions are framed. It is deployed to problematise poor public finances, service fragmentation, poor patient experience, a lack of patient decision making, and high levels of demand from an increasing elderly patient population. Hughes (2017) argues that 'integrated' care policy discursively smooths over tensions associated with health and social care funding, facilitating the continuation of austerity and the fragmentation of services. However, some research still evaluates IC service change as a technocratic response to a set of depoliticised problems (e.g. Lalani et al., 2019). Despite integrated care policy failing to meet stated objectives of reducing acute hospital admissions and improving patient care, it remains a key tenet in UK government policy discourse purportedly aimed at combatting these issues (Harvey et al., 2018; Raus et al., 2020).

Hughes (2017) and Glynos et al.'s (2015) studies provide important critical takes on IC policy, illuminating the political and ideological work performed at the discursive and policy level. Our objective in this paper, however, is to move beyond the discursive realisation of IC policy in official governmental texts to instead investigate its enactment among practitioners 'on the ground'. 'Governmentality' forms a connection between technologies of domination and technologies of the self, inferring the animation of agency, and where possibilities are structured not only in oppressive ways, but also in enticing and desirable ways (Foucault, 2008). Responding to criticisms of a programmatic bias in governmentality studies, where analysis has depended on formal texts and official programmes of neoliberal rule (Barratt, 2008; McKinlay & Pezet, 2017), we adopt (Fairclough's 2008) Dialectical Relational Approach (DRA) as a complementary analytical approach to offer a more nuanced account of agency, resistance and materiality. Through this approach we expose the shifting articulations and enactments of IC policy discourse as it moves through implementation within a community based integrated care service (CBIC). In this context, we examine how IC policy discourse becomes a conduit for other established managerial discourses, notably 'lean' working.

Our paper illustrates how the discourse of integrated care policy constructs subjectivities that neatly align with more centralised political objectives, whilst stimulating resistance among frontline staff. By addressing integrated care within the frame of neo-liberal government, we contribute to studies of IC implementation that demonstrate a displacement of improving patient care in favour of efficiency savings (e.g. Maniatopoulos et al., 2020; Gadsby et al., 2022) showing how IC policy provides a means and justification for agents at the local level to enact austerity. Secondly, we contribute to studies of the effects of austerity policies upon both frontline staff and patient care (Stuckler et al., 2017; Kerasidou, 2019; Owens et al., 2019) by revealing the opaque workings of power operating through health and social care policies: where frontline workers are responsibilised for austerity policies with little positive impact upon patient care. Given the international emphasis on the benefits of integrated care policies for patients and the public (Goddard & Mason, 2017; Harvey et al., 2018; Raus et al., 2020) our findings have wide ranging implications for challenging dominant governmental narratives.

The article is structured as follows. Firstly, we situate our study within the UK health and social policy context from 2010 to the present day. We then set out our theoretical framework before describing the data collection and our approach to analysis. The main findings are then explored. We demonstrate how meso level construction of the CBIC as '*transformational*' and '*system wide*' change evolves into the local deployment of IC discourse based on the shaping of the '*ideal integrated worker*' as an eliminator of '*waste*'. Subsequently, the paper turns to the discourse of resistance put forward by community health assistant practitioners. Finally, we set out our main theoretical and empirical contributions to the study of integrated care, austerity, and governmentality studies.

2. Integrated care and the politics of austerity

In 2010 in the UK the Coalition government embarked on a programme of austerity, aiming, it was claimed, to reduce the national deficit following the 2008 financial crash. The public sector was to dramatically reduce expenditure and use existing resources more efficiently (Kerasidou, 2019). The NHS, whilst technically not receiving direct funding cuts, received much lower-than-average funding increases which did not align with growing demand (Robertson et al., 2017; Owens et al., 2019). Funding cuts to social care and mental health were more severe, with local authorities tasked with saving 26% from their adult social care budgets between 2010 and 2014 (Miller & Glasby, 2016).

The HSCA 2012 moved to decentralise health and care by abolishing the main commissioning bodies within the health service, Primary Care Trusts (PCTs), as well as 10 regional bodies called Strategic Health Authorities (SHAs), which oversaw PCTs and were accountable to the Department of Health (DH) (Hammond et al., 2019). Devolved budgetary provisioning was granted to General Practitioner (GP) led Clinical Commissioning Groups (CCGs) at a more local level, further entrenching the purchaser/provider split and privatisation by introducing the 'any qualified provider' (AQP) principle (Allen et al., 2017). The HSCA 2012 not only reorganised the English NHS into a competitive market of providers, but also paved the way for further austerity policies and funding cuts, notably impacting local government, social care and mental health services (Miller & Glasby, 2016).

During the austerity period, health and social care integration was endorsed through a series of policy statements, including the *Five Year Forward View (FYFV)* (NHS England, 2014), *NHS Long Term Plan* (NHS England, 2019) and *Integration and innovation: working together to improve health and social care for all* (Department of Health and Social Care, 2021). Despite dropping competition from its discursive narrative (Allen et al., 2017), the FYFV deployed IC as a conduit for managerial discourses, perpetuating neo-liberal objectives of reduced state funding and individual responsibility (Miller & Rose, 2008). Discourses of efficiency were writ large within the FYFV, with an explicit call for savings of £22bn to be made by 2020 (Kerasidou, 2019). These savings, it was suggested, would be met through 'new models of care' that would lead to innovations across primary, secondary and community settings (Hammond et al., 2017). Managerial techniques and 'philosophies' such as 'lean', designed to reduce 'waste' and add 'value' to processes, were further entrenched in public, health, and care sectors (McCann et al., 2015; Waring & Bishop, 2010). This context, in which health and social care came to be framed in terms of economic cost and benefit (Speed, 2016), provided the backdrop to the development of our CBIC case study. More recently, IC policy iterations have seen a return to place-based health and care planning, with local health organisations coming together in 2016 to form 44 STP footprints across the country (Hammond et al., 2017). The 2022 Health and Care Act put these footprints on a statutory footing and have evolved into 42 ICSs (Charles, 2022).

The further neo-liberalisation of health care has been demonstrated in recent evaluations of IC flagship policies, illustrating harm to patient care. Maniatopoulos et al.'s (2020) study of a NCM programme across five sites in North East of England found that CCG senior managers struggled to achieve efficiency savings and performance outcomes related to hospital admissions, severely hindering progress on improving care. Gadsby et al. (2022) argue that actors within a Discharge to Assess service in Kent experienced conflict between an ethic of efficiency and an ethic of patient-centred care, resulting in a focus on the speed of discharge without establishing a holistic 'wraparound' service for patient

benefit. Nevertheless, despite integrated care implementation being marred with failures, allegiance to the overall narrative by health and social care managers is often maintained with integrated care viewed as a 'moral imperative' (Stocker et al., 2018, p. 3), the 'right thing to do' (Eyre et al., 2017, p. 9) or as a response to an untenable status quo (Maniatopoulos et al., 2020).

In the following section, we demonstrate how the theoretical perspective of governmentality can be brought to bear in the study of IC implementation.

3. Governmentality and the DRA

Foucault's work has had an extensive influence across the social sciences for several decades. His own writings shifted from an early focus on archaeology of knowledge and discourse to an emphasis on genealogies of knowledge and power. Rather than regulative 'discursive formations', attention turned instead to how relations of power fashioned 'discursive regimes' (Foucault, 1982). The influence of Foucault's 'middle' genealogical period, drawing from *Discipline and Punish* and *The History of Sexuality, volume one*, brought an arguably partial reading of his work to the field (Raffnsoe et al., 2019), portraying obsequious and regulated subjects with little evidence of agency or contestation, and where power became synonymous with repression. Readings of the 'later' Foucault, and in particular the concept of governmentality (Foucault, 1982), have provided critical perspectives on neoliberal societies where individuals and groups are not only targets of power, but also effective in its operation. Recalling sixteenth-century connotations, 'government' for Foucault refers not just to the management of states, but also the manner in which the conduct of groups and individuals may be directed. 'Conduct', in this sense, has two meanings, to both lead others in more coercive ways, and a way of behaving within a more or less open field of possibilities. 'Government' thus points to the link between relations of power and processes of subjectification at the local and individual level (Foucault, 1982). Within this frame, ethical subjectivity is the manner in which individuals and groups are required to address themselves as moral subjects of their own actions (Foucault, 1983).

Studies of governmentality have been critiqued for relying too heavily on the 'programmers perspective' and official texts (Barratt, 2008; Walters, 2012). Governmental programmes have been addressed as complete projects, depicting already fully formed neoliberal subjectivities, assuming automatic assimilation into dominant discourse (McKinlay & Pezet, 2017). Analysis does not have to remain at the level of programmes and strategies, but can also examine how they are translated into the 'witches' brew' of practices on the ground (Foucault, 1991, p. 81). Governmentality scholars (see: Martin et al., 2013; Waring et al., 2016; Waring & Martin, 2016; Martin & Waring, 2018; Waring & Latif, 2018) have sought to address this limitation by incorporating Foucault's concept of pastoral power to demonstrate how governmental discourses are mediated by healthcare professionals and managerial intermediaries acting as 'pastors'. Pastors deploy methods 'operating at the nexus of discipline and subjectification' to shape subjectivity of those 'target groups' on the receiving end (Martin & Waring, 2018, pp. 1300–1304). Waring and Latif (2018), in particular, expose the potential for agency amongst healthcare intermediaries who are grounded in shifting professional identities and practices while enacting their pastoral role. In their study of the New Medicines Service (NMS), General Practitioners (GPs) used greater disciplinary means to encourage medication adherence amongst patients, whilst Pharmacists encouraged greater self-reflection as they gently shaped patient behaviour.

While these governmentality studies offer welcome developments in exploring the complex translation of governmental discourse into subjectivities, they can also be critiqued for neglecting materiality (Sims-Schouten & Riley, 2014). Given the myriad of resource pressures created through austerity policies, as well as patient illnesses and conditions that impact both the 'bodies' of clinicians and patients in the delivery of IC, the role of materiality can be brought into a more equal dialogue with discourse. By adopting DRA (Fairclough, 2008), we are mindful that discourses may remain unactualized within local settings, with their reproduction dependent on local power relations and the interaction with materiality and agency (Zotzmann & O'Regan, 2016). Drawing on a form of realist social constructionism, we conceptualise discourse as semiosis (meaning making through language/visuals), that works through practices in dialectical interplay with non-semiotic mechanisms such as materiality, social relations, psychological processes, technology, and subjectification. Discourse within these specific interactions is flexible and contextually mediated in ways that can lead to discourse being dialectically transformed into new ways of acting and being, as well as new material arrangements. Each element of practice 'internalises' the others, whilst retaining its own causal power (Fairclough, 2008, 2013; Fairclough et al, 2002). This perspective enables a more nuanced exploration of IC discourses articulated through official texts on the one hand, and the perspectives of situated actors negotiating governmental objectives and discourses among complex material realities 'on the ground', on the other.

Deploying the perspective of governmentality operationalised through DRA, we address IC as the enactment of neo-liberal austerity through seemingly beneficial, seductive, but nevertheless vague and decentralised social policies that obscure austerity and leave local agents struggling to cope (Hoppania, 2019). The power of integrated care to facilitate this process is reflected in STP policy that works to define health budgets in relation to specific places, financially incentivising organisations to collaborate while holding them responsible for 'local' failures (Hammond et al., 2017; Leys, 2016). Following the HSCA 2012, IC policy discourse facilitates processes of responsibilisaton (Burchell, 1996), where local actors and organisations are 'offered' ways in which to participate in action to resolve problems previously in the hands of government agencies. Some, as highlighted above, may internalise the 'moral imperative' of integrated care (Stocker et al., 2018, p. 3), whilst ambivalence, begrudging acquiescence, and practices of resistance are also features among the governed (Lorey, 2015). A governmentality perspective complemented with the DRA provides a framework for a detailed empirical yet theoretically sensitive analysis of integrated care discourse, materiality reality, and its effects 'on the ground'.

4. Methods

4.1. Data collection

Data was collected between April 2017 and April 2019 as part of a wider research project exploring integrated care policy implementation. The study investigated a community based integrated care service (CBIC), operating across four localities (East/West Hallstone, East/West Greenfay) in one region of the UK. All place names, organisations and participants are pseudonymised. Each locality had an 'integrated care team', made up of a core community nursing service and a community rehabilitation service tasked with visiting patients in their homes within their area. Each locality also 'hosts' other community services, such as pain management, that have responsibility for patients across the region. The Greenfay locality is more challenged than Hallstone, both in respect of deprivation and the proportion of elderly residents with long term conditions including dementia, diabetes, hypertension, and musculoskeletal conditions. The CBIC contract was won by a social enterprise, Oaklea Community Care (OCC), following a competitive tendering process by the CCG, with service delivery 'going live' in April 2016. The study was sponsored by OCC who granted organisational access to the lead author.

Data collection was split into two phases. Phase 1 involved analysing both interviews and organisational documents as 'texts' to identify early discursive construction of the CBIC at the meso level. 9 interviews with senior management within the lead provider, the Clinical Commissioning Group and the County Council (collectively described as Local Policy Implementers - LPIs), were conducted. Interviewees were selected

purposively based on involvement in the original development of the CBIC, the bid writing or contracting process, and/or management of the CBIC. Three organisational texts (the CBIC Business Case, a tender document and a staff training video) were selected to examine the way in which the CBIC had been communicated at the early stages of development and contracting. Analysis from this phase guided the subsequent data collection in phase 2.

Phase 2 data collection, at the micro level, included 40 interviews with frontline staff (inclusive of middle managers), 6 interviews with patients and 3 of their carers/friends. The phase also included 3 weeks of observation in Integrated Care offices, and the analysis of 8 organisational texts (training session/manual, staff newsletter, meeting observations, website text, a poster and a promotional video). Organisational texts were selected to provide a "semiotic ‘point of entry’" (Fairclough, 2008, p. 169) into the research field. An example includes a newsletter distributed to update all staff on organisational developments and changes. Semi-structured interviews and observations provided data sources for extra-discursive mechanisms of social practice. Extra-discursive mechanisms included material, technological, organisational, or managerial procedures introduced to frontline staff, such as training implementation strategies, as well as their responses to delineated subjectivities and ways of (inter)acting, such as adopting the ‘*ideal integrated worker*’ subject position. Interview questions such as ‘Can you describe the biggest changes to your role since the introduction of CBIC? How was this communicated? How did you respond? How did this make you feel towards your role/professional identity?’ were asked to elicit processes of subjectification for frontline staff.

Ethical approval was gained from the East Midlands - Leicester Central Research Ethics Committee on 26th March 2018, ref: 18/EM/0084. All interviews were conducted in person by the lead author at the health professional/manager's place of work or within patient's homes, recorded on a Dictaphone and transcribed verbatim. Observation fieldnotes were recorded into the lead author's laptop and contained no identifiable information.

4.2. Data analysis

Phase 1 data was analysed using CDA semantic and linguistic analysis of texts to determine how discourses were being realised at the meso level. Semantic and linguistic analysis includes asking what expressive values words have, what metaphors are used, what levels of responsibility are ascribed to agents, and the level of modality expressed. Modality is the degree to which the speaker expresses confidence in what they are saying through use of modal verbs, such as ‘can, could, may, might’. These texts were viewed as having the ability to illuminate meaning making and power relations, whilst also being conditioned and determined within particular structural and social contexts. Texts draw upon and contribute towards existing systems of meaning and discourse, whilst also entering into dialogue with things previously said through intertextuality (Fairclough, 2001, 2003). Using this textual analysis, questions were asked of the data including, how do these linguistic features within texts draw on discourses within wider discursive practice? In what ways are problems and solutions constructed? What ways of interacting and identities/subject positions is this discourse trying to enact? How do these findings correspond with theoretical concepts in governmentality studies?

‘Texts’ or semiotic ‘points of entry’ identified in phase 2 were analysed using the same approach as above. Interview and observation data collected within phase 2 was analysed as illustrative of extra discursive mechanisms (identities/subject positions, ways of (inter)acting, materiality, technology, managerial processes/strategy). Interview and observation data was analysed to capture real phenomena and processes, as well as the discourses they were in dialectical relationships with. Data was coded using conceptual labels that explained what was being represented at a higher degree of abstraction (Charmaz, 2014). These conceptual labels represented either a context (i.e. individual, interpersonal, institutional factors) that CBIC was being introduced into, a resource (managerial, technological, material) that was seeking to enact change, a response (ways of (inter)acting and identities/subject positions adopted), and outcomes (in terms of either patient or staff experience). Data representing different elements of social practice were drawn together using the context-mechanism-outcome (CMO) heuristic from realist evaluation (Pawson & Tilley, 1997). This involved making analytical memos throughout the coding process to explain how context, resource, response, and effect codes linked together. Data pulled into the CMO heuristic was then compared with the discourses analysed within the semiotic ‘points of entry’ and theoretical concepts from studies of governmentality.

5. Findings

5.1. Integrated care as a neoliberal governmental programme

This section charts the CBIC's discursive evolution from ‘*transformational change*’ to neo-liberal subjects performing generic roles by analysing organisational documents and the narratives of LPIs. During the contracting stage, the CBIC, working as part of the wider governmental programme of integrated care, was constructed in the Business Case through IC policy discourse, with explicit intertextual links to the HSCA 2012, the FYFV, and the BCF.

In the following statement, the Business Case places the CBIC within the wider policy narrative of integrated care:

> *"[CBIC] will transform the delivery of physical, mental health and social care services across [the region] over the next 7–10 years. The way in which these services are currently delivered will change dramatically, leading to more integrated services which encompass all the above, based on individual needs and with appropriate care planning"*

Similarly, in other sections, the CBIC text outlined ‘*system wide, transformational change*’ that would provide the solution to a range of problematisations, including financial unsustainability, rising demand amongst an elderly population with comorbidities, service fragmentation, and a lack of patient discretion over healthcare decisions. For example:

> *"Increasing demand is placing significant strain on the sustainability of the local health and social care economy. The CCG is projecting a financial shortfall of some £80 million over the next five years. Meeting this level of challenge will require a system wide, transformational change in the way that services are commissioned and delivered for our residents. Doing nothing will mean that our health and social care economy no longer remains sustainable, impacting on the services we can commission for our population."*

Whilst the dire consequences of ‘*doing nothing*’, resulting in the unsustainability of the health and social care economy, was prophesised. In another section, the Business Case also explicitly claimed that ‘*efficiencies through integration by reducing fragmentation and repetition currently within the system*’ would be created. The CBIC is therefore framed within integrated care policy discourse and the appeal to fears about fragmentation, poor public finances, and increasing demand wrought by an ageing population (Glynos et al., 2015; Hughes, 2017).

Compatibility with the FYFV is made through intertextual links that emphasise the ‘ethical’ nature of aligning with government policy.

> *"CBIC is very closely aligned with the key messages of the recently published NHS Five Year Forward View. This has provided assurance that the CCG is ‘doing the right thing’. The project is in line with NHS England Policy, and the risk of policy changes following the general election have also reduced."*

Being ‘*in line with NHS England Policy*’ draws on ‘voices of authorization’ (Aggerholm & Thomsen, 2016, p. 200) that determine how ‘*doing*

the right thing' is framed. More specifically, the Business Case aligned CBIC with the multi-speciality community provider model (MCP), detailed within the FYFV (NHS England, 2014) as 'new models of care', designed to drive through greater integration between community, primary and social care. By aligning the CBIC with the MCP model, the Business Case was not only claiming to be consistent with national policy but was implying a direct enactment of the FYFV and new models of care.

The problematisation of patient demand and poor public finances, necessitating the need for savings and efficiency, framed the CBIC within prevailing neoliberal economic rationalities, outlining diminishing public provision for health and social care (Speed, 2016). By drawing on the IC discourse and intertextual links to national policy, the CCG reframed policy discourse to deal with local financial constraints, acting discursively to legitimise the service change. The governmental programme of integrated care, then, facilitates the politics of austerity through a framework within which both problems and solutions are addressed, justifying the enactment of programmatic aims at the local level.

5.2. *'Transformational change': intra-organisational integration and generic roles*

Despite claims of '*transformational change*', reablement (the social care element) was dropped from the CBIC prior to competitive tendering in April 2016 and mental health services no longer formed part of phase 2 implementation plans. Ex CCG CEO, Michael, described the local authority's engagement as '*warm words*', with the authority being unable to break up their social care provision across the region and retaining responsibility for reablement. CCG senior manager, Shirley, explained how the tariff for mental services could not be migrated to the community, creating difficulties with arranging the contract. Alignment with the MCP model was also uncertain, given the lack of contractual integration between primary care and community services within the CBIC (NHS England, 2016). '*System wide, transformational change*' was reduced to the provision of community health services such as community nursing, therapies, continence, stroke rehab, and speech and language. Nevertheless, the CBIC contract contained substantial financial efficiency savings, with OCC Senior Manager, Bev, reporting that there was '*year on year efficiency within the contract*' on top of existing expected NHS efficiencies (CBIC contract value fell from approx. £33.8m to £32.8m from 2017–18 to 2018–19 financial year, and from £32.8m to £32.3m between 2018–19 and 2021–22). It was within conditions of funding depreciation and little contractual integration between community services and social care/mental health/primary care that LPIs shaped organisational practices to deliver 'integrated' care and meet efficiency savings.

In LPI interviews, '*integration*' between teams became synonymous with the roles of co-located community nursing and therapy staff becoming '*generic*'. Generic community health staff are those that acquire competencies beyond their existing professional boundaries, such as therapists being trained in wound care, or incorporating mental health and social care tasks in their roles. LPIs discussed changes to roles and integration between the teams interchangeably. Below, LPI Jill makes a discursive link between '*greater integration between teams*' and being '*more generically trained*'.

> *"So, I think from a bottom-up perspective, it's greater integration between teams. So, breaking down things like the physical and mental health barriers, so people are more generically trained. We've got mental health first aid, even if they're a community therapist doing principally physical services, so we can treat the patients holistically. Using a more dynamic workforce model to satisfy patient need so you're not repeatedly having staff going into a patient's home, when actually one person with some generic training could do that. So, a more efficient model"*

Holistic care, which is often linked with integrated working (Brighton et al., 2019; Santos et al., 2018) refers to understanding a patient's experiences and building this into care delivery. It involves taking the 'physical, psychological, social and spiritual needs of individual patients, and their families or carers' into account' (Brighton et al., 2019, p. 271). By encapsulating generic roles within the broader integration narrative, Jill constructs the performance of different tasks within one visit (mental health first aid, physio, taking blood) as taking a range of patient needs into account while increasing efficiency.

Through the alignment of generic working within IC policy discourse, community healthcare workers were delineated within neo-liberal enterprising and responsibilised subject positions aimed at efficiency savings (Du Gay, 1996; Miller & Rose, 2008). Generic workers who deliver multiple tasks within one visit were described by Jill as '*dynamic*', implying flexibility, versatility and a willingness to adapt to change. Fulfilling this role, which '*reduces down on the duplication*' was constructed as common sense by OCC Senior Manager, Bev:

> "*I think what we're looking for is you get a better outcome for patients, but it reduces down on the duplication, so I might deploy a nurse, but the next week or in the same day a therapist might go out and then a social worker goes out, well actually completely wasting every bodies time, so it might be better to say the overarching needs of patient is nursing but the nurse can deliver some lower level therapy, and she's got enough to know about social services to act on behalf on social care. So, she wouldn't be making all of the decisions, but she could coordinate the care as opposed to having three people go out doing what 1 person could do*."

Bev asserts, using categorical modality, that nurses '*can deliver some lower-level therapy*', whilst knowing enough '*about social services to act on behalf of social care*.' In this sense, 'empowered' nurses would be tasked with drawing from additional skills during interactions with patients in a manner understood to be seamless and intuitive. Ultimately, Bev's responses highlight a process of responsibilisation and work intensification that facilitates economic austerity: a nurse would holistically co-ordinate care, '*as opposed to having three people go out doing what 1 person could do*'.

Community healthcare workers who resisted the role changes were, by contrast, depicted as morally culpable by LPI Henry for not taking on additional work.

> *"Sometimes some of the tasks are really small and really common sense. For example, let's say I was a nurse and I popped round, and I'm giving the medication to somebody, but I noticed that the person maybe needed a bit of a clean– Maybe even their dinner putting in a microwave, or something, because, for a lot of frail people, they're struggling to clean themselves. They're struggling. Rather than go and send them, which has just wasted somebody else's time, travel time and the waiting time as well for somebody to get out, you'd think, don't you? Common sense, "What could I do? How could I do it?" If it's a big task then, yes, but—"*

Repetition of *'really'* works to emphasise the apparent insignificance of these *'common sense'* tasks and his use of *'popped round'* implies that nurses are not in a hurry. Confronted with patients who are '*frail*' and '*struggling*', he asks these subjects to engage in confessional self-questioning in the form of '*What could I do? How could I do it?*'. Technologies of the self were thus deployed to responsibilise workers as self-governing subjects, tasked with reflecting on and actively managing their wider generic roles. '*Integration*' was therefore being delivered through subjectivities delineated by LPIs.

5.3. *Shaping the 'ideal integrated worker'*

Phase 2 data collection focussed on micro-level implementation with middle managers, frontline staff, and patients. We have illustrated how LPIs addressed community health staff as responsibilised neo-liberal subjects tasked with alleviating poor patient care through '*integration*'. However, at the local level, IC policy discourse interacted with the

material reality of funding cuts and the agency of actors, paving the way for 'lean' discourses to displace concerns for improving patient care. The targets of organisational discourse at this more localised level, in the 'witches' brew' (Foucault, 1991, p. 81) of everyday practice, moved from community health workers to a more specific focus on role changes for both rehabilitation and nursing band 3 Assistant Practitioners (APs).

For middle manager, zoe, the material reality of funding cuts was palpable

"Unfortunately, due to financial pressures, community nursing … there was some hours removed from my budget for qualified nurses which has been really detrimental to my team"

Within this context, generic roles were framed in an interdiscursive mix of lean discourse and integrated care, where the focus centred on removing '*wasted intellect*' from the rehabilitation team. Two semiotic 'points of entry', a staff newsletter distributed to staff in September 2018 and an '*integration meeting*', were analysed. The newsletter sets out five '*transformation projects*' underpinned by a '*waste watcher*' philosophy, where staff were asked to become active in the process:

"*Removing or reducing waste - be it wasted intellect, surplus stock or excess travel – can all have a positive impact on our overall organisational cost savings*."

The reader is then directed to a YouTube video link that outlines the 8 '*wastes*' of lean working. The '*Model Team Project*' describes using the '*waste watcher*' philosophy with the aim of '*reducing waste of staff intellect by ensuring that tasks are carried out by the most suitable individual*'. Here, we see generic roles becoming dislocated from its association with '*integration*', to a focus on reducing the '*waste of staff intellect*'. The newsletter claimed that:

"*[The] project will also create upskilling opportunities for staff, supporting career development"*

This suggests that adopting the role of '*waste watcher*' would allow staff to accumulate competencies for career advancement. The text outlined a process responsibilisation (Miller & Rose, 2008) through '*upskilling*' and the delineation of the enterprising subject (Du Gay, 1996), where staff take on the role of '*waste watcher*'.

The '*integration meeting*' involved two middle managers (Michelle and Claire), a senior band six nurse (Kath), and three band six physiotherapists (Kimberley, Addison, and Rebecca). By contrast, the title of the '*integration meeting*' and the labelling of generic working as '*integrated roles*' implied that at least discursively, the role change was tied to the integration narrative. References were made by attendees to those assistants with joint competencies as being '*integrated*', such as '*I know they've all got to be integrated*', '*she has really good integrated experience*', and '*she's the ideal integrated worker*'. Despite linguistic references to integrated care, the discussion focussed on identifying the most suitable assistants to be retrained and the types of additional tasks, with a notable absence of any discourse on how tasks could be combined to improve patient care. This focus was reflective of strategies to reduce staff's '*wasted intellect*' and mirrored lean discourses articulated in the September newsletter.

During a discussion for identifying appropriate APs for '*upskilling*', the main criteria was centred on those who could act as '*positive examples*'. Kath stated, '*We almost need another Candice to be a positive role model because she was so enthusiastic*'. Candice is described as the '*ideal integrated worker*', able to perform all tasks with '*everything*' written next to her name on the board in terms of competencies and with less of her intellect being '*wasted*'. The '*ideal integrated worker*' meant that staff not only take greater responsibility for additional tasks, but also began to see their own professional desires and actions in line with prevailing economic rationalities (Miller & Rose, 2008).

5.4. Managerial practice and the dislodgement of concern for improving patient care

The discursive narrative articulated in the integration meeting and staff newsletter discussed above, and dialectically transformed into managerial practice, sought to shape frontline staff into the '*ideal integrated worker*'. This side-lined concerns for improvements in patient care whilst prioritising efficiencies. This practice was enacted in three ways: 1. A training implementation strategy 2. Seeking to persuade and influence 3. A time limit for middle management offering support to resistant subjects.

1. Training implementation strategy

Firstly, the training implementation strategy focussed on identifying and eliminating '*wasted intellect*' in the rehabilitation team to compensate for resource pressure in the nursing team. Some nursing assistants were also trained in joint competencies, but with less of a managerial focus. Rehab assistants were trained in nursing competencies, with scant guidelines on how these tasks would be performed together during patient visits. References made by LPIs to holistic patient care were thus 'empty words', remaining unactualized into non-discursive practice (Chouliaraki & Fairclough, 1999, p. 29). As middle manager, Katherine explained:

"Again, it's about every contact counting. When we started looking at this our first point of call was to up-skill our community therapist, the core. The core services as opposed to the hosted services. The core and it was let's get the therapy unregistered staff delivering competent in giving insulins, because it's the insulins that when you've got so many to do morning and evening, if you've got more people that can do it, if you've got more people who can get on with the rest of the jobs. That didn't come out of any logical, so you're getting a community rehab member of staff going to see someone who's had a hip replacement and they need their clips removed. We didn't do the clips first or the wound care, we did the insulin because it was more about our pressure as opposed to what was logical."

Here, Katherine frames reducing wasted intellect as '*every contact counting*', where rehab assistants trained in insulin injections can allow '*more people who can get on with the rest of the jobs'* to deal with the '*pressure*' in the nursing service. She emphasises that this strategy deviated from original aims around holistic care, where rehab assistant would both remove surgery clips and guide patients with exercises.

2. Seeking to persuade and influence

Middle managers reported that they had experienced substantial resistance to the workforce change from rehab assistants. They had adopted a strategy of persuasion, as described below, by middle manager, Denise:

"*So they'll say "well I'm a physio and that's what I wanted to do. If I wanted to do x,y,z, I'd have trained to do x,y,z. If I wanted to be a nurse, I'd have trained to be a nurse … This is my profession. That is what I want to do". But by explaining the wider system and explaining how health care needs to work across the health economy and explaining the benefits of (CBIC) and integration, they are gradually coming to terms with it and as time's gone on, they have understood and appreciated first-hand the benefits that can have for a patient. So instead of working in a silo by being able to add more value to their visits, they've seen the value of that now first-hand.*"

Denise describes a journey from a position of self-interested reasoning, '*If I wanted to be a nurse, I'd have trained to be a nurse*', to one in which the benefits of integration are accepted over time. Emphasising the subjectifying nature of Denise's interactions, her staff are described as having '*understood and appreciated first-hand the benefits that can have for a*

patient'. Interestingly, persuasion by middle managers sought to draw on the patient benefits of integration, despite a lack of attention to this in the training implementation strategy. The process described by Denise shifts from staff being focussed on their own preferences, to one in which they move beyond their own self-interest in considering the benefits for patients, acting upon themselves in line with an ethical framework of integrated care.

3. Time limited support

Middle managers described a time limit to patience and support offered to resistant rehab assistants. Middle manager, Fiona, blamed the assistant's '*age*' and '*confidence*' for the difficulties they were experiencing adopting the role, whilst emphasising that support was on hand from herself and senior clinicians. Staff were urged to come forward, with Fiona stating, '*if you don't understand something, just say*'. She argued that it was the responsibility of the assistants to '*push themselves to do it*' and they '*need to get on with it*'.

Middle manager, Michelle, individualised barriers to assistants taking on the generic role by addressing objections to generic working as preferences. In the below example, an assistant who is happy to do venepuncture (withdrawing blood), but has a severe stress response to wound care, is characterised as exhibiting a preference. This serves to delegitimise workplace stress as an acceptable objection to a change of job role.

> *"She's pushed back a lot saying, "Is there any way that I can be excluded from it? I really hate it. I never wanted to work with wounds. I find it disgusting. It makes me sick. It's making me feel really stressed." She's got eczema and said that her eczema was getting worse and she was getting stressed out I think. With her, I just said that "Look you've got the opportunity to go to occupational health, you can self-refer." I said, "If you feel that really strongly, you can speak to an HR advisor about it". She did approach HR about the role and asked if she could be excluded. Now, they spoke to me and said "Is there any way that this can't happen?" I said, "It really– If we exclude one person just because of a preference, we can't really, we can't really allow that. Otherwise, other people, they would be able to come also and say "I can't do this. I can't do that". It would really be difficult"*

Conceptualising the response as a '*preference*' problematises the individual and allows an equity claim to be made on behalf of staff who have retrained. It also silences any claim that the clinician may have to be exempt from a particular task, and shifts responsibility away from management, enabling Michelle to refuse an exemption for wound care. The assistant is advised to go to Human Resources or Occupational Health, indicating that dialogue has been exhausted and that options for the assistant are narrowing. Here, the assistant is encouraged to become solely responsible for her stress response and any difficulties associated with the role change.

The socially structuring effect of funding cuts and resource pressure in the nursing team meant that IC discourse was operationalised through managerial practice to shape '*waste watcher*' subject positions. Below, we demonstrate how APs resisted these subject positions, which we conceptualised as a 'perception of injustice'. Nevertheless, APs remained powerless to resist the changes materially.

5.5. Assistant practitioners and the perception of injustice

A perception of injustice characterised the response from the APs interviewed in this study to attempts to shape the '*ideal integrated worker*' through 1) the training implementation strategy 2), seeking to persuade and influence, and 3) a time limit for support. These subjects strongly rejected becoming empowered to eliminate '*wasted intellect*' through '*upskilling*'. Specifically, rehab assistants rejected being made responsible for '*integration*' and for problems associated with their role change. Instead, they described feeling anxious and disorientated whilst carrying out these duties, sought to reaffirm previous professional identities, and described generic working as a waste of their expertise. The rejection of generic working and the reaffirmation of professional identities illustrated a struggle over the terms of government: resistance akin to a "return to scripture" (Foucault, 2009, p. 281), where professional principles were deployed against the 'pastorate'. Moreover, some rehab APs reported that they felt they were taking on the burden of what was considered '*integration*' in the organisation:

> "*It was frustrating … when we started doing the insulins it was like we were sold this as 'integration', but all that we could see was us integrating, we couldn't see anybody else doing anything back. I don't know whether that would have sort of softened the blow, but you kind of thought, "Why is it just us?*" (Diana, AP)

Other APs described this burden in starker terms, with Laura stating that '*APs have really [taken] a hammering with this (CBIC)*', and that they '*have got the blunt end of it*'. Representing their treatment through violent imagery suggests that Laura perceived rehab assistants to be subject to more coercive discipline, as opposed to more subtle forms of persuasion.

Middle managers emphasised that APs were well supported in their change of job role, both in terms of training and ongoing support from senior clinicians. Barriers to fulfilment were ascribed to the assistants themselves, framed as preferences, age, and confidence, thus legitimising management's stated limitations on willingness to tolerate resistance. Below, Candice, who Kath described as the '*ideal integrated worker*', discussed the difficulties with '*upskilling*' required within her new role, where the materiality of care means you have '*constantly got to keep on thinking on your feet all day long*' which can leave you '*stressed out*':

> *"You feel a bit pressured I suppose, because I feel like I have to be quite relaxed to take blood. If I'm all stressed out, I can't really do it and then things end up taking longer than they would do normally. Quite often we've rehab visits, they quite often stipulate 'not in the morning', and then you've got that to contend with it as well as all your other work to do. You might also get triage phone and say, there's a blocked catheter and as you're there can you go and do that as well? There is a lot to think about. You've constantly got to keep on thinking on your feet all day long.*"

Moreover, Diana further emphasised her insecurities and incongruence with how she understands her professional expertise compared to nursing, by describing feeling like '*a bit of a fraud*' and that '*it was a bit frightening really*'. In a more alarming admission, she revealed that she had not been signed off by a senior nurse for some the nursing care she was delivering. In relation to wound care she said:

> *"We worked that out amongst ourselves, what's not going to cause any harm. Might not necessarily be good, but what's the one dressing. Once we had worked that all out. I suppose perhaps with time, confidence has grown, but no, not at first.*"

Her reference to how they '*worked that out amongst ourselves*' also suggests a lack of support and/or training in fulfilling the role, directly challenging the managerial problematisation of '*preference*' or '*confidence*'. Whilst fear over causing physical harm emphasises how bodily effects can influence processes of subjectification.

Nursing assistants, although less dismayed, described a feeling of futility towards rehab tasks. In contrast to rehab assistants, challenged by the difficulty and responsibility of taking on extra nursing tasks, nursing assistants described rehabilitation as lacking the variety of their usual duties. For example, Leah, described rehab as both '*boring*' and '*monotonous*'. In this sense, they felt that nursing skills were being wasted to fulfil tasks considered to be less important, or incompatible, with their professional identity. Amber performed her own '*waste watching*' by asserting that her skills were being '*wasted*' in the generic role, and challenged the notion of '*upskilling*' by describing rehab as '*a very unskilled job*'. Despite this, Amber stated, '*I go and do it*'. Both nursing and

rehab APs also reflected that nursing and rehab tasks were often incompatible in the same visit due to the time sensitive nature of insulin administration, or the pain and discomfort caused. Despite a misalignment between organisational discourse reframed through IC policy discourse and their own professional identity, APs assumed responsibility for funding cuts and many of the difficulties associated with their role change, yet with little benefit for patient care.

6. Discussion and conclusion

Our paper has developed a critical perspective that challenges the dominant orthodoxy of integrated care as an apolitical technocratic intervention designed to meet challenges of high hospital admissions, poor patient experience and fragmented care (see: Middleton et al., 2019; Trankle et al., 2019; Lalani et al., 2019). Our study supports findings from recent evaluations that highlight how efficiency and cost reduction aims within integrated care implementation have dislodged concerns for patient care (Eyre et al., 2017; Maniatopoulos et al., 2020; Gadsby et al., 2022). However, in our view, conflict between improved patient care and efficiency is not just something that 'happens' through integrated care implementation. We found that integrated care is 'offered' to those at the local level with a promise of better patient care, which they deploy flexibility within the constraints of funding cuts. Power acted through this local deployment and sought to shape frontline staff into ethical subjectivities that enacted government 'at a distance' (Miller & Rose, 2008).

Other studies (i.e. Fraser et al., 2019) have sought to adopt the perspective of governmentality to explain how health service reconfiguration becomes a desirable response to 'risks' and 'dangers', enacted through processes of subjectification for health professionals and the wider public. The present study builds on this work by detailing how health professionals become the targets of power within the context of community based integrated care to mobilise neo-liberal austerity. Glynos et al. (2015, p. 56) argue that IC has an "'empty' oppositional status" in which it acts as a 'conduit through which a set of wider discourses and fantasies can play themselves out'. By exploring the way in which the IC policy discourse was received and enacted through different levels of implementation, and its interaction with materiality and the agency of actors, we have shown how discourses interact and mutually constitute each other at the local level. The broader narrative of integrated care became a conduit for more established discourses of lean working, emphasising that the empty nature of the IC policy discourse provides a space within which local actors to modify established practices associated with neoliberal government. Throughout, managerial techniques to derive efficiency and savings are prised over professional judgement (Speed & Gabe, 2013), exposing the intricate workings of power that operate through integrated care policy.

Our analysis has sought to develop a normative critique of IC policy discourse and its role in facilitating the enactment of austerity at the local level. The politics of austerity are known to have harmful effects on health in the UK and Europe by reducing health coverage, restricting access to care, and deteriorating working conditions and pay for health and social care workers (Stuckler et al., 2017). The drive for efficiency under funding constraints leads to task orientated care and a withdrawal of clinical judgement, empathy and compassion in patient-clinician interactions (Kerasidou, 2019). It can also lead to work intensification, isolation, and alienation for staff (Owens et al., 2019). Whilst a recent study on role change initiatives within the NHS found that 'skill mix employment' was alluring to both GPs and managers in promising to deal with staff shortages and cost-efficiencies, findings did not reflect interprofessional competition or guarding of professional boundaries (McDermott et al., 2022). By contrast, alienation, stress, loss of enjoyment from one's role, and a disconnection from one's professional identity, were day-to-day experiences for many of the subjects in this study. These findings demonstrate a dislocation from stated FYFV objectives, the MCP model, and wider integration narratives promising improved patient care through health and social care integration, upon which the CBIC derived its legitimacy. Given the international attention on the benefits of integrated care policy for patients and the public (Goddard & Mason, 2017; Harvey et al., 2018; Raus et al., 2020), these findings have wide ranging implications for challenging dominant governmental narratives on the benefits of IC.

We have proposed that governmentality studies would benefit from drawing on the DRA as a methodological and analytical framework to help tease out shifting articulations of discourse, materiality, and agency within empirical study. By analytically separating discourse in its semiotic form from its differential retention into non-discursive practice, we have shown how IC policy discourse was drawn upon, interpreted and enacted at different stages of policy implementation. Importantly, we demonstrate how IC policy discourse shifts from its meso-level articulation as '*transformational change*', to micro level '*waste watching*' within the material reality of funding cuts. Our findings complement Waring and Latif's (2018) work on pastoral intermediaries by illustrating how differentially situated middle managers, rehabilitation, and nursing assistants hold identities that animate varying forms of agency and resistance. By taking seriously the influence of materiality in shaping governmentality, we also show how actors grounded in the materiality of care are structured in the way they interpret, draw upon and enact discourse. This was particularly pertinent in relation to physical disgust, fear of causing harm, and stress in the performance of tasks.

Given the dominance of integrated care as a governmental discourse in UK health and social care, further research might consider a governmentality perspective upon more recent iterations of integrated care policy, including STPs and ICSs. In particular, this work could follow arguments made by Leys (2016) and Hammond et al. (2017) on the responsibilisation of local areas for funding constraints at the expense of improved patient care within STPs. Again, those at the local level are 'offered' ways of resolving often irreconcilable conflicts leading to subjects becoming the targets and vehicles of power for perpetuating governmental objectives. These policy initiatives differ from the present case study in that they attempt to move beyond individual integration projects to 'placed-based' planning and delivery over a wider geographic footprint. Further research may explore how problems, solutions and failures are framed, negotiated, and justified within this context.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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