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International Entrepreneurship and Management Journal
https://doi.org/10.1007/s11365-019-00583-8

How far has the integrated care come? Applying an asymmetric lens to inter-organisation trust amongst health and social care organisations

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Published online: 04 May 2019

Abstract

The extant literature on interpersonal and inter-organisational trust reveals there are many factors that can influence an organisations' services to integrate and exchange. While these studies have enhanced our understanding of organisational collaboration, we propose an asymmetric perspective that concentrates on factors that eventually lead to the loss of inter-organisational trust in the context of the (National Health Services) NHS and local government by seeking to join-up health and care services. This paper explores trust and asymmetry factors that undermine collaborative spirits towards successful service integration among health and care players. Based on interviews with 42 subjects in the NHS England Better Care Fund (BCF) programme, we present a model that distinguishes between asymmetric factors and affected health and care service integration. Our findings contribute to a scholarly understanding of asymmetry in the public sector and the role of trust in overcoming divisions and facilitating joint-up services among health and care organisations.

Keywords Asymmetric lens · Better care fund · Inter-organisational trust · National collaboration for integrated care and support · Public sector inter-organisational initiatives

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Introduction

Over the past three decades, broad changes in the practice of integration between health and social care services have been occurring across North America, Europe and elsewhere (Campbell et al. 1998; Kodner and Spreeuwenberg 2002; Ouwens et al. 2005) as a means of providing better and more cost-effective health and social care. As a result, scholars have become increasingly interested in what leads countries, institutions and departments to integrate successfully. A considerable amount of published research on integrated care has focused on identifying factors that influence integration, such as service sectors, professions, settings, organisations and types of care (Ahgren and Axelsson 2005; Busse and Stahl 2014; Kodner and Kyriacou 2000; Valentijn et al. 2013). These studies are generally described as investigating the degree to which particular, pre-designated factors lead to integration between health and social care services. Other studies in the area mostly discuss the integration process by articulating the various steps patients go through in their care (Bartels 2004; Bousquet et al. 2011; Casas et al. 2006; Chen et al. 2016; Lambeek et al. 2010). Although, such studies tend to report integration between health and social care services as a one-dimensional phenomenon. These streams of research have increased our understanding of factors that influence service integration between health and social care, and patient flow in health systems. However, there are a number of important critiques of these approaches that point to an important area for further exploration.

First, despite the literature successfully highlighting various factors that may influence integration between health and social care services, the loss of trust surrounding public sector integration initiatives have not been fully captured. For example, patient-practitioner relationships continue to be under debate from a trust perspective. Yet, there are still few empirical studies on inter-organisational trust that review problems of inter-organisational relationships that may cause low levels of trust or undermine the integrated care process. For example, cognitive and organisational differences between health and social care services are mentioned in the literature as causing organisations to lose trust in each other. However, it is unclear as to why this might be. Is it because of differences in management styles, skills and expertise, or because of differences in performance regimes and reporting requirements? (The King's Fund 2012, 2013). In order to understand what particular factors lead to the loss of inter-organisational trust in health and social care services, we need to understand how organisations interpret and make sense of these types of factors.

Second, existing decision-making models of inter-organisational trust are highly instrumental and generalized. These models are founded on transaction cost economics, resource-based view, inter-organisational cooperation, sociological and psychological theories (Dyer and Chu 2000; Möllering 2002; Nooteboom et al. 1997; Young-Ybarra and Wiersema 1999; Zaheer et al. 1998). However, there is evidence that these are sometimes highly rational processes for the inter-organisational trust that do not provide a practical approach for capturing how trust is currently formed, developed and maintained. For example, in health and social care, most empirical investigations of inter-organisational trust examine the phenomenon from the perspective of only one partner. Considering inter-organisational cooperation from the perspective of both partners is imperative, especially when partners depend on each other (McEvily et al. 2017). Relationships that include asymmetric independence and power are more

dysfunctional and less stable than symmetric relationships (Kumar and Van Dissel 1996). In these situations, inter-organisational trust differs according to the partner's position in the relationship, that is to say, their relative independence and power. Accordingly, the loss of inter-organisational trust is more likely to occur due to dynamic factors (i.e. asymmetries, "differences" amongst partners) rather than easily representable static factors that remain consistent throughout the course of a relationship. In short, a more nuanced review of the literature could shed more light on our understanding of how health and social care organisations decide to trust.

Third, there are implications for viewing inter-organisational trust through an asymmetric lens. Applying an asymmetric lens focuses our attention on factors that may influence inter-organisational trust and the process through which it is formed, developed and maintained. A common pitfall of this approach is that it fails to address how organisations come to understand thoughts and stories concerning their partners, as well as why those thoughts and stories occur. Accordingly, a qualitative exploratory approach (Merriam 2009) can complement our study on inter-organisational trust giving subjective meaning to these thoughts and stories bringing them to the fore.

To address these three assessments, we conducted an inductive study of health and social care services in England with 42 subjects, through a qualitative exploratory approach to understand inter-organisational trust. A qualitative exploratory approach focuses our attention on the thoughts and stories that organisations use to comprehend their loss of inter-organisational trust, in addition to the subjective meanings behind those thoughts and stories. As a result, this qualitative exploratory approach to understanding the loss of inter-organisational trust enables us to gain insights into why specific factors influence the loss of inter-organisational trust. Moreover, a qualitative exploratory approach highlights the contextual limitations and constraints that organisations believe lead to the loss of inter-organisational trust. Our findings suggest that existing literature overemphasises interpersonal trust (i.e. trust between individuals) in inter-organisational trust relations. While the link between asymmetry and inter-organisational trust largely remains unexplored. Finally, a qualitative-exploratory approach extends our current understandings, because it emphasizes the subjective meanings behind losing inter-organisational trust.

Public sector inter-organisational initiatives

The use of government-funded inter-organisational initiatives has been characterised as a powerful strategy for administrative reform, offering important strategic options to address the multiple and complex needs of a populous. Although with the caveat that there will be significant ramifications to public sector organisations (Gil-García and Pardo 2005; Scholl and Klischewski 2007; Schooley and Horan 2007) and individuals within them (Paul Battaglio Jr and Condrey 2009; Buchan 2000; Moynihan and Pandey 2007; Yang and Holzer 2006). Governments pursue these initiatives to achieve a multitude of outcomes such as higher agility; enhancing government's capacity to act by forging strategic inter-organisational coalitions; improving policy effectiveness, developing citizen-centeredness, accountability, transparency, and active participation; reducing operating costs, and increasing efficiency in government operations and services (Bellamy 2000; Bertot et al. 2010; Dawes 1996; Fedorowicz et al. 2009;

Garson 2004; Luna-Reyes et al. 2010; Reddick 2009). Much of the earlier research in this area has been conducted from different vantage points. But, it can be generally categorized as addressing questions such as the benefits of integration, barriers and costs (Dolowitz and Marsh 1996; Gil-García and Pardo 2005; Jordan and Lenschow 2010; Lam 2005; Yildiz 2007).

Though, many, if not most inter-organisational initiatives suffer from a high rate of failure (Heeks and Bhatnagar 1999; Economist 2000). For instance, Heeks (2003) showed in his study that 35% of public sector ICT projects from around the world could be categorized as total failures, 50% as partial failures, and only 15% as successes. Therefore, scholars have recommended further studies in this area to avoid future failures (Kaaya 2004; Peters et al. 2004). Our review of the literature on critical success factors and barriers on these initiatives identified the loss of inter-organisational trust as one of the key areas of concern (Almarabeh and AbuAli 2010; Bhatnagar 2004; Ebrahim and Irani 2005; Kumar et al. 2007; Ndou 2004). Further to, recognising the importance of "closer working relationships between government stakeholders" as an underlying trend for success (Gil-García and Pardo 2005; Lam 2005). Similar to other practitioner-oriented discussions (Bellamy 2000; Harris 2000; Das et al. 2010; Dawes and Pardo 2002; Rocheleau 2000) as well as reviews (Heeks and Bailur 2007; Kim et al. 2007). For example, according to Ebrahim and Irani (2005) organisational issues such as, coordination and cooperation between departments, operational support from leadership and commitment amongst senior public officials, clarity of vision and management strategy, complexity of business processes, politics, cultural issues and resistance to change at all levels of an organisation act as key barriers to integration. While Heeks and Bailur (2007) similarly emphasize the recognition of human and other contextual factors in his appraisal of e-government research as a positive feature for extending the present body of knowledge.

Inter-organisational initiatives and trust

We are of the view that inter-organisational trust is an "a state of mind, a belief, or an expectation held by an agent that its trading partner will behave in a mutually acceptable manner" (Sako and Helper 1998). "Trust between individual and/or collective actors is based on the decision of one party to rely on another party under conditions of risk. The trustor permits his or her fate to be determined by the trustee and risks that he or she will experience negative outcomes, i.e. injury or loss, if the trustee proves untrustworthy" (Bachmann and Inkpen 2011); resulting in a trust violation i.e. failure of one party to perform in accordance with the expectations of the other, "an occurrence quite frequent in inter-organizational contexts" (Janowicz-Panjaitan and Krishnan 2009).

The ever-increasing body of literature and commentary has created numerous definitions of inter-organizational trust over the years. Studies conducted take very different approaches, depending on researchers', theoretical backgrounds, and empirical context (Blomqvist 1997; Hosmer 1995; Rousseau et al. 1998). In addition, "there seems to be some discrepancy as to what is actually being studied. Some studies clearly set out to measure the trustworthiness of the other party, while others focus on mutual trust." (Seppänen et al. 2007). In this paper, we attempt to add to the stream of research

on mutual trust, which we term as a "generalized expectation that the promise of an individual can be relied on" (Rotter 1967).

A key challenge of inter-organisational initiatives is the loss of trust. In the context of public sector initiatives, sufficient trust is needed to "initiate co-operation, and a sufficiently successful outcome to reinforce trusting attitudes and underpin more substantial subsequent collaborative activity" (Hudson et al. 1999). In other words, trust makes cooperative endeavours happen (e.g. Arrow 1974; Deutsch 1977; Gambetta 2000), and researchers on inter-organisational relationships have consistently argued that mutual trust is an essential factor for good relationship quality and performance (Seppänen et al. 2007). For example, a book on partnering recently quoted a representative business person as saying, "...'there are a lot of issues in partnering,… but trust is truly the key. Everything else has to be based on it. Without trust, there is no basis for partnering. It's the bottom line...'" (Rackham et al. 1996).

So, "Trust is often identified as a '*sine qua non*' of successful collaboration and -conversely- mistrust as a primary barrier" (Hudson et al. 1999). A number of features in inter-organisational initiatives can be associated with lower levels of trust. Some are relating to asymmetry – a lack of equality or equivalence in the inter-organisational initiatives at an individual and/or organisational level (e.g. alignment of cultures, resistance to change, and loss of professional identity), while others relate to diversity of character or content amongst organisations (e.g. restrictive laws and regulations, separation of funding streams and budgets and power inequality); fundamentally qualifying how similar or dissimilar two organisations are in an alliance and its effects on trust outcomes (e.g. perception of violations of the psychological contract, low levels of information sharing, knowledge and learning). These issues from our review of the literature are summarized in Table 1.

Despite these notable contributions to understanding public sector inter-organisational initiatives, there is a number of important limitations in this work that presents opportunities for further research. Firstly, more often than not, the concept of trust is used loosely in an everyday manner, with confusion apparent, and without the meaning of the concept being fully clarified, despite the complex nature of trust and differences between its dimensions. For instance, interpersonal and inter-organisational trust are often treated as interchangeable terms across the collected work and/or individual studies see (The King's Fund 2013). Regardless of both terms having specific characteristics and requiring personalised research approaches. Secondly, in the field of health care research, most studies have heavily focused on patient-practitioner relationships and less on the specific inter-organisational trust relations occurring between network nodes (organisations). That is to say, inter-organisational trust receives far less attention in the literature, despite its demonstrated value in other fields, and few studies have been undertaken with the aim of understanding it in health care. Therefore, there is a scarcity of literature about inter-organisational trust in health and care organisations and it is time to fill the gap.

Asymmetry and inter-organisational trust

Literature shows that organisations collaborate for a number of reasons including, but not limited to, sharing risk, gaining access to resources, growth and long-term strategic

Table 1 Issues of inter-organisational initiatives

Asymmetry	Sources
Low perceived value of knowledge, expertise and capabilities of less dominate organisations	Sako and Helper (1998)
Absence of a positive history of interactions among organisations	MacDuffie (2011)
Cultural differences between organisations	Ariño et al. (1997)
Low levels of information sharing, knowledge and learning among organisations	Das and Teng (2001)
Organisational/individual resistance to change	Van Dam et al. (2008)
Perception of violations of the psychological contract i.e. expectations both between individuals and organisations	Grimshaw et al. (2005)
Perceptions of low levels of organisational justice i.e. fairness	Zaheer et al. (1998)
Lack of improvement in job security or other similar rewards	Stahl et al. (2011)
Uncertainty in the border social, economic and demographic context	Rousseau et al. (1998)
Lower levels of organisational independence	Nooteboom et al. (1997)
Separation of funding streams and budgets, obscuring financial responsibility and accountability, creating perceptions of cost-shifting	Smith and Barclay (1997)
Restrictive/conflicting laws and regulations	Ring and Van de Ven (1994)
Power inequality among organisations allowing one or more organisation to excerpt more control over others'	Bachmann (2001)
Absence of effective staff engagement and leadership	The King's Fund (2012)

advantage (Pfeffer and Nowak 1976; Hennart 1988; Hagedoorn 1995; Dunning 2015; Glaister 1996; Inkpen and Beamish 1997). Therefore, collaboration can be described as an approach to reducing uncertainty in relation to demand and competition (Burgers et al. 1993). Pooling skills, expertise and resources to meet common goals, innately linked to the strategic objectives of the organisation (Varadarajan and Cunningham 1995). Alliances provide a great value proposition for public sector organisations, and so they have increased significantly in recent years. However, it is widely accepted that alliances are rarely formed among equals, leaving some parties more favoured than others (Harrigan 1988).

Very broadly, the concept of asymmetry is a rejection of symmetry. Following this line of thinking, (Melin and Axelsson 2004) describes symmetry as two parties equal in terms of power, information access, initiatives, commitment etc. A review of recent literature shows asymmetry has been used to label tangible, and intangible facets of inter-organisational relationships, particularly those in alliances (Cimon 2004). Five commonly mentioned tangible asymmetries include: eclectic asymmetries (e.g. asset size, national origin and venturing experience levels) (Harrigan 1988), strategic asymmetries (e.g. endeavours dedicated to survival) (Hannan and Freeman 1984), competitive asymmetries (e.g. threats organisations pose to one another) (Chen 1996), power asymmetries (e.g. reflected by size or by control of resources or of inter-organizational dependencies) (Oliver 1990), and network asymmetries (e.g. position of partners in link alliances) (Hennart 1988). These types of asymmetries are mainly studied in relation to size or other structural and governance factors. However, in part, they have failed to incorporate other types of asymmetries such as intangible assets. In contrast, knowledge-based asymmetries are associated with issues of

opportunism and methods of operation (Papadopoulos et al. 2008), and is often discussed as unobservable asymmetry (Ariño et al. 2001; Casciaro 2003; Chen 1996). Our research largely falls into this area.

Knowledge-based asymmetries seek to provide protection of "specific assets" from opportunism, which is a major concern for organisations in partnership (Williamson 1979). Knowledge-based assets are typically subject to this type of protection because they are non-rival assets and related to an organisations interdependence (Pfeffer and Nowak 1976). Organisations often try to participate in inter-organisational partnerships to engage in opportunistic behaviour and partners need a "hostage" of sorts, in order to increase confidence towards them (Williamson 1983). Although, collaborating solely for the purpose of "egotistical" self-centred motives constantly lead to sub-optimal payoffs (Thaler 1992), and manifests negative effects on trust (Ariño et al. 2001).

In essence, trust acts as a basis for a stable relationship and knowledge helps to determine the trustworthiness of a partner. Hardin (2002) describes this as "knowledge to allow the trusted to trust" while stating this type of knowledge is typically developed through day-to-day experiences, interactions and relevant evidence "information". Similarly, Hovland and Sherif (1952) argue that a series of complex attitudes can respond favourably or unfavourably to an object, person, institution, or event. Therefore, it is possible to conclude that an increase in knowledge (information, experience and attitude) will lead to a more accurate assessment of the trustworthiness of a partner. For example, if an individual expects a partner to act or behave in a specific way according to a contractual agreement, knowledge about the actual actions or behaviours of a partner makes those expectations more certain, allowing for a more accurate assessment of their trustworthiness. Therefore, the smaller the knowledge asymmetry between an individual and a partner, the more accurately the individual can assess their trustworthiness, effectively balancing trust and control elements of the inter-organisational relationship and perception of risk and consequence.

Also, high levels of asymmetry may lead to a lack of synergy between collaborating organisations. An imbalance of organisational structural factors linked to asymmetries such as fragmentation and poor relations, and communication between departments and organisations, and acceptance by senior management of the strategic benefits of new inter-organisational initiatives are likely to influence loss of trust. (Aichholzer and Schmutzer 2000; Fletcher and Wright 1995). As well as other factors such as business process management, strategy and organisational culture (Lenk and Traunmuller 2000; McClure 2000; Li 2003). Similarly, it is widely acknowledged by academics and practitioners alike, that strong leadership and responsive management processes are a crucial element of successful inter-organisational alliances because of the complexity and scale of changes that take place during collaboration in an organisation (Bonham et al. 2001; Burn and Robins 2003). However, some government officials perceive inter-organisational collaboration as a potential threat to their power and viability because it may undermine their authority. Therefore, becoming reluctant to "participate" in the collaborative exercise. In addition, competency-based factors linked to asymmetry, for instance, a public-sector officials' willingness to change and re-engineer processes to suit new strategies, and a culture of collaboration are also likely to affect trust formation and development. Moreover, funding for public sector organisations is another issue, as traditionally financial resources have been allocated to public sector organisations by the central government or local authorities, which is

hard and difficult to control, and sometimes politics is at play (Heeks 1999). Hence, making it difficult to plan sustainable inter-organisational initiatives, and, many authors have also argued that a lack of financial resource is a significant barrier to public sector inter-organisational alliances such as e-government (Norris et al. 2001).

In the literature of inter-organisational alliances, there is a small body of work addressing asymmetry; according to Papadopoulos et al. (2008) "few authors have undertaken in-depth reviews of the theoretical foundations behind asymmetrical alliances" and "the managerial and academic implications of these issues been explored fully". Similarly, our review shows such work is still quite rare (e.g. Blomqvist 2002) and no studies have yet explicitly explored the connections between asymmetry and loss of inter-organisational trust. Our goal in this study is to begin to fill this gap and our research questions are as follows: (a) what are the asymmetry factors that lead to low levels of trust in inter-organisational initiatives; and (b) what role does asymmetry play in inter-organisational trust in the context of health and care joint-up services?

Methods

Trust in integrated care is an emerging concept that has begun to attract researchers from a wide range of disciplines, especially when it comes to the complexity and dynamics of inter-organisational relationships amongst health, social care and local authorities. We have adopted a qualitative-exploratory approach to comprehending "the meaning people have constructed, that is, how people make sense of their world and the experiences they have in that world" (Merriam 2009), where the focus is to study the natural setting (Denzin and Lincoln 1994). Qualitative studies are suggested to be most appropriate for reviewing poorly understood phenomena (Marshall and Rossman 1995), especially when contextualisation, dynamic structured works and the worldviews of people are under study and important (Lee 1999). A detailed qualitative investigation is therefore appropriate for our purpose because 1) what leads to the loss of inter-organisational trust in the context of integrated is not well understood; 2) we are interested in the worldviews of key stakeholders in integrated care including health, social care and local authorities experiencing the loss of inter-organisational trust; 3) our study is exploratory and is aimed at building theory (e.g. Eisenhardt 1989; Yin 2013).

Furthermore, it is said that existing literature is overly quantitative and they 'would like to see new conceptual development and more qualitative work' (Möllering 2002). Therefore, our qualitative approach is also consistent with what is needed in trust literature i.e. more qualitative work and reality checks. We have used existing trust theory and the understanding of integrated care outcomes to form a Literature Review, which has served as an overview to see the "world in a certain way" (Klein and Myers 1999). An interpretive approach was adopted to understand this phenomenon, through examining the natural settings from the perspective of participants (Orlikowski and Baroudi 1991) and to highlight their viewpoints, expressed through their narratives.

Better care fund and healthcare service providers

We have selected to study inter-organisational trust by focusing on the "Better Care Fund" programme in the United Kingdom. The Better Care Fund (BCF) spans both the

NHS and local government and seeks to join-up health and care services, so that people can manage their own health and well-being, and live independently in their communities for as long as possible. The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life, aligning to the vision outlined in the NHS five year forward view (NHS England 2012). The Better Care Fund will provide financial support for councils and NHS organisations to jointly plan and work together to deliver local services (Department of Health and Department for Communities and Local Government 2017). The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding. Local service providers under better care fund include hospitals, ambulances, pharmacies, general practice, care home, personal helpers, community groups etc. It involves NHS, local authority and voluntary sectors. The voluntary and community sector is a provider operating on an equal playing field with NHS and private health care providers in the 'any willing provider' market (Department of Health 2016). Examples of the voluntary sector include Age UK as the UK's largest charity dedicated to helping everyone make most of later life and British Red Cross helps people in crisis. Partnership working between the voluntary sector, local government and the NHS is crucial to improving care for people and communities.

We selected the BCF in this research project for several reasons. First, the BCF represents a unique collaboration between NHS England, communities and local government, department of health and the local government association. The BCF requires cross-cutting partnerships to support local areas to plan and implement integrated health and social care services across England. Preliminary research revealed that there was a problem with inter-agency relationships resulting in or generating low levels of trust relations, which was believed to be undermining the progress with older people 'falling through gaps' between services (The King's Fund 2013).

This makes our data selection have a 'rare or unique' quality justifying its logical candidacy for "theoretical sampling" in this research project (Eisenhardt 1989; Yin 2013). Second, the BCF is recognised as one of the most ambitious programmes ever introduced across the NHS and local government providing the biggest ever-financial incentive (Department of Health 2016). The BCF has already made real changes and impact on the integration of local health and social care systems. This has generated a considerable amount of press interest and availability of a tremendous range of information on the integration programme. Our data collection and analysis attempts to identify trust challenges, what factors lead to the loss of inter-organisational trust, which have a direct influence on integrated care outcomes. The consideration of trust theory and the investigation of integrated care outcomes provides us with a guide to design our data collection process. In sections 5.1 and 5.2, we present further details of our data collection and analysis.

Data collection

We collected data over a 12-month period from March 2016 to March 2017. The aim was to study the BCF and understand how trust-based relationships are formed, developed and maintained in a particular region of South East England across

individuals, agencies and sectors. We interviewed 42 subjects including, healthcare professionals, nurses, integration managers, IT professionals, community and voluntary organisations and subject matter experts. Individual interviewees were selected based on guidance provided by integration managers for specific areas, and suggestions from individuals of significant power or experience were taken into consideration for interview selection. This provided a wide range of interviewees across the health and social care system and its counterparts ensuing representation of different stakeholder groups. Each interview was recorded and transcribed then we performed the thematic analysis. In addition, notes and diagrams were created by the interviewer on site to document additional contextual data about each interview. The narratives used in this research paper were generated from these interview transcripts. Each interview session lasted on average of an hour and included subjects from different backgrounds offering rich perspectives on trust-based relationships.

Our interview questions consisted of two parts. The first part focused on the interviewee's experience in delivering joined-up services and working in cross-cutting partnerships. A flowchart describing the architectural view of the integrated care process and interaction among stakeholders was used to engage participants throughout these discussions. Consequently, the flowchart acted as a living document that evolved from interview to interview facilitating the data collection process. Furthermore, specific questions were created based on the background of each participant, as they possessed vastly different knowledge, experience, and perspectives.

The second part of the interview questions focused on organisational asymmetry, inter-organisational trust, and its impact on integrated care. In response to these types of questions, interviewees sometimes raised the topic of trust in their responses, if this did not, they were probed about their understanding of trust and its influence on their relationships with other individuals, groups and organisations in the BCF programme. Moreover, we supplemented our research through secondary data such as journals, conference papers, books, articles, government reports, and news sources, which were mentioned by interviewees or identified through our independent literature review. Our study on inter-organisational trust is consistent with the notion of trust as an expectation or belief held by an agent that its trading partner will behave in a mutually acceptable manner (Sako and Helper 1998) and in other empirical studies such as, (Atkinson 2004; Möllering 2002).

Data analysis

Qualitative data is described as "*Immersing oneself in the data and then searching out patterns, identifying possibly surprising phenomena, and being sensitive to inconsistencies, such as divergent views offered by different groups of individuals*" (Hammersley and Atkinson 2007). We carried out a systematic approach using thematic and interpretive analysis theorizing across a number of cases in order to find patterns across participants and their stories and thoughts (Riessman 2005).

The data analysis involves four stages. In the first stage, all interviews were transcribed- "*transcription entails a translation*" (Slembrouck 2007). These transcriptions provided a means to evaluate a participant's relationships and context depicted in the transcripts. We thoroughly examined what was said in each interview and iteratively converted the stories and thoughts into a written document (Bryman and Bell 2015).

In the second stage of data analysis, the transcripts were coded using thematic analysis. Once the data was collected, we attempted to identify and highlight passages in which interviewees referred to their thoughts and stories relating to the current integration of health and care services, inter-organisational trust and organisation asymmetry. Codes were created to depict the frequency of occurrence words and phrases to denote a theme. After which, these themes were reviewed, defined, and named according to their content, and organised into a taxonomy. Next, we concentrated our efforts towards understanding the process of trust in health and social care by highlighting the characteristics of organisational asymmetry. We independently examined and identified tentative descriptions of each of these areas and how they formed a basis for inter-organisational trust; further to what leads to the loss of inter-organisational trust amongst professional groups and organizations.

The third stage concentrated the interpretive analysis on quotations from narratives. We loosely coupled our descriptions of trust dimensions to integrated care outcomes. As we improved our appreciation and knowledge of integrated care and trust dimensions, we developed a better understanding of our data and existing theory. In addition, we refined our initial tentative descriptions of the two and their interrelationship. We continuously revisited our integrated care outcomes and trust dimensions until they encompassed all our findings. The combination of methodologies such as interviews, news media and government reports helped to distinguish between our preconceived idea(s) or prejudice as researchers and inspired greater confidence in our findings. As a result, this analysis identified various types of loss of inter-organisational trust that interviews expressed as having an impact on integrated care outcomes.

The fourth stage identified relationships amongst organisational asymmetry, inter-organisational trust and health, care and support services. This analysis was performed on the data, existing research and theory until the emerging patterns could be refined into adequate conceptual categories (Eisenhardt 1989). This permitted a synthesis attached both empirically to our data and theoretically to the literature. Furthermore, as we discovered our results we ensured alignment amongst our data set, existing theory, results and findings through triangulation to ensure data consistency.

Findings

As individuals relayed their narratives about the loss of inter-organisational trust, they referred to the thoughts and stories that shaped how and why they lost their trust. These thoughts and stories are consistent with previous research in other fields outside of health care (Chiu et al. 2006; Kasper-Fuehrera and Ashkanasy 2001; Luhmann 1979; McEvily et al. 2017; Hsu et al. 2007; Panteli and Sockalingam 2005; Rousseau et al. 1998; Vangen and Huxham 2003). In the following section, we outline the five types of narratives that emerged from our analysis. Each narrative consists of specific aspects of asymmetry that affects inter-organisational trust in integrated care. The meanings are unique to each narrative, together with each aspect of asymmetry. However, it should also be noted that the narratives are not mutually exclusive. Rather, participants often provided a number of different narratives for their loss of inter-organisational trust.

Knowledge asymmetry and trust between organisations

Ambiguity in roles and responsibilities in partnerships and inter-organisation trust

In the interest of dealing with tasks and roles, there is a division of labour and responsibilities within organisations. As a result, functional differentiation, usually leading to structural differentiation of functional departments and other organisational units occur (Galbraith 1977). This means division, decentralisation, and specialisation found in the architecture of more complex organisations such as health and social care interferes with the efficiency and quality goals of inter-organisational relationships due to role ambiguity and conflict (Kodner and Spreeuwenberg 2002). With regard to the loss of inter-organisational trust, a lack of clarity about roles and responsibilities between health and social care organisations emerged from our data as thoughts and stories; participants had difficulties in establishing and understanding the intentions, beliefs and commitments of partners because of different employment terms and conditions. Similarly, McAllister 1995 identified a narrative of individuals meeting expectations in roles and responsibilities as a factor in an individual's assessments of a peer's trustworthiness. In this narrative, participants referred to different employment terms and conditions as a factor that could cause tension between staff as they were brought together for integrated care. Conversely, if the terms and conditions were consistent, this was cited as a positive factor in promoting affiliation. In particular, the thoughts and stories of participants were based on job purpose, scope and dimension in their particular organisation. For example, some health employed interviewees felt additional work was being allocated to them and their team that should have been given to a social care organisation, as their new role and tasks were unclear in an integrated care setting. They were deterred from learning the necessary skills, expertise and capabilities for their new position. This affected the exchange process between health and social care providers, which acted as a safeguard mechanism for stewardship behaviour at a collective level, eventually leading to the loss of trust because of competency and expertise. In the next section, this notion is further discussed with supporting narratives.

Information asymmetry in the expertise of partners and trust between organisations

Interviewees also reported being unable to identify, monitor and review the expertise of partners, which lead to the loss of inter-organisational trust in a partner's competence. They described this as information asymmetry. "Interviewee 19" for example, refers to not being able to ascertain a partner's inherent skills causing overlapping models of care out in the community. Leading the voluntary sector employed interviewee to deal with issues of alignment with health:

> "*I think it's not really the voluntary sector that created all these models, it's the Clinical Commissioning Groups (CCG's) in different places, asking for different things. There are similarities between the four so-called different models in our area, and if you think about it the local authority works with over 60s like us and some of what they are doing overlaps with us. So, I would say, there is overlap.*" (Interviewee 19).

Information asymmetry in the expertise of partners also frequently involved a sense that the health organisation was not referring individuals to the voluntary sector because they were unable to identify partners with the necessary skills to support their care strategy. By identifying and capitalizing on the expertise of partners, a health organisation can enhance trust and continuity of care. This can affect the perception of organisational boundaries and "closeness" between partner relations.

"Interviewee 10" in her voluntary organisation, spent a great deal of time promoting their services to health. She describes the health organisation as being unaware of the services offered by the voluntary sector, making them hesitant to refer individuals, creating trust deficits in their partnership:

> "*Most of the time, I would say there is not a referral from a statutory organisation to the voluntary sector. Partly, because they don't know whom to refer to. Or they thought they knew, and that person disappeared or that service disappeared. Besides, in terms of awareness in health as a whole about the voluntary sector, I would say it's quite low.*" (Interviewee 10)

In addition, "interviewee 11" from another voluntary organisation similarly refers to a loss of confidence because of this adverse selection problem:

> "*How can we develop confidence in GPs and the secondary sector to refer to us? The confidence that their patients will get a quality service because I think that's not there for some people at the moment.*" (Interviewee 11)

In other words, the health organisation is hesitant to refer individuals because they perceive the voluntary sector as impeding their quality delivery.

A hallmark of identifying information asymmetry in the expertise of partners is that they are narrated as an "information gap". Unlike, "ambiguity in roles and responsibilities", information asymmetry in the expertise narrative was not based on inconsistent employment terms and conditions, but rather on the ability of an organisation to easily gain precise information about the expertise of a partner in a multidisciplinary integrated care setting to coordinate care. This affected the willingness between health, social care or voluntary organisations to rely on each other as exchange partners with confidence that the other will reliably fulfil their expectations, eventually leading to the loss of trust.

Power asymmetry and inter-organisational trust

Capacity imbalance and trust between organisations

In the capacity imbalance narratives, participants offered financial explanations for why they lost trust in the health organisation. This included asymmetry aspects such as, under-resourcing or financing the social or voluntary organisation as opposed to health, sometimes in the context of organisational change. They felt that the financing provided to the health organisation was far less likely to be questioned at the time of allocating resources, sometimes "not at all" or when cutting back services. This narrative also

differed from "ambiguity in roles and responsibilities" in that it was based upon financial accountability rather than inconsistent employment terms and conditions:

> "*I think people see the council as taking children away from their families, putting old people in horrible, cheap homes, and emptying their bins. It's a shame, it's not right, I think it's our job to correct that, I can't blame the public for thinking that. And it does mean that the NHS budget will be protected and the social care budget clearly isn't protected at all.*" (Interviewee 1)

Due to the public's current perception of social work, interviewees reported the health organisation doing a better job at promoting their profession, in turn affecting the interaction between health and social care from a financial perspective. In addition, participants provided other examples about a lack of public visibility of health budgets and accountability. In these narratives, some interviewees reported the interaction between these budgets to be unclear. Interviewee 3 a social care manager states:

> "*Without people being able to see the interaction between those budgets and the dependencies between those budgets because clearly, the NHS is finding it difficult because the social care budget has been cut. I imagine they are not making too much of that, because any money that comes to us will probably come from them.*" (Interviewee 3)

In many instances of capacity imbalance, participants indicated that huge financial and operational pressures were driving the health organisation and social care apart. Accordingly, they opted to draw boundaries of strict liability to protect their vested interests:

> "*We are in this situation, where we are having to say, is that an NHS responsibility? Or a social care responsibility? 8 years ago we would have gone don't worry about it, we are all in this together, but now we are fighting over the pennies*". (Interviewee 7)

While capacity imbalance frequently occurred between the health organisation and social care, some participants also reported the health organisation not actively supporting social care. For instance, "interviewee 30" recounted her interactions with health:

> "*A similar issue to that is Funded Nursing Care, which is a health organisation contribution to residential care for older people, so when older people go into residential care or nursing care and they need particular health input. They can sometimes qualify for Funded Nursing Care, it's about £120.00 a week so it makes a considerable impact if we get it. It's been very difficult to get that from health, so it's similar lines to the continuing healthcare funding, we apply, we try and we don't get it. I think that's just bureaucratic, and just an administrative issue, and again integration feels very far away when you can't even get some basic statutory elements like that sorted.*" (Interviewee 30)

Thus, the capacity imbalance could be either related to organisations not wanting to work together or financial and operational pressures restricting integration. The defining characteristics of this narrative are that commissioning across the health organisation and social care involves a fear of cost shifting between purchasers, nurturing a belief that protective structures are not in place for situational success. This has led to a decrease in beliefs and intentions that partners will act fairly to create positive outcomes for the good of the relationship, eventually leading to the loss of trust between health and social care because of capacity imbalance. In the next section, the moderating effect of power distance is examined resulting from the inequality brought about by capacity imbalance.

Power distance and trust between organisations

Participants also indicated that generalist medicine tends to favour overly cautious strategies, in inter-organisational initiatives with specialist medicine, because of their relative operational and financial size. In these cases, the process of collaboration was shaped by the specialist medicine organisation sending participants a signal that their services were no longer under their control. Thus, participants felt there was an unequal distribution of power in the relationship. The asymmetry aspects that sent this message included experiencing organisational change and a reduction in operational/financial autonomy.

> "*I think one of the fears from our side, which might be replicated over there, is that one will take over the other. And there is certainly a fear, I know, in social care generally that the government appears to be pushing for the NHS to take over social care rather than social care to take over the NHS. That is worrying for us in terms of our professional capabilities, where we have tried to merge teams in the past, social work and social work profession standards can get lost in the NHS profession standards. So, I can understand there is a fear there of being taken over by a more powerful organisation.*" (Interviewee 28)

There were instances in which interviewees described power distance in other situations. For example, some interviewees reported that their role was not as important as health employed individuals. Others indicated that, although they were working closely with the health organisation, it was clear that a health agenda was dominating inter-organisational initiatives. "Interviewee 27", for example, reported feeling disenfranchised after a commissioning meeting with health:

> "*I don't believe we have been given enough money to run our statuary services, we are trying our very best to come in within budget here, but ultimately I believe we don't have enough money.*
> *60% of the overall budget is allocated to health and 40% to social services, but we are scrutinized far more severely than health.*" (Interviewee 27)

In each of these cases, participants suggested that control is kept by one or more organisations over others by operational or financial means. Accordingly, the

perception of loyalty, satisfaction and equality in the other party's commitment to the relationship was compromised eventually leading to the loss of trust because of power distance.

Organisation model, cognitive asymmetry and inter-organisational relationship

A number of participants reported that organisational or cognitive-based differences with the health organisation led to integration issues that caused them to question: the value of the "partnership" and does it make sense in terms of effectively developing their work. These questions in the back of their minds meant that individuals began to shift their strong emphasis on collaborative activity and, instead, focus on protecting their professional identities, positions and self-interests. Importantly, these organisational or cognitive-based differences were narrated as responses to specific asymmetry aspects such as, their perceived value in the health organisation that instigated them to re-evaluate the relationship. Managerial styles or cultural differences are two examples of such asymmetry aspects. After establishing their perceived value, collaboration no longer seemed so important and the individual's realised that despite actively wanting to work with the health organisation they were discouraged by how they were seen. For instance, "Interviewee 16" recounted a conversation she had with a health-employed director that was open to supporting the social care element as much as health:

> "*I visited a health hub and it looked very good, the director there was health employed, he was sitting in a health office with council workers, working with council workers all the time. He was so open to developing something together, and that's one of the first times I have seen that in a person. Now, I could work with him and I could feel that the social care element was respected and brought into the system, just as much as the NHS's views and vision was brought into the system. He was somebody, who could work across the two, and I absolutely respected that, it's rare to find that in a person, and we need more people like that who are open to both cultures and visions and are willing to incorporate them both into the overall system.*" (Interviewee 16)

Other organisational or cognitive-based differences were also narrated as having a similar effect. After working in both health and social care organisations, Interviewee 14″ realised that developing a mutual understanding is the key to successful collaboration:

> "*Social care works to a social care model; health works to a medical model. I have worked in health in joint social care teams... and I think the difference in thinking, values… and models… is what causes integration issues. I think once you build a relationship and understand each other's then collaboration works well. I think the key issue is people don't understand each other.*" (Interviewee 14)

For "interviewee 10" an integration manager, these cultural differences impeded the smooth resolution of conflicts between health and social care managers:

> "*Some [health managers/teams] are quite set in their ways. It's very difficult to the change the way they do things because they don't act on feedback, and they don't want to interact with others [social care managers/teams] in an "integrated" manner. I really don't know what to do with them.*" (Interviewee 10)

"Interviewee 10" points to this as "people not wanting to change their way of working or behaviours".

When participants narrate loss of trust in terms of organisational or cognitive-based differences, they report experiencing, feeling like they are outsiders in the health organisation causing them to rethink the relationship. This realization leads them to decide that investing further in the relationship is no longer a priority for them and there are other things in their own organisations that they should be concentrating on. Thus, a lack of commonality across organisational boundaries impedes trust causing considerable difficulty in health and social care collaboration, as parties are not able to predict with confidence the actions of others affecting the ways in which they make sense of the exchange process.

Figure 1 shows how asymmetries affect inter-organisational trust in the context of health and care organisation joint-up services. In a summary, our analysis reveals that competence-based trust and sense of partner's credibility can be reduced due to knowledge asymmetry regarding lack of knowledge on the partner's skills and expertise. On the other hand, the level of ambiguity of roles and responsibility can affect the exchanging behaviour that normally acts as a safeguard mechanism for mutuality between partner organisations. In the context of integrated care where health and social care seeks to join-up services, this asymmetry can, in turn, have an effect on successful service consolidation and functional decentralisation. In the situation of asymmetric power between organisations, imbalanced capacity. It can lead to a reduced feeling of fairness and equality; sometimes it can even increase the fear of losing identity, which in turn can affect successful inter-agency planning and budgeting among health and social care organisations. The intrinsic culture and structural asymmetries that lie in different organisations, especially different perceptions and priorities on developing and maintaining inter-organisational relationships, can impede confidence and

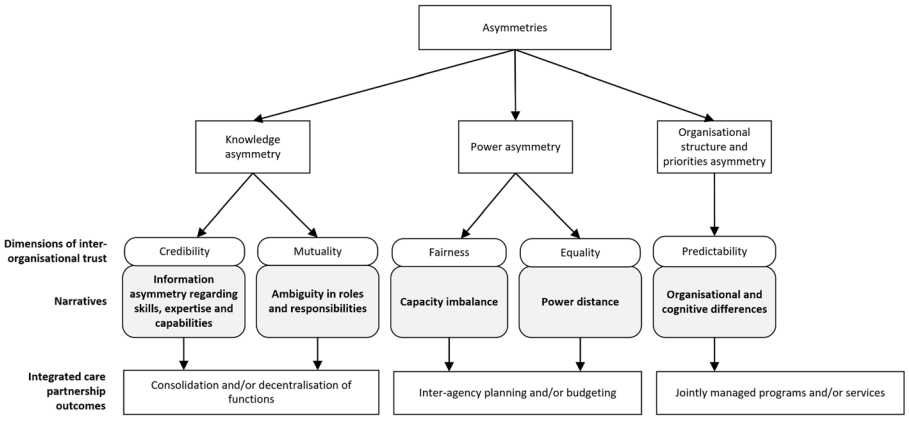

Fig. 1 The effects of asymmetry narratives on inter-organisational trust, health and social care partnerships

predictability in exchanging behaviours such as jointly managed programmes or services between health and care.

Discussion

In this paper, we contribute to the growing literature examining issues of trust in health care. In particular, we focus on inter-organisational trust, show that it can be related to asymmetry factors, that can result in a continual loss of inter-organisational trust following an integrated care initiative. To begin with, immediately following an integrated care initiative, the level of asymmetry between two or more organisations is unclear and this weakens inter-organisational trust. Organisations and individuals do not experience high levels of trust because, in the absence of dissimilar affect and cognitive-based narratives in the collaborating organisation(s), there are differing opinions and views of which characteristics are most important, in a way that one's own organisation and that of partners are experienced as uncertain and risky regarding actions and behaviours. Afterwards, as narratives of organisations become consistent across tasks, processes and activity, some individuals may still experience low levels of inter-organisational trust if they are unable to associate themselves with the characteristics of the new inter-organisational initiative as beneficial to themselves, their organisation and its partners. Our findings indicate this is more likely to occur when the inter-organisational collaborative initiative generates a new setting that is significantly different to that of individuals in each organisation where they experience their interests and well-being to be maintained. That is to say, if individuals experience an inter-organisational initiative to be detrimental to themselves, they are likely to not form or develop benevolence or goodwill-based trust, as well as, competency-based trust, and, thus, their inter-organisational trust can be weakened.

It is clearly evident that more research is needed to fully understand the intricacies of inter-organisational trust in health care, we believe our study has pointed to a promising new line of enquiry relating inter-organisational trust, to asymmetry factors, and we believe it makes a number of important contributions to the body of knowledge. First, our study goes beyond existing research in the sense that, it is one of the few empirical studies of inter-organisational, rather than interpersonal, trust in an organisational setting and provides an asymmetry-based framework for understanding the formation and development of inter-organisational trust, as well as, loss of inter-organisational trust in health care. Taking into account that few studies have been carried out on the subject matter, our case study of the Better Care Fund provides an important first empirical look into the basis of inter-organisational trust and narratives through which it is lost. Second, our research provides insights into the continual loss of inter-organisational trust following an integrated care initiative. More specifically, our work demonstrates that challenges of inter-organisational trust need to be considered as theoretically and practically aligned with issues of interpersonal trust in an inter-organisational initiative. Our findings emphasise the importance of asymmetry-based narratives in relation to the loss of inter-organisational trust and, together with extensive research on the trust of inter-organisational initiatives, suggests that these alliances can take steps to improve inter-organisational trust. For example, high levels of power distance along with low-levels of staff engagement have been linked to loss of inter-organisational trust (Bachmann 2001; The King's Fund 2012) so reducing the power distance between organisations and improving involvement, openness and transparency

can establish a setting of perceived organisational justice and uphold psychological contracts by the actions and behaviours of leadership. Third, our research has important implications for the trust literature. Our study of trust in the Better Care Fund helps us to distinguish an important aspect of inter-organisational trust that depends on asymmetry. Researchers have used the concepts of asymmetry-based factors to describe many different types of organisational phenomena: variables, (Dunning 2015) survival, threat (Pfeffer and Nowak 1976), and power (Veugelers and Kesteloot 1996) but there is little to no work associating asymmetry-based factors to inter-organisational trust. Predominantly, our research links individual narratives of asymmetry to an important outcome – inter-organisational trust, and offers empirical support in the increasingly important context of health and social services. Fourth, our findings also highlighted mechanisms underpinning high levels of inter-organisational trust that can contribute to organisational success but at times i.e. "different professional and organisational cultures, different values and interests, and differences in the commitment of the individuals and the organisations involved" (Vangen and Huxham 2003) can be detrimental. However, low levels of asymmetry during collaboration can be implicitly linked to positive organisational outcomes, such as common "aims and objectives, accountability, commitment and determination, compromise, appropriate working processes, communication, democracy" (Vangen and Huxham 2010). Lastly, our findings point out that inter-organisational trust depends on asymmetry based factors, but we also recognise that interpersonal trust provides a basis for forming and developing inter-organisational trust (Mayer, 1995). Further research, could, therefore, investigate the relationship between inter-organisational and interpersonal trust in the context of health and social services.

In summary, we found that the narratives respondents provide for asymmetry can be related to aspects of inter-organisational trust and, subsequently, that can be undermined by the absence of cognitive and affect-based trust factors.

Practical implications, limitations and future work

As the context of integrated care changes in Europe and throughout the world due to an increasing population, particularly those over the age 65, growth in (planned) elective and non-elective care, increasing A&E attendances, and pressures on urgent and emergency capacity, delayed transfers of care and subsequent bed days lost, nourished by increasing pressures on social care for community packages and care homes, along with inequality of access to services across the "whole system" and "whole week" models; further heightened by significant financial challenges across acute and community providers, CCG's, ambulance trusts and local authorities. Individuals and organisations will likely face new challenges moving forwards as they contemplate "how" to further integrate health and social services to counter these pressures. Conceptualising the salience of trust to integrated care and the notion of a more collaborative whole system model could provide useful insights to individuals and organisations trying to achieve full integration. As services are continually challenged with growing uncertainty and complexity, the distinct relationships between loss of trust narratives and integrated care outcomes as per our findings could help individuals and organisations anticipate potential issues related to normative integration and social inferences. Further to, developing leadership in ways that break down rather than reinforce silos, between structural and interpersonal exchanges, and the wider social and

political environment. In addition, research suggests that there is a strong causal relationship between employee trust and engagement (Wang and Hsieh 2013), through which staff are likely to deliver better outcomes for patients such as, more appropriate care for individuals with long-term conditions, often leading to improved patient satisfaction – "loyalty" and financials. Comparatively, a report found that actions at all levels of health and social services need to give greater priority to patient and staff engagement starting from NHS Commissioning Boards to frontline services delivering care to patients.

If we accept that trust enables collaboration, and engagement develops and forms the trust for example, through effective appraisals, clear job design and psychological safety in a team environment, arguably it could help to show staff that leadership cares about their health and wellbeing. As researchers have consistently found positive relationships between generic employee attitudes and their individual performance at work (Judgde et al., 2001). Our perspective empowers individuals and organisations to alleviate the loss of trust in relation to integrated care outcomes that suit their needs, to foster an improved whole system perspective.

In terms of particular insights, trust is personal to individuals and organisations and is influenced by whether if expectations are clearly defined i.e. roles/responsibilities, staff are given tools to lead service transformation, and feel job satisfaction, and perceive themselves and their peers as part of a culture based on integrity and trust. Public health and social services do not seem to differ in comparison to other industries, in the sense that effective leadership and staff engagement can influence — have substantial implications, for trust formation and development. Equally important is the need to recognise that the occurrence of this process can serve as a basis for lessons learnt. Hence, councils with a strong history of integrated care initiatives are more susceptible to trust and are able to construct and share it, both individually and collectively in a whole system model, opening up new possibilities for those who follow. In that, their actions and behaviours might form the basis for new ways of nurturing trust. For instance, the discharge to assess scheme at Sheffield's Frailty Unit is highly regarded within the NHS as successfully merging health and social services to deliver care to frail and elderly individuals, and so others have sought to follow this model, and in doing so, started to respect the social care element as much as the health. Our research seeks to stress the importance of not losing trust to local authorities.

We believe that our research should be of interest to practitioners and researchers in the area of integrated care and management, although it does have some limitations. First, our findings are situated in an analysis of the Better Care Fund in five councils, and therefore require careful judgement or application in the loss of trust of other types of integrated care programmes. Conversely, our work is based on an in-depth qualitative study versus statistical generalisations and we do not endeavour to make assumptions about the degree to which our findings might apply in an alternative context(s). Second, another boundary condition to our work is that we drew subjects from a wide range of organisations, spanning multiple sectors. Therefore, we were unable to give greater priority to organisational factors and sectors. Third, while the number of subjects we interviewed is in-line with other studies of trust, it still offers an imperfect data pool to draw insights from on the wider whole system model. Equally, subjects were chosen based on experience from a randomized pool of participants, while this functioned well in providing a wide range of views and opinions, it also means that the generalizability of the findings in this study need to be applied with caution in situations where participants have been selected through more stringent means. Forth, our work concerns staff members in the construction of narratives of loss of trust.

However, we do believe that our findings might act as a basis for validation and exploration in future studies, which could be designed to compare if and how differences in employee roles/responsibilities contribute to loss of trust. Particularly, as the role of a subordinate in an organisation is different from other roles played by managerial staff from a "power imbalance" perspective. Fifth, the external validity of our results might be questioned, as the research is depended on interviews to identify and assess the loss of trust. Subjects might have been influenced by their political sensibilities, which could have prevented them from speaking freely on a topic. One should note, however, that we had no evidence suggesting that this was the case based on speech patterns and audio recordings, and all subjects were informed of their actions and statements being fully anonymised. In addition, our study was conducted following radical cuts to combat the growing deficit in health budgets, subjects identified payment models as a key source of loss of trust but this view could have been opinionated based on the circumstances.

Further research is needed to determine the contribution of this paper to research and practice. In particular, future studies should examine the frameworks relevance to different countries and their health and social care services, developing and testing some theory as to how and why the loss of inter-organisational trust occurs with attention to partnership asymmetries. The health system differences exist widely in UK, Europe and the rest of the world, in terms of service providers, financial resources, information resources, performances. However, integrated care system for seamless healthcare services appears to be a key common pursuit among most health systems in different countries. The next logical step towards assessing our frameworks generalizability is to set-up a European Delphi panel to validate the framework outside the context of the NHS England Better Care Fund programme. Operational, tactical and strategic employees working in an integrated manner from these health and social care systems, could be introduced to the concept of inter-organisational trust and questioned on what asymmetries need to be reduced for effective integration of services. This open-ended discussion could be followed by a more focused discussion on the contents of the framework and the extent to which the contents resonate with them. For example, is it important to have a shared awareness of the skills, expertise and capabilities of partners? Or is having a shared understanding of roles and responsibilities enough? In addition, how might capacity imbalance or power distance affect these types of asymmetries? Likewise, does the degree of similarity or dissimilarity between health and social services really have an impact on collaboration? In summary, a better understanding of the relationship between different partnership asymmetries could help to improve integrated working.

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