Integrated Care: The Presence, Nature and Development of

Integrated Care in Community Health Services

in England and Ireland

By

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A thesis submitted to satisfy the requirements for the degree of Doctor in Philosophy in Health Sciences (B91P)

University of Warwick Medical School

Submission July 2012

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ACKNOWLEDGEMENTS

DECLARATION

This research study was designed and carried out by the author. I carried out research on integrated care using two programmes as case studies; the "Integrating Care - One Network" (ICON) programme in Ireland and the Community Hospitals Association (CHA) Innovations and Best Practice (I&BP) programme in England. I carried out secondary analysis on qualitative and quantitative data from these two programmes, and the analysis and the presentation of results is the work of the author alone.

The author worked as a consultant and researcher to the ICON programme and was a member of the project team collecting and collating primary data. I want to thank the Chief Executive of the Community Hospitals Association, Barbara Moore, for her support to analyse survey data collected and published by the CHA (Appendix A). I was a member of a sub-committee of the CHA responsible for the Innovations and Best Practice programme. I also want to thank the Chairman of the ICON Steering Group, Pat O'Dowd, for his permission to use data in the public domain and also the use of additional documents held by the project team (Appendix B).

There is no conflict of interest in any of the roles I have had during the period of this research study. The ICON programme had concluded, and I suspended consultancy commissions in community hospitals in the programme during this study. No part of this thesis has been previously submitted for a degree at any other university. Three published articles on the programmes are referenced, as well as subsequent publications in peer reviewed journals.

ABSTRACT

Background: Integrated care is a policy imperative in health and social care services globally, and yet there are reported difficulties in defining, developing and sustaining this way of working.

Research Question: This research explores staff views and experiences of the presence, nature and development of integrated care in two programmes of community services.

Method: A case study approach was adopted using secondary analysis of qualitative data from staff questionnaires using themed content analysis and pattern matching, with findings triangulated with documentary sources. The study considers the presence and nature of integrated care using the conceptual framework "to what extent integrated care is for everyone (inclusive) and not just for some (exclusive)" as interpreted from the literature. The development of integrated care was explored using systems theory for the management of change in a complex environment.

Findings: A meta-analysis of the two case studies demonstrated that integration was **present** in all 66 services within the two programmes. The **nature** of integrated care varied and was demonstrated as multiple types (in community hospitals) and processes (in community services). The most frequently reported type was multidisciplinary working. The processes most teams chose to develop were information sharing systems. The **development** of integration within the case studies was affected by a number of factors, such as commitment and staffing.

Conclusion: This study provides new evidence of the presence, nature and development of integration within a wide range of established services spanning all ages. From this and other measures, the extent to which integrated care is presented as "exclusive" can be questioned. These findings have informed the development of a framework of five principles, reflecting whether integrated care is: for everyone, extensive, enduring, can be enabled and essential. The implications and application of this research for policy, service development and training are discussed, and proposals for further research include testing the applicability of this framework and widening this study.

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LIST OF ABBREVIATIONS

A/E	Accident and Emergency Department
AGPCH	Association of GP Community Hospitals
BMA	British Medical Association
CARMEN	Care and Management of Services for Older People in Europe
CASP	Critical Appraisal Skills Programme
CH	Community Hospital
CHA	Community Hospitals Association
CSIP	Care Services Improvement Partnership
DH	Department of Health (England)
DHSS	Department of Health and Social Security (England pre 1984)
DOHC	Department of Health and Children (Ireland)
ESRC	Economic and Social Research Council
EHMA	European Health Management Association
EPICS	Elderly Persons Integrated Care System (Buckinghamshire)
GP	General Practitioner
HSE	Health Service Executive
IC	Integrated Care
ICO	Integrated Care Organisation
ICON	Integrated Care, One Network
I & BP	Innovations and Best Practice Programme

I & MT	Information and Management Technology
LA	Local Authority
MHB	Midland Health Board
MIU	Minor Injuries Unit
NFHA	National Federation of Housing Associations
NGO	Non-Governmental Organisation
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
OPD	Out-patient department
P3	Phase 3 ICON Programme
PCCC	Primary, Community and Continuing Care (Ireland)
PCT	Primary Care Trust (England)
PROCARE	Providing Integrated Health and Social Care for Older Persons
PHN	Public Health Nurse
RCGP	Royal College of General Practitioners
RCT	Randomised Controlled Trial
SHA	Strategic Health Authority
SOP	Standard Operating Procedures
WHO	World Health Organisation

1. INTRODUCTION: CONTEXT AND OVERVIEW OF THE STUDY

1.1. Introduction

In order to set the context for this study I have reflected on experiences within my career which have provided my interest and motivation for this research. I have observed services where parties work together for the benefit of the service user in situations such as multi-disciplinary teams working in community hospitals, joint working across statutory and voluntary agencies in learning disability services, partnership working in housing association community care services, and continuity of care in community health services. In contrast, I have witnessed the impact of fragmented services which has limited the availability, accessibility and quality of care to patients. According to Holliday *"getting into qualitative research is very often about grasping opportunities that address a good idea or a long-standing preoccupation."* (2007:22). Integrated care has been a theme running through my work experiences (Tucker 1987, Tucker *et al.* 2004a, Tucker *et al.* 2004b, Tucker *et al.* 2005, Tucker 2006, Tucker 2010, Tucker *et al.* 2011, Tucker and Burgis 2012). This research provides an opportunity to explore the presence, nature and development of integrated care in community health services more fully. The following section is a personal account, providing an illustration of the extent and limitations of my experience to date.

1.2. Secondary Care in the early 1980s

As a medical records officer in an acute hospital, I was witness to the pressures on professional and support staff as they struggled to meet demand in an unmanaged

service. Consultants bargained for beds and theatre time, patients with life-threatening conditions had operations cancelled, and morale amongst staff was low. This was before the introduction of general management, at a time when administrators attended to peripheral and environmental issues rather than the business of managing health care (Tucker 1986a). My preparation as a regional administrative trainee in Wessex and my Institute of Health Management qualification felt insufficient in the face of clinical chaos. My perspective at the time was that the system encouraged professionals to work against each other rather than as teams, as they fought for resources for their patients. The lack of systems and management cohesion meant that emergency admissions were overwhelming the system. Hospital staff were highly frustrated and eventually demoralised as they were unable to deliver high quality and timely care.

1.3. Community Hospital Care from the mid-1980s

The contrast could not have been greater in my next substantive post as administrator in a GP hospital giving me my first real experience of services designed around the patient and not the other way round. Multidisciplinary team meetings with the matron, GP, physiotherapist, occupational therapist and social worker were designed to appraise the needs of patients and families, and agree as a team how best to employ the community hospital services to meet those needs. The operational management of the hospital was a tripartite arrangement, between the administrator, matron and the GP. Regular meetings and continual communication meant that clinical and managerial issues were addressed collectively. The range of care offered was impressive, and included services for people with long term conditions, intermediate care, palliative care, emergency care, maternity,

diagnostic services, mental health services and acute medical care. The facilities in the hospital I managed included four wards, clinics, minor injuries unit, rehabilitation unit, and day care. The location of the GP practice on site meant that primary and community care were managed together, and the family doctors were part of the hospital team.

The services were provided by community hospital staff working with staff from the community, acute trusts, mental health trust, voluntary agencies and many volunteers. For example, district nurses would offer continuity of care to patients by seeing them when they were inpatients or day patients, and agreeing care plans with the hospital nurses and therapists. Voluntary agencies provided services and self help groups met regularly in the hospital. The number of volunteers justified the appointment of a paid volunteer coordinator, who attended to training and support. The League of Friends was generous in their financial support to the hospital as well as providing services such as the hospital shop and the library service. The service also benefited from the co-location of the ambulance station, and a sister community hospital which offered diagnostic and treatment services through its operating theatres and facilities. Visiting consultants and GP clinical assistants held outpatient clinics at the hospital, and waiting times for an appointment as well as the waiting times within the clinics were all less than the national average for a District General Hospital (Tucker 1985). The size and scope of the community hospital meant that it offered an ideal placement for training and development for nursing and management staff (Tucker 1986a), helping to build joint working between professionals and practitioners (Tucker 1986b).

The matron described the ethos of the community hospital as one of promoting health and well being, and helping people to stay out of acute hospital care. The community hospital was embedded in the community, and there was a strong sense of pride and purpose. My experience was that the level of collaboration and cooperation was high.

I needed to know if the experience in this GP community hospital was exceptional, or whether there were other examples throughout the country so initiated a study which was funded by the Kings Fund (Tucker 1987a). The findings of the research were that community hospitals were providing a wide range of services and were valued for their access, quality and continuity of care. The study recorded the diversity of provision for patients of all ages. Within the study I carried out a review of national and local health strategy and policy documents which found no mention of community hospitals leading me to conclude that nationally they were hidden assets although highly valued locally (Tucker 1987b).

The literature showed that this was a part of the health service that was not widely researched so I was pleased to have an opportunity to work and publish with colleagues. A review of community hospitals and their role and function was published with Dr Roger Jones (Jones and Tucker 1988). A consultancy commission into the community hospitals in Clwyd, Wales was published, with many findings which could be generalised to community hospitals nationally (Tucker and Bosanquet 1991). The Department of Health commissioned a study into financial management and strategy in community hospitals (HACAS 1991) in which a costing system was piloted and developed in six community hospitals (Tucker 1992).

I have visited over 130 of the 296 community hospitals in England, either through my work as a management consultant or in my voluntary role as a committee member of the Community Hospitals Association. Work experiences have ranged from facilitating one day workshops, to project managing the development of a new community hospital as an integrated health and care facility over a ten year period (Tucker 1995).

1.4. Services for people with learning disabilities in the 1990s

Another aspect of integration opened up when I was appointed joint lead with a social services colleague to be responsible for developing a strategy for services for people with a learning disability. The post was joint-funded by health and social services, with a responsibility for stimulating the growth of the voluntary sector in preparation for offering people living in long stay hospitals and opportunity to live in their own homes in the community. A feature of this service was its value base in human rights social role valorisation with principles including respect, dignity, privacy and community presence. In order to support individuals to live the lives they choose, all agencies needed to work together as this concerned not just their health and wellbeing, but also their housing and lifestyle choices.   Individuals required services to support them in all aspects of their lives including health, social care, housing and education. My commitment to this work led me to undertake a role as founding Chair of a Housing Consortium, with a board that included service users and parents, social services colleagues, counsellors, housing association managers, medical staff and health professionals. Our task was to pool resources to create a range of appropriate housing, care and support services for people moving out of long-stay hospital accommodation into the community.

1.5. Housing, health and social care in the mid 1990s

My experience in working on a multi-agency board tackling the challenge of designing, developing and providing integrated housing, health and care led to management consultancy commissions with a number of housing associations and voluntary agencies. This involved providing advice on service and organisational development and management support. An example was the National Federation of Housing Associations (NFHA) who commissioned a study into the contribution that housing associations were making to implement the policy of community care. This study concluded that housing associations had a unique role in crossing housing and care boundaries by assuming a strategic role supported by local networking, often acting as a catalyst in establishing new services (NFHA 1995).

1.6. Primary, Community and Social Care Services 2000 onwards

A number of commissions have been undertaken regarding community hospital services that have integration at their heart. A commission I undertook for the Department of Health (DH) for a report on models of ownership of community hospitals illustrated the range and development of organisational structures and ownership arrangements (CSIP 2001). One of the models was the social enterprise, formed to address considerations such as organisational boundaries across the statutory and voluntary sectors and another was to optimise local community involvement. I have been working with a number of communities assisting them in their ambition to become more closely involved in maintaining and developing their valued local health and social care services through forming community ventures, charities and social enterprises. The community venture

formed by local residents in Wells-next-the-sea in North Norfolk was cited as an

example of good practice in the DH White Paper setting out a new direction for

community services (DH 2006a). Another example was a local charity formed to

develop and manage Rye Community Care Centre in East Sussex which provided scope

for integrating not only health, social care and housing, but also complementary

therapies such as NHS homoeopathy (Tucker 1993a; Millar 1992). The charity

continues to manage the community hospital in partnership with the NHS (Tucker

2006).

National and local interest in the changes in community hospitals was raised as

reductions in beds and services in community hospitals were witnessed and challenged

(Tucker 2007). A study was commissioned from the CHA by the Department of Health

to profile community hospitals in England over a ten year period. The CHA had

information and resources through its membership network, and I designed a system of

analysing and cross checking five databases, analysed the results and was author of the

report. The results were validated and interpreted with a team of committee members

of the CHA. The report identified a reduction in the number of community hospitals

with beds, a reconfiguration of some community hospitals as resource centres without

beds, and the pending development of a number of new community hospitals, some of

which were developing as integrated facilities with health, social care and Local

Authority services (Community Hospitals Association 2008). The Department of

Health commissioned an updating of the Health Building Note for community hospitals

and other primary and community care facilities, linked to the Government investment

in community hospitals, and I represented the CHA on the team who produced the publication (Department of Health 2009c).

Joint working across professionals, agencies and sectors is now assuming a high priority nationally, and many commissions and studies have featured connectivity and continuity of care and support. I am currently providing organisational development support to an Integrated Care Organisation pilot (ICO) in Norfolk which involves 32 GP practices in six localities covering 300,000 people. The initiative is one of 16 national pilot ICOs and is designed to improve the integration between primary, community and social care services.

This overview of my career, voluntary work and research demonstrates recurring themes of integrated care and community based services. Two further programmes of work and voluntary activity exemplify this, and I have selected these as case studies for this research study. The rationale, benefits and limitations of this approach are set out below and expanded in Chapter 5.

1.7. Community Hospitals in England

A programme that presents an opportunity for being a case study in this research is the Community Hospitals Association's (CHA) Innovation and Best Practice programme (I&BP), designed by the CHA and funded initially by the Department of Health to identify and formally recognise and promote good practice. Within the programme, staff working in community hospitals were invited to submit an account of their service and demonstrate how they were meeting criteria for quality and good practice including partnerships, joint working, person-centred care and integrated care. Staff were required

to complete a questionnaire describing the service within their hospital, how they

developed their service, their views on what helped and hindered service development,

and which lessons and learning they wished to share. The questionnaire is summarised

in chapter 5 and replicated in Appendix C. Staff were also asked to provide supporting

documentation and evidence and take part in on-site interviews with CHA committee

members in order to validate the data in the questionnaires. Up to ten awards are given

each year for community hospitals in England, which are promoted through

presentations at a national conference and a publication. Staff's accounts of their views

and experiences of developing a service within a community hospital were available for

six years of the programme. My role in the programme as a voluntary committee

member and Chair of the CHA was to lead the design of the programme, develop the

quality criteria, apply for funding and contribute as a member of the panel in assessing

bids in the first two years. The programme was developed to share good practice and

learning, and also to encourage more research and evaluation. The questionnaires

completed by staff for award winners and those highly commended were published

verbatim in an annual CHA publication (Tucker *et al.* 2000; Marriott *et al.* 2001;

Marriott *et al.* 2002; Jones *et al.* 2003; Jones *et al.* 2004; Jones *et al.* 2005). An

overview of the programme has been published (Tucker 2006). Primary analysis of the

data was carried out by the panel in order to evaluate compliance with the published

criteria (Tucker *et al.* 2000). I have selected the CHA I&BP programme as a case study

for this research, as it provides data in 48 questionnaires on staff views and experiences

in community hospital services in England that are not readily available elsewhere. I

have chosen to re-analyse a sub-set of the qualitative data in the publications in order to

explore supplementary questions focused specifically on the presence, nature and development of integrated care (Heaton 2004:59). I detail this further in chapter 5 where I expand on my research approach including the rationale, benefits and limitations.

1.8. Community Services in Ireland

A consultancy commission that generated new learning was a three year programme to support the Midland Health Board in Ireland to develop integrated care across primary, community and continuing health care across the organisation. As lead consultant for the programme and the author of the consultancy reports, I supported practitioners and managers who were committed to redesigning their services and systems in order to provide a more person-centred and integrated service. The visual model that was developed was ICON (Integrated Care – One Network) and this was implemented by 18 teams across the organisation. Staff recorded their experience and views throughout the programme in questionnaires, presentation material and reported accounts, and these were documented and analysed in consultancy reports for each phase of the programme. The data from the programme provide an opportunity for more detailed and in-depth analysis and further reflection, now that the consultancy commission has been concluded (MHB/Secta Consulting 2003a; MHB/Secta Consulting 2003b: Tucker for Tribal Secta 2005). Progress with the programme, its impact, outcomes and learning from the project are set out in articles published in peer reviewed journals (Tucker *et al.* 2004a, Tucker *et al.* 2004b, Tucker *et al.* 2005). I have selected primary data sets in the form of questionnaires from the programme that enable me to explore the questions of integrated care in respect of presence, nature and development from the perspective of

staff (Appendix D). The data available to me as a primary researcher and consultant has provided an opportunity for the ICON programme to be considered as a case study for this research (Conti 2006). I set out more details of the programme, the data available for analysis, and the decisions made regarding my research approach in Chapter 5.

1.7 Basis for Research

My consultancy and research career has provided an opportunity to work across sectors such as health, social care and housing, and to carry out commissions that range from support to local community groups, working with practitioners delivering services, advising on management systems and processes at organisational level, and carrying out strategic and policy reviews at a national level with Government Departments. The experience of working with those commissioning and purchasing services, those providing services, and those advocating and campaigning for services has exposed me to the differences and similarities in perspectives with regard to integration. My observation is that the diversity of need, services, providers and commissioners creates a risk of fragmentation and discontinuity for service users. Although organisations may share a vision of putting the patient first and integrating care around their needs, the differences in organisational agendas, systems, structures, funding and even language makes integrated working across agencies and staff a challenge. There are however examples of good practice at service delivery level, where practitioners work together for the benefit of the patient, leading me to want to explore questions within my research on the presence, nature and development of integrated care at an operational level.

Consultancy commissions incorporating evaluation have provided me with an opportunity to work with staff and managers on service initiatives. The timescales and contract terms of commissions do not usually accommodate an in-depth analysis of the data collected, or allow time for reflection or shared learning. This research study has been designed to re-visit two programmes which accumulated data on staff views and experience in developing joint working and integrating care.

The primary analysis of data in both programmes was focused on evaluation. The ICON programme was evaluated in respect of achieving project objectives, and the I&BP process involved evaluating submissions against agreed criteria. As the primary researcher, I wanted to re-use a sub-set of this qualitative data to carry out supplementary analysis in order to answer my research questions of where integrated working was taking place, what was its nature, and how was it being developed (Heaton 2004:38). This study enables a retrospective secondary analysis of the available data in order to optimise the learning from these programmes. It also provides an opportunity to compare and contrast the two programmes, and to reflect and consolidate the learning from these two programmes.

1.8   Safeguards to Research Integrity and Quality

The University of Warwick's guidance on the conduct of research is framed around principles including excellence, integrity, accountability, honesty and openness (University of Warwick 2009). I have taken a number of steps to safeguard the integrity and quality of the research, including understanding the quality and limitations of the primary data, verifying the suitability of the data to answer the research question and

carrying out content analysis which is a research methodology used most frequently by researchers who re-use qualitative data (Heaton 2004:97).

Heaton describes three main challenges for re-using data as: data fit, verification and "not being there" and stresses the importance of data accessibility, quality and suitability (Heaton 2004:57). This introductory description of the process of collecting and collating primary data in the two programmes is intended to illustrate the appropriateness, suitability and quality of the primary data. In Chapter 5 I identify and address limitations more fully.

In the ICON programme I was commissioned by MHB in Ireland to provide advice on the development of improved integrated working between community, social care and primary care services. The tasks in the commission in this three year programme included service redesign, service development, organisational support and evaluation. The evaluation included designing and analysing staff questionnaires. The programme was carried out as action research, with ongoing feedback and review, with the author actively participating in organisational change whilst carrying out evaluations (Bowling 1997: 366). I analysed the primary data in the questionnaires as part of the evaluation, and this was shared with the project team, verified with the staff, and reported for scrutiny to the Project Board. The primary data was therefore subject to checks and validation within the programme. One of my challenges was to carry out independent analysis and become "a stranger to your data" in the secondary analysis of the data, and to preclude any experiences or knowledge that was not represented by the data alone

(Holliday 2007: 20). However, in the interpretation of the data, an understanding of the context as a primary researcher is considered to be a benefit (Heaton 2004:60).

With regard to the Community Hospitals programme, I helped to design the process, including the questionnaires that staff completed when describing their service which they put forward as an example of good practice (described more fully in Table 14, Chapter 5). The 48 nursing staff and managers were advised that the contents of their questionnaires would be in the public domain and therefore their assertions of good practice would be subject to open scrutiny. When the questionnaires were received, they were scrutinised by a panel of designated committee members and also by an independent member from the Queens Nursing Institute. The panel shortlisted applications according to defined criteria. The panel validated the contents of the questionnaires by visiting each hospital, interviewing staff, and reading relevant documentation. Therefore, safeguards were in place to enable an impartial assessment to be made of the service, and for the accuracy of the data to be confirmed. As a member of the panel, I took part in the first two years of short-listing and visits. The process of checking the questionnaires verified the accuracy of the primary data. The CHA I&BP programme had been instigated to draw attention to the practice to encourage and support formal evaluations of services in order to build up an evidence base (Tucker *et al.* 2000).

In both of these programmes I was in a position of promoting confidence in the service and advocating for the services and the practice of integrating care. This raises a significant question of conflict of interest and potential bias. In order to undertake this

research I adopted an impartial role to ensure a rigorous and independent analysis of the data. I understood that the findings may be contrary to the messages within the programmes, and that limitations and shortcomings may be identified. However the overriding consideration is to add to the evidence base on integrated care and community hospitals and community services in order to add new learning. This view is shared with colleagues in both programmes. I explore the benefits and disadvantages of the primary researcher undertaking secondary analysis in chapter 5.

There is a growing interest in re-using qualitative data for secondary analysis (Heaton 1998). The Economic and Social Research Council (ESRC) established a qualitative data archival resource centre (Qualidata) to encourage secondary analysis of qualitative data which is now part of the UK data archive (Heaton 2004:21). The ESRC now requires applicants for research funding for qualitative studies to consider whether their research can be undertaken using existing resources, and whether researchers would consider depositing data sets from their research so that they are available for secondary analysis (Heaton 2004:23). This illustrates the recognition of the value of re-using qualitative data.

After careful consideration, I concluded that there were considerable benefits in analysing the readily available data, and that rigour in the research process would counter concerns (Kiecolt and Nathan 1985:75). Secondary analysis is described as an attractive strategy, as it allows a researcher to capitalise on previous efforts (Robson1993:282). According to Hakim, in future years secondary analysts may simply

be regarded as data analysts who use existing material to yield its fullest results (Hakim 1982:172).

1.9 Ethical Approval

This study has been carried out in compliance with the requirements of the University of Warwick for integrity and quality as set out in their internal policy research code of practice (University of Warwick 2009). The proposal for the research was approved by the University. The safeguards for the study in terms of ethical compliance were as follows:

- There was no new data collection

- The primary data was in the public domain, published and/or online

- Data was anonymised

- My research was self-funded and therefore independently financed

- There was no requirement to submit proposals to NHS ethics research committees at the time this research was funded.

- Permission was granted by the two organisations concerned (Appendix A and Appendix B)

I consider ethical considerations when considering my research approach in Chapter 5.

1.10 Overview of Thesis

The overarching research question is to explore the presence, nature and development of integrated care from the perspective of staff working in community health services.

With respect to the presence of integrated care, I want to determine whether integrated care is taking place. The nature of integrated care concerns component parts such as types of integration and the processes in place to support integrated working. In order to understand the development of integrated care, I want to examine what staff views and experiences are of what helps or hinders the development of integrated care, and how integrated working has been developed.

The pursuit of integrated care has become a global phenomenon which is reflected in Government strategies and policies and is integral to the World Health Organisation's priorities (WHO 2008), although recent studies have concluded that there has been limited evidence of integrated working in practice (Leichsenring 2004) and that there is a need for countries to learn from each other (Mur-Veenan *et al.* in Van Raak 2003:169). Studies have concluded that definitions of integrated care vary according to political, social and organisational contexts, although there is a commonality in the drivers for change (Nies and Berman 2004). The case studies in Ireland and England provide an opportunity to compare and contrast the experience of staff working in two different countries, systems and settings as they seek to improve their services and the way that care is integrated.

The design of the study, with two programmes as case studies, provides an opportunity to compare and contrast the experience of staff working in different ways, within different health systems and different countries. I have summarised some of the similarities and differences between the two programmes in Table 1. The decision to research two case studies was made on the basis that this would optimise learning, enable comparisons and contrasts to be made, and provide an opportunity to reflect and consolidate on experiences.

Case Study Profiles	Community Hospitals Association Innovation and Best Practice Programme (I&BP)	Integrated Care, One Network Programme (ICON)
Programme	Community Hospitals	Primary and Community Services
Country	England	Ireland (Midlands area)
Scope	Country-wide	Organisation-wide
Services	Primary and community services within local hospitals	Primary, community and continuing care services (PCCC)
Geography	Rural (predominantly)	Rural
Time Period	2000-2005	2002-2005
Timescale	Tradition of integrating care over 150 year history although unrecognised	Intensive time limited programme to support integrated working across the whole health system
Model of Integrated Care	Implicit and informal	Explicit, with visual model and formal definition
Number of services studied	48 services	18 services
Funder	Department of Health (for first two years) and CHA	Midland Health Board (MHB)
My Role	Chairman of CHA, voluntary committee member	Management Consultant on contract to MHB
Topic for Analysis	Types of integrated care 69 staff experiences and views on developing services 48 services in community hospitals	Organisational processes to support integrated care 63 staff experiences and views on the definition and features of integrated care 18 staff views (team leaders) of the development of processes to support integrated care

Table 1: Comparing Case Studies – CHA I&BP and ICON Programmes

Table 1 illustrates some of the similarities and differences between the programmes, which are re-visited in the analysis of the findings of the study (Table 52). This research provides an opportunity to study integrated care in services in a national programme

(I&BP) and an organisation-wide programme (ICON) to explore whether integrated care is confined to one client group, single types of integration, and restricted to short term special projects and how integrated working is developed in community based services.

1.11   Definitions

In order to set the parameters for this research there is a need to define the key terms and services within the study. Where there is some discussion and contention regarding definitions, I have set out a simplified version that guides the research. The terms I have attempted to define are: integrated care; care; community hospitals; community services and complex care. This is also explored in detail in the literature review.

– Integrated Care

This research is concerned with the presence, nature and development of integrated care. In order to scope this study, I have created a simple definition of integrated care, based on the literature, and this is explored more fully in Chapter 3.

 "*Integrated care is defined as separate actors, agencies or services working together for the benefit of the patient.*"

I have developed this definition as the term "integrated care" does not have a universally recognised definition, despite pan-European attempts to create a definition that may be widely-applicable (Leichsenring 2004). To compound confusion regarding terminology and definition, there are a number of terms that are used interchangeably with the term integrated care, such as collaboration, coordination, partnership working, joint working

and continuity of care (Freeman *et al.* 2001, Coxon 2005; Leichsenring and Alaszewski 2004:18). These terms have particular attributes and may be used flexibly or in particular contexts. Where there are definitions or descriptions of integrated care, these typically focus on either: values such as being person-centred; processes such as care management or outcomes such as improved patient care, with typically more focus on processes than outcomes (Glasby and Dickinson 2008:27). In this context, the definition of care includes "to provide for physical needs, help or comfort, and also to be concerned (Collins 2004).

Integrated care is a global priority, and yet is often poorly defined (Leichsenring 2004). It is a term that is context-specific with multiple meanings and interpretations. There are terms that are used as an alternative or substitutes to the term integrated care which may provide a distinction or a subtle difference (Thistlethwaite 2004; Nies and Berman 2004:12; Kodner and Kyriacou 2000). I searched the literature for terms and meanings, and prepared a table of 18 terms with definitions or descriptions to help illuminate the issue of language and terminology. The terms are then discussed more fully. I have grouped the terms into five categories: concept, levels/degrees, systems, types and structures (Leathard 2003:6; Iles 1997).

Term	Definition and Descriptions of Integrated Care
Concept	
Integration	"Regularised ties, interchanges or reciprocity of practices between either actors or collectivities" (Giddens 1979:76)
Integrated care	"In its most complete form, integration refers to a single system of needs assessment, service commissioning and/or service provision" and is between different agents/agencies (Thistlethwaite 2009)
Integrating Care	A state of developing integrated working, suggesting movement and progress rather than achieving a state of integration. (Woods 2001)
Continuity of care	"The experience of a coordinated and smooth progression of care from the patients point of view" (Freeman, G. *et al*. 2001). Continuity to be simultaneous and also sequential (Nies and Berman 2004).

	A patient perspective of continuity (Grone and Garcia-Barbero 2002).
Levels/Degrees	
Linkage	Informal connections regarding patients made, requiring a sharing of information and knowledge of roles. Referred to as level 1 (Leutz 1999)
Coordination	Formal systems and structures to manage patient care across agencies/professionals Referred to as level 2 (Leutz 1999)
Full Integration	Full integration is a formal system of pooling resources with agencies/professionals using a common system. Referred to as level 3 (Leutz 1999)
Co-operation	Contacts between independent organisational units, usually by a designated coordinator or network manager (Ahgren and Axelsson 2005; Leichsenring, 2004).
Collaboration	Collaboration is a process focusing on activities of working together with the aim of improving care to patients (Leichsenring and Alaszewski 2004:70)
Systems	
Managed care/Care management/Case management	"The integration of medical and social services in a continuum of care with case management programmes" (Bernabei *et al.*1998).
Teamwork	Teams have shared objectives, are interdependent and a defined organisational function. Teamworking is a team in action, and also about how teams relate to wider systems (Jelphs and Dickinson 2008:6)
Joint working	Described by staff as a multi-professional team working in an inter-disciplinary way on an inter-agency and intra-agency basis, particularly in the context of health and social care. Joint working could be formal or informal (Coxon and Billings 2004). The term is typically used in the context of health and social care (Glasby and Dickinson 2008:5)
Structures	
Networks	Multiple organisations and parties coming together, usually informally and voluntarily, with a shared interest (Based on Glasby and Dickinson 2008)
Partnerships	Involve negotiations between different people from different agencies committed to working together (Sulllivan and Skelcher 2002 in Glasby and Dickinson 2008). "...requires a relationship between them that involves a degree of trust, equality or reciprocity" (Glendinning *et al.* 2002 in Glasby and Dickinson 2008)
Hierarchies	"Co-operation bound by rules and structure" (Glasby and Dickinson 2008)
Types (some examples)	
Multi-disciplinary/ interdisciplinary	"Colleagues from two or more disciplines/professions who work together for the benefit of the patient" (Leathard 2003:5).
Intra-disciplinary	"Staff from the same profession (i.e. nursing) who have distinct specialisms, working together to provide care" (Leathard 2003:5)
Multi-Agency/Cross Agency	Integration across agencies, rather than within an organisation (Coxon, 2005).

Table 2: Definitions and Descriptions of Terms for Integrated Care

The definitions and descriptions present integrated care as individuals (actors/agents) and organisations (agencies/collectivities) working together. In the absence of an agreed common definition, the term integrated care may be used in various ways in different contexts. Terms are used to describe levels or degrees of integration (linkage and coordination), types (multidisciplinary), systems (case management) and structures (hierarchies, partnerships and networks). Terms are fluid within the parameters of the

concept and, according to Ouwens, "pose a problem for researchers and managers as they try to compare services and develop a body of evidence within the field of integrated care" (Ouwens *et al*. 2005).

Terms may be used to differentiate an aspect of integrated working, such as continuity of care. The continuity may be simultaneous or sequential, and focused on the service user experiencing a continuity of experience through the staff and service (Freeman *et al.* 2001). A service user may experience continuity of care from their GP, for instance, without this indicating that there is integrated working with a team.

Three levels of integrated care were shown on a matrix by Leutz, namely linkage, coordination and full integration (Leutz 1999). Other researchers have also chosen to add a further level on a spectrum of integrated care, starting with the opposite of integration, namely segregation (Ahgren 2005) or autonomy (Grone and Garcia-Barbero 2002). Ahgren also suggests that there is a level between coordination and full integration on the spectrum which he terms co-operation (Ahgren 2005). Three levels of integrated care put forward in a World Health Organisation paper were autonomy, coordination and integration (Grone and Garcia-Barbero 2002).

Terms are used as alternatives and substitutes for the term "integrated care," such as when staff are describing their way of working (joint working, multidisciplinary working) Coxon 2005. An appreciation is needed of the definitions and descriptions of integrated care and related terms, particularly when analysing and interpreting data from questionnaires completed by staff.

The multi-faceted aspects of integrated care are explored within the review of the literature, and the definitions and types most relevant to this research study are highlighted.

This research study focuses on integrated care in respect of clinical and care practice and operational systems rather than financial, managerial or structural integration. It also concerns integration between staff and services, rather than between organisations. Both horizontal and vertical integration are included within this study. The terms "integrated care" and "integration" are used throughout the thesis. Other associated and similar terms are used throughout the study, such as "joint working" where it has been used in survey data from questionnaires or is appropriate to the context.

- **Community Hospital**

There is no nationally agreed definition of a community hospital, although they are often described as small local hospitals staffed by local GPs and community-based staff (Primrose 1998). Community hospitals were originally called cottage hospitals (Emrys-Roberts 1991), and these terms are used interchangeably throughout this research. A more recent definition offered by Meads has been adopted *"The community hospital is a service which offers integrated health and social care and is supported by community based professionals who have direct access to its services"* (DH 2006a).

- **Community services**

A community service is a term used to describe a full range of locally based services within communities. In Ireland these are described by the HSE as including: general

practitioner services, public health nursing, child health services, community welfare, chiropody, ophthalmic, speech therapy, social work, addiction counselling and treatment, physiotherapy, occupational therapy, psychiatric services and home help.

1.12   Thesis Content

A flow chart of my thesis, setting out my research questions, approach, key findings and conclusions is shown in Figure 1. The table provides a way of navigation, and provides a guide to content in each chapter.

In Chapter 2, I have carried out a literature review on the disciplines of research and consultancy and examined the differences and similarities. This introduction has highlighted the need for the author to change roles from consultant and advocate to researcher. As this is fundamental to the legitimacy of this research, I have addressed the challenges of using data from consultancy for research, set out how the integrity of the research will be maintained, and explicitly addressed the limitations of this approach. This has helped to frame the research approach and understand how to interrogate and manage the data sourced from consultancy and interpret the findings.

In Chapter 3, I have reviewed the literature on integrated care, considered where integrated care is taking place, and how it is being developed. There were a number of questions I wanted to explore, such as why we are interested in integrated care at this time and when did it become an important factor in health and social care. I wanted to know more about what integrated care meant in different health care systems and what the experience internationally was of designing and developing integrated care systems.

I hoped that the review of the literature would further clarify the definition of integrated care and provide evidence of how integrated care is being designed, developed, and sustained in community health services. My experience in community health services had led to me to believe that integrated care was taking place more widely than had been recognised, both in supported structured programmes and also in an informal way of working, and I wanted to explore this further. In particular, I wanted to explore the literature on processes and systems that supported integrated working such as those concerned with care management and information systems, and explore this further in the integrated care programme case study in Ireland. From the review of the literature I developed a conceptual framework of inclusivity, whereby I challenged the predominance of an exclusive service of integrated care focused on model short term projects with one type of integration and designed for one client group, namely older people.

I have devoted Chapter 4 to community hospitals and their history, role and function in order to determine whether there is evidence of a tradition of joint working in local hospitals, how this manifests, and what pertinent factors influence the extent of networking within and beyond these hospital services. I have explored the partnerships in community hospitals and, from the literature, identified eight frequently occurring types of integration. These were integration between community hospitals and: primary care; secondary care; social services; Local Authority; the third sector; patients and the community as well as integration between professionals.

The rationale for my research approach is presented in Chapter 5, with an appraisal of methods for my research approach. This includes an assessment of the extent and limitations to the study, particularly in regard of the secondary analysis of qualitative and quantitative data that had been collected for evaluation purposes in the two case studies. Questionnaires completed by staff working in community hospital and community health services provide the majority of the data, which I have analysed using themed content analysis. The findings on staff views and experiences on integrated care in community hospital services in England are presented in chapter 6, in which the frequency of occurrence of eight types of integration from the literature review are identified in 48 services. In addition, staff views of factors influencing service development are analysed.

The findings from the data analysis on staff views of the meaning of integrated care, the development of integrated working and the implementation of processes to support integrated working in community health services in Ireland are presented in Chapter 7. The results are contextualised within five services which are presented as embedded case studies.

The findings are discussed in Chapter 8 in the context of the concept of integration being inclusive rather than exclusive, and an approach to managing change in health and social care is explored so that integrated working may be sustained. In Chapter 9, I identify new learning, review the appropriateness and limitations of the research methods adopted and consider the implications of the study. I consider the new learning about the presence of integrated care in local community services, its multi-faceted

nature in terms of types and components, and what can be learnt about the development,

implementation and sustainability of integrated working. Following my overall

conclusions, I discuss the impact and implications of the study and identify areas for

further research. I suggest the creation of a new framework for integrated care which

sets out the features and principles of integrated care which may be generally applicable.

This study contributes to the ongoing debate about the nature of integrated care and how

integrated working is to be developed for the benefit of users of services. Figure 1 is a

flow chart, setting out in diagrammatic form the content of my thesis by chapter.

The Presence, Nature and Development of Integrated Care in Community Health Services.

Two case studies: Community Hospitals in England (CHA I&BP) and Community Health Services in Ireland (ICON).
Staff views and reported experience of integrating care – secondary qualitative analysis of questionnaires
Is IC exclusive?

	Research Questions *Chapter 1* **Presence** - Where is IC taking place? **Nature** - What are the characteristics of IC? **Development** – How is IC being developed?	
Literature Review CH *Chapter 4* What is a CH? What is the history of CHs? How have CHs developed? What is the role and function of a CH? What is the international experience of CH hospitals? Is integration evident in CH?	**Literature Review** *Chapter 2* **Management Consultancy and Research** How are management consultancy and research defined? What are their similarities and differences? How may the understanding of the two disciplines help inform the design of this research study?	**Literature Review IC** *Chapter 3* What is IC? What is the social theory for IC? What is the health theory for IC? What are the characteristics of IC? What is the rationale for IC? Why is IC a global priority? How is IC developed? How is development of IC managed? What is the impact of IC?
	Analytical Framework *Chapter 5* What are the types of IC? What are the component parts (processes) of IC? **Conceptual Framework** Where is IC on Inclusive /Exclusive spectrum?	
Analysis I&BP *Chapter 6* 48 service – community hospitals 8 pre-defined types of IC Factors supporting or hindering IC	**Methodology** *Chapter 5* 147 staff questionnaires for 66 services Case Study Approach Secondary qualitative analysis of primary data Themed content analysis & triangulation	**Analysis ICON** *Chapter 7* 63 staff define IC 18 community health services 8 pre-defined processes for IC Factors supporting or hindering IC
Findings I&BP *Chapter 8* Multiple types in all CH services 4 (median) range 2-8 IC for all ages and all services studied Most types: palliative care, long term conditions and health promotion Helps: commitment, Hinders: staffing levels and funding		**Findings ICON** *Chapter 8* Multiple processes in all services 4 (median) at start rising to 5 at end IC for all ages and all services studied Most progress: children's services, Most processes: disability services and primary care. Small teams made most progress
	Conclusions & Reflections *Chapter 9* **Presence** IC present in all services in this study **Nature** Multiple simultaneous types Multiple processes to support IC IC for all ages and services in this study **Development** Systems approach may be applicable **IC defined** Propose a framework of 5 principles **Inclusive/Exclusive** Research shows IC positioning on spectrum shows may be more inclusive.	

Figure 1: Flow Chart of Thesis

2. LITERATURE REVIEW: MANAGEMENT CONSULTANCY AND RESEARCH

2.1. Introduction

In this chapter I explore the differences and similarities between the two disciplines of management consultancy and research in order to help inform the design of my research. This research re-uses primary data that was collected in order to evaluate two programmes which were carried out as management consultancy commissions. This exploration was undertaken early in the process of undertaking my PhD to inform the design of my secondary analysis, enabling me to critically reflect on the approach I use in my consultancy role and the different approach I would need to nurture in order to undertake research.

Within my career I have undertaken both management consultancy commissions and research, both individually and as part of a team. I have provided an overview of this chapter 1 and referenced publications from both consultancy and research. Examples of publications from management consultancy commissions are: a review of community hospitals in North Wales (Tucker and Bosanquet 1991); the development of a financial management system for community hospitals (Tucker 1992); the first Innovations and Best Practice report (Tucker *et al.* 2000) and articles on the ICON programme (Tucker *et al.* 2004a; Tucker *et al.* 2004b; Tucker *et al.* 2005). Two examples of research publications are: a study on the role and function of community hospitals for the Kings

Fund (Tucker 1987) and a review of the role of Housing Associations in community care for the National Federation of Housing Associations (NFHA 1995).

This chapter considers the questions:

- How are management consultancy and research defined?

- What are the similarities and differences between management consultancy and research?

- How may the identification of these similarities and distinctions be used to inform the design of this research study?

To help answer this question, I have read the literature on the history, role, function, approach, outcome and application of the two disciplines. I have considered the characteristics of health service research and management consultancy, drawing out the similarities and differences from the literature. I have chosen to discuss in more detail two specific activities that can be considered both consultancy and research. These are health service evaluation and social action research. I have assessed the overall findings within the context of my personal experience and then considered the implications for this study so that safeguards are put in place to help ensure the integrity of my research.

2.2 Method

I have carried out a review of the literature using three main steps: i) identification; ii) assessment against criteria and iii) analysis and synthesis.

Identifying the literature

To answer the question of the similarities and differences in health service research and management consultancy I sought literature that i) clarifies the nature of management consultancy or ii) clarifies the nature of research or iii) considers the similarities and differences between management consultancy and research. This narrowed the scope of my literature review to literature that provides commentary on research and/or consultancy rather than reporting original research. I also aimed to limit my scope to literature commenting on research and/or consultancy in the context of health care wherever possible.

To explore the use of electronic databases for identifying literature for this chapter, I searched Pubmed using the key words of "research," "research methods," "management consultancy" and "business consultancy" then limited the search to the domain of health care. This search identified thousands of publications. An examination of the publication titles suggested that this search was identifying a wide range of types of literature and that identifying 'expert commentary' by this method would have been time consuming, and potentially less productive than other methods (Greenhalgh and Peacock 2005). I therefore considered an alternative approach of accessing my own sources and networks through personal knowledge, and then pursuing references of references, a method termed as "snowballing" (Greenhalgh and Peacock 2005). In their study of effective search methods for systematic reviews of complex evidence, Greenhalgh and Peacock identified 51% by snowballing, 24% by personal knowledge or contacts, and only 30% from database and hand searches (note some double counting).

The authors concluded that snowballing and personal knowledge increased the yield and efficiency of search efforts (Greenhalgh and Peacock 2005). This suggests that my main approach to identifying literature was likely to be productive. Greenhalgh and Peacock (2005) go on to suggest that "...formal protocol-driven search strategies may fail to identify important evidence" and that snowballing and personal knowledge are "especially powerful methods for identifying high quality sources." Horsley *et al.* (2011) also endorse the practice of identifying literature through snowballing concluding that it is widely practiced, it is a method that yields additional studies and can be viewed as a supplement to searching electronic databases.

I developed a library of publications throughout my career in consultancy. This includes many of the papers by recognised experts in the field. I identified relevant literature for this chapter from my personal collection then checked each of the reference lists in these publications for other relevant material. I also used lists of research books and methodological papers from my supervisors and relevant university courses to identify key publications on research and again searched the reference lists for relevant publications.

The nature of my research question makes the primary use of electronic databases problematic. My literature review for this chapter is therefore based on literature written by people recognised as having expertise in the field of consultancy/research predominantly in health care through the process of peer-review for papers published in peer reviewed journals, editorial review for books, and citation of their writing.

In my methods for carrying out this literature review, and the literature reviews in the next two chapters, I have followed methods and checklists as set out by Bowling in order to include papers and publications that are pertinent and valid (Bowling 1997:119). I have reviewed references and carried out an internal check to ensure appropriate use of quality publications such as RCTs and peer-reviewed articles as well as frequency of citation. I have re-read my references, considered the issues raised by each source and then synthesised these with the other literature in relation to my research question (Robson 1993:24). I have also considered carefully the outputs of systematic reviews to verify key and seminal publications. I have utilised personal libraries and databases built up over many years for organisations such as the Department of Health and the CHA as well as for my own use, which is considered to be an effective and efficient way of identifying high quality sources (Greenhalgh and Peacock 2005). I have scrutinised the references I have chosen to use in my research for their applicability and quality. I am aware of the limitations of this approach, particularly in respect of the current standards of critical appraisal such as in the Critical Appraisal Skills Programme (CASP). I started my research in 2003, and in the process of successfully upgrading to studying for a PhD in 2006 I submitted a literature review. The CASP method was launched in 1993: http://www.phru.nhs.uk/Pages/PHD/CASP.htm. On reflection, a critical appraisal approach may have provided a clearer assessment of the quality of the evidence and enabled me to categorise and weight references. It has not been possible to revisit the three literature reviews and carry out this method in retrospect. I acknowledge that this may be a limitation within my three literature reviews, and the referencing of literature throughout my study (Holliday 2007:44). I

would in future consider methodological options for carrying out a literature review, such as adopting a critical appraisal method. As such this has been valuable learning.

Assessing the literature against pre-established inclusion criteria.

Having identified the literature I assessed it against the following inclusion criteria:

1. It considers the definition/nature/purpose of consultancy and/or research

2. It is a peer reviewed paper or book of recognised standing in its field

3. Written in the English language

4. Considers health care research/consultancy or can be applied to this context

I identified 29 sources, 11 of which were specific to health services.

Analysis and synthesis

I have re-read my references and considered the issues raised by each source. I made notes on key themes related to my research question (Robson 1993:24). These were: the definition and role of consultancy; the definition and role of research; and an exploration of the similarities and differences between consultancy and research. I went back through all the literature, re-interrogating it for text on these themes. I reviewed all the relevant text on these themes and developed a description of consultancy and a description of research. Using the literature that itself compared consultancy and research I extended the published comparisons by drawing on the other literature included in my review. During this process of synthesis I identified two types of research/consultancy where the activity was very similar although there were differences

in purpose when the activity was considered research and when it was considered consultancy. These were health service evaluation and action research. I therefore identified text about these two example activities and compared and contrasted the text to deepen the analysis of the difference between consultancy and research. These activities are of particular relevance to my own research. The secondary analysis reported in this thesis uses data from i) an evaluation of health services (ICON and I&BP) and ii) a form of action research (ICON). Finally, I identified the lessons from this analysis and synthesis for my own research.

2.3 Management Consultancy – Definition and Role

In the context of business, a management consultant is a professional who provides advice and support to organisations which require specific technical expertise, experience and knowledge (Institute of Business Consulting 2009). This view of the consultant as an advisor is reinforced by Tisdall, who describes a management consultant as "an independent and qualified individual who supports organisational development and change in one of three roles: an advisor, facilitator, or as an additional resource as an interim manager" (Tisdall 1982:96). Within the NHS the term "consultant" is used in the context of medical staffing to denote the most senior medical position in the UK who has a role in advising, teaching and supporting clinical staff as a specialist who gives expert opinion, advice or information (Collins 2004). Management consulting is considered to be a profession and a method (Kubr 2002:xvii), which involves imparting advice and transferring knowledge to clients (Kubr 2002:4).

Management consultancy is considered to be a relatively new discipline, with its roots in the early 1900s in efficiency studies (Clark and Fincham 2001:3). Pioneers of what was termed "scientific management" included Frederick Taylor who developed a time study to improve manufacturing performance (Tisdall 1982:16). The impact of efficiency studies on individuals, referred to as the "the human factor", was recognised by Gilbreth and Gilbreth who involved employees in time and motion studies (Tisdall 1982:19). The World Wars brought further attention to improving efficiency and effectiveness but Tisdall notes that it was not until forty years later that significant growth was recorded (Tisdall 1982:35). Although management consultancy continues to be based on "advice giving and contributing skills" (Clark and Fincham 2001:2), it is considered to be changing and adapting to meet new demands and opportunities, particularly in what is known as the "knowledge economy" (Kubr 2002 :xvi). The notion of "adding value" to an organisation is becoming more prominent, and is reflected in new term of "business consultancy" rather than management consultancy (Kubr 2002:27). The role has recently been described as "individuals or teams applying their knowledge, experience and problem solving skills to add value to organisations "(Institute of Business Consulting 2009). These organisations include the public sector and specifically in the NHS, where business principles are being adopted as the market system develops.

A management consultant is therefore someone who has "expertise in a particular area and can offer unbiased help, opinions and advice for a fee" (Gray 1989:13). Sturdy describes instances where clients require assistance from consultants who have analytical, creative and technical skills in order to help resolve problems (Sturdy 2009).

A typical consultancy assignment proposal would detail the purpose of the commission in response to a client's brief, detailing the expertise being offered, the nature and sequence of tasks, a deliverable outcome, the client's role, a timetable, fees and any other conditions (Kubr 2002:24). The outcome or deliverable from the commission is required to be explicit, so that expectations are clear, performance can be monitored, and accountability for funding, particularly public monies, be addressed. Consultants are required to demonstrate a familiarity with the subject, relevant experience, a track record in similar commissions, and a reputation that can be checked through references. The method adopted is often at the discretion of the consultant, designed to accommodate the brief, timescales and the capacity of both the consultant and the client. Therefore there may be a pragmatic approach to relevant data collection, according to the specific brief, which may be at variance with research methodologies (Ormerod 1996).

Gummesson describes the work ethic and motivation of consultants, as primarily focused on achieving client satisfaction and generating new assignments (Gummesson 1991:148). Consultants are viewed as professional helpers, particularly in terms of supporting organisational development, and offer benefits in that they may provide useful information, and enable the client to select which aspects of advice they want to take (Clark and Fincham 2001:5). Independence is viewed as a feature of consulting, whereby a consultant can be unbiased and detached (Kubr 2002:7).

Gummesson identifies quality components of consultancy services which include a company's resources (specialist knowledge and individual consultants personal characteristics), the operation of the assignment (diagnosis, problem and goal

formulation), and the output (solution to a defined problem and implementation) (Gummesson 1991:166). Gummesson stresses his view that the customer has limited interests in methods employed and is primarily concerned with the results (Gummesson 1991:167). This message is reinforced by Ormerod, who also observed that consultants lacked an explicit philosophy, and that this impacted on the coherence of their practice (Ormerod 1996). The outcome is often a management report which is owned by the customer or client. An outcome of a consultancy assignment may be organisational change, which the consultant may or may not be involved in, although there are those who advocate that as change agents it is essential that consultants be involved in implementation (Gummesson 1991:167).

Consultancy has a role as contributing to the efficiency of an organisation or services, through functions such as reviewing, diagnosing and problem-solving, and is characterised as having a practical application. Management consultants have been seen as depicting innovation and knowledge and, more recently, are presented as in partnership with clients in a facilitative role (Sturdy 2009). Consultants may have a role as an enabler (Kubr 2002:3), and may offer coaching, support and training for staff, to help build the expertise within the organisation (Kubr 2002:16).

There has been a significant growth in management consultancy in the public and service sectors in recent years, where consultants in clinical and health care contexts have been employed to encourage management learning and to facilitate reflection in practice (Clark and Fincham 2001:4).

The literature review shows that management consultants, independent advisors or enablers are typically commissioned by organisations which require additional resources, expertise, skills or capacity for a specific task. A contracted commission will typically have a defined outcome in the form of recommendations or suggested plan, which may lead to an implementation process concerning service development and improvement. Therefore the method adopted would be outcome-focused with a pragmatic approach to data collection which is orientated to the specific requirements of the commission.

The most comprehensive definition of management consultancy is offered by Kubr:

"Management consulting is an independent professional advisory service assisting managers and organisations to achieve organisational purposes and objectives by solving management and business problems, identifying and seizing new opportunities, enhancing learning and implementing changes" (Kubr 2002:10).

The definition stresses the independence and the range of functions including problem solving and supporting improvements. Such commissions generate data that can assist in learning and knowledge transfer and may be used for discerning trends in sectors (Kubr 2002:59). Kubr states that outstanding benefits can be drawn from combining consultancy, teaching and research to promote knowledge transfer (Kubr 200:48).

The exploration of the definition and role of management consultancy from the literature provides a basis for comparing and contrasting to the definition and role of research.

2.4 Research –Definition and Role

A researcher has an aim of generating new knowledge (Bowling 1997:1), and is someone who "seeks and searches again" (Collins 2004). The discipline of research is defined as "the systematic and rigorous process of enquiry which aims to describe phenomena and to develop explanatory concepts and theories" (Bowling 1997:1). The systematic and explicit methodology is required so that studies can be replicated and findings further tested and validated.

In the context of health services research, the origins may be traced to Hippocrates over 2000 years ago who aimed to demystify healing and disease by using observation and evidence, referred to as bedside medicine (Porter 1997:58). The Hippocratic Corpus, consisting of over sixty texts, was distinctive in that it defined health and illness as an upset to equilibrium which could be explained by reasoning rather than religious or supernatural factors (Porter: 1997:56). Research institutions such as the Medical Research Council were established in the early 1900s (Porter 1997:529).

A wider context for health and illness was presented by Foucault who was concerned with increasing knowledge both of the healthy and the sick in order to compare them, and suggested a different "gaze" (Foucault 2003:38). The move from the disease-based biomedical model of health to a social model of health has been captured by the World Health Organisation (WHO) as defining health as "not merely the absence of disease but a state of complete physical, psychological and social well-being" (WHO 1978). This widening interpretation has led to what is termed health research, which incorporates health needs as well as sociological and psychological aspects of health, and health

services research, concerning the relationship between health needs and health service delivery (Bowling 1997:2).

An approach to research for social scientists and practitioner-researchers is outlined by Robson in what he calls "real world research" (Robson 1993:2). He suggests that a research study starts with a research question, a line of enquiry or hypothesis, followed by a review of the literature in order to determine what is already known about the subject. The question is then refined, and a conceptual framework designed in order to help manage and understand the data. Data are collected through designed instruments, and are then analysed, interpreted and validated. Findings are discussed in relation to existing knowledge and suggestions made for further research as appropriate. The research findings are published and disseminated (Robson 1993:411). Research is typically undertaken in order to generate new knowledge, by creating or testing a theory (inductive or deductive), and by using a systematic approach (Bowling 1997:104). The design of the research study is required to be systematic and robust, and the steps taken to code, collect, collate and analyse the data to be carried out objectively. With respect to qualitative research, methods need to be explicit including how the data were accessed, collected, coded and themed, and how the data provide the evidence for the discussion on what has been found (Holliday 2007:43).

The increase in importance of research to provide an evidence base for policy and practice in the NHS is shown in developments such as the role of the National Institute for Clinical Excellence (NICE), a body which includes in its role a review of evidence of effectiveness of treatments and medication. The Cochrane Centre was developed

following the case made by a GP in Dorset for more evidence of benefit of health care interventions through the use of randomised clinical control trials (Cochrane 1972:97). The Cochrane Centre is now the NHS Research and Development Centre for Evidence-Based Medicine which supports research and development, and coordinates the Cochrane Collaboration which undertakes systematic reviews of research (Bowling 1997:119). The first randomised controlled trial of community hospital services in England was included as evidence in the White Paper on developing community services (DH 2006a). As observed by Haines and Donald, the pace of change of knowledge is increasing, and the advent of research-based information for patients and practitioners means that there will be increasing pressure to demonstrate the application of research based learning in policy and practice (Haines and Donald 1998:8).

This research study is designed as health services research, and is concerned with improving the efficiency and effectiveness of health care systems and services (Bowling 1997:2). It is a qualitative study, interrogating data from staff questionnaires in order to capture their views and experiences of integrated care. The review of the literature on research has illustrated the focus for research in terms of adding or confirming knowledge, and has also demonstrated the rigour of method in respect of a clear research question to be answered, a conceptual framework, and a replicable method of research for data collection and analysis.

2.5 Similarities and Differences between Research and Consultancy

In describing the respective roles of consultancy and research, some of the similarities and differences have started to emerge, and these need to be explored further in the

context of this study. The table below is replicated from the work of Kubr, who points out the distinctions between research and consultancy, but also discusses the many similarities (Kubr 2002:59). The values held by the researcher and consultant have been referred to as the scientific paradigm and consultant paradigm respectively, with distinctions and similarities identified (Gummesson 1991:15).

Factor	Research	Consultancy
Problem	Mainly fashioned by researcher; more open-ended especially in exploratory research	Mainly fashioned by the client; sometimes on a joint basis
Timescale	Usually flexible	Tighter and more rigid
End Product	New knowledge and new theories and ? better practice	Better management practice
Ownership of Information	Usually publicly available	Often confidential
Decision-making	Focus may change at researchers discretion subject to plan	Discretion limited to the main task only
Academic rigour	Methodology tight	Minimum level appropriate to the problem
Evaluation	External by peers in scientific community; policy makers	Internal by company

Table 3: **Factors Differentiating Research and Consulting (Replicated from Kubr 2002:58)**

Kubr observes that, in spite of their differences, research and consultancy have a lot in common and can be very useful to each other (Kubr 2002:58). The use of data from consultancy for research purposes is not unique, and is referred to by Kubr who states that: "The data collected in client organisations by consultants can serve wider research purposes" (Kubr 2002:58). Kubr discusses the importance of consultants drawing on research when dealing with practical management problems and this was the case in the ICON programme (Tucker *et al.* 2003, Tucker *et al.* 2005).

I have developed a table summarising some of the key characteristics of health service research and management consultancy and populated it with references to help illustrate the two disciplines.

Role/Function	Characteristics of Health Service Research	Characteristics of Management Consultancy
Aim	"Generate new knowledge by creating or testing a theory and by using a systematic approach" (Bowling 1997:104)	"Individuals or teams applying their knowledge, experience and problem solving skills to add value to organisations" (Institute of Business Consulting 2009)
Objective	"Research aims to contribute to a scientific body of knowledge" (Bowling 1997:1) Research is the systematic and rigorous process which aims to describe phenomena and to develop explanatory concepts and theories" Bowling 1997:1) "Research is intended to make a contribution to science" (Gummesson 1991:184)	"A professional who acts as an advisor, facilitator or interim manager to an organisation" (Tisdall 1982:96) "Consultancy is intended to make a contribution to the client" (Gummesson 1991:184)
Role	Researcher to view all empirical and recorded data as fresh phenomenon, taking nothing for granted, holding everything they do up for scrutiny, and accounting for every action (Holliday 2007:20)	The consultant may be required to adopt multiple roles including "fact finder, problem solver, trainer/educator, informational expert and advocate" (Robson 1993:457).
Preparation	Researcher can be new to topic and context	Management consultant has "expertise in a particular area" (Gray 1989:13)
Approach	Has a conceptual framework or theory (Robson 1993:26) and may be either hypothesis-testing or hypothesis-generating (Muir Gray 2001:118). Theoretical framework and methods are explicit (Bowling 1997:314). Research approach designed to answer a research question (Robson 1993:25)	The brief for the study would be negotiated with the client with a proposal from the consultant defining the scope, method and outcome (Gray 1985:62).
Bias	"One of the defining features of qualitative research is that it requires a means of identifying whether there are biases in the collection of information or drawing of conclusions" (Muir Gray 2001:161).	Among the standards in the code of conduct for the Institute of Management consultants is "independence, objectivity and rigour" (Gray1985:221)
Method	Research follows a clear, well-defined study protocol and defined project management (Muir Gray 2001:117) Methods include interviews, case studies, documentary analysis (Bowling 1997:311)	Methods typically at the discretion of the consultant, and may include the application of management tools and techniques, as well as interviews, focus groups, data analysis and documentary analysis (Gummesson 1991) .
Findings	Analysis of data, with triangulated methods to test the validity of the data, lead to findings, which are then interpreted within context (Bowling 1997:314)	Findings considered based on evidence and interpreted with the consultant's knowledge, experience, expertise and judgement.
Outcome	A publication, so that the report on findings can be accessible to all who could benefit from them, and also be open to critical examination (Muir Gray 2001:117)	Report with recommendations that typically "support organisational development" (Clark and Fincham 2001:5) Also recommendations for improvements to the efficiency of organisations and services (Sturdy 2009).

Table 4: Characteristics of Research and Management Consultancy in Health and Social Care

Key points from the literature are that research is intended to generate new knowledge,

requires a theoretical framework, and has an explicit and replicable methodology

whereas management consultancy is typically advice-giving as a contribution to service

improvement or organisational development, drawing on knowledge and experience as well as management tools and techniques. This generalisation makes differences explicit and yet there are also areas of similarity and overlap. Some of the points are further developed below.

Ormerod claims that consultancy can provide useful research material (Ormerod 1996), and this point is further substantiated by Kubr who refers to client assignments as a source of information as well as for testing and applying research results (Kubr 2002:630). According to Holliday, work and research can merge (Holliday 2007:23).

It may be argued that both research and consultancy can be concerned with generating new knowledge, as consultancy also generates knowledge for both the client and the consultant through a knowledge transfer (Kubr 2002:5).   Robson challenges the idea that research studies are undertaken purely as part of a disinterested search for knowledge and understanding, but argues that many studies are pursued because of the possibility of the potential for helping to understand and inform change (Robson 1993:430).   Research into health practices, systems and services can provide evidence for improved performance in the same way that management consultancy contributes to organisational and business effectiveness, recognising that problem-solving is common to both disciplines (Institute of Business Consulting 2009).

Gummesson proposes increased interaction between academic researchers and management consultants in an action science strategy for qualitative research in management, as he argues both are knowledge workers (Gummesson 1991:187).

The question of independence and bias has been raised, and Ormerod challenges the notion that consultants are independent (Ormerod 1996). Consultants are required to demonstrate their level of authority in the field in order to gain the credibility and confidence to be commissioned (Gray 1989:15). This may mean that they have taken an ideological position or have a particular perspective that matches the client's requirements. Although it is pointed out that clients who turn to professional advisers should expect to receive impartial advice free from prejudice or bias (Kubr 2002 :136). Researchers do need to show how they are managing any possible bias or subjectivity through explicit methods (Holliday 2007:42), and demonstrate that they see everything as "fresh phenomenon" (Holliday 2007: 20).

The timeframes of the two disciplines can be seen as a distinction. Consultancy assignments are often short-term time-limited commissions which are designed to meet an organisational objective, whereas research studies may typically be carried out over a longer period without the immediacy of an organisational requirement. This difference is illustrated by respective publication timescales, where the popular management press is current and timely, and academic literature can be slower to reach publication (Clark and Fincham 2001:2).

Research is required to be systematic, rigorous, reliable, and replicable, using instruments for measurement (Bowling 1997:127). In consultancy methods are not always required to be explicit and shared, and may be based on experience and judgement without the need to produce a method that is replicable. Shaw comments that

only by using objective research methods can clinical outcomes be measured, along with the impact of management (Shaw 1980).

Research requires a conceptual framework, which is a way of being explicit about the features of the research and their presumed relationships (Robson 1993:150). The conceptual framework sets out the ideology of the researcher (Holliday 2007:59). Consultancy does not require this explicit positioning, although clients may commission consultants that share values and ideologies. There are examples of frameworks, tools and techniques that are adopted by consultants, such as the 7S model (Iles 1997:52). The 7S model has been used in the ICON programme (Tucker 2005). Frameworks that support change programmes include the Theory of Constraints, Force Field Analysis and Soft Systems Methodology (Iles and Sutherland 2001:29).

Research studies are carried out in order to make a contribution to science, whereas consultancy commissions are carried out to make a contribution to a specific client or organisation (Gummesson 1991:184). The client typically owns the intellectual property rights and has discretion over the application and dissemination of the work (Gummesson 1991:148), whereas research is shared with the wider scientific community (Kubr 2002: 58).

2.6 Health service evaluation

Evaluation has been defined by the WHO as "the use of the scientific method and the rigorous systematic collection of research data to assess the effectiveness of organisations, services and programmes in achieving pre-determined objectives." An evaluation is a study with a distinctive purpose, which is to assess value or effectiveness

(Robson 1993:170). Evaluations may be focused on activity, quality and/or cost, and are carried out in a way which is systematic.

Evaluation is a relatively new discipline which has rapidly developed, leading some writers to observe that "everything but everything needs evaluating" in reference to Kaplan's "Hammer Theory" which describes the similarity with giving a child a hammer and then observing the child wanting to hammer everything (Pawson and Tilley 1997:214).

Evaluation involves an assessment against objectives, differentiating it from monitoring, reviewing and audit which assess performance against standards. According to Robson, evaluation is required to be useful, feasible, accurate and have propriety (Robson 1993:181).

Evaluation would typically be carried out at the instigation of an organisation or individual, with an understanding that the findings from the evaluation will inform decision-making regarding the future of the service. According to Robson, evaluation inevitably has a political dimension, with innovation, policy or practice being evaluated having "sponsors and advocates as well as sceptics and critics" (Robson 1993:183). A health service evaluation may result in an outcome that may help to determine whether a service is expanded, maintained, reduced or closed (Robson 1993:183). Evaluation as an activity may be undertaken as a consultancy commission or as applied research, and there may be political dimension applicable to both (Robson 1993:172).

Evaluation may be considered to be one type of applied research using the same methods as for other types of research, although this view of continuity between

research and evaluation is not universally shared (Robson 2002:174). In describing

evaluation as applied research, six types of evaluation have been identified:

experimental, pragmatic, constructivist, pluralist, comprehensive and realistic (Pawson

and Tilley 1997:214).

There are two main approaches to evaluation: method-led or theory-led. The method-

led approach is based on a view that a robust and rigorous methodology addresses

potential problems in evaluation (Dickinson 2008:59). However, for evaluations of

changes in health care provision the simple "cause and effect" model is considered

inadequate as the context is complex and there are multiple variables (Dickinson

2008:59).

In a theory-based clear box approach, each stage and variable of the evaluation is

analysed and impact assessed (Dickinson 2008:54). Theory-based evaluations consider

the not only the inputs, outputs and outcomes but also the process that leads to outputs

and outcomes. Evaluations that consider inputs, outputs and outcomes have been

described as the "black box" approach, and those that are explicit on taking account of

the process have been described as a "clear box" approach (Robson 1993:180).

Realistic evaluation is a theory-based approach to evaluation and offers an equation –

context plus mechanism equals outcome (C+M=O).   Variations in context and/or

mechanism will impact on the outcome. This is relevant to case study research, as

contexts vary from teams, clients, services, timescales etc. and different mechanisms,

processes or interventions may be applied. Therefore, although improved integration

may be recorded for a team from applying an intervention, this same intervention might

not result in improvements in other teams. Various interventions may result in similar improvements when used in different contexts.   Tilley explains that evaluation studies produce "context mechanism outcome configurations" (CMOC) which capture the link between context mechanism and outcome, and that valuations can test CMOC theories (Tilley 2000).

In respect of learning from realistic evaluation, it is suggested that there is a "cumulative potential of knowledge," when the CMOC is repeated and shows the same or similar outcomes (Dickinson 2008:62).   It is also suggested that attention to the micro-level theory and detail of characteristics helps to build up knowledge.

This is significant for the two programmes studied in this thesis, where there are common objectives of improving integrated working, sharing learning and building on good practice. Whilst teams in ICON agreed to give attention to particular processes to support integrated working, any conclusions regarding the impact of the intervention would need to take account of the particular context. The same outcome may not be demonstrated in a different context, even though the intervention was the same. There was scope within the ICON programme for teams to choose their intervention from the eight interventions that teams agreed as a priority, so there was a potential for the same outcome to be achieved using a different intervention. The theory therefore sets out to challenge what works, for whom and in which circumstances (Tilley 2000). In making the case for a realistic evaluation approach for social policy and practice Tilley recognises the importance of a sensitivity that takes into account context and application, and facilitates a creative rather than mechanistic approach (Tilley 2000).

In summary, an evaluation study concerns the review of performance against a defined objective and provides recommendations that may assist with decision making and action and may be considered either applied research or a management study.

2.7 Social Action Research

Social action research is described as a method of generating knowledge about a social system whilst simultaneously trying to change it (Bowling 1997:366).

Action research is described as a technique for attempting to achieve improvements by auditing processes and critically analysing events, using multiple research methods most of which are qualitative, although some quantitative surveys may form part of the process (Bowling 1997:367). Action research uses an inductive process, which is a critical self-reflective bottom-up and collaborative approach to enquiry that enables people to take action to resolve identified problems described as a cycle of planning, acting, observing and reflecting (Bowling 1997:366).

Bowling describes this as a method of community or organisational development and investigation by stakeholders, and attributes the interest in action research stemming from disillusion with positivist methods of evaluation (Bowling 1997:366).

The problem-orientated approach is endorsed by Hart and Bond, who describe action research as problem focused and educative with an aim of improvement and involvement. They developed a typology for four types of action research, experimental, organisational, professionalising and empowering and suggest that this is relevant for

not only action researchers but also for those involved with evaluative research (Bowling1997: 366).

Kubr describes action research as being on the border of consulting as it aims simultaneously to solve a meaningful practical problem and yield new knowledge about the social system under study (Kubr 2002:59). Kubr suggests that consultants and researchers can learn from each other, particularly on methodology (Kubr 2002 :59).

There is an acknowledged problem with putting research findings into practice, as health systems have lacked a coordinated mechanism for managing change in systems and education (Haines and Donald 1998:8). Management consultancy commissions typically result in recommendations and action, with consultants often employed to act as catalysts or change agents (Gray 1989:87). The development of the RDDA model (research, development, dissemination and adoption) was designed to encourage the adoption of research findings in managing change, although there has been disillusionment with this (Robson 1993:437). Action research has however been used successfully in a variety of change programmes in health services, and Iles provides specific examples resulting in quality improvements (Iles and Sutherland 2001:85). Social action research methods have been recognised as a technique for achieving improvements through multiple research methods and are characterised by being collaborative and reflective (Bowling 1997:367).

The concept of action science (action research) is described as research and consultancy combined, although Gummesson acknowledges that requirements may differ (Gummesson 1991:189). Robson provides examples of studies in social sciences that

follow lines of enquiry that may be classified as either consultancy or research (Robson 1993: 2). Robson describes examples of studies where practitioners, consultants and researchers work together and he advises on early clarification of respective roles (Robson 1993:457).

Consultancy roles include problem solver, informational expert and advocate, and in studies such as social action research is a dynamic process designed to generate knowledge about the system whilst simultaneously trying to change it, where the researcher is a participant in the process (Bowling 1997: 366; Flick 2009: 296).

2.8 Implications for Study

Consultancy and research, although distinct disciplines, share many similarities and overlaps in role, purpose, method and application. This study re-uses data for research that has been collected through the author's involvement as a consultant in management consultancy commissions in the ICON programme and the CHA I&BP programme.

The CHA programme for Innovations and Best Practice (I&BP) was developed in order to encourage the evaluation of practice in community hospitals against defined criteria (Tucker *et al*. 2000). The ICON programme was evaluated against its objectives, considering inputs, process, outputs and outcomes (Tucker *et al.* 2005). The ICON programme for developing integrated care may also be considered to be social action research (Tucker *et al.* 2005). One of the limitations of utilising this data is that there was an expectation of partnership working and integrated care inherent in the design of the programmes. I have described the steps taken in the collection of the primary data to

validate its authenticity which enables me to analyse the data objectively with confidence (Table 14 and supporting text for the I&BP programme). These programmes provide data that has the potential to provide an insight into integrated care in practice that would not otherwise be available.

A particular factor in assessing the data for research purposes is the question of bias, as in both programmes the brief for the work was to promote service improvements and share good practice. The focus of the work was on building confidence and building on good practice. That is not to say that the challenges and hurdles were not clearly identified (Tucker *et al.* 2000; Tucker *et al.* 2003; Tucker *et al.* 2005). However there may be a concern that the consultancy commissions were focused on supporting partnership working and integrated care in a way which may be viewed as biased, whereas a research study is required to be objective in respect of whether integrated care is present or otherwise.

There are key distinctions between the disciplines that are particularly relevant for this research study. Consultants may express a view or judgement based on experience or expertise as well as drawing on data from consultancy commissions. Researchers will draw on findings from data and evidence, and contextualise the findings. This research provides an opportunity to analyse the data from the case studies in an independent and objective way, being a "stranger to the data" and viewing the data as a new phenomenon (Holliday 2007:20). A challenge has been to find a way to safeguard the independence and validity of the findings, whilst enabling the interpretation of the data to be undertaken with the contextual knowledge gained from being a participant in the two

programmes. The benefits of the primary researcher re-using data in secondary analysis have been documented, with safeguards and checks suggested on accessibility quality and suitability (Heaton 1998).

My experience of consultancy commissions to date is that they have been typically focused on change management and action and are time-limited whereas research provides an opportunity to add new learning through reflection or reflexivity (Holliday 2007:138). It is the opportunity to explore the learning from the consultancy commissions in a reflective way in a timely manner that has motivated me to undertake this study. The selection of two programmes across two countries presents an opportunity to examine, compare and contrast the staff experiences and views of integrating care.

2.9 Conclusion

This review of the literature was designed to determine what has been written about management consultancy and research in order to distinguish them, and also to determine their similarities. This thesis utilises primary data from management consultancy in order to carry out secondary analysis for research purposes, and therefore an appreciation of the characteristics of both needed to be explored.

In hindsight, an additional approach to answering the research question regarding management consultancy and research might have been to undertake a comparative analysis of reports of consultancy and research that tackled a similar topic. For example, I could have taken my thesis topic – integrated care – and compared and contrasted

research reports with consultancy reports, drawing out their similarities and differences. This method could have been used to assess the themes that have emerged from the review of the literature. I have considered factors such as proportionality of work and issues of access to reports and concluded that the literature review provided me with an appropriate level of context for the design of my research. However further study using this method may well be productive and could be considered for future work in this area.

The literature clarified that research is characterised by the objective of generating new knowledge, using methods that are explicit, robust and replicable, and is driven by a theoretical framework or hypothesis. Management consultancy has an objective of advising and supporting organisations with a focus on service improvement, by applying knowledge, experience and evidence from investigations. Methods applied for research and consultancy may appear similar, such as questionnaires, interviews and focus groups. Activities such as health service evaluation or social action research may also appear similar and be carried out either as consultancy or research, and this is particularly relevant given the data sources from ICON and I&BP.

The key lessons for the design of the secondary analysis undertaken for this thesis are as follows.

1. A change in role from consultant to researcher requires taking a step back from the data and developing a critical or 'objective' approach to the data

2. A fresh approach to the data is needed which involves reflexivity about any assumptions and pre-existing knowledge that I, as a researcher, bring.

3. A critical approach to the nature of the data: how was it obtained, from whom, when and for what purpose in what context

4. An explicit method for analysing data incorporating quality checks

Following this review of the disciplines of research and consultancy, I undertook a literature review of integrated care. This was to establish what is already known about integrated care, and to help formulate the research questions for the thesis more precisely.

3 LITERATURE REVIEW: INTEGRATED CARE

3.1 Introduction

This literature review of integrated care is focused on exploring questions such as the definition of integrated care, the rationale for integrating care, and the characteristics and components of integrated care. Social theory and health care theories are explored to help set a context for integrated care in terms of changes in society and approach to illness and health. The literature on experiencing, developing integrated care services is explored, including approaches to managing change.

3.2 Method

I carried out a literature review using the search terms: integration, integrated care, integrating care, joint working, partnerships, networks and continuity of care. I carried out electronic searches using sources including Pubmed and Google Scholar. I accessed specialist journals such as the International Journal of Integrated care and the Journal of Integrated Care as well as publications sections of websites such as RCGP and BMJ. I sourced publications that were regularly cited. I attended conferences on integrated care, which contributed to my bibliography. I searched libraries including the Kings Fund and the University. I have hand-searched stored references, either electronically or in paper version to select appropriate references for this study. In addition to appraising publications on integrated care, I also searched on supplementary aspects on the development of integrated care such as systems theories including complexity theory,

complex adaptive systems and systems thinking. I have hand selected references according to their relevance to the research questions, currency, appropriateness and publication status. I carried out cross-checking with other studies such as systematic reviews (Banks 2004; Reed *et al.* 2005; Heaney *et al.* 2006, and Ouwens *et al.* 2005).

I have not restricted the reference list to peer reviewed articles as this would have limited the number of sources for topics. Therefore grey literature such as reports and articles has been included where appropriate to the focus of the study. However, I have reviewed the publications and accorded those peer reviewed articles, RCT studies and highly cited publications more prominence when exploring my research questions. All references have been stored electronically on Endnotes and are fully searchable, with URL links and documents attached where available. Hard copies of books and documents are also stored and are fully accessible. I undertook my initial literature review at the start of this study, without the benefit of a critical appraisal methodology, which is a limitation to the literature review. However, the literature on integrated care internationally is growing as a highly topical issue and, from my continued reading of publications, I am confident that I have referenced important and seminal publications in order to enable me to assess the current evidence base on integrated care relevant to this research. As referred to in the previous chapter in 2.2, I would carry out a critical appraisal for any future literature reviews.

A variety of terms are used in the literature and by staff and organisations within the case studies. Some prefer the term "integrating care" as this may illustrate work in progress rather than an accomplishment. Others prefer "integrated working" to describe

a method, whilst "integrated care" may be viewed as describing a model. "Continuity of care" presents a different perspective, and suggests how care is experienced by the service user (Freeman *et al*. 2001). The phrase "joint working" has been used by staff and is readily recognisable (Coxon and Billings 2004). Terms are used interchangeably within this study, according to the context and voices as described and substantiated in Chapter 1.

3.3 Research Questions

A prompt for this study came during an international conference, when the Chairman John Baldock Dean of the University of Kent, announced that whilst there had been a considerable number of presentations and papers over the three day conference, there was little evidence of integrated working in practice that was sustained. Baldock concluded that *"it is a paradox - there is a wealth of knowledge on integrating care but this is not matched by progress"* (PROCARE 2004). The PROCARE programme had been funded through a European Union programme from 2002-2005 to explore issues, problems and solutions in the provision of integrated health and social care for older persons and the conference in Venice was designed to showcase international experience and innovation. The conclusion of the conference was that more research was needed into integrated working, beyond the innovative, short term and isolated projects that were currently being evaluated. This prompted me to consider researching two examples of integrated working that I had experienced, as these had the potential to demonstrate, through staff experience and perspective, that integrated working had a

history and longevity, were sustained, and were not restricted to particular types of integration nor isolated only to a specific patient group.

Before this could be taken forward, there was a need to ascertain what was already researched and evaluated, and whether there was potential for a "real world enquiry," by studying staff experience in real world settings (Robson 1993: 11) which would add to the learning about the nature and development of integrated working within a theoretical and policy context. The research questions pursued in the review of the literature were:

- What is integrated care?

- What is the social theory for integration?

- What is the health theory for integration?

- What are the characteristics of integrated care?

- What is the rationale for integrating care?

- Why is integrated care a global priority?

- How is integrated care developed?

- How is the development of integrated care managed?

- What is the impact of integrating care?

3.4 The Definition of Integrated Care

The literature contains definitions and descriptions of integrated care and can be broadly summarised as separate actors, agencies or services working together for the benefit of the patient. The use of terminology and the subtle differences in meanings around integrated care have been explored in chapter 1 of this thesis.

There is a widely held view that the competence to provide complex health and social care does not reside within any one agent or agency, and therefore collaboration is required (Edgren 2008). The feature of integrated care being person-centred and for the benefit of the patient is drawn out in the Audit Commission's study which describes integrated care as a whole system approach which is organised around the needs of the service user and one in which the user experiences the services as seamless (Audit Commission 2002). It builds on the theme of social inclusion and the empowerment of individuals. This view is developed in the model of a "resourceful patient" who leads and coordinates their own care (Gray 2002).

The aspect of different actors, agencies and services coming together in an integrated way is described as working in partnership, or joint working (Glasby and Dickinson 2008). The aspect of separate parties is emphasised in the following definition *"integration refers to a single system of service planning and/or provision put in place and managed by partners (or parent bodies) who nevertheless remain legally independent"* (Thistlethwaite 2004). This definition clarifies the principle that integration concerns joint working between separate parties, who may be distinguished in ways such as different professions or organisations. Integration is not the same as

unification, and clearly, in a complex service such as health care, there will continue to be separate parties who will need to work together in order to provide a service.

There is no consensus on the definition of integration (Stone 2000). The definitions offered throughout the literature can be categorised into three types: i) values-based; ii) process orientated and iii) outcome focused. Some definitions combine these categories. The value-based approach is described as "the experience of a co-ordinated and smooth progression of care from the patient's point of view," emphasising that if the patient experiences care as integrated, then it is integrated (Freeman *et al*. 2001). Values and principles include "seamless," and "holistic" (Thistlethwaite 2008).

The process approach describes integrating care as a journey (Nies and Berman 2004), or steps "in the process of health care systems and health care delivery becoming more complete and comprehensive" (Kodner and Kyriacou 2000). The mechanisms and processes are described as a "discrete set of techniques and organisational models designed to create connectivity, alignment, and collaboration between the cure and care sectors at the funding, administrative and/or provider levels" (Kodner and Spreeuwenberg 2002).

Outcomes can include improved efficiency, cost-effectiveness and satisfaction of providers of care (Leichsenring and Alaszewski 2004:15). The World Health Organisation definition sets out processes as well as outcomes; *"Integrated Care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and*

efficiency" (Grone and Garcia-Barbero 2001). It is therefore described as a means to an end, not at end in itself, meaning that patient benefit should be the objective rather than working in an integrated way for its own sake. This view is supported by the Integrated Care Network in their guide to integration (Thistlethwaite 2008). In describing integrating care as a journey, Nies and Berman record that *"Integrated Care is not an outcome, but a means to achieve optimum performance at service level"* (Nies and Berman 2005). Integrated care is not a means in itself, and can only contribute when it is considered in relation to a systems purpose, such as maximising population health (Plochg 2006).

The definition used by the Department of Health on their website launching their programme of pilot integrated care organisations focuses on health and social care integration: *"Integrated care is when health and social care services work together to ensure individuals get the right treatment and care they need for their health concerns"* (Department of Health 2009b). Earlier definitions were developed in America as part of the need to manage care in order to contain costs within their insurance-based system, and referred to the integration health care and finance systems (Satinsky 1997: 23).

The language of integration and fragmentation is value-laden and the literature draws attention to this. There is the question of whether integrated care is necessarily a good thing in all contexts and whether there is a case to be made for isolated and disconnected episodes of health care in society. Freeman challenges the assumption that continuity and integration is always what is needed by a patient, and suggests that discontinuity

may be of value when patients want a one off consultation with an anonymous health provider (Freeman 2003).

Positive attributes may be assigned to the term integration with associated terms such as such as coordination, cooperation, networking (Leichsenring and Alaszewski 2004:18) and characteristics including seamless, coherent and coordinated (Van Raak *et al.* 2003:11). Terminology includes managed care in the US, shared care in the UK, transmural care in the Netherlands (Kodner and Spreeuwenberg 2002), continuity of care (Freeman *et al*. 2001), chains of care (Ahgren 2003) and seamless care (Grone and Garcia-Barbero 2002).

Negative connotations of integrated care may include monopoly, assimilation and subsumation whilst positive connotations of the opposite of integration in the context of health care may be diversity, choice and segregation. Professionals and managers seem to treat continuity of care as self-evident, *"belying its ambiguous and multi-faceted nature"* (Freeman *et al*. 2001). Leathard also cautions about judgements being made about partnership working, pointing out that the term collaboration has been used to describe collaborating with the enemy as well as working in combination with others (Leathard 2003:6).

Fragmentary is defined in negative terms as disjointed, incoherent, partial and unsystematic (Collins 2004) and it is assumed that fragmentation is not desirable in the context of health care. Kodner cautioned that it is as important to study fragmentation and segregation as it is to study integration, and points out that *"discontinuities in health care are inevitable given the increasing complexity of care, specialisms, range of*

services and providers, choices exercised by users, and innovative developments that may create disintegration and fragmentation" (Kodner and Spreeuwenberg 2002). A patient may want to make a positive choice for an interaction with a healthcare provider that is anonymous, and therefore discontinuity is valued by the service user (Freeman *et al*. 2001). Assumptions are also made about the vision of integration, and authors have challenged this and suggest that full integration may not be feasible nor desirable (Edwards and Millar 2003; Kodner and Kyriacou 2000).

The opposite of integrated has been termed differentiated (Kernick 2004), and has been used to describe the segmentation of different types of health care, often brought about because of increased specialisation (Freeman *et al.* 2001). The creation of divisions can also be brought about because of organisational growth, where services are grouped into manageable parts, thereby creating boundaries between functions (Senge 2006:24). The creation of new primary care organisations was described as "mixing oil and water" in terms of the stakeholders and new relationships (Mead 2005:37).

In the foreword to Kernick's publication on complexity and health care, Bevan describes a health care system of the past that we characterised by episodic and often isolated events, where the care and safety of patients was considered an individual responsibility. Bevan describes a transition to a whole system of health and social care with a collective responsibility where care is continuing and integrated (Kernick 2004: vii). A key theme emerging from the literature is that of having a whole system approach, enabling the integration of care for the benefit of the person as a whole.

3.5 Social Theory of Integration

My research questions needed to be set within a theoretical framework and in context. According to Giddens, "theories involve contrasting abstract interpretations that can be used to explain a wide variety of empirical or factual situations" (Giddens 2009:11) Goodwin makes the case for "advancing the science of integrated care in order to develop theories about care integration"(Goodwin 2010). His observations on the proceedings of an international conference on integrated care were that many pilots and innovative services failed to survive and, that given his view that the evidence base for integrated care is weak, he believed a clearer theoretical basis may help sustain this way of working (Goodwin 2010).

My research questions concern whether integrated care is in place and, if so, what does it look like and how is it being developed. A definition of integrated care that emphasises interdependencies states that integration *"regularised ties, interchanges or reciprocity of practices between either actors or collectivities"* (Giddens, 1979:76).

In order to contextualise the research and appreciate the theoretical framework for the study, I considered social theories and theories relevant to integration.

Social Theory: Functionalist Theory and Conflict theory

Theories - Integration: Systems Theory; Complexity Theory; Network Theory and Collaboration Theory

Social theory and the development of theoretical frameworks help to study, interpret and make sense of phenomena (Giddens 2009:11). The study of social behaviour, integration and isolation provides a context to this study.

The origins of social theory are thought to have come from Greek philosophers such as Plato who linked medicine, philosophy, health and politics in his recognition of the two arts of the body and the soul. He held views on social behaviour and believed in moderation in order to achieve bodily health and soundness of mind (Porter 1997:64). Themes of balance, order and control emerge from the literature documenting the history of health, illness and medicine relating to integration from antiquity to the current day. Hippocrates in the fifth century BC presented medicine as a science and an art, based on experiment and rationale argument separating the discipline of medicine from religion. Hippocrates believed that disease was not a punishment but rather the product of environmental factors and life style (Porter 1997). The Hippocratic Corpus was concerned about the relationship between the doctor or healer and the patient and was described as patient-orientated, perceiving a human as a "complex differentiated integrated whole" (Porter 1997). Aristotle considered that each organ or part of the body only made sense when viewed as a whole system and drew the parallel with the position of individuals within the State (Jackson 2003:4). Therefore, health care was set in the context of individual and collective responsibility within a whole system.

Social theory as a way of trying to understand and predict human and society behaviour emerged as a distinct discipline at the turn of the century. Theories about social behaviour have adopted two distinct approaches: the naturalist approach which is based

on a belief of inherent behaviour, and the individualistic approach based on the belief of unique qualities of individuals (Jones1991: 1). This was called "public issues and private troubles," showing the connection between individual action and patterns of behaviour in society (Giddens 2009).

Functionalism

One of the twentieth century theorists, Herbert Spencer, attempted to catalogue the characteristics of societies in 15 volumes of "Descriptive Sociology," providing a valuable archive for secondary analysis (Heaton 2004:20). Spencer subscribed to the structural consensus theory (also known as the integration theory) that socialisation is learnt behaviour, and that the rules which govern thought and behaviour, otherwise referred to as culture, provide the structure for consensus on social order (Jones 1991:20). Spencer compared society's structure with that of a living organism with systems and structures that were interdependent and indispensable, and were required to function in an integrated way (Jones 1991:23). Spencer was concerned with the core ideas of integration and described increases in size and complexity leading to the need for structure (Andreski 1971:126-7). This is relevant for health and care services, where an increase in specialisation as well as an increase in size has led to an increased need for attention to integration and continuity (Freeman *et al.*2001). Integration is defined by Spencer as the internal cooperation of the separate parts of the whole, and he defines differentiation as being the division of labour within the whole (Andreski 1971:109). Although he viewed modern societies as highly differentiated, he stated that a defining characteristic of modern society is its integrating capacity which is reflected in its

economic interdependence, voluntary cooperation and political liberalism. Spencer argued that mechanical forms of integration in formal groups were being replaced by organic forms of solidarity through cooperation and culture (Andreski 1971:110).

Durkheim was concerned that the society of his time had reached a transition at which the mechanical forms of integration, such as those found in less complex societies, had broken down, and modern forms had not yet emerged. He was therefore primarily concerned with the moral dissolution and social disintegration resulting from the onset of modernity (Giddens 2009:79). Durkheim focused on group phenomena that he called social facts, observing society as an integrated whole with interdependent parts that had a life and structure separate to individuals, and needing to work in harmony (Giddens: 2009:90). Durkheim analysed pre-existing census and administration records in his studies such as suicide rates (Heaton 2004:3). Durkheim emphasised integration and harmony, following a consensus approach, and believed that organic forms of solidarity created stronger bonds of mutual interdependence (Giddens 2009:79).

Functionalism required a moral consensus and shared values, and was based on the concept that society is a complex system whose various parts work together to produce stability and solidarity (Giddens 2009:23). However, by the 1960s the limitations of functionalism were being shown as being inadequate to describe social change.

Conflict theory

Structural-conflict theory, such as Marxist theory, recognised power, control and conflict. Marx described societies in the way that they organise their production and differentiated between classes according to those who own the means of production and

those who do not (Jones 1991:43).   It is thought that social cohesion may either be compromised through this conflict or may be maintained by a dominating class. The theme of order and control in order to achieve integration was also put forward by Delanty. He stated that: *"Social theory was greatly preoccupied with the search for a principle of integration that would be capable of reconciling the contradictions of modernity and imposing unity on a disordered and fragmented world"* (Delanty in Turner 2000:21*).*

In an exploration of power, Foucault maintained that *"there is no relation of power without resistance."* Foucault discusses maintaining social order and equates integration with control. His analysis of the role of the physician and the context of power and knowledge is a helpful development of structuralist theories. Foucault presented the early hospitals in France as a way of grouping together patients for the doctors' benefit of studying the disease rather than for the primary benefit of individual patients. This created an order and cohesiveness to the management of hospital and healthcare and required cooperation and collaboration (Foucault 2003:122).   Hospitals or clinics became places where the course of diseases were studied (Porter 1996:96), although Edward Shorter in this publication quotes a Professor of Medicine in Vienna who said in 1882 *"I repeat once again, medicine is about treating sick people, not diseases."* (Porter 1996:143). Foucault was concerned about what he called the space occupied by the body and disease, and wrote of the physician's "regard" (translated as "gaze") by which the physician could diagnose the patient based on his experience, and thereby study the trajectory of a disease or illness. He said that medicine should be concerned not only with the study of techniques for curing illnesses but it should also be

concerned with gaining knowledge about a healthy man (Foucault 2003:39). The link between power and knowledge has been explored, concluding that physicians are able to exercise their power through scientific medicine (Peckham and Exworthy 2003:33).

Follet presents an alternative view of conflict as a constructive force and describes this as preferable to conformity. She made the case that conflict could be dealt with through domination, compromise or integration. Integration was based on the idea of joining powers, and meeting the mutual interests of the respective parties. Follet promoted group networks to replace bureaucratic institutions and celebrated diversity as the most essential feature of life. Graham presents Follet's view that businesses even in a competitive context should be groups interacting and influencing one another rather than being dominated by one leader. Among the prerequisites for effective group working were: "connecting, always connecting; welcoming difference, exchanging fair values and establishing group objectives" (Graham 1991: 52). Follet advocated the replacement of bureaucratic organisations with group networks (Graham 1991: x).

The role of professionals as specialists in health accords them a degree of power because of their specialist knowledge according to those subscribing to Marxist influences. There is a view that it is in the interests of professionals to retain their high status and high earnings as well as their power-base and this is contrary to the idea of working in a shared or integrated way (McNeill and Townley 1986:390). However, it is argued that professional power-bases are already being eroded as the definition of a professional begins to lacks clarity. Professionals include qualified professional staff, semi-professional staff and inter-professional team members from the third sector (Leathard

2003:6). These observations on power and control are central to understanding professional and practitioner autonomy, and the shift that is required to cede power as professionals work together in teams, and start to change their relationship with patients.

The motive for acting in a particular way is explored by Parsons, who discussed action that is "value-based" versus action that is "based on the end justifying the means." Parsons concludes that in the latter case there may be exploitation of others (Parsons 1951:47). This raises the question of how societies maintain a manageable degree of integrated order. Parsons observes that perfectly integrated societies are rare and concludes with respect to systems theory that *"any regularity of relationships can be more adequately understood if the whole complex of interdependencies of which it forms a part is taken into account"* (Parsons 1951:55). Questions of how power is acquired and exercised is an important consideration. One example is the medicalisation of natural phenomenon such as child birth, tiredness and unhappiness (Giddens 2009:396). With knowledge comes power, but there is a realisation that it is not only the medical specialists who know about health and illness, but that patients and communities can also contribute to enhancing understanding (Giddens 2009:399). This power shift may be considered in the context of the relationship between practitioners and patients, and the relationships between practitioners. There is an increasing role for individuals and communities, as achieving, maintaining, improving and sustaining health is seen as concerned with lifestyles and environments as well as biomedical interventions. Communities have created social movements in order to further a common interest such as securing, preserving or developing health and social care services which they have been unable to influence within systems of the established institutions (Giddens

2009:1010). Examples of these have included disability rights movements and community hospital campaigns (Tucker 2006).   Health care is described as a personal-service occupation which requires a server and a client and thereby reinforces the theory of power, dominance and class (Goffman 1961:285). Goffman was interested in the study of social life as it was actually experienced (phenomenology) shown in his publication "Asylums" when he worked in closed communities of a mental hospital and prison and observed behaviour, rituals and displays of power and subservience within these institutions (Goffman 1961).

Discussion on Social Theories

Functionalism, which is the structural-consensus theory or integrated theory, was an attempt to present social behaviour as a science, leading to positivist approaches to research using mainly quantitative methods. Giddens contrasts consensus theory, where there is a shared interest attracting cooperative action, with conflict theory which uses coercion and manipulation to achieve its end (Giddens 2009). In citing these differences, Giddens (2009) describes the difference between integration theory and conflict theory as the processes that give rise to systems. In this section I consider systems theory, complexity theory, network theory and collaboration theory and follow this exploration with a consideration of the application to my research.

Systems Theory

"Integration is at the heart of systems theory" according to Kodner (2002). Systems thinking is described as a conceptual framework that helps identify patterns in the whole rather than viewing isolated parts of a system (Senge 1993: 6). Systems have both hard

and soft systems, as well as closed and open systems (Foote and Stanners2002:47). Health care is defined as a soft system, as it is concerned with human interaction and learning, in contrast to hard systems such as engineering which are designed for regularity and control, have clear causal links, and are predictable. Health care is pluralist (many participants with differing views) as opposed to positivist (based on a single definition) and is therefore multi-faceted (Kernick 2004:40).

Understanding how integrated care takes place and how integrated care may be further developed therefore requires a new way of thinking. Traditional organisational thinking has been based on analysing component parts of the organisation, adopting logical and linear processes, setting goals and measuring performance. This is termed reductionism, when the individual parts, and the interaction of the parts, is studied in order to try and understand the whole (Jackson 2003). Systems thinking is distinguished by taking a holistic and whole system approach by recognising that the organisation is different to the sum of its parts, making decisions through intuition, exploring, experimenting thereby enabling new ideas to emerge, and placing a value on quality and learning. Jackson stresses the need for creativity and states that a systems approach which is holistic rather than reductionist is required. Jackson advocates a systems approach in services such as health care where managers are faced with complexity, change and diversity within their organisation (Jackson 2003: xv).

Complexity Theory

Complexity science is referred to as the latest generation of systems theory (Edgren 2008). Complexity science, and in particular complex adaptive systems, is considered

by some to offer an insight into change in health care services and systems (Kernick 2004:40). Examples of complex adaptive systems in health care contained within the literature relevant to this research are: patients (Hassey in Sweeney and Griffiths 2002 :67) ; a primary health care team (Plsek and Greenhalgh 2001); general practice (Love and Burton 2005 ; Griffiths and Byrne 1998); palliative care services (Munday *et al.* 2003) and healthcare organisations (Rickles *et al*. 2007).

A complex adaptive system is defined as *"a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions change the context for other agents"* (Plsek and Greenhalgh 2001). Complex systems therefore consist of multiple interacting components that are interdependent and produce unpredictable behaviour. The new science of complex adaptive systems is considered to be appropriate for health care teams (Innes *et al*. 2005), where parts are neither independent, constant or predictable (Plsek and Greenhalgh 2001), suggesting a more organic approach.

Foote and Stanners provide a rationale for their decision for adopting a complex adaptive systems approach to integrating care for older people in Buckinghamshire in their EPICS (Elderly People Integrated Care System) programme (2002:47). The authors describe their approach to designing and implementing an integrated care programme, and use system mapping to illustrate the interconnections of systems in multi-disciplinary and multi-agency care that has examples of both vertical and horizontal integration (Foote and Stanners 2002:48). Using a case study of an elderly

patient, the authors illustrate the characteristics of a complex adaptive system as adaptive, non-linear and self-organising (2002:59).

The culture of the complex organisation is the recognition of the creativity of ambiguity and uncertainty, where self-organising networks replace bureaucratic and hierarchical structures (Kernick 2004:89). The Stacey diagram illustrates the zones that he refers to as stable, unstable and the edge of chaos, characterising the edge of chaos as prompting self-organisation and innovation (Hudson 2006).

Edgren makes the case for replacing the machine mindset with a more organic view based on interdependencies and stresses that the internal self-organising and adaptability characteristics need to be recognised. He advocates viewing integrated teams as dynamic living systems and says that order, innovation and progress arise naturally within the teams and that external governance would not achieve this in the same way (Edgren 2008). This suggests that if health services were treated as complex adaptive systems, then management styles would need to be changed accordingly, from a command and control hierarchical system of external governance to a more indirect style (Plsek and Wilson 2001). Goodwin argues that central leadership is still required to ensure effective stewardship so that there is a clear vision, disputes are brokered and that progress is encouraged and facilitated. (Goodwin *et al.* 2008). Rather than focus on a polarisation of views regarding central or local leadership, or external or internal management, it may be more helpful to consider the benefits of visionary leadership providing the environment, conditions and culture for locally devolved autonomy.

Network Theory

Networks may be for individuals or organisations, and may be bounded or unbounded. Networks are formed through relationships which are coordinated and managed in order to achieve positive outcomes (Kilduff and Tsai 2003:14). One of the earlier organisational studies was the Hawthorne study which used sociograms to illustrate the structure of freely chosen social interactions and demonstrated that social network analysis had its roots in organisations (Kilduff and Tsai 2003:14).

Networks are often characterised as being based on informal relationships and reciprocity, and contrast with hierarchies (with rules and structure) and market relationships based on contracts and competition (Glasby and Dickinson 2008:9). The authors suggest that networks represent a particular form of partnership (Glasby and Dickinson 2008:10).

There is a debate about whether network theory exists and whether it is best viewed as a collection of methods whilst others claim that there is a theory of social structures in the social network approach (Kilduff and Tsai 2003:36).

The theory of systemic networks states that there are four factors for interagency collaboration: the willingness to collaborate, the need for expertise, the need for funds, and the need for adaptive efficiency (Ref). There are tools and models to assist in the assessment of partnerships and relationships, such as the Leutz matrix of three levels of integration (Leutz 1999), and tools to measure depth and breadth of relationships (Glasby and Dickinson 2008:83).

In the publication "Managing across diverse networks of care", the authors identify the way that organisations within a network can address problems across boundaries with better outcomes (Goodwin *et al*. 2004). A typology for networks in health and social care is offered by the authors: informational networks (such as clinical pathways); co-ordinated networks (hospital and clinical networks); procurement networks (integrated healthcare networks) and managed networks (such as Social HMOs) (Goodwin *et al.* 2004).

Collaboration Theory

It is argued that current health and social care issues cannot be tackled by individual organisations acting unilaterally, as the skills and knowledge required do not reside in one organisation alone. Therefore, collaboration is required (Huxham and Vangen 2005). Among the incentives to achieve a "collaborative advantage" is the need to provide a seamless public service, improve efficiency, and optimise learning (Huxham and Vangen 2005).

Huxham and Macdonald (1967) usefully distinguish between collaboration, co-operation and co-ordination in developing their concept of collaborative advantage. Collaboration is described as a situation whereby participants work together to achieve a meta-mission (in addition to their own missions); co-operation is when organisations interact in order to achieve their own mission more effectively and coordination is where each organisation takes into account actions of the other.

Hudson describes different approaches to delivering public services in the past, which have ranged from "separatism" when agencies operate in isolation from each other;

"competition" which he describes as separating purchasing from providing and providers compete with each other; and "partnership" when agencies work together for specific purposes (Hudson 2006b).

Application to This Research

The literature shows some examples of integrated working in specific projects, but also reveals a level of dissatisfaction with implementing and sustaining this way of working. It would appear from the literature that traditional and conventional management systems have not been appropriate for change in a complex environment and there is now an increasing interest in developing a systems approach drawing on systems thinking (Foote and Stanners 2002: 46; Edgren 2008). A brief examination of the literature on change management in complex health systems has been undertaken, in order to provide a framework for assessing the staff experience and views of developing integrated working in the two case studies.

An exploration of systems thinking and complexity theory may help in understanding the context, factors, conditions and drivers for managing change in health and care services and systems. *"Complexity does not offer ready solutions to organisational change, but shifts the gaze. It focuses on the patterns of relationships within organisations, how they are sustained, how they self-organise and how outcomes emerge"* (Kernick 2004:83).   This may help in interpreting different rates of progress in developing integrated working, and factors to be taken into account.

My research focuses on understanding the elements of integrated care, having determined the multiple dimensions of integration in the literature according to context,

and in particular the types and processes of integration. The study deconstructs integrated care into types and processes in order to identify some of the component parts of integrated care. There are risks attached to deconstructing integrated care by reducing it to types and components, as this presents an oversimplification. The approach may be considered reductionist if not set within a wider framework of integrated care and managing change in health systems. The importance of understanding connectedness and of taking a whole system approach is stressed within the EPICS programme, and the authors observe that: "*it is human nature to reduce problems to their component parts and then produce isolated solutions. Although superficially logical, this mechanistic approach prevents insight into the connectedness of the parts, and inhibits the realisation that the solutions are most often not within the problem itself but outside it*" (Foote and Stanners 2002:47).

Complexity theory leads to a whole systems theory and has been shown to be an appropriate theoretical framework for exploring the concept of inclusivity of integrated care.

3.6 Health Theory for Integration

The absence of a theory of health has been presented as a significant limitation to the development of health services internationally according to Seedhouse, who describes international health reform as being driven by systems which are self-limiting rather than being shaped by philosophies or theories (Seedhouse 1995:1). Seedhouse puts forward two alternative views of health: a narrow view of health, which in summary describes a person as healthy in the absence of disease, disability, injury or depression

whilst the broader view of health concerns an optimum state that enables a person to work to their potential (1995:231). Newman challenges this polarisation of narrow and the broad views of health and puts forward a theory of consciousness that is based on a unitary view of the whole person, taking into account individual patterns and ongoing variations in order-disorder (Newman 1990). Newman describes nursing as an interaction that supports an evolving pattern of consciousness that equates to health. Newman makes the case that the manipulative view of health (in which one can promote health, prevent disease and cure illness) needs to be replaced with the concept of the whole person. Newman says *"Disease...is not a separate entity; it is a manifestation of the person pattern of consciousness",* and with pattern recognition comes the potential for possibilities for action (Newman 1990). Parsons describes illness as a disturbance of normal functioning which may be not only biological but also socially-defined (Parsons 1951:431).

Illich describes *"man's consciously lived fragility, individuality and relatedness make the experience of pain, of sickness and of death an integral part of his life"* (Illich 1976:275). Health and illness may be viewed as a spectrum, which everyone moves along during the course of their life. Illich challenges modern medicine and argues that professionals can be disabling by monopolising certain areas of knowledge as their specialisation and exerting their power (McNeill and Townley1986: 390). A social control theory has been put forward, making the case that an holistic approach to medicine gives doctors licence to intrude in all aspects of a person's life, whilst pathological medicine is considered as reductionist as it address the symptoms and disease and not the whole person in context (Davey *et al.* 2001:33). The concept of a

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sick role was widely accepted, whereby individuals with illnesses were expected to concentrate on becoming well and to withdraw from their usual obligations (Parsons 1951:440). A more recent concept is that of a remission society, described as people who are effectively well but could not be considered to be cured. This is in recognition of the many people who are living with long term conditions and disabilities such as diabetes and cardiac problems (Bury and Gabe 2004:308).

Marxist theorists view the development of health care systems as a way of maintaining a healthy and productive workforce although McNeill raises the question as to why health systems are not designed to help prevent illness and disease in the first place (McNeill and Townley 1986 :389). As a post-structuralist, Foucault considered hospitals as a way of controlling the population and of managing and studying diseases (Giddens 2009:96). Symbolic interactionists such as Goffman are interested in how people cope with disease and chronic illness (Giddens 2009:424). Goffman's direct experience of institutional mental health care enabled him to study behaviours of staff and patients, and led him to conclude that a medical maintenance model was being pursued rather than a medical service (Goffman1961:333). The current policy of moving care out of hospitals, empowering individuals and pursuing a primary care-led public health agenda for health care provided by teams addresses key power bases in health care systems. These include the power of institutionalisation and hospitalisation, the power of professionals in hierarchies and the power of specialists over generalists.

The post-community care service may be described as a social inclusion model. It has also been described as the political "third way", with the first being asylum (collectivism

and state dominated) with classical social democracy, the second being care in the community with neo-liberalism (individualism and mixed economy). The third way focuses on rights and responsibilities of individuals, active citizenship and positive welfare (Giddens 2009). Underpinning the development of health care and the increase in interest in person-centred care is the commitment made by the World Health Organisation at Alma Ata, "*People have a right and a duty to participate individually and collectively in the planning and implementation of their health care*" (WHO 1978). This aligns to the concept of person-centred care (DH 2006a) and the need for the active participation of citizens and communities. An exploration of different models of integration in services for older people led to the creation of a "civic" model of integration, described as a unifying super-ordinate whole systems model that recognised an individual's responsibility for their health and well-being, supported by and contributing to the community (Foote and Stanners 2002: 87). There is thought to be a blurring of the roles of professional, informal carers and patients, as all may be partners in the planning, delivering and monitoring of care. This is particularly the case where more patients can be supported at home through technological developments and where patients and families become expert in care-giving (Peckham and Exworthy 2003:178).

The concept of all stakeholders being part of a whole system approach is explored by Hudson who describes the involvement of all stakeholders of inter-dependent domains in service change, rather than each stakeholder focusing only on their own service (Hudson 2006b). Hudson draws on systems thinking and complexity theory to inform his approach (Hudson 2006b). Senge believes that building a shared vision is insufficient if not underpinned by systems thinking (2006:214).

The whole system approach, described from a person-centred perspective, covers the many dimensions of a life experience, including not only health and social care needs, but also factors such as poverty, housing, emotional well-being and extent of social exclusion. *"Many services tend to focus on people's problems in isolation from the rest of their life. Rather than experiencing a single targeted intervention to meet their whole needs, they receive multiple interventions that lead them on to an unpredictable and repetitive journey around different agencies"* (Rankin and Regan 2004).

In disability services, an individual model of disability (or invalidity) is being replaced with a social model, which recognises the collective responsibility of society to be liberating in terms of enabling people with disabilities to be full citizens with equal rights and responsibilities (Giddens 1990:417). This model of self-help and person-led care within an enabling society is a critical element in integrating staff and services in a way that is designed by an individual, within the context of society. This model is being further enabled through the entitlements to personal budgets in self-directed support schemes, where individuals can manage and fund their care according to their needs and preferences (Sanderson *et al*. 2006).

The literature characterises integrating care as person-centred care with individual empowerment leading to social inclusion. The conceptual framework of person-centred care is supported and is described as an approach whereby the patient is empowered as an equal partner to make decisions about their health and health care (Peckham and Exworthy 2003:203). This has been further developed by Godfrey *et al*. who argue that the term "integrated care" is too narrow and the case is made for the term *social action*

which embraces and is focused upon the interrelationship between environmental, economic and social factors at the individual, social network and wider locality levels (Godfrey *et al*. in Van Raak *et al*. 2003:151). The authors go on to make the case that integration extends to *social inclusion* and suggest that this should be the true aim.

Integrated care requires a shift of power from an individual autonomous professional to teams of professionals and support staff who collaborate and are collectively responsible. An overview of the theories of structural consensus theory (integrated theory); structural conflict theory (Marxism) and interpretivism through the key social theorists provide a context for this and other studies. Applying these theories to a particular programme for integrating care for older people in Buckinghamshire (EPICS) it may be seen that the structural consensus theory could be appropriate as there was a shared vision of those concerned (Foote and Stanners 2002:47). At the same time, the power and status issues concerning professionals would suggest that structural conflict theory was more appropriate (Foote and Stanners 2002: 306). The authors however recognised the complexities in systems and relationships that were more in keeping with the interpretive theory, choosing a complex adaptive systems approach which provides a framework for simple rules that can reflect complexity (Foote and Stanners 2002:63). The author's account of the design, implementation, and evaluation of their structured programme using a systems approach is highly instructive and has provided invaluable learning in parallel with the case studies in this research and will be explored more fully throughout this study.

3.7 Characteristics of Integrated Care

Integration is described in the literature, not only at service delivery level for patients and clients, but also at every level of planning, managing, monitoring and commissioning health and social care. Integration is described as being required at administrative, organisational, service delivery and clinical levels, as well as at Government, corporate and delivery levels (Kodner 2003). Integration is considered for staff teams, services and organisations (Thistlethwaite 2004). There are a variety of ways that the many dimensions of integration are presented such as between service sectors, professions, settings, organisations, and types of care. These can be described in three levels: the macro-level (societal), the mezza level (organisational) and the micro level (individual service user) (Reed *et al*. 2005). The term integrated care is used in many contexts with many different meanings and Satinsky has suggested six different applications: horizontal, vertical, functional, clinical, virtual and visual (Satinsky 1997:1). Vertical integration describes levels of increased specialisation of care such as primary care, secondary care and tertiary care through which patients are often managed using mechanisms such as care pathways whilst horizontal integration is described as integration between professions, departments or agencies on the same level, such as multi-disciplinary teams (Grone and Garcia-Barbero 2001). In his review of the literature on integrated care, Ling identifies integrated care by type, breadth, degree and processes, in terms of functional, organisational, professional and clinical integration (Ling 2009). Therefore there are many ways of deconstructing integrated care into component parts.

Multi-disciplinary working is one of the frequently referred to types of integration at service delivery level and is defined as two or more individuals from different professional backgrounds or disciplines working together to provide care to patients (Leathard 2003:5). Distinctions have been drawn between intra-disciplinary (within professions), inter-disciplinary (across professions) and multi-disciplinary (multiple professions), with the latter term being considered as limited as it indicates many people coming together but who may work in parallel (Leathard 2003:5). In practice, the term multi-disciplinary has come to be regarded as indicating staff from more than one profession or discipline working together. Partnership working across health and social services in England can be referred to as joint working, joint management, and inter-agency collaboration (Glasby and Dickinson 2008:5), although is most commonly referred to as integrated health and social care. Partnership working between Local Authorities and the NHS in England is also often described as joint working, such as in Joint Strategic Needs assessments (DH 2008). Studies have shown that co-terminosity between health and social care boundaries can minimise the effects of fragmentation, and that the concept of a defined locality can encourage inter-agency collaboration (Exworthy and Peckham 1998).

Multi-agency working typically refers to joint working between health systems and the third sector, namely voluntary and private organisations in health and social care. The question is raised as to where integration should begin and end, and who should be involved (Leathard 2003:39). Leathard goes on to ask whether health and care should be fully integrated, extending Local Authority and NHS integration to include housing as well as integration the statutory and third sector (Leathard 2003:39).

Integrated care requires partnership working. Three types of arrangement are: hierarchies (typically a single organisation bound by rules), a market (where partnerships are contractually based on incentives) and networks (informal collaborations and interactions based on trust) (Glasby and Dickinson 2008:9).

Hierarchies set out clear roles and responsibilities, although can be viewed as bureaucratic, expensive and unresponsive (Glasby and Dickinson 2008:10).

Markets provide consumer power (or commissioner power on behalf of consumers) as in the NHS current system to develop World Class Commissioning (DH 2008). However this can create fragmentation through competition and contractual boundaries and barriers.

Networks, such as those established for specific clinical conditions, such as the National Cancer Care Network, can bring professionals and agencies together. The function of networks within health and social care include sharing information, reducing costs, increasing power, reducing risk, sharing scarce capacity and piloting innovation, although there are questions of collective responsibility (Goodwin *et al*. 2004).

One of the most influential thinkers on integrated care is Leutz whose ideas, "laws" and matrix are often cited (Thistlethwaite 2004, Glasby and Dicksonson 2008:19). The rationale behind his concepts for integrated care is considered in some detail, as they are thought to be of significant relevance to how integrated care is viewed internationally (Goodwin *et al.* 2004).

Leutz has developed a framework for understanding integrating care by creating six "laws" of integration as a stimulus for provoking a debate (Leutz 1999, Leutz 2005).

No.	Six Laws of Integration
1	You can integrate all of the services for some of the people, some of the services for all of the people, but not all of the services for all of the people
2	Integration costs before it pays
3	Your integration is my fragmentation
4	You can't integrate a square peg and a round hole
5	The one who integrates calls the tune
6	Integration must be local

Table 5: Leutz Laws of Integration

Leutz believes that integrated care needs to be prioritised for those with the most complex care requirements such as those with severe disabilities that are unstable, long term and have minimal ability for self-direction (Leutz 1999). Leutz proposes that integration will benefit the few, suggesting an elitist approach to integrating care only for those with the most complex needs. Goodwin, in his study on network theory, agrees that full integration, referred to in his work as a "hierarchical network" is most appropriate for a subset of chronically ill patients where professionals require ongoing collaboration (Goodwin *et al*. 2004). This is in contrast to the view that full integration would have a positive impact for all (Kodner and Kyriacou 2002), whereas Goodwin is concerned that this would result in an over-managed and structured approach to care which would restrict flexibility and may be inappropriate for some patients (Goodwin *et al*. 2004).

With regard to the second law, Leutz warns of the need to invest in changing practices and systems before any savings are to be made, Leutz advises that funding be allocated

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for start-up costs such as staff time, systems and services and advices that the lack of availability of funding for replication of successful projects may result in small short term time limited projects that are not applied more widely (Leutz 1999). Integration has been advocated as an efficient way of working with demonstrated financial savings (Lyon *et al*. 2006) although there is a view that that savings should not be anticipated or be the reason for the change in practice (Lloyd and Wait 2005).

The law expressing the view that "my integration is your fragmentation" (Law 3) is explained by Leutz, who describes staff needing to expand their scope of work beyond their immediate service to enable services to be joined up around the needs of service users. There is a continued debate about the need to differentiate the role of professionals, and whether blurring boundaries and transferring skills undermines the role of each practitioner or enhances the shared abilities of the team (Jelphs and Dickinson 2008).

Leutz also raises some questions in his 4th law about the difficulty of integrating "a square peg with a round hole," using the illustration of the non-alignment of funding systems. An example Leutz cites concerns the different benefits and eligibility funding streams for health and social care in England. Another example is the funding and payments to GPs for unscheduled care in their own practices, minor injuries units, or GPs working in accident and emergency departments in DGHs (Salisbury, Dale and Hallam 1999:159).

Leutz suggests that "he who integrates calls the tune" (Law 5). Leutz notes that typically non-physicians have led initiatives in integrated care. Leutz advocates that

service users are involved strategically and that integrated care needs to be backed by commissioners.

Six years after Leutz published his five laws he developed a sixth which states that integration must be local. This law describes local services with identifiable and known team members who are then able to build trust (Leutz 2005, Foote and Stanners 2002, Bell *et al*. 2008). I re-visit these six laws at the end of my research, to assess their applicability (chapter 9).

Leutz sets out a matrix of three levels: linkage, coordination, and integration and discusses the appropriateness of levels according to context, clients and services. Leutz concludes that integrated care requires a comprehensive approach which requires the redesign of whole systems (Leutz 1999). The matrix provides an illustration of levels, using topics such as financial management, information management, care management and strategy. The matrix has been used to illustrate the linkage of informal networks, the coordination of more managed networks and integration in a hierarchical network (Goodwin *et al*. 2004). Two examples from the matrix are extracted and summarised in Table 6 below to illustrate his approach.

Operations	Linkage	Coordination	Full Integration
Information	Provide information when asked and ask when needed	Define and provide items/reports routinely in both directions	Use a common record as part of daily joint practice and management
Finance	Understand who pays for each service	Decide who pays for what in specific cases and by guidelines	Pool funds to purchase from both sides and new services

Table 6: Extract from Leutz Matrix on Levels of Integration (Leutz 1999)

A variation on this matrix was developed for the WHO, distinguishing autonomy, coordination and integration and measuring levels of integration for health information, a vision of the system, the use of resources, decision-making and nature of partnership (Grone and Garcia- Barbero 2001). Leichsenring noted that three terms were commonly used in his European study indicating differing levels of joint working: i) coordination, which implied hierarchy; ii) co-operation, which indicated joint working; and iii) networking which required closeness and continuity (Leichsenring 2004). Other researchers have since further developed the matrix and proposed additional levels. For instance, it has been suggested that the first level should be "segregation," and that an additional level of "co-operation" would be appropriate (Ahgren and Axelsson 2005). In practice, the three levels in the Leutz matrix are often applied (Kodner and Kyriacou 2000).

3.8 The Rationale for Integrating Care

It is helpful to raise the question of why there is an interest in integrated care at this particular time, and to ask when an interest in integrated care began. Themes have emerged from the literature regarding why integration is a priority, such as pressures of demographic changes, cost containment and empowerment (Nies and Berman 2004). The move away from institutionalisation (Jones 2004, Tucker 2001) and the changing role of the doctor (Balint 1951; Meads 1996a) has led to an increase in the need to develop team work within and across communities. According to Porter, health care in the past was dominated by individual healers such as physicians, apothecaries and barber surgeons who typically worked alone.

"Medicine used to be atomised, a jumble of patient-doctor transactions, and it was war and plague that prompted a change of operation that required teams to operate within a bureaucratic framework" (Porter 1997:628). Events such as the First World War prompted the need to coordinate efforts and optimise the health of the fighting force as well as the general population for war or work (Porter 1997: 642; Meads 2006) and to develop public health imperatives combining the curative and preventative approaches to health (Porter 1997:635). Porter describes medicine as transforming from being traditionally small scale and disaggregated to becoming major corporate institutions and a major employer in a number of countries (Porter 1997). There was an increase in specialisation, which took a number of forms such as by disease, life events or age groups such as rheumatology, obstetrics and care of the elderly (Porter 1997:381). According to Porter there was controversy between the generalists and the new specialists (1997:382).

In a three year programme, staff were initially concerned that integration would dilute their professional roles. The outcome from this study was that there was an improved understanding of roles and responsibilities and an improvement in the flow of information (Workman and Pickard 2008). In a community care centre, an observer of team working recorded *"It takes a certain courage and a definite commitment to step out of a clearly defined role, to accept blurring at the edges"* (Wilce 1989:55).

It is argued that more attention has been given to specialisation within health and social care, than to considering how the increasingly complicated services can work together (Freeman *et al*. 2001).

Drivers for integrating care are summarised by the WHO as either demand or supply. Demand drivers include demographic changes, epidemiological transitions, rising expectations and patients rights, whilst supply drivers include medical technologies, telemedicine, information systems and economic pressures (Grone et Garcia-Barbero 2001).

Integrated care can be seen as a means of providing care in a way that optimises scarce resources to an increasing and ageing population in an efficient and effective way, utilising the benefits of new technology and other advances. People living with long term conditions, particularly frail older people, typically require continuity of support from the cure and care sectors to meet their physical, mental, social and other needs in a way that do not fall neatly into specialty definitions of disease-specific or condition-specific pathways (Ling 2009). Other prompts for integrating care have arisen from service failures which have had catastrophic and fatal outcomes. The inquiry into the death of a child (Victoria Climbié) following the failure of child protection concluded that staff and services did not work together. The discovery of poor quality services for people with learning disabilities in Cornwall also showed a lack of coordination and integration (Peck and Dickinson 2008, Laming 2000, Bell *et al*. 2008). A message emerging from the literature is that in complex health and care systems, integration is essential and not an option (Dickinson 2008). Plochg raised the question of whether community-based integrated care was "a myth or a must" and the experience above suggests that community based integrated care is a must (Plochg and Klazinga 2002). The consequences of fragmented care for vulnerable people who have limited ability to self-direct their care, such as children and people with a learning disability as referred to

above, have been serious, highly damaging and in a number of tragic cases (Laming 2000). Laming reported on the lack of coordination and communication between the many individuals and agencies involved in child protection in his report (2000) and has subsequently re-visited his recommendations following further cases.

The rationale for integrating care has been challenged provocatively by Goodwin who argues that integrated care may damage your health through delays in being referred and diagnosed (Goodwin 2008). He cites the conflict between the agenda of the shift to patients with long-term conditions and chronic care needs being cared for at home by primary care staff in the community rather than in specialist institutions, with the increase in the management of health promotion, disease prevention and accessible universal care by generalist physicians in primary care. Goodwin raises concerns about the pressures on GPs with regard to competency, capability and capacity and queried how well equipped they may be for problem recognition, diagnosis and onward referral, particularly with the ever-increasing disincentives to refer patients to hospitals. The problem is described as a disconnection between horizontal and vertical integration, and he advocates measures such as co-locating specialists in primary care teams, reviewing diagnostic and referral practices, and carrying out a systematic approach to avoid adverse outcomes (Goodwin 2008). This is an example where a whole system approach using systems thinking may assist in order to assess the intended and unintended implications of policy on the overall complex health care system in a holistic way (Kalim *et al*. 2006).

The principle of integrated care is now enshrined in the NHS constitution for England. The constitution is underpinned by values, one of which is working together for patients

and putting the needs of patients and communities before organisational boundaries. The NHS constitution in England makes a commitment to joint working and partnerships as part of its seven core principles. The constitution states "*the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and wellbeing"* (Department of Health 2009a). The constitution provides a commitment to choice as well as to integrated care, representing a challenge to delivering on both policy agendas at the same time (Kodner 2003).

The Department of Health signed up to a quality agenda and made a commitment to pilot new integrated care organisations in order to provide more integrated services for patients. These were described as *"bringing together health and social care professionals from a range of organisations – community services, hospitals, local authorities and others, depending on local needs"* (DH 2008). The principle of integrating care is also a priority for the Health Services Executive in Ireland, with person-centred care being a core value within the charter, and a commitment from the Chief executive to *"continue to integrate hospital and community based services so we can provide more seamless and streamlined services..."(*HSE 2009). The HSE made integration their first of six transformational priorities (HSE 2007). Integration was at the heart of their ambitious primary care strategy, designed to promote a team-based

approach to service provision to achieve a fully integrated primary care service which has become central to their National Service Plan (HSE 2009). Professor Drumm, Chief Executive of the HSE, summarises the HSE position: *"I am absolutely confident that with organisation wide team-working, which works very well in many health services in other parts of the world, we will be able to greatly enhance patient care and increase job satisfaction"* (HSE 2009).

The overall driver for integrating care is, in theory at least, to improve the experience, outcome and service to the patient. The literature raises a significant question on whether integrated care is person-centred, with a distinct polarisation of opinions. Some researchers define integrated care as only being fully understood if it is defined from the perspective of the person (Freeman *et al*. 2001). There is an alternative view that the move to "consumer-directed care" is not compatible with integrated care, as consumer choice is limited within a fully integrated system and co-operation rather than competition (Kodner 2003). Whilst policies in the UK have been designed to increase choice and access routes into health care by increasing the access to primary care, studies have recorded that this in itself can compromise the continuity and coordination of care which is highly valued by patients (Gillam and Brooks 2001).

This debate leads to questions regarding aspirations of integrated care facilitating social inclusion as attention is being paid to improving access for everyone in society, including previously marginalised groups and individuals (Godfrey *et al*. in Van Raak *et al*. 2003:151).

3.9   Integrated Care as a Global Priority

The quest for integration is a global phenomenon in health care, as shown by the English and Irish Government priorities above, is matched by other governments across the world (WHO 2008). The global health care priority of integrating care is shown in national health strategies and policies (Woods 2001, Leichsenring 2004). The WHO gave prominence to integrating care, promoting the Alma-Ata principles of equity, universal access, community participation, and inter-sectoral approaches (WHO 1978), and endorsed this in its more recent primary care report (WHO 2008).   The WHO strategy entitled "Now More than Ever" makes the case for investing in primary care in order to address world health problems and states that *"comprehensive and integrated care for the bulk of the assorted health problems in the community is more efficient than relying on separate services for selected problems, partly because it leads to a better knowledge of the population and builds greater trust* (WHO 2008:49).

Integrated care is a declared national priority for many countries, with the World Health Organisation promoting and funding this area of work with significant programmes devoted to integrating care where countries are collaborating.   The table below summarises the most frequently referred to programmes by name, description, location and also provides a reference.

The table highlights the focus on older people, and reinforces the perception of integrated care being offered exclusively to one section of the population.

Name of Model/Service	Description	Location	Client Group	Author Reference
CARMEN	Care & Management of Services for older People in Europe Network	11 countries in Europe Belgium Denmark Finland Germany Greece Ireland, Italy Netherlands Spain Sweden, UK.	Older People	Nies and Berman 2004
PROCARE	Providing Integrated Health and Social Care for Older Persons	9 countries in Europe Austria, Denmark, Finland, France, Germany, Greece, Italy, Netherlands, UK.	Older People	Leichsenring_ and Alaszewski 2004 Billings 2005; Coxon 2005
Castlefields	Unique Care Model	UK	65+	Keating 2008; Lyon *et al.* 2006
EPICS	Elderly Persons Integrated Care System	UK	65+	Foote & Stanners 2002
Case Management	RCT - Social and Medical Care	Italy	65+	Bernabei *et al.* 1998
On Lok	Integrated Day Care	USA	55+	Foote & Stanners 2002:360; Leutz 1999
PACE	Programme of All Inclusive Care for the Elderly	USA	55+	Kodner & Kyriacou 2000
Social HMO	Social Health Maintenance Organisation	USA	Older Frail People	Kodner & Kyriacou 2000
SIPA	Système de soins Intégrés pour Personnes Agées	Canada	64+	Bergman *et al.* 1997
CHOICE	Comprehensive Home Option of Integrated Care for the Elderly in Canada	Canada	Older People	Hebert *et al.* 2005
PRISMA	Programme of Research to integrated Services for the maintenance of Autonomy	Canada	65+	Hebert *et al.* 2005
Chains of Care	Collaborative network	Sweden	Older People with multiple diseases	Foote & Stanners 2002:366; Ahgren 2005
Evercare	Integrated Care (adapted from USA)	UK	Frail older people	Stone 2000
Kaiser Permanente	Synchronised care	USA	Comprehensive for members	Feachem *et al.* 2002

Table 7: Integrated Care Programmes by type, location and client group

A programme which involved the collaboration of eleven countries in Europe was the CARMEN (Care and Management of Services for Older People in Europe) programme, designed to analyse interfaces between primary care and secondary care; between primary care and residential care and between residential care and secondary care at policy, client and organisational/network level (Nies and Berman 2004). Another European programme involving nine countries explored 45 models of integration in the PROCARE (**Pro**viding integrated health and social **Care** for older persons: issues,

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problems, solutions) programme to develop a common definition and a best practice model applicable across Europe (Leichsenring and Alszewski 2004).

A number of programmes and models have been developed in America, such as the Social HMO (Social Health Maintenance Organisation) and the PACE (Programme of All Inclusive Care of the Elderly) both of which were shown to be feasible and transferable in services for frail elderly people (Kodner and Kyriacou 2000), although this has been criticised by commentators for selecting clients (Stone 2000). The On Lok project in San Francisco combined medical and nursing care and was originally established to meet the needs of a Chinese community of older people (Foote and Stanners 2002:360). The Evercare model for managing nursing home care residents in America has attracted the support of some nursing home providers where they can see the market advantage in the improvement in the coordination of care their clients receive, and as they support people who would otherwise be in hospital (Stone 2000). The Kaiser Permanente model is a model that has captured the imagination of the Department of Health and is considered to have lessons for the NHS in England, embracing a labour-management partnership and a team-based concept of care (Ham *et al*. 2003). In Canada, a programme of research to integrate services or maintenance of autonomy (PRISMA) developed what was referred to as an umbrella system linking health and social care across public, private and voluntary services, avoiding organisation structural solutions to integration. The study concluded that research and politics could be combined to improve services for frail elderly people (Hebert *et al.* 2005:6). A similar study in Montreal known as SIPA was also focused on integrating services for older people to improve autonomy and independence. The CHOICE

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programme (Comprehensive Home Option of Integrated Care for the Elderly) was an adaptation of the PACE programme from America (Hebert *et al*. 2005:9-10).   A programme to improve integrated care for older people in Sweden described "chains of care" and concluded that systems needed to be community-based and local (Foote and Stanners 2002:366).   A model that has been developed in the UK, and in particular in Buckinghamshire is EPICS (Elderly Persons Integrated Care System) which adopted systems thinking and modelling as a tool for transforming the service, and developed a "*concept of "community" as the corporate relationships of caring that bind people together: older people, their carers, and professionals in their localities"* (Foote and Stanners 2002:16).   Other models in the UK include programmes for integrating care for people with chronic illness (Ouwens *et al.* 2005) and the Unique Care Model (Lyon *et al*. 2006). What these programmes have in common is that their focus is on older people, particularly those who are frail and/or have complex needs.

Integrated care has arguably become a core component of health care reform in Europe and across the world as a way of addressing changing demand from an aging population, offering person-centred care and social integration for vulnerable groups, and improving service efficiency (Lloyd and Waite 2005). The types of integration explored within international programmes established to research and share good practice on integrated care have exposed the different political and social agendas that prompt interest in particular aspects of integration (Van Raak *et al*. 2003, Leichsenring 2004). In Greece for instance, the KAPI system has focused on integrating formal and informal carers as this has been a priority for supporting older people at a time when social and family networks have been changing (Sissouras *et al*. in Leichsenring and Alaszewski

2004:348). In Canada, programmes have focused on a multi-agency integration by linking the public, private and voluntary sectors (Hebert and Veil 2004). In America, a priority is being given to linking acute care and long term care (social care) for older people (Kodner 2003). Contributions to international studies from England have been concerned with integration between health and social services, focusing on intermediate care (Alaszewski *et al.* 2003) and services for older people with dementia (Godfrey *et al*. in Van Raak *et al*. 2003:145). A model of practice cited in the CARMEN study for Ireland was the "Home First" initiative, which combined primary, secondary and social care services (Nies and Berman 2004:116). A number of studies consider the transition and integration between hospital to the community (vertical integration) health and social care (horizontal integration), and between formal and informal care. These represent significant challenges for managing continuity according to Freeman who states that *"Organisationally and professionally these points provide the most visible potential fractures in continuity of care"* (Freeman *et al*. 2001).

The different types of integration and the types that are prioritised within countries suggest that integrated care is contextual, according to the health care systems and services, social, political and environmental context for each country and programme. The rationale for pursuing integrated care includes the need to improve efficiency and to provide appropriate care.

3.10   The Development of Integrated Care

There are many factors identified within the literature regarding what helps and hinders the goal of integrating care. Lack of funding, incompatible systems of finance and

legislation, organisational structures, lack of human resources and lack of quality management are all factors identified within two European programmes (Nies and Berman 2004, Van Raak *et al.* 2003). Van Raak also adds to this the differences in ideologies and domain struggles, although concludes that much of the evidence on integration is itself disjointed and limited (Van Raak 2005). In Sweden, the cornerstone of health care was expected to be chains of care in each of the councils, but delays were attributed to challenges to power structures and weak incentives (Ahgren 2003).

The lack of choice in managed care systems in the US has been considered to be one of the causes of failures of networks and integrated systems (Gleave 2009). A practical example is the creation of a single entry point to a service that is then fully integrated, giving the consumer in a National Health Service one choice of provider. In practice, the encouragement of a multi-provider service that is no longer dominated by a state provider may well accommodate the notion of choice and competition, although how this is achieved alongside the concept of collaboration across statutory and third sectors has yet to be determined (Ham 2008). It has been argued that integrated care has the potential disadvantage of restricting choice for service users and is incompatible with consumer-directed care (Kodner 2003). One of the most well-established models of integrated care in the US, Kaiser Permanente, is reported to welcome the fact that local people have an option as to whether they sign up for their system or choose a more conventional arrangement, as the organisation believes that this is an important stimulus for innovation and competition (Gleave 2009).

Although there is a concentration on the structural hindrances to integration, many share the view that it is values, not structures, which are the major barriers to integration and argue that to achieve a change in values requires a cultural change from the ground (Godfrey in Van Raak *et al*. 2003:160). Typical barriers to collaboration across health and social care include differences in structure, funding, procedures, professions and legitimacy according to Hardy (Peck and Dickinson 2008:5). Researchers note that countries in the PROCARE study experienced common problems in attempting to develop integrated care such as structural difficulties (Billings *et al*. 2004). This is typically cited as an example of the Leutz law where you cannot integrate a square peg in a round hole – the challenges of integrating services that may be free under the NHS and are charged for under social services in England are considerable (Thistlethwaite 2008). Similarly, the democratic and elected nature of Local Authorities is often contrasted to the legitimacy and status in the NHS which lacks any elected representation. An international study of primary care concluded that effective modernisation of complex health care services required a national strategic approach and a framework that encompassed patient and community participation, stressing the importance of the transferable learning from social movements, civil societies and community participation, drawing on experiences in countries including Chile, Peru and Uganda (Meads *et al*. 2006a; Meads *et al*. 2006b). Other factors within the proposed framework were inter-professional education, multiple funding, and the diversification of non-governmental organisations.

The approach taken to improve integrated working differs across countries. In Finland, there is a focus on improving technology, communications and systems to facilitate

integrated working (Van Raak *et al*. 2003:36). Improvements in technology and in information exchange are key developments to achieving integrated care according to studies in WHO (Grone and Garcia-Barbero 2001). In the Netherlands, there is attention on negotiating partnerships and collaborations across multi-agencies, considered to be a challenge in a market economy (Van Raak *et al*. 2005). In England, the approach to integration is considered to be particularly robust, strengthened by legislation with the Health Flexibilities Act and the NHS constitution, underpinned by incentives and sanction. An example of a financial incentive is a funded integrated care pilot programme and an example of a financial sanction is the system for charging for delayed patient transfers from health to social care (Van Raak *et al*. 2003:174). It has been suggested that integrated care needs alignment of three levels of decision making, namely patient care, organisation and financing/policy (Plochng and Klazinga 2002).

Many initiatives for integrating care focus on developing systems and processes such as joint planning and shared information systems (Leutz 1999). There is often attention given to aligning systems or creating single systems such as for management, budgets, accommodation and records, as well as focussing on values and culture (Thistlethwaite 2004). In a systematic review of thirteen international programmes for integrating care for chronically ill patients, researchers found widely differing definitions and components of integrated care, leading to some caution regarding comparisons between the programmes. However the researchers found that the components that were common to the majority of programmes were case management, multidisciplinary team working, multidisciplinary care pathways and patient education (Ouwens *et al*. 2005).

The reviews included disease management programmes for patients with heart failure, patients requiring stroke care and patients with other long term conditions.

The CARMEN programme incorporated components to support integrated working including a standard referral system, an assessment team, a clear system of client access, and shared records (Nies and Berman 2004: 120-121). A guide for managers puts forward the need to develop processes and systems for sharing information, standardising communication through protocols, multidisciplinary single assessment, pathways of care and single access to care (Lloyd and Wait 2005). The Integrated Care Network in England issued a practical guide on standards for integration on individualised case records, case management and assessment of needs (Thistlethwaite 2008). There are a number of components of integrated care that are regularly referred to in guidance documents and studies, which can be categorised as care management processes and information systems. A study of systematic reviews of integrated care programmes for long term conditions concluded that consistency in component interventions and definition would have enabled a better understanding of the comparative effectiveness of integrated care programmes (Ouwens *et al.* 2005).

The evidence in the literature is that attention to culture as well as processes is required for the development of integrated working. According to the Audit Commission, the development of integrated working needs to be viewed as a long-term programme of change requiring sustained staff support and organisational development (Audit Commission 2002). Central to this is the development of relationships and establishing trust.

The notion of trust in working together is described as a foundation stone and as a way of celebrating diversity (Graham 1991:74). The drive for uniformity, and the view of diversity as a problem to be solved, is one of the eight elements of failing management according to Senge. The lack of trust and the suppression of conflict in favour of superficial agreement is also cited as a management failing (Senge 2006:xii). Another is fragmentation, described as "the loss of the whole" (Senge 2006:xiiii).

Freeman argues that trust is more important than establishing systems and processes in developing integrated care and cites situations where scarcity has led to high levels of cooperation and trust (Freeman 2003). A study of the role of the GP as an integral part of the treatment of patients was carried out by Balint who also advocated viewing patients from a psychological and societal perspective and not just in terms of medical conditions (Balint 1951:267). An exploration of the relationship between family doctor and patient in terms of continuity found that that there were benefits of interpersonal continuity, but that there was also a need for informational continuity supported by excellent consulting skills (Freeman *et al*. 2003). Provider continuity was associated with lower health care costs in a recent study, demonstrating the importance of a structured primary health care service for a cost effective health policy (De Maeseneer *et al*. 2003). The notion of trust is a challenge in a rapidly changing society where traditional community connections are being dissolved and individuals and organisations may not be known, requiring a confidence in abstract systems (Giddens 2009:100). This may in part be countered by a new virtual system of trust through new technologies and communication systems of networking. Trust needs to be developed through establishing relationships. According to Farmer, this is best achieved in small

local areas where there is regular contact between those needing to work together, and with clear roles for professionals to play (Farmer *et al*. 2003). The importance of working with and for local people in an appropriate local context, where relationships and trust can be established, was emphasised by Schumacher in his study of global economics requiring local solutions (1994:54). This reinforces the sixth law developed by Leutz, that integration must be local (Leutz 2005). Staff within remote and rural communities, such as those with community hospitals, may be in a position of sharing scarce resources and skills, requiring a degree of cooperation and transferable skills, based on trust.

3.11   The Impact of Integrating Care

Woods raises fundamental questions about the vision and the ultimate expression of integrated care (Woods 2001). This is echoed in the foreword to a study on lessons for the NHS from the US on integrated care, where integrated care is described as a holy grail for the NHS (Gleave 2009). This view encouraged the use of the term "integrating" rather than integrated, and returns to the earlier point suggesting a journey rather than a destination, and the difficulty of visualising and articulating a fully integrated health system and their consequent benefits for service users.

Benefits of integrated care for older people are cited by Leichsenring from the Procare programme as being "keeping people safe" by offering person centred care and evaluating risks collectively, "enabling people to thrive" through good care, and helping individuals to achieve social inclusion through maintaining social network (Leichsenring and Alaszewski 2004:91).

However concern is expressed about the concentration on "model projects" and the limitations to their evaluation and wider applicability (Leichsenring and Alaszewski 2004:47). Leichsenring declares that *"long term strategies and solutions building on gained experience and evidence from single model projects are scarce,"* and concludes that model projects are often badly documented, not evaluated, and often not followed up. He cites just one exception as being the Skaevinge Project in Denmark which he describes as a valid inspiration for integrating health and social care (Leichsenring and Alaszewski 2004:44). This view about individual projects in special circumstances is echoed in experience in Scotland (Bell *et al*. 2008). With regard to the learning from model projects, it is recognised that staff behaviour may be influenced by the attention being given to them and their service, known as the Hawthorne effect (Bowling 1997:137).

In assessing the integration between acute and long term care (which is broadly equivalent to social care), Stone observes that, despite the rhetoric, the lack of examples of successful innovation in integrated care in America is unsurprising, given the financial barriers in the system (Stone 2000).

However, a number of projects and services have attracted attention in respect of demonstrating positive outcomes. A particularly persuasive study was carried out in Italy to measure the benefits of integrated care on the functioning of older people. The RCT demonstrated that integration of medical and social services together with case management programmes would improve such care in the community, achieving benefits with regard to reduced admissions to acute hospitals, reduced functional decline

for patients and also a reduction in costs (Bernabei *et al*. 1998). The Castlefield's

Unique Care model in the UK demonstrated the positive impact of having a dedicated

social worker as part of a primary health care team in an integrated case management

approach which helped to reduce admissions to hospital and expedited discharges (Lyon

et al. 2006). The integrated way of working resulted in quicker assessments and

decision-making. When the project was concluded and the social worker left, the

benefits in the improved service and reduced hospital bed occupancy were lost (Lyon *et*

al. 2006). A further study in Enfield replicated the Unique Care model in a 22 week

pilot of integrating health and social care that resulted in improved care and cost savings

(Keating *et al*. 2008). In a review of the evidence of the effectiveness of programmes

for integrating care, there were few examples of cost savings, less than half provided

evidence of increased service user satisfaction and just over half recorded a positive

health outcome (Ling 2009).

Community Hospitals have been cited for the benefits of integration and described as

"platforms for flexibility" (Aaraas 1998). A randomised controlled trial in England

concluded that care in a local community hospital was associated with greater

independence for older people than care in wards for elderly people in a district general

hospital and concluded that the role of community hospitals was developing (Green *et*

al. 2005).

An evaluation of American models of integration for frail elderly people using the Leutz

matrix and patient satisfaction studies show that up to 85% of users of the service were

satisfied with the service, and in particular with access, convenience, quality and competence of care (Kodner and Kyriacou 2000).

A qualitative study comparing integrated and vertical care approaches to leprosy concluded that there was less social stigma attached to people with leprosy if their care was provided in an integrated way with other local community services, and that this integrated approach to community-based primary health care is effective in reducing leprosy stigma in society (Arole 2002). This study is part of a wider project, the Comprehensive Rural Health Project (CRHP) based in Jamkhed in India, in which doctors conclude that one of the most important aspects of the project has been the development of totally integrated services in which they cite the integration of preventative and curative services as well as the medical, social and economic services, which has created empowered communities that have gained self-esteem and self-confidence (Arole *et al*. 1994:251-252). This emphasises the messages in Schumacher's publication entitled "A Study of Economics as if People Mattered", that approaches need to be locally defined, locally relevant, locally owned and integrated into the local way of life (Schumacher 1974:233).

A programme that has been sustained is the Kaiser Permanente scheme in America, and although there has been some dispute over claims of costs and efficiencies when compared to the NHS (Feacham *et al*. 2002, Talbot-Smith *et al*. 2004), there is a view that there is much to be learnt from the emphasis on self-care, the approach to chronic disease management, the role of intermediate care and the clinical leadership (Ham *et al*. 2003). A study on lessons for the UK concluded that although the integrated care model

and context was different in the US, there were useful lessons such as having integrated governance, integrated health information technology and appropriate risk management systems (Gleave 2009).

An international study on health systems performance explored quality improvement dynamics and within this major study recognised the unifying concept of community based integrated care in improving effectiveness (Arah *et al*. 2003).

Benefits of collaboration, interdependency and partnership working include the demonstration of synergy, in that the whole is considered to be greater than the sum of the parts (Iles 1997:35). Iles provides case study examples of well managed services, in mental health services, community care, and children's services (Iles 1997:109-183).

With regard to measuring benefit, tools have been developed and tested and conclusions are that multiple measures are appropriate for complex measurements (Browne *et al.* 2004, Hebert and Veill 2004). Benefits of services which are models of integration are described, with methods suggested for assessing continuity of care, meeting needs, harm minimisation, person-centred risk and social inclusion (Leichsenring and Alaszewski 2004:88-89). However research in Maryland in the United States failed to find any significant relationship between integration of services and outcomes (Newhouse *et al.* 2003).

Creating a challenge to integration are the organisational and sector barriers, described as "Berlin walls," within NHS sectors and between health and social care are well documented in English policy documents (DH 1998, DH 2006a). *"Although health care depends largely on productive interaction, the organisation and management of its*

delivery surprisingly does not always reflect this insight. In the United Kingdom, for example, having separate budgets and performance targets for primary care, secondary care and social services promotes an internal focus on the operation of each of these parts, but not necessarily the good functioning of the system as a whole" (Plsek and Wilson 2001).

Lessons for integrating care are offered in a guidance document in the evidence supporting integrated care for Integrated Care Pilots in England (Ramsay and Fulop 2008). A key message is to integrate for the right reasons and to get "buy in" from staff with appropriate incentives. The authors warn against starting with structural changes, and against having a financial motive. The authors also argue for an appreciation of the context for integration in terms of environment and culture and the need for patience (Ramsay and Fulop 2008).

3.12   Conclusion

This chapter highlights that there is no common definition of integrated care (Leichsenring 2004, Thistlethwaite 2004). The term integrated care is value-laden, and has therefore been considered in respect of positive as well as negative connotations. The opposite of integrated care, defined in terms such as differentiated and fragmented, has also been explored (Kodner and Spreeuwenberg 2002). The literature provides examples of integrated care being described using frameworks and models, with a caveat that integrated care is not a definitive state but an ongoing journey (Woods 2001). Definitions that have been offered have been categorised according to whether they focus predominantly on values, process or outcome (Freeman *et al.* 2001; Nies and

Berman 2004; Grone and Garcia-Barbero 2001). I have adopted a working definition for this study based on the guide written by Thistlethwaite (2008) which is that integrated care is "actors and agencies working together for the benefit of the service user."

Social theory has been considered in order to help explain social patterns, observed phenomena and concepts (Giddens 2009:11). In particular, functionalist theories and conflict theories have provided a historical and conceptual basis for understanding the origins of integrated care. In addition, four theories that are most frequently cited in connection with integrated care in services and programmes are explored, namely systems theory, complexity theory, network theory and collaborative theory (Foote and Stanners 2002; Plsek and Greenhalgh 2001; Edgen 2008; Glasby and Dickinson 2008; Goodwin *et al.* 2004; Andrews and Read 2009). The learning from these theories and models has been applied throughout the thesis, and has provided a framework to help interpret staff actions and relationships within services.

Health theory, or the absence of a theory of health, has also been considered, given that integrated care is interpreted by many as "person-centred care." It is therefore helpful to consider the literature on illness and health and the view that individuals have an individual and collective responsibility for their health. Integrated care has been portrayed as being about social action and social inclusion, and ideally driven by individual patients, referred to as the "resourceful patient" (Gray 2002). There is interest in the role of staff in developing person-centred integrated care.

Integrated care is multi-faceted and multi-layered, and is categorised and deconstructed in a variety of ways in the literature. Integration may take place across organisations, services and/or staff; at levels of administration, services, delivery, clinical and government; and concern delivery, planning, management, monitoring and commissioning. Integration may be described as vertical (such as between primary and secondary care sectors) or horizontal (across health and social care at a community level) and considered at a macro, mezza or micro level. Terms used to describe degrees and types of integration include coordination, co-operation, collaboration, partnerships and joint working. The subtle differences and overlaps between these terms are exposed through the literature, and summarised in Table 2. The analysis of the literature has shown that integration may take place at all levels and across all services and functions with all health and care services.

This chapter sets out the work of Leutz as being of particular relevance to the research question, and of being highly influential and frequently cited (Kodner and Kyriacou 2000; Glasby and Dickinson 2008; Thistlethwaite 2004). Leutz set out three distinct levels of integration, which demonstrated the characteristics of relationships, namely linkage, coordination and full integration (Leutz 1999). Leutz advocated that the level of integration was dictated by the needs of individual patients, with those with greatest need, highest dependency and most complex conditions requiring full integration. Leutz also set out six laws of integration, two of which are based on the premise that integrated care is exclusive and therefore not for everyone. The laws are: *"You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people"* and *"Your*

integration is my fragmentation" (Leutz 1999, Leutz 2005). These laws raise questions about who is entitled to receive integrated care and the implications for patients, staff, organisations and the whole system.

The rational for integrating care is explored in the literature, to try and answer questions of why integrated care is a priority now. Meta analysis on 14 international studies, 13 of which focused on care for older people, has illustrated the respective history, context and drivers. The types of integration pursued depended on context, and include integration between formal and informal carers, between health and social care, and between professionals.

There is extensive literature on the development of integrated care, with a growing understanding of what helps and hinders integrated working. There is a common agreement however that the level of understanding is not reflected in success rates in sustaining integrated working (Goodwin *et al*. 2004; Leichsenring 2004). An overriding theme is the need for trust, with an understanding of respective roles and responsibilities (Freeman *et al*. 2001; Audit Commission 2002).

The impact on patients, staff and services is explored in the literature, with measurable benefits being recorded on the state of health and independence of patients in some studies (Bernabei *et al*. 1998; Kodner and Kyriacou 2000), improvements in staff satisfaction (Coxon 2005) and improved service efficiency (Keating *et al*. 2008). However the evidence of benefit of integrated working is not extensive (Goodwin 2010). There is lack of evidence of benefit for patients, and few studies describing the experience of integrated care from either the service users or the staff. Given that

integrated care is often described as "person-centred" care, this represents a significant gap in the literature.

3.13 Conceptual Framework

My observations and experience from working with community services led me to want to research whether integrated care was in fact taking place, and if so what it looked like and how it was being developed. I wanted to frame this question around the question of inclusivity, so that I could pursue whether integrated care was in fact an "exclusive" service offered only to certain clients in particular contexts, as shown in the literature, or whether integrated care could be considered inclusive and applied more widely.

The term "exclusive" is defined as catering for a particular individual or group, or a privileged minority, with similar terms being restricted (Collins 2004:409) and the term "inclusive" is defined as comprehensive, the state of being included and all-embracing (Collins 2004: 600).   The literature shows a difference of views as to whether integrated care should be targeted to certain patients such as older people and those with complex care needs (Leutz 1999, Keating *et al.* 2008) or whether it has a wider application as a model of social inclusion (Godfrey In Van Raak *et al.* 2003:151)

This study explores staff views of integrated care in their community services which will help answer the question of where these services sit on the spectrum of "exclusive – inclusive." I have developed this concept of exclusivity from the literature as a new way of looking at integrated care. The review of the literature demonstrated a focused service, and I wanted to explore the possibility that integrated care could be offered on a wider scale. Given the global priority being given to developing integrated care for

older people with complex care needs and high dependencies (Van Raak 2003:11), I wanted to explore the possibility of integrated care being offered more widely. I also wanted to explore the possibility that integrated care did not refer to just one type of joint working according to a context, but that there were multiple simultaneous types of integration in place for service users. In addition, I wanted to consider whether integrated care was destined to become a short-lived special project, or whether there was any evidence of sustained services.   Accounts of integrated care have described the initiative as an additional feature rather than integral to the way of working (Tucker *et al.* 2005). I wanted to explore the notion of integrated care being essential, and was influenced in this by the many public inquiries and service reviews that concluded that lack of "joined up thinking" had resulted in poor care or even fatalities (Glasby and Dickson 2008:xi).

Rather than illustrate this as a simplistic and polarised view, I have shown this as a spectrum, identifying key aspects that have emerged from my analysis of the key findings from publications in the literature review.

Is Integrated Care Inclusive?	Spectrum	Is Integrated Care Exclusive?
For all patients/clients or services	⟵⟶	For defined clients or service
Multiple simultaneous types		In one form at a time
Sustainable		Short term projects
Capable of being developed		Difficult to implement
Critical and essential		Optional

Table 8: Conceptual Framework – Integrated Care on a spectrum of inclusivity/exclusivity

Table 7 illustrates the predominance of integrated services for older people internationally.

3.14 Refining the Research Question

I have reviewed the literature in this chapter to help answer nine questions. These were:

- What is integrated care?

- What is the social theory for integration?

- What is the health theory for integration?

- What are the characteristics of integrated care?

- What is the rationale for integrating care?

- Why is integrated care a global priority?

- How is integrated care developed?

- How is the development of integrated care managed?

- What is the impact of integrating care?

The review of the literature has shown that there are multiple terms and definitions used for integrated care (Ling 2009). I found in the literature characteristics of integrated care which I wanted to pursue further. I also wanted to explore how integrated care was being developed, and in particular from the perspective for staff responsible for service delivery.

I have therefore refined my research questions to be the presence, nature and development of integrated care in community services:

- Is integrated care present in community hospitals and community health services in the two programmes?

- What is the nature of the integration present?

- o Which types of integrated care are evident?

- o Which processes are in place to facilitate integrated care?

- o Which patients are receiving integrated care?

- o Which services demonstrate integrated care?

- – How is integrated care being developed?

In answering the question of whether integrated care was present in community services, I wanted to seek the views of staff on their understanding of the term integrated care, so that there was a common understanding of what was being assessed.

The literature has shown that integrated care is multi-faceted (Thistlethwaite 2008), and can be deconstructed in many ways (Grone and Garcia-Barbero 2001). I considered that there was scope to research the presence and nature of partnerships and joint working in community hospitals, which are typically small rural hospitals (as reviewed in the literature in the next chapter). The 8 types of integration frequently referenced in the literature for community hospitals were multi-disciplinary, multi-agency, health and social care, health and council services (Local Authority); across sectors such as primary, community and acute care; and between services and patients and the community. I also considered that there was scope to examine whether processes had been put in place to facilitate integrated working in practice (Kodner and Spreeuwenberg 2002). The 8 components (processes) frequently referred to in the literature were care management (referral, assessment, care planning, outcomes) and information (single client record, information sharing protocols and service information)

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and systems for team building. These 8 types and 8 components (processes) form the basis for my analytical framework (Figures 3 & 4 in Chapter 5).

Few of the studies in the literature examine staff views (Coxon 2005), suggesting that there is scope to consider the perspective of staff who are providing the service. Staff views and experiences of the development of integrated care would provide an opportunity to consider these accounts within complexity theory and network theory explored in this chapter (Kernick 2003, Goodwin *et al.* 2004).

Therefore there is scope to add new knowledge by studying the presence, nature and development of integrated care in existing community services from the perspective of staff.

Before considering a research approach for the two case studies, the literature on the community hospital model of care needed to be examined, in order to assess what was already known about the presence and extent of integrated care, and whether there was a history or tradition of staff working in an integrated way in small local hospitals.

4   LITERATURE REVIEW: COMMUNITY HOSPITALS

4.1 Introduction

This chapter explores the history, role and function of cottage and community hospitals in order to provide a context to the views and experiences of staff working in community hospitals in the case study. The review of the literature has been carried out to try and establish what was already known and recorded about the definition, role and function of cottage and community hospitals, as well as their history and contribution to communities. The literature was also reviewed to determine whether there was evidence that integrated care was taking place and if so, what was its nature and how was it being developed.   The overarching research questions are therefore:

- Is integrated care taking place in community hospitals?

- What is the nature of integrated care in community hospitals?

- How is it being developed?

4.2 Method

I have maintained a bibliography for cottage and community hospitals for over 10 years in my role as Vice Chair of the Community Hospitals Association. This library of publications includes original source material from research studies (Cavenagh 1978; Tucker 1987, Emrys-Roberts 1991) and historic records and publications from

individual cottage and community hospitals which have been donated to the CHA. This library of publications was enhanced with historic records from the Wellcome Trust library in London, enabling me to access publications and records that were not otherwise available (Burdett 1896, Swete 1870), although some of these have now been issued digitally. Therefore I had an historic and updated bibliography that I had maintained.

This was supplemented through a literature review that I undertook in 2003 for the Department of Health. This work was undertaken within a subgroup of the Care Services Improvement Programme (CSIP), with this bibliography being made available on the DH website, and a new definition and description of community hospitals being adopted nationally (DH 2006a, DH 2006b, and Meads 2004).

I carried out a search for literature at the start of my study using key words of: cottage hospital; community hospital; GP hospital; primary care hospital and intermediate care using Pubmed and Google Scholar with a time frame of 1850 to 2006. During the course of the research the literature review was refreshed and more recent publications incorporated. The results of the searches were considerable, as these terms are not specific in themselves. Using predefined criteria, I refined the results by excluding all community hospitals from America (as these are a different model), and any publications that were more general to community and primary care. I cross checked regularly cited references, and through this process, confirmed my existing bibliography and also added recent international studies that were relevant (Charante 2004; Garason 2007; Tediosi 2004). I continued to cross check my bibliography with published studies

and citations. An integrative thematic literature review on community hospitals published during the study helped to inform the development of the bibliography and allowed for further cross checking and "snowballing" to ensure key studies were included (Heaney *et al*. 2006). The review by Heaney identified 16,000 references and using criteria selected 113 papers to be included, with only one RCT and one non-RCT controlled trial (Heaney *et al*. 2004).

When reviewing the literature I critically reviewed the papers in terms of their methodology and strength of the evidence they provided, I gave more weight to those that were methodologically robust (such as RCTs and systematic reviews) and seminal works that were frequently cited. This review of the literature for community hospitals has not been limited to peer reviewed articles and research as there have been few studies and publications of this type, as verified by other researchers in this field (Heaney *et al*. 2006; Young *et al*. 2001). Young's research drew over 3,700 references using key words of community hospital, cottage hospital and general practitioner hospital, and searching using Medline, CINAHL and Cochrane, but only 25 of these references were considered as evaluations. The majority of publications were opinion pieces and descriptive studies. Young stated that "although the descriptive studies demonstrate the flexible multi-purpose role of community hospitals, there is a worrying paucity of clinical outcome studies and no robust health economic evaluation" (Young 2001).

 I have carried out a review of the literature on community hospitals and cross referenced with the literature review in the previous chapter. As previously stated, the

review of the literature has limitations because of the lack of critical appraisal methodology. Substantial checks have been made to ensure that seminal work has been included in this review as far as possible.

4.3 Research Questions

The question posed in this study is whether integrated care is present in community hospitals, its nature, what types are evident, which client groups and services are involved, and whether it is sustained. These investigation areas have been reframed into these questions:

- What is a community hospital?

- What is the history of community hospitals?

- How have community hospitals developed?

- What is the role and function of a community hospital?

- What is the international experience of community hospitals?

- Is integration evident in community hospitals?

4.4 Definition of Cottage and Community Hospitals

A definition that is frequently cited states that a community hospital is: "*A local hospital or unit, providing an appropriate range and format of health care facilities and resources. These will include in-patients, out-patient, diagnostic, day care, primary care and outreach services for patients provided by a multi-disciplinary teams*" (Ritchie 1996:11). Ritchie also describes the role of the GP providing the medical care, and liaising with nursing staff, consultants and paramedical staff.

Community hospitals provide generalist extended primary care services, where primary care is defined as *"that level of a health system that provides entry into the system for all needs and problems, provides person-focused (not disease orientated) care over time, provides care for all but very uncommon or unusual conditions and coordinates or integrates care provided elsewhere or by others" (*Starfield 1998:8-9).

A community hospital was described as an extension of primary care, and recommended that *"its objectives should be to meet the local community's non-specialist health needs, to take a holistic approach to patient care and to work towards maintaining patients in the community wherever possible"* (Tucker 1987a).

Cavenagh carried out a survey of 53 community hospitals (a sample of 1 in 7 of the 350 in England and Wales) and concluded that 20 DGHs would be needed to cope with the workload carried out by the community hospitals. He observed that each community hospital is unique to the community it serves (Cavenagh 1978). Grant argues that the diversity and variation between community hospitals is not a result of *"fanciful planning eccentricities"* but based on local need and is *"modern practical expressions of appropriate cost effective health care"* (Grant 1989).

Given this diversity, the challenge is to capture the essence of this model and define the service. This challenge has been taken up by Meads, whose definition has been adopted by the Department of Health in their White Paper: "*The community hospital is a service which offers integrated health and social care and is supported by community based professionals who have direct access to its services"* (DH 2006a). This definition is applicable to the increasing variety of models of community hospitals.

This definition is supported by a fuller description offered by Meads: *"A modern community hospital service aims to provide an integrated local health and social care resource for the local population to which it belongs. These local facilities develop as a result of negotiations between local people, practitioners and the NHS. Community hospitals are an effective extension to primary care, with medical support provided largely from local GPs. The service models include rehabilitation, palliative care, intermediate and surgical care plus emergency and maternity facilities. Community hospital interventions, ranging from day surgery to medical inpatient episodes are characterised by care pathways that maximise local sources of support, including those outside the NHS and health care professionals. This integrated systems approach and sense of devolved accountability places the community hospital as a focus of local community networks"* (DH 2006a). The definition was initially published in the University Of Warwick newsletter in 2004 when presenting the work of Meads and Tucker for the Department of Health Change Agent Team (Meads 2004).

The emphasis of treating the patient as a whole, in respect of health, social care and other needs is repeated throughout the literature, particularly in respect of generalist rather than specialist services (North *et al*. 1984).

4.5 A History of Community Hospitals

This literature review explores the history of cottage/community hospitals in order determine the presence and nature of integrated care and to determine if there is a tradition of integrating care in local hospitals. Tradition is defined as a custom or

practice that passes through generations, and is regarded as a means of transferring knowledge within a social context (Collins 2004:1265).

I have explored the literature for evidence of integrated working in community hospitals throughout their 150 year history and chosen to highlight four key time periods or years: 1890s; 1920s; 1970s & 2008. These periods reflect changes in direction for community hospitals and have been recorded in seminal studies. Community hospitals were originally cottage hospitals, with the first opening in 1859. By 1890 over 240 cottage hospitals were founded, and their presence, role and function were recorded in detail (Burdett 1896:360-363). I refer to this period as the creation period. Cottage hospitals continued to be established throughout Great Britain. A growth period was recorded in the 1920s as hospitals were built as war memorials when 600 cottage hospitals were recorded (Abel-Smith 1964:408). I have referred to this period as a growth period. In 1970, the model of a "community hospital" was put forward in Oxfordshire, expanding the role of the cottage hospital (Bennet 1974). At this time 350 local hospitals were recorded (Tucker 1999). I have referred to this as a period of conversion. In the last 30 years there has been a mixed pattern of closures, reconfigurations, redevelopments and new community hospitals. The latest study to profile community hospitals recorded 296 community hospitals with beds, and for the first time community hospitals without beds (16) giving a total of 312 community hospitals (Tucker 2008). I have described this period as diversification, with a mixed picture of closures, reductions of services, as well as new and developing community hospitals in a variety of models. I have developed this classification to illustrate the history of community hospitals focused around key time periods.

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Creation of Cottage Hospitals

The first recognised cottage hospital was Cranleigh Hospital in 1859 (Swete 1870). A

cottage hospital was defined by three features: it was a GP hospital, employed a nurse,

and patients paid a contribution (McConaghey 1967). These features distinguished

cottage hospitals from charitable voluntary hospitals, specialist hospitals with surgeons,

and dispensaries without nursing staff. Cranleigh was the first officially recognised

cottage hospital that was considered to launch the movement (Swete 1870). Cranleigh

Hospital was founded from a cottage donated by a pastor who saw the need for a

building where the local doctor could work in a clean and spacious environment, and a

nurse could be employed (Swete 1870). The pastor wanted to create a designated local

health facility that would enable procedures to be carried out by a doctor and nurse

working together, and save patients from long and life-threatening journeys to city or

town-based General Hospitals (McConaghey 1967). One impact of the agricultural

revolution was the increase in serious injuries caused through mechanisation, resulting

in local doctors undertaking emergency procedures. Once established, cottage hospitals

provided the environment for this, and a comparative review showed a higher survival

rate for those treated in a local cottage hospital than a General Hospital (Burdett 1877b).

Links were established in cottage hospitals between local doctors and surgeons, based

on personal contacts and location, and which were in some cases extended to formal

agreements (Emrys-Roberts 1991:155). Local doctors were able to treat cases locally

that would have previously been sent to the County Hospital (Abel-Smith 1964:103).

The roots of the cottage hospital movement were medical integration, linking local

family doctors with specialists and enabling them to work and train together in a local

hospital environment. This linkage also extended to collaborations between general practitioners, as evidenced in a study of East Anglian cottage hospitals in which GPs attended to each other's patients and cooperated in performing operations (Cherry 1992).

The employment of a nurse was a first step to creating a multi-disciplinary team at a time when the professions of nursing and general practice were just being recognised. The nurse employed within Cranleigh Cottage Hospital was expected to look after patients in the hospital and also attend patients within their homes which provided continuity across the cottage hospital and domiciliary home (McConaghey 1967).

The cottage hospital provided an alternative environment to the overcrowded agricultural cottages, where levels of social deprivation and poverty were exacerbated by ill-health, particularly of the primary wage earner (Swete 1970:10). Integration across health care and welfare services was unusual, as Local Authorities were too preoccupied with their responsibilities under the Poor Law Act to become involved in cottage hospital developments (Emrys-Roberts 1991:8). One exception was the Great Western Railway Medical Fund Society's Accident Hospital founded in 1872, which co-located welfare services with the cottage hospital which included consulting rooms, a dispensary, dental services, and physiotherapists. This integration of health, welfare and wellbeing was further enhanced by the inclusion of indoor swimming pools (Emrys-Roberts 1991:160). Another example of health promotion was offered by Longton Cottage Hospital which employed hospital nurses to be itinerant and offer preventative care and Wirksworth cottage hospital which offered meals to the community (Emrys-

Roberts 1991:107-8). The locally accessible service offered by the cottage hospital avoided prolonged separation of families as patients could be nursed within the village or town (Swete 1870).

Cottage hospitals were developed very quickly, with the first open in 1859, eighteen by 1865, and a recorded 180 by 1880 (Abel-Smith 1964:102). One of the factors that helped with the growth of cottage hospitals across the UK was that hospitals could be created from existing buildings at a very low capital cost (Anonymous Editorial 1868). Revenue sources were also readily attracted, and the public and community support to the founding and ongoing funding of cottage hospitals enabled them to be created and sustained at a remarkable rate. 174 cottage hospital accounts were analysed by Burdett to demonstrate the extent of the financial revenue support from the community through donations, payments, church collections and subscriptions, prompting him to suggest that cottage hospitals had the potential to become one of the permanent charitable agencies of the country (Burdett 1896:35). Integration with the community is shown where *"the whole village was involved in caring"* such as in Lynton Hospital where local people contributed in ways such as donating locally grown produce (Emrys-Roberts 1991:107-8).

As early as 1868, a case was made for there to be a cottage hospital in every village ten miles distant from a town or country hospital (Editorial 1868), and that there should be one bed for every 1,000 of the population (Swete 1870). Twenty five years later 284 such hospitals were recorded in the UK, with 240 of these in England (Burdett 1896:35).

The rate of growth was extraordinary and was to change the landscape of local rural health care for the next 150 years. Cottage hospitals were open to all local general practitioners, and the new generation of GPs who had been taught in large general hospitals began to acquire their own rural hospitals (Abel-Smith 1964:103). Burdett worked at creating a community hospital movement, encouraging all cottage hospitals to contribute to a national fund, which he called the Napper Memorial Fund (Burdett 1882). In 1889 Dr Holden, in his BMA Presidential address, spoke of 400 cottage hospitals with 4,000 beds opening up across the UK. He cited advantages such as their rural location with clean air, close proximity to friends and relatives, and their domestic design. Holden described twenty years in St Leonard's hospital in Sudbury, and gave evidence of the clinical and cost effectiveness of the service. Holden predicted the impact on secondary care services: *"Eventually cottage hospitals must, to some extent, affect the county infirmaries, as they receive not only the accidents and emergencies of their neighbourhood, but have generally the first selection of curable cases, while the chronic and incurable are passed on to these most excellent and more commodious institutions"* (Holden 1889).

The literature shows that inter-disciplinary and multi-disciplinary integration were key factors in the creation of cottage hospitals. Patients and communities were fundamentally involved in creating and supporting the facilities, such as through donating land, buildings and finance. Integration across welfare and health was less well developed.

Growth of Cottage Hospitals

Particular growth was witnessed around the events of the 1920s when cottage hospitals were built as War Memorials, and there was considerable support and patronage (Emrys-Roberts 1994:146). The growth of cottage hospitals was considerable, increasing from 200 at the turn of the century to 600 by 1935 (Webster 1993:101). According to Abel-Smith "Britain became littered with small hospitals" (Abel-Smith 1964:406). Not all local people were convinced of the benefit of the close proximity to sick people, and there were those who considered that those who had accidents should travel to infirmaries (Emrys-Roberts 1994:24).

In 1920, Lord Dawson published a report which set out proposals for the design of health services around primary health centres, with a role and function that closely match many of those in cottage hospitals with facilities including wards, clinics, operating room, radiography, laboratory, dispensary, equipment for physical culture, and communal services such as child welfare, ante-natal care, school health and occupational health. *".....A Primary Health Centre - an institution equipped for services of curative and preventive medicine to be conducted by general practitioners of that district in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists.....it would be impossible to exaggerate the benefits that would accrue to the community by the establishment of these Primary Health Centres."* (Dawson 1920). The primary health centres were, according to Porter, essentially cottage hospitals staffed by GPs who would use them as their surgeries (Porter 1997:643). Dawson promoted a role for these centres in health education and health promotion, denoting a shift from personal care for individuals to collective care for the

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whole community, and integrating preventative and curative services (Webster 1993:89).

Dawson's report has re-emerged as relevant to current thinking (Webster 1993:89). The WHO Health Evidence Network (HEN) report in 2004 on health care systems focused on primary care acknowledges Dawson's influence, noting that this was the direction being adopted by many countries (Atun 2004). The eventual blueprint for a national health service was presented by Beveridge and was considered by Porter to be *"the most far reaching administrative action concerning hospitals ever brought about in a western nation",* leading to the government being responsible for 1143 voluntary hospitals and 1545 municipal hospitals (Porter 1997:653). Divisions between primary and secondary care enabled GPs to operate as small businesses outside of the NHS (Porter 1997:654). It would appear that community hospitals, which were then known as GP hospitals, fell between the GPs who provided medical support and being within the NHS as a hospital service. By 1948, many small voluntary hospitals (70% with less than 100 beds and 30% with less than 30 beds) were taken into the new National Health Service, with Aneurin Bevan proposing hospital planning to improve the quality of management (Abel-Smith 1964:481). Bevan was famously quoted as saying that *"Although I am not myself a devotee of bigness for bigness sake, I would rather be kept alive in the efficient if cold altruism of a large hospital than die in a gush of warm sympathy in a small one"* (Abel-Smith 1964:481). This comment was viewed as an indictment of cottage hospitals. It was however taken up by those who were concerned with palliative care who stressed the importance of the appropriate environment for patients who were dying and needed symptom relief, and viewed the comment as a focus on only the curative

aspect of health care (Granshaw and Porter 1989: 234). Studies have emphasised the importance of palliative care in community hospitals (Lyon and Love 1984; Thorne *et al*. 1994*;* Seamark *et al*. 1997; Llewellyn *et al*. 1999 and Payne *et al*. 2004).

A strategy for centralising hospital care in District General Hospitals in the Hospital Plan for England and Wales in the early 1960s created uncertainty about cottage hospitals (Abel-Smith 1964). This prompted the creation of the Association for GP Hospitals in 1969 (which became the Community Hospitals Association) and a series of policy documents from the Royal College of GPs, which was an idea originally put forward by Swete 100 years previously (Swete 1870). The creation of the NHS led to a strong focus on specialist large secondary care hospitals, to the point that small local hospitals were not mentioned at all in policy or regional strategies (Tucker 1987a). According to Higgins, the hospitals were often "isolated, heterogeneous and ...a law unto themselves" (Higgins 1993:4). In the 1970s and 1980s the NHS focused strategic attention on the larger high tech secondary and tertiary care hospitals as the service sought to optimise the clinical and technological breakthroughs in specialist services, and the potential development of community hospitals within the health care system was not explored (Jones and Tucker 1988). There were few developments in cottage hospitals after transfer into the NHS, as they came under state management and there was a period of consolidation. The focus of the new NHS was on large centralised hospitals that offered curative medicine and the small local hospital was for the most part ignored.

Conversion of Cottage Hospitals to Community Hospitals

Small hospitals experienced new attention and a revival following work in Oxford. This work focused on the concept of a community hospital model as a style of care and an approach to patient management that was more holistic and concerned with meeting the total medical and social needs of the patients (Bennett 1974). It was developed in the early 1970s by Dr Rosemary Rue and Dr A Bennett (Bennett 1974) some fifty years after the Dawson report (Dawson 1920). A key breakthrough was the declaration of the community hospital as an extension of primary care, rather than as a satellite of the DGH, and the value of integration across primary and secondary care (Bennett 1974). An Oxford researcher evaluating the pilots pointed out that Rue and Bennett did not address the question of whether the 350 General Practitioner hospitals that were already established by the 1970s could also be defined as community hospitals, and that this led to confusion and may have hindered development (Loudon 1972). The lack of a clear definition and a lack of understanding of the basis of the concept may also have hindered the progress of the development of community hospitals. A group of GPs concluded that: "*in view of the size of their contribution to the NHS, the ignorance about the work and function of GP hospitals (at all levels except for those who have direct experience of them) is remarkable*" (Sichel and Hall 1982). Some of the reasons for this lack of recognition put forward include their uneven distribution, their lack of linkage with Consultants in acute hospitals, and the protection of GP privacy in their local hospital (Sichel and Hall 1982). A cost-effectiveness analysis of the Oxford Community Hospital programme concluded that community hospitals incurred less

capital cost than a DGH, and recommended ward units of 35 beds for optimum cost per

bed which would be cheaper than a DGH bed (Rickard 1976).

Attention started to be paid to community hospitals. Policy guidance on the

development of community hospitals was issued which described their role in

supporting patients discharged from acute hospitals (DHSS 1975). The policy stated that

the Government was convinced that they needed to strengthen the role of the family

doctor and community hospital services. The document acknowledged that local

communities had campaigned to keep their threatened hospitals open, and that many

were originally built with community subscriptions and donations (DHSS 1974).

Community hospitals, if considered as extensions of primary care, were viewed as an

opportunity for GPs to organise the care of a whole community (Cochrane 1972:84).

The community hospital was *"heralded as an important development towards an*

integrated health provision, providing economic, satisfactory care in local

surroundings" (Kernick and Davies 1976).   There was concern about any national

policy or standardised approach, given the different local contexts, different GP

attitudes, and the difficulty in agreeing the criteria for patients appropriate for

community hospitals (Kernick and Davies 1976). Community hospitals, as providers of

intermediate care, were described as providing either substitutional care as an alternative

to a DGH, or complex care by catering for people with highly complex needs (Hadridge

1997).   An intermediate care strategy was launched in England, with a commitment to

create 3,000 intermediate care beds. The strategy defined intermediate care as being a

service designed to avoid unnecessary admission to an acute hospital, to expedite

discharges from acute hospitals, and/or to delay/avoid admission to long term care (Hadridge 1997).

Whether community hospitals are an extension of primary care, a support to secondary care, or a bridge between them has continued to be debated (RCGP 1995). A RCGP policy group explored community hospital services relationships in a diagrammatic illustration of integration designed by Tucker, showing a wider network of relationships across health, social care and the voluntary and independent sector (RCGP 1995). The orientation of these hospitals is an important consideration as it helps to clarify their position within the overall health care system (Higgins 1993).

Higgins focused on local support for community hospitals and predicted a new style of collaboration evolving in a highly localised way, particularly with proactive support from individual patients and the community (Higgins 1993). The community is recorded as proactively supporting their hospitals through funding, volunteering and managing hospitals which are viewed as being locally owned (Tucker and Bosanquet 1991).

Diversification of Community Hospitals

Local support for community hospitals has been evident throughout their history and none more so than in the period between 2005-8 when an NHS financial crisis prompted proposals for reductions of services or closures in 150 community hospitals in England (Tucker 2007). The response was a network of public action which included petitions, public marches, political pressure through MPs, and high profile campaigns, demonstrating the community hospital movement as a social movement, as described in an earlier chapter (Giddens 2009). The contrast between the national policy of

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investing in community hospitals with the reality of announcements of closures of services or entire hospitals was challenged in local and national campaigns, which led to PCT reappraisals and the establishment of formal public engagement and consultation processes in many areas. Studies have demonstrated the negative impact of losing local rural hospital services both to the quality of medical care and to the community infrastructure (Humphreys 1973).

National policy in England has set out the model of integrated care, within the strategy of services provided "closer to home." The following is an extract from "Keeping the NHS Local- A New Direction of Travel" which describes community hospitals as having a "rich variety of local health and other community services" (DH 2003:17). *"It is an exciting time for smaller hospitals in particular, as their traditional roles are developing and changing as they can provide a more integrated range of modern services at the heart of the local community* (DH 2003:4). The document also goes on to record: *"We are likely to see larger, multi-disciplinary primary care teams. Some will work out of traditional health centres, but others may move to more community-based facilities as part of an integrated health, social and education community resource* (DH 2003:10).

The DH announced a community hospital investment plan and stressed the engagement of the local community (DH 2006b). The document gives examples of each of the types of integration shown above, and although published after the CHA surveys were completed, it is built on many previous studies and policies, particularly on intermediate care.

The White Paper focuses particularly on community hospital integration with social care and education (DH 2006b). According to a recent study on community hospitals by CSIP, communities view their community hospitals as integrated health and social care resource centres (Balcombe 2008:8). National policy documents and the literature frequently refer to integration in community hospitals as integration between Health and Social Services, and Health and Local Authority services such as education.

PCTs proposing to reconfigure, reduce or close community hospitals or services were required to consider community hospital developments with *"new pathways, new partnerships and new ways of working"* in their role in supporting the implementation of the Government policy of care closer to home (DH 2006a). Community hospitals have been recognised as long established and important components of health care in England particularly for intermediate care (O'Reilly *et al*. 2008). Local hospitals have provided a focus for interaction between GPs as community-based generalists and consultants as hospital-based specialists, and such integration can be built on for services such as primary care diagnostics and care for people with long term conditions (Summerton 2004). The role of community hospitals in providing diagnostic services and multidisciplinary rehabilitation services has been viewed as significant for community hospitals in England (Seamark *et al*. 2001, Tucker 2008). The community hospital role is considered to be strengthened by their relationships with primary care and with their communities (Seamark *et al*. 2001). Relationships between patients and practitioners are changing, with the patient becoming a more proactive participant in care (Gray 2002). Community hospitals are being presented as integrated health and social care organisations with a potential for redevelopment, expansion, enhancement

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and redevelopment in order to create increased capacity and being viewed as social

assets (Tucker in Meads and Meads 2001:118). The policy of care closer to home

encourages primary and community services to be to more efficient and responsive and

to *"seize the opportunity to provide a wider and more integrated range of services"*

(DH 2008:7.4).

4.6 History and Tradition of Community Hospitals

The literature shows that community hospitals have had strong medical advocates

throughout their history such as Burdett and Swete; Dawson; Rue and Bennett and

latterly Cavenagh and Emrys-Roberts. One in five GPs were been recorded as being

involved in community hospitals (Cavenagh 1978, Seamark *et al*. 2001). Given that

many community and cottage hospitals were created as War Memorials in the 1920s and

funded through public subscription, this strength of feeling regarding their status and

symbolism within towns is a strong factor in the view of local people regarding the

support for their continuation (Webster 1993:10). Cochrane, who advocated evidence-

based medicine and the value of RCT research, drew attention to the benefits of access

and stated that every community which is a sociological entity needs a focus of interest

which creates local pride and suggested that the NHS take account of this (Cochrane

1972:34). In challenging criticisms levied at community hospitals as old fashioned and

supported through modest fundraising efforts, a response was published stating that

Leagues of Friends were often so well placed that they could fund significant building

programmes or even take over their hospitals, stressing that *"people power and the*

skills, resources energies and imagination of local people should not be

underestimated" (Tucker 2007). The desire to preserve and extend small hospital

services appears to reflect a number of concerns: "*a sense of history, safety/security,*

reducing isolation, continuity of family care, financial investment, a feeling of

"ownership" and community solidarity" (Higgins 1993:57). There are illustrations of

integrated working throughout the history of community hospitals originating from its

founding principles although this has not been formally recognised or researched to

date. There is a case to be made that community hospitals have been offering an

integrated service which spans multidisciplinary, multi-agency working, as well as

working across sectors such as primary and secondary care. Integration with the

community and patients is also a feature. This next section explores the literature for

illustrations of the range and breadth of services, and the client groups catered for by

community hospital services.

4.7 The Role and Function of Community Hospitals

Community hospitals have been generally viewed as a rural commodity (Haynes and

Bentham 1979) located in places such as market towns averaging just under 15miles

from a DGH (Seamark *et al*. 2001) with the highest density of community hospitals in

the South West and Oxford (Tucker 2008). A review of 64 community hospitals in

Scotland recorded an average distance of 30 miles for the nearest DGH, and concluded

that the contribution that these hospitals made to the health of local communities should

not be under-estimated (Grant 1984).

A survey in 2001 showed that there were 322 community hospitals in England with nearly 8,500 GP beds supported by 20% of the GP workforce (Seamark *et al*. 2001). The study concluded that the association of such hospitals with local communities, the extent of primary care involvement, multidisciplinary rehabilitation services and diagnostic services would indicate that these hospitals should have a significant role in the evolution of intermediate care and in alleviating the pressures on larger specialist hospitals. A more recent survey identifies 296 community hospitals with beds, and 16 community resource centres which were reconfigured community hospitals without beds, with over 20 community hospitals being developed (Tucker 2008).

In the 1980s, 98% of community hospitals in England had outpatient departments, with an average of 10 visiting consultants. Almost half had more than 10 consultant outpatient clinics each week (Jones and Tucker 1988). Ramaiah advocated that community hospitals move away from in-patient provision and concentrate on clinics, day care, minor injuries and community nursing (Ramaiah 1994) and surveys have shown that since 1999 over 3,000 community beds have closed (Tucker 2008). It is noted that there has been a reduction in NHS beds overall, as there is a shift in the balance in provision to care at home, and shorter inpatient stays in hospital.

Community hospital services include inpatient care and minor injuries services; diagnostic and treatment services such as imaging and rehabilitation, interventions such as surgery and anaesthetics, and also maternity and palliative care (CHA: 1999:18-26). Services are provided to the whole community, including children, adults and older people, with services including mental health needs, care for people with long term

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conditions, palliative care and intermediate care (CHA 1999:10). There is not an exhaustive list of services, care pathways or client groups relevant to community hospitals, as community hospital services vary according to local circumstances (Cavenagh 1978) and are often viewed as being imaginative, innovative and flexible in meeting local needs (CHA 1999:10). Community hospitals have been cited for the benefits of integration and described as moderating the flow of patients between primary care and the DGH, enabling better access to care for patients at an overall lower cost (Aaraas 1998). An RCT in England concluded that care in a community hospital was associated with greater independence for older people than care in a DGH (Green *et al*. 2005). Post acute care was deemed to be cost-effective in a community hospital (O'Reilly *et al*. 2006; O'Reilly *et al*. 2008), and there were benefits in patient outcomes, leading to questions about the future of community hospitals and intermediate care (Young *et al*. 2003; Young and Stephenson 2006; Young *et al*. 2007). Benefits of community hospital services have been demonstrated in providing services such as palliative care (Seamark *et al*. 2001), clinics and diagnostic services (Clewes 2006), intermediate care (Tucker in Meads and Meads 2001:105) and rehabilitation (Green *et al*. 2005).

A number of studies have demonstrated the clinical effectiveness of care and the potential cost savings of community hospital care (Green *et al*. 2005; Coast *et al*. 1996; Treasure and Davies 1990 and Tomlinson *et al*. 1995). Three studies concluded that the availability of community hospital beds may reduce the use of a DGH for that population, but the usage of beds was higher overall (Cook 1998; Baker *et al*. 1986). A study on the alternatives to hospital care examined the capacity of community services

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including community hospitals, and the factors that influenced decision making (Hensher *et al*. 1999). One of the studies concluded that community hospitals offered accessible health care and merited systematic evaluation of costs and benefits as there was evidence that savings could be achieved through improved efficiency (Hine *et al*. 1996). Cochrane had described the community hospital as being of great value in reducing inefficiency, in treating patients who might otherwise be admitted to a DGH and had stressed the need for a clinical evidence base. Cochrane stated that *"only those patients would be admitted for whom hard evidence existed that there was little risk of medical detriment in treating them in the community hospital as opposed to the District General Hospital"* (Cochrane 1972: 35). Patient selection has been a theme in the evaluations of the use of community hospital beds (Donald *et al*. 2001: Higgins 1993). In a study involving 27 GPs, Grant researched what influenced GPs in deciding to admit patients to a community hospital. He concluded that patients with social care and medical care needs were straightforward, but that each GP's competency regarding more complex care needs meant that the level of comfort/discomfort was a prime determinant (Grant 2002). This raises questions of equity within and across community hospitals, as the range of services and options for admission have been shown to be based not only on local need but also on local medical practitioner interest and competence (Liddell 1994). In a comparative study, it was concluded that there were advantages offered through community hospitals staffed by GPs, but warned of the need for training for GPs and careful monitoring (Smith *et al*. 1973).

A study of six urban community hospitals noted that there was a wide variation in service provision, and that each hospital played a different role in their health care

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system, concluding that the costing of inpatient facilities, if extrapolated across the country, could save the health economy significant revenue, as well as releasing scarce acute hospital bed capacity (Rawlinson and West 1998). An experiment with an inner city hospital in London was found to reduce the pressure on acute hospitals, and also decrease the isolation of community health workers, although there was a difficulty in attracting qualified staff to work in the hospital (Victor 1988). Victor predicted that community hospitals would be vulnerable to closure unless they could be shown to be effective and efficient. Researchers also explored whether GPs in inner cities wanted community hospitals (Hull and Jones 1995). A more recent study found that elderly patients in an urban community hospital experienced a similar outcome to those in a DGH, but that they were more positive about their care and had improved mental functioning (Boston *et al*. 2001). However it is noted that the vast majority of community hospitals are in rural areas, and that the principle of equity may be considered as being subverted by giving isolated communities access to local hospitals in a way which patients in urban areas do not have (Higgins 1993:67).

Community hospitals may be viewed as healing places as represented by Gesler, who has been researching environments that are conducive to physical, mental, spiritual, emotional and social healing. Gesler developed a four dimension framework in order to assess the potential for places for healing, which are the natural, built, symbolic and social (Gesler 2003:8). Gelser's work provides a strong message about healing (from haelon meaning wholeness), and the themes of integration concerned with *"physical, mental, spiritual, emotional and social healing"* (Gesler 2003:2). Researchers have explored the rural context and environment for community hospitals and concluded that

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there was a social and psychological benefit to patients with regard to the accessibility and smallness of local hospitals (Haynes and Bentham 1979). There are many accounts extolling the virtue and value of community hospitals from the perspective of the community (Dopson 1979; Farmer *et al*. 2003; Hyde 1979). Although subjective views, these are presented powerfully in the literature, such as in the following extract: *"If anyone ever doubted the intrinsic value of the community hospital/health centre, simply being an observer ...would dispel all misgivings. It is in environments such as these that health care begins"* (Rose 1975).

There is a general agreement in the literature that Community hospitals provide an appropriate location for services such as palliative and terminal cancer care in rural areas (Thorne *et al*. 1994). Their role in services is as diverse as homoeopathy (Tucker 1993b), mental health services (Rawlinson 1990), day surgery and maternity (Cavenagh 1985), and telemedicine and imaging (CHA 1999). Community hospitals also provide a role in unscheduled care by providing a base for out-of-hours services and providing a minor injuries service thereby acting as one of the bridges between Accident and Emergency services (A/E) and the primary care interface (Dale in Salisbury *et al*. 1999:96).

Whilst the literature provides evidence for a wide range of roles and functions, there is also concern at the lack of a focus, mission and philosophy (Tucker and Bosanquet 1991:18). The decentralisation of services in rural community hospitals has illustrated some of the difficulties and tensions in regard of consistency of range and standard of services (Higgins 1993:47). There is also an argument that investment in models and

services need to be considered as an alternative to community hospitals (Bosanquet 1974; Higgins 1993:72).

Whilst authors have identified the lack of research into community hospitals, they stress that this does not mean that they are not effective (Heaney *et al.* 2006; Higgins 1993). This view has been expressed by many others including Ritchie, who contrasted the lack of evidence in comparison with alternative care models (Ritchie 1996), and Shaw who said that community hospitals must be adept at demonstrating their effectiveness (Shaw1983). The RCGPs recorded that there was inadequate data on standards of care and outcomes in community hospitals (RCGP 1990:4). Heaney makes the case for more research into the number, location, clinical and cost-effectiveness, community impact and sustainability (Heaney *et al.* 2006), and internationally there is now some progress on research into this area (Charante *et al.* 2004, Atun 2004, Green *et al.* 2005).

4.8 International Studies

Community hospitals in the UK have few equivalent models internationally, as they are based on a model in which GPs extend their practice in local hospitals. Local hospitals that have similarities to the UK model are those in Scandinavian countries such as Finland and Norway which have developed as similar extensions of primary care. A review of the use of community hospitals in Norway over a five year period found that GP hospitals reduce the utilisation of general hospitals, and can result in better access to quality health care for people in rural areas at a lower cost than alternative options (Aaraas 1998). A randomised controlled trial in Norway concluded that intermediate care at a community hospital significantly reduced the number of readmissions for the

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same disease to a general hospital and also increased the level of independence of patients supported in community hospitals as opposed to those cared for in general hospitals (Garasen *et al*. 2007). This finding concurs with the study in Bradford (Green *et al*. 2005).

A network of eleven community hospitals has been developed in Tuscany. An evaluation of these services found a wide variety in their role including intermediate care, and palliative/terminal care (Tediosi 2004).   The study concluded that community hospitals could play a relevant role as providers of intermediate care at a relatively low cost (Tediosi 2004). The first GP hospital in the Netherlands has recently been evaluated. The findings show that it is considered to be a valuable alternative to care at home, nursing home or general hospital, particularly for older people who have a poor quality of life related to their health conditions and who require short term care (Charante *et al.* 2004). Another model that has been developed in the Netherlands is described concerns neighbourhood community health centres offering integrated primary care (Oosterbos 2006). This model is designed for a local population and would contain GP beds, housing, pharmacy, nursing home, GP practice, home care, mental health care and diagnostic facilities, thereby describing many community hospital facilities (Oosterbos 2006).

The European Integrated Care Programme, PROCARE, has included a community hospital as one of its case studies. The case study illustrates the challenges in the UK of integrating across disciplines, particularly across health and social care (Coxon and Billings 2004). The Health Evidence Network (HEN) of the World Health Organisation

makes a financial case for community hospitals whilst stating its findings that there is no significant difference in health outcomes or patient satisfaction between community hospitals and general hospitals: *"General practitioner-led hospitals in Norway provided health care at lower cost compared to alternative modes of care, due to averted hospital costs. United Kingdom studies confirm that GP hospitals save costs by reducing referrals and admissions to higher-cost general hospitals staffed by specialists"* (Atun 2004). There is an evidence base developing internationally of the effectiveness of local hospitals and community resources, demonstrating the efficiency achieved through integrated working.

4.9 Integrated Care in Community Hospitals

In considering the presence of integrated care in community hospitals, I examined the literature for evidence of types of integration, partnerships and joint working. A feature of community hospitals is that services are provided by multidisciplinary teams (Ritchie 1996). Staff and patients have described the benefit of multidisciplinary rehabilitation close to home in a review of community hospitals in Clwyd (Tucker and Bosanquet 1991) and researchers found that there was evidence that professional boundaries were flexible in the community hospital setting, especially for nurses (Heaney *et al*. 2006). Heaney *et al*. in their integrative systematic review of community hospitals, listed professional groups and staff working in community hospitals. This list does not include staff from the third sector, volunteers or other visiting staff (Heaney 2006). The extensive list shows the range of 21 professional groups working within community hospitals (Heaney *et al*. 2006).

The improving links between health and social services suggest that community hospitals could be utilised more fully, particularly for complex packages of health, social care and public health (Heaney *et al*. 2006). Community hospitals are viewed as being at their most successful when they blur these boundaries (Higgins1993:67).

A number of community hospitals have become adept at innovation (Tucker *et al*. 2008). According to Higgins, changes in professional practice can be implemented in days instead of the months or years which it can take in large NHS hospitals because of the size of the service and the short chains of command (Higgins 1993:65). Higgins suggests that community hospitals should enhance their profile with commissioners so that purchasers look to them first, not last, for services such as respite care, rehabilitation, post-operative care, terminal care (Higgins 1993:72). There is a view that the strengths of community hospitals may be in linking primary and secondary care and providing a location for the delivery of complex packages of health and social care and public health (Heaney *et al.* 2006).

Not all hospitals have become adept at innovation, and a number have been declared as no longer fit for purpose. A survey of community hospitals from 1998-2008 showed that during that ten year period there was an overall loss of 38 community hospitals. A total of 65 hospitals had closed or been re-designated, and 27 had been newly built either as a new service or a re-provision of a single hospital or combination of hospitals (Tucker *et al*. 2008).

Higgins described three key points of integration for community hospital services: i) in the relationship between statutory and voluntary organisations, ii) in the overlap

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between health and social care and iii) at the interface between primary and secondary care" (Higgins 1993:40). Significantly, these are the three areas that Freeman recognised as the "most visible potential fractures in continuity of care", describing these as "between formal and informal care, health and social care, and hospital to community" (Freeman *et al.* 2001).

As previously discussed, as early as 1920, Dawson, in proposing primary care centres, recorded that *"Measures for dealing with health and disease have become more complex and therefore less within the power of individuals to provide but rather require combined efforts"* (Dawson 1920). This signalled the widening responsibility of the GP as a generalist from providing care to individual patients to providing care to the whole community collectively, adopting a public health role as well as a health promotion and curative role. This change in responsibility would require the creation of new teams. This is now extending to primary care collaborations across practices as GPs take on commissioning roles (Clewes 2006) and encourage community hospitals to provide a focus for extended primary care, with many generalists and specialist teams working together across disciplines, sectors and agencies.

The role of the individual is critical in this, as enshrined by WHO which recognises that people have a right and a duty to be actively involved in their care (WHO Alma Ata 1978). This was echoed by Wilce who made a record of the Lambeth Community Care Centre, an urban community hospital: *"But the most important distinguishing feature of the centre is that it is equipped not just with a new building and set of services, but with a coherent philosophy, a conviction that the patient should be enabled to share in*

his/her own health care as part of a multi-disciplinary team" (Wilce 1988:9). A

national study in Sweden concluded that it was service users themselves who needed to

create service values, and advocated that integrated care needed to incorporate

integration with patients (Ahgren 2003). The early involvement and partnership with

service users is a strong theme in the literature (Leutz 1999). The support given to

community hospitals through financial support and volunteering, as well as the strength

of feeling demonstrated when services are threatened, illustrates the extent to which

communities feel ownership of their local hospitals.

Studies show that patient satisfaction and outcomes of care in community hospitals

compare favourably with other models of care (Green *et al.* 2005). A study on patient

satisfaction of community hospital services demonstrated a positive outcome, although

found less evidence of collaborative care and patient participation (Small *et al*. 2007).

An account of the founding and development of an urban community hospital in

Lambeth by Wilce provided an independent record of a community hospital (Wilce

1988). The publication provides an insight into the model which demonstrated

partnerships across disciplines, services, agencies and sectors which has summarised the

most frequently referred to types of integration.

The centre required a shared commitment from professionals, managers and the local

community (Higgs 1985). The facility had an explicit aim of an integrative approach,

particularly with the community and this was facilitated by the creation of a community

support worker who encouraged full participation and involvement from the community

through schools, the church, housing associations, advocacy groups and others

(Wilce1988:127). The centre promoted patient autonomy, with the patient taking a proactive lead role in their care (Wilce1988:6).   The centre enabled GPs to extend their medical practice and work within multidisciplinary teams (Wilce1988:49), and also create more opportunities for them to work with consultant colleagues (Wilce1988:43). Partnership working was developed with voluntary agencies, the Local Authority and social services (Wilce1988:66) and space created for dentistry, workshop facilities, and social community link work (Higgs 1985). The Lambeth Community Care Centre was considered to be an innovative model of intermediate care and one that was subject to audit and evaluation (Higgs 1985). The Centre demonstrated a number of types of integration such as multidisciplinary; health and social care; multi-agency, community hospital and Local Authority, community hospital and the community and community hospital and the patient. In addition, there was evidence of integration between the community hospital and primary care as well as with secondary care. These eight types of integration are further explored in this research and are the basis for my analytical framework (Figure 4 in Chapter 5).

The DH policy was for each locality to have community services that integrate local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training, suggesting a central focus for co-location (DH 2008). Community hospitals have an important role in transforming whole health and social care systems into local, accessible, integrated and person-centred services (Tucker 2006).

The Next Stage Review of the NHS places primary care and GPs in a central position in the re-design and modernisation of the service as providers of primary care services, gatekeepers to specialist services, and commissioners of health care for a defined community (DH 2008). GPs are employers of staff, and are being encouraged to extend primary care services through becoming practitioners with special interests, and to create capacity within primary and community services for diagnostics and treatment services as well as screening and health promotion. The strategy of "care closer to home" places the community hospital in a key position in providing a focus and forum for health and social care providers to co-locate and develop a range of services in locally accessible facilities (DH 2006a; DH2006b). This is particularly pertinent to rural communities, where evidence shows that people living in rural areas are less likely to receive services comparable with those living in urban areas (Pugh *et al*. 2007).

GPs now have the mechanisms in place to support the community hospital service model through commissioning, as shown in the achievements of a practice-based commissioning group in Gloucester who succeeded in reversing a PCT decision to close their local hospital (Clewes 2006). GPs are well placed to extend their primary care services through clusters of GP practices and the development of community hospitals as resource centres that extend primary, community and social care, and offer a focus for multi-provider services and facilities from the statutory and third sector to serve the whole community. To conclude, the diversity of services in these multi-provider facilities has been developed on a multi-agency, multi-economy and multi-disciplinary basis according to local need and priorities (Tucker in Meads and Meads 2001:111).

4.10 Conclusion

The review of the literature has helped to define the community hospital as a small local hospital serving a defined population with generalist services that may be considered either as an extension of primary care or as an outreach of secondary care. The review has shown that community hospitals are diversifying in their role and function. Although previously unrecognised in national policy (Tucker 1987a), there is recognition of their potential: "community hospitals are particularly well placed to offer integration of services" (Department of Health 2006a).

Improving the understanding of the contribution of the community hospital within the healthcare system has been helped through the research and the analysis of databases (Tucker 2008, Cavanagh 1978, Seamark *et al*. 2001). Researchers have recognised the value of the integration in rural community hospital services in the UK (Ritchie 1996, Ritchie and Robinson 1998, Jones and Tucker 1988, Cochrane 1972, Young *et al*. 2001) although Higgins cautioned that community hospitals need to make sure that they are at the crossroads and not the margins of integrated care (Higgins 1993).

The literature has shown that there is a history of staff and services working together, within and outside of community hospitals. As a generalist service functioning as extended primary care, these local rural hospitals are multi-provider units providing a wide range of services for the whole community. Integrated working is integral to small, local rural hospitals that, through scarcity of resources, need to rely on available staff and resources to work together to meet local needs (Freeman *et al*. 2001).

There has been a lack of clarity and precision in terminology which has hindered the recognition and development of what Meads has called the NHS' "best kept secret" (Meads 2001).   When the intermediate care strategy was launched in the 1990s, the lack of recognition of the existing role of community hospitals in providing intermediate care through inpatient beds and community outreach services meant that only new and innovative services drew attention and financial support (Tucker *et al*. 2000). It may be argued that this pattern is repeated for integrated care, where attention by academics and policy makers is on innovative projects, rather than on integrated working in practice. The lack of research and evaluation into community hospital services in England has meant that its role has not been fully documented in the past in respect of its role and function in providing integrated care.

A theme in the literature is one of community engagement, showing that local people are, and always have been, legitimate stakeholders of "their hospital," demonstrating a person-centred and community led model of care, extending to a social movement and facilitating social inclusion.   Another theme is the extent of local networks and partnerships which make up the community infrastructure in rural settings. This shows that simply listing the services and facilities offered does not fully describe the importance of the interdependence and integration of the service within and beyond the community hospital. The literature draws on the importance of local, accessible services that provide a continuity of care by practitioners that patients know and trust.

This review illustrates the lack of research into community hospitals as a model of care, particularly with regard to partnerships, networking and social impact. The literature

review has shown the lack of research into community hospitals and a predominance of grey literature such as reports and opinion pieces which are typically favourably disposed to this model of service.

The literature review has provided evidence which starts to answer some of the research questions. Integrated care has been shown to be part of its origins, history and tradition. Community hospitals are characterised in policy papers as being a focus for integrated health and social care, although this has yet to be proven. Therefore there is scope to research this further and contribute new knowledge on the presence, nature and development of integrated care in community hospitals.

This review of the literature has helped to answer some of the questions posed. A definition of a community hospital is offered, and characteristics identified. The history of cottage and community hospitals over the past 150 years reveals an originating function of providing an environment for local doctors, consultants and nurses to work together, and the importance of partnerships with communities and other agencies in the creation and development of small hospitals. The support given by communities has also been illustrated. Issues of isolation and inequities are raised, in such a decentralised and a locally driven service. The role and function of the hospitals is generalist, and typically viewed as an extension of primary care as well as an outreach of secondary care. Therefore, the links between staff in GP surgeries, DGHs and other healthcare facilities are important to the hospital function. There is an interest and growth in this model of local care internationally. The lack of research in community hospitals has been noted, and in particular with regard to the definition, model of care, effectiveness, efficiency, patient outcomes, and community engagement. There has not

been a study that has specifically explored the range and type of partnerships in community hospitals and types integrated working. There is scope to study community hospitals and contribute new knowledge in this poorly researched field.

4.11 Refining the Research Question

The questions posed for this review of the literature were:

- − What is a community hospital?
- − What is the history of community hospitals?
- − How have community hospitals developed?
- − What is the role and function of a community hospital?
- − What is the international experience of community hospitals?
- − Is integration evident in community hospitals?

My review of the literature has helped to determine the definition, characteristics, history and development of community hospitals, which has set the context for this study (Ritchie 1996, Seamark *et al.* 2001, Tucker *et al.* 2008).   I have also considered the literature from international developments (Charante *et al.* 2004, Aaraas 1998,). I concur with the conclusions of the systematic review of the literature carried out by Aberdeen university, that the literature is "long on opinion and short on robust studies" (Heaney *et al.* 2006).

The literature review has led to the framing of the question of whether integrated care takes place in community hospitals, and if so, what types of integrated care are evident and how is it being developed.

- Is integrated care present in community hospitals?

- What is the nature of integrated care in community hospitals:

  o Which types of integrated care are in place

  o Which patients receive integrated care?

  o Which services demonstrate integrated care?

- How is integrated care being developed, and in particular what helps and hinders the development of integrated care?

The eight types of integrated care within and outside of community hospitals that are most frequently referred to in the literature are: primary care, secondary care, social services, third sector, Local Authority, multidisciplinary, patients and communities. These eight types of integration provide an analytical framework for this study. There is an opportunity to use case study data to research staff views and experiences in community hospitals in England. There is the potential to provide an insight into whether integrated working is taking place and, if so, to define the types of integration and to consider what staff believe help and hinder such service developments. The theoretical framework I have developed is that integrated care considers the position of integrated care on a spectrum of exclusivity and inclusivity, and considers whether

integrated care can be considered as more widely applicable than presented in the literature (Kodner and Kyriacou 2000, Nies and Berman 2004, Billings 2005).

The next chapter considers a research approach and method for answering questions on the presence, nature and development of integrated care in community hospitals and community health services.

5   RESEARCH APPROACH

5.1 Introduction

In this chapter I review my research questions that have been refined following the three literature reviews. I provide an introduction to the two programmes under consideration as case studies. I consider options for carrying out research to answer these questions considering factors such as whether to undertake primary research or secondary analysis of existing data, sources of data, whether to undertake qualitative or quantitative analysis, whether to seek data from service users, staff or organisations, over what time period. I conclude that I will undertake a case study approach using secondary qualitative analysis on data from staff questionnaires, and will triangulate the findings using documentary sources. I assess the benefits and limitations of this approach, and in particular the need for objectivity given my previous role in both programmes. I set out a detailed method for each programme, identifying the data sources and how the research will be undertaken.

5.2 Research Questions

This research is seeking to answer three questions regarding community hospitals and community health services concerning the presence, nature and development of integrated care.

Presence: Is there evidence of integrated working?

Nature: What types of integrated care are evident?

What systems and processes are in place to support integrated care?

Which patients receive integrated care?

Which services demonstrate integrated care?

Development: How is integrated care being developed?

In this chapter I consider a number of research approaches to answering these questions and assess options by source of data, type of research, timescale and method. I conclude that the most appropriate method would be to carry out secondary analysis on data collected on 66 community hospital and community health services in two programmes in England and Ireland. The English programme was the Innovations and Best practice programme (I&BP) for community hospitals and provided published data on 48 services. The Irish programme, known as ICON, provided data on 18 community health services.

I considered that those best placed to comment about the delivery of integrated care would be the staff working in the services. There were few studies in the review of the literature on the reported views and experiences of staff, and this was an opportunity to add new knowledge (Coxon and Billings 2004). Questionnaires had been completed by staff in both programmes in order to evaluate the services. I had collected and analysed the primary data when undertaking a management consultancy commission (ICON) and as a voluntary committee member of the Community Hospitals Association (I&BP), and had access to the data, with reports and questionnaires in the public domain.

I needed to appreciate the differences and similarities between the disciplines of

management consultancy before designing a research approach. The literature review in

Chapter 2 has informed my transition from consultancy to research.

In undertaking the review of the literature on integrated care (chapter 3) I found that

there was not a universally accepted definition of integrated care, and that in many cases

it was context-specific. In the ICON programme staff had been invited to provide their

own definition of integrated care and this was available for analysis to help determine

the values, processes and outcomes of integrated care from the perspective of local staff.

Whilst the meaning of integrated care is not commonly agreed, there is agreement on the

multi-faceted nature of integrated care, with studies offering ways of categorising and

classifying integrated care. When reviewing the literature on community hospitals in

chapter 4, I found that the types most frequently referred to were integration between the

community hospital and: primary care; secondary care; social services; Local Authority;

patient; community and the third sector (Tucker 1987, Wilce 1988, Tucker 2006, Ritchie

and Robinson 1998). In addition, multidisciplinary team working is often referenced

(Tucker 2006, Higgins 1993, Heaney *et al*. 2006). I decided to explore the presence of

these eight types of integration in the data in 48 community hospital services as

discussed in chapter 4 section 11.

An additional way to identify the presence and nature of integrated care is to consider

whether there are systems and processes in place to support this way of working.   This

approach to use "proxy" measures to demonstrate integrated care in practice has been

supported by Ramsay and Fulop in their review of the evidence of integrated care

(2008). Sources in the literature review in chapter 3 typically referred to care management systems and information systems (Kodner and Spreeuwember 2002, Nies and Berman 2004). The ICON programme was designed to further develop integrated working in primary, community and social care in Ireland, and was focused on supporting staff in local services. The staff in the programme chose to develop eight integrated processes to focus on: common referrals, single assessments, care plans, single files, data sharing protocols, joint outcome measures, shared service information and training for team working (Tucker for Tribal/Secta 2005). I wanted to explore the presence of these eight components to support integration in community health services.

Factors helping or hindering integrated care are well documented and I wanted to assess the view of staff on the development of integrated care within the two programmes.

My reading of the literature led me to question whether integrated care was a way of working that was exclusive to particular client groups or services as many studies were only concerned with one group (older people), one type of integration at any one time, one service and one short time-frame (Lyon *et al.* 2006, Keating *et al.* 2008, Coxon and Billings 2004, Leichsenring and Alaszewski 2004). I developed my conceptual framework to test to what extent integrated care could be considered inclusive or exclusive and presented this in chapter 3. The two programmes as case studies provided data on who the service was for (by client age, service or condition) and what type of integration was in place to help answer this question.

In this chapter I consider the data from each programme that would help answer the research questions. I design an analytical framework based on the eight types and eight

processes. I assess the methods adopted for the collection of the original primary data in order to understand the context, quality and limitations of the data (Conti 2006). I then consider options for re-using this data, or subsets of the data, with an understanding of the context of its original purposes in evaluating services (Heaton 2004:59). Therefore this section describes in some detail the methods for both the primary and the secondary quantitative and qualitative analysis.

I consider the ethical implications of secondary analysis of this data. I provide a rationale for carrying out a secondary analysis of qualitative and conclude with an appraisal of the advantages and limitations of this approach.

5.3 Designing a Research Method

The setting of a precise research question is considered to be critical to managing subjectivity and establishing rigour in qualitative research (Holliday 2007:29). Holliday recommends three important steps: set the research question, develop specificity in the question and set out the wider agenda and context. The latter is presented in earlier chapters of the thesis.

The overarching research question for this thesis is as follows: "Is integrated care present in community health services, if so what is its nature and how is it being developed?" The first part of the question suggests description of whether integrated care is present or not. The answer would be a categorical response (yes/no) that could be counted. The second part of the question suggests a description of its nature and how it is being developed which would require collection of qualitative data. For descriptive

research it is also important to consider from which perspective the description will be provided, which adds specificity to the research questions.

Specifying the research question and research approach

Integrated care is experienced by patients and is often defined and distinguished as being person-centred, designed around individual need rather than the needs of organisations or staff. This would suggest that the patient may be the best source of data for describing integrated care. However patients were not always aware of the arrangements for their care. Further, in this thesis I have explored the difference between integrated services being offered to one particular client group (older people) which I have termed "exclusive." I have used the term "inclusive" to describe integrated care that is offered to all (universal) across a wide range of services and care pathways (comprehensive) in multiple types of integration and multiple systems to support integration (multi-faceted). To explore this difference further, the data describing integrated care would need to include data about the organisation as a whole. In particular the study seeks to illuminate the characteristics of integrated care in terms of types and components, and to determine who receives integrated care. Although the patient's perspective on the organisation might be insightful, those working in the organisation are able to provide richer data on what happens day to day in the organisation. A specific focus for the study is the relationship between the frequency of integrated care and the organisational context. For this, I therefore needed data for understanding the organisation as well as data on integrated care. A case study approach is suitable for understanding organisations (Yin 2003). Within the case study I focus on

collecting data that illuminates the nature of integrated care and how it is being developed.

I therefore need to consider a research method that will help me answer this question. My study seeks to identify the characteristics of integrated care in terms of types and components (processes), and to determine who receives integrated care. The wider agenda is the challenge of implementing and sustaining integrated working.

The consideration of research methods therefore follows the setting of the question and articulation of the conceptual framework.

Appraising Research Methods

In assessing research methods, I have illustrated the steps and approaches I have taken when considering options and alternatives, drawing from guidance (Robson 1993:xv11; Bowling 2003:126). I have shown the steps taken in the diagram below and underlined the chosen methodology.

Appraisal of Research Methods

A. Source of Data	D. Collect Data
Patients	*Collect new data*
Organisation	*Use existing data plus new data*
Staff	**Use existing data**

B. Type of Research	E. Type of Secondary Analysis
Quantitative	*Supra analysis*
Qualitative	*Re-analysis*
	Amplified analysis
	Supplementary analysis

C. Time	F. Method
Prospective	**Case study**
Retrospective	**Questionnaires & Documents**
	Content Analysis

Figure 2: Appraisal of Research Approaches

In the section below I expand on this diagram under the six headings.

A. Source of Data

The first consideration was the source of the data to help me to assess the presence, nature and development of integrated care. A logical source would be the patients themselves, as integrated care is often defined and distinguished as being person-centred, designed around individual needs rather than the needs of organisations or staff. However studies have shown that patients were not always aware of the arrangements for their care, and have an expectation of professional collaboration (Tucker and Burgis 2012). I considered assessing integrated care on an organisational basis, thereby researching integration on a strategic and management level. Staff questionnaires on partnerships have been utilised nationally such as those using the Partnerships Outcomes

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Evaluation Toolkit, which asked staff to describe their experience of partnership and their views of outcomes for service users (Dickinson 2008:63). Service users and carers are also asked for their views on outcomes (Dickinson 2008:64). I concluded that it was the staff providing services who were best placed to provide the data on whether they were working in a way which could be considered integrated. I therefore decided to focus on practitioners at an operational level.

B. Type of Research

As discussed earlier, integrated care is difficult to define, describe and measure (Ahgren 2005). This led to a decision to carry out qualitative rather than quantitative research. According to Bowling, "qualitative techniques are essential for exploring new topics and obtaining insightful and rich data on complex issues," which contrasts with quantitative techniques concerned with measurement (Bowling 1997:114). In answering the research question on whether integrated care is present, its nature and development requires an account within a context rather than specific measures. It has been said that all qualitative research contains an element of quantitative data in any event (Heaton 2004).

C. Timeframe for Research

The next step in my decision-making regarding the construction of the research study was to consider whether the research should be a prospective study utilising primary data or whether it should be a retrospective study utilising secondary data. My experience of working with staff in community health services in England and Ireland led me to consider using data that had been already gathered to evaluate standards,

quality and integration. One of the programmes required staff to complete

questionnaires at the start and end of their programme, providing an opportunity for a

longitudinal study (Tucker *et al*. 2005). This would be very difficult to replicate in new

research. Therefore there was a benefit of carrying out retrospective research, and in

particular in services over a time period of a number of years.

D. Primary Research or Secondary Analysis

I considered the option of carrying out primary research or secondary research so that I

could be confident that my research approach was the most appropriate way of

answering my research questions.

If this had been intended as a primary research study, I would have designed a

questionnaire for staff and framed the questions around my research questions in a way

in which the responses could have been recorded and analysed in a consistent way. The

question of whether integrated care was present could have been a section setting out

options requiring a yes or no answer. I would have based the study on a random sample,

which would have reduced any potential bias and made the overall findings more

generalisable. If designing a new questionnaire, I could have asked for responses on the

level of integration using the Leutz matrix with examples as evidence which would have

been highly informative (Leutz 1999). In a new study, there would have been the

potential to follow up questionnaires with interviews (telephone or face to face) which

would have enabled me to clarify, verify and contextualise the data more fully.

The disadvantages to creating a new study would be time, cost and potential disruption

to staff and services in carrying out such a study. A questionnaire would have to be

designed and piloted, and a random sample created. Given the number and range of community health services and community hospital services, this would have been a challenge. I could have designed a stratified sample such as by size of community hospital. In primary research, there is the potential for a low return on questionnaires.

I considered carefully the option of carrying out secondary analysis on existing data in order to answer my research questions. An advantage was that the data was readily available and that I had been involved in primary data collection I had knowledge of the process. Another advantage was that data within the questionnaires addressed my research topic. The availability of questionnaires for two programmes gave an opportunity for comparing and contrasting the experience and views of staff, thereby adding to the learning. In the review of the literature I had found a lack of studies on community hospitals and integration, and also few studies that considered integration from staff's perspective.

Disadvantages of re-using this data was that there are few research studies that have utilised data collected through management consultancy commissions and therefore there was little precedence for this, although there is a recognition of the value of this (Kubr 2004).

Given that I had access to existing data on a number of services, this represented an opportunity for detailed analysis. According to Holliday, it is recognised that experience in work can provide a context and an opportunity for study (Holliday 2007:41). Benefits of secondary analysis of existing data include the opportunity to carry out

comparative studies, longitudinal studies and avoid unnecessary duplication of data collection (Heaton 2004:27).

I assessed whether a combination of secondary analysis of existing data with collecting new data in order to fully explore the staff experience and to provide a current update in answer to the research question would be possible. This option was discounted on the basis of feasibility and access to all of the staff concerned. An assessment of the data fields in the questionnaires and in the documents led me to conclude that there the existing data would help to answer my research question.

E. Type of Secondary Analysis

I concluded that the secondary analysis of existing data would be categorised as "supplementary analysis", which is defined by Heaton as "a more in-depth investigation of an emergent issue, or an aspect of the data that was not fully considered in the primary study" (2004:38). This is contrasted with supra analysis which examines new theoretical or methodological questions, and re-analysis which can be undertaken in order to verify the primary analysis of data.

The existing data was held in two programmes, the ICON programme and the CHA Innovations and Best Practice programme. Data in the questionnaires was in the public domain along with reports and documents. A full list of available data for the two programmes is in Appendix E. I read all the material available, and "sorted" data sets that could help answer my research question.

In designing my research approach I have been mindful of the need to be systematic and rigorous (Robson 1993:303), to follow essential steps in the process and to show my workings at every stage (Holliday 2007:43). The decisions on methods have taken into account the context with respect to feasibility and appropriateness, considering the view that "The rigour in qualitative research is in the principled development of strategy to suit the scenario being studied" (Holliday 2007:8).

F. Research Methods

In order to answer the research questions, I considered that a case study approach to the two programmes would be most appropriate using thematic content analysis to analyse the data in the staff questionnaires. Triangulation would be carried out by analysing supporting documents in the programmes.

I have therefore chosen to analyse data from existing staff questionnaires and documents in a retrospective qualitative study to assess whether integration is present, its nature and characteristics, and how it is being developed. I also analyse the data to help determine where the 66 services in the two programmes sit on the spectrum of "exclusive to inclusive" as defined in the conceptual framework.

5.4 CHA Innovations and Best Practice (I&BP) programme

The CHA Innovations and Best Practice (I&BP) programme was established with funding from the Department of Health in England to "identify services that had "*made a differenc*e" and had genuinely contributed to the health and well-being of local people through constructive partnerships and joint working" (Tucker *et al.* 2000:6). The

programme was designed to identify traditional, established or innovative ways of joint

working, encourage good practice to be shared and promote evaluation of services. The

CHA gave 48 awards to community hospitals over the six years being studied, and has

provided information on the services through an annual publication of staff

questionnaires (Tucker *et al*. 2000, Marriott *et al.* 2001; Marriott *et al*. 2002; Jones *et al*.

2003; Jones *et al*. 2004; Jones at al 2005).

The following section describes the process adopted by the CHA to assemble the

primary data, so that an assessment can be made of the appropriateness of the data in the

questionnaires with regard to the research question, and also to the quality of the data

(Heaton 2004:93).

The CHA invited staff in community hospitals in the UK to complete an application

form describing their service and setting out why they considered their service to be

innovative or best practice. Staff described either a service within a community hospital

(such as a clinic), or a community hospital service for the whole hospital, or an initiative

that concerned more than one community hospital (Application Forms in Appendix C

and summarised in Tables 10 and 11).

The criteria for evaluating services for innovations and best practice were developed by

the author, based on the National Service Performance Framework, which included

efficiency, health outcomes, patient experience, and fair access (DH 2000). The criteria

are reproduced in Table 9 below and include team working and partnerships. Services

were rated by a panel against these published criteria using a scoring system (Tucker

2000:6). The panel analysed the staff applications and supporting documentation, in

order to assess compliance with criteria.

No.	Criteria for Evaluation of Submissions
1	Is the project innovative?
2	Is it more than just locally applicable?
3	It is a well planned proposal?
4	Are there benefits to patients?
5	Is there evidence of teamwork?
6	Is there evidence of partnership working?
7	Is there an audit/evaluation strategy?
9	Is there management support?
10	Does this help personal/professional development?
11	Does this contribute to health improvement?
12	Does the service improve fair access to services?
13	Does the service improve effective delivery of healthcare?
14	Does the service improve efficiency?
15	Is there evidence of improve patient/carer experience?
16	Are there defined improved health outcomes?

Table 9: Criteria for Evaluation of I&BP Submissions

The questions in the application form are listed in Table 10 and detailed in Appendix C.

The questions were "closed" questions at this stage, to enable a simple assessment of the

nature and scope of each project in order to consider suitability for a second stage

(Bowling 1997:246). The applications were not in the public domain.

Ref	Information Required	Options to be ticked / completed	Research Question
A	Project Name and purpose		Scope
B	How long has this project been running?	Commencement date	Duration
C	Which practitioners are involved?	13 professionals named plus "others please specify"	Types of IC
D	Which agencies are involved in this project	7 agencies named plus "others please specify"	Types of IC
E	Is this service being evaluated?	3 methods plus "others please specify"	Supporting Evidence
F	Please supply supporting documentation	8 documents plus "other please specify"	Supporting Evidence

Table 10: CHA I&BP Application Forms

The data in the submissions were assessed by a panel which was made up of CHA committee members and an independent member from the Queens Nursing Institute. As an example, in the first year of the programme, the CHA received 100 forms, and shortlisted 19 after assessing the applications against the criteria in Table 9, and verifying content with documentation received (Tucker *et al*. 2000). Up to 3 members of the panel, including the author of this research, visited the hospitals in order to verify the data in the submissions, which they did through interviews of staff, managers and patients as well as reviewing documentation and practice. Resource material provided by community hospital staff included policies, procedures, brochures, plans, service management tools and systems (Tucker *et al*. 2000). Therefore there was an audit trail and evidence to support the applications submitted.

The panel invited staff in those services considered of a sufficient standard for an award, to complete a questionnaire, referred to as the "proforma questionnaire." This questionnaire had open questions which enabled staff to describe their service in 2000 words. These questionnaires provided information on types of integrated care and how joint working was developed and were published by the CHA. This process was continued throughout the programme, and illustrates the steps taken to ensure the quality and accuracy of the data. It is this second questionnaire (Table 11) that is in the public domain and available for secondary analysis.

Section	CHA I&BP Proforma Questionnaire	Research Question
1	Summary of the project – background and purpose	Scope
2	What did you hope to achieve?	Scope
3	How did you go about it, and who did it involve? (professions, agencies, partnerships)	Types of IC
4	What helped?	Development – help
5	What hindered?	Development – hinder
6	What does the service offer?	Scope
7	What are the benefits to patients/carers?	Benefits
8	What are the benefits to the organisation?	Benefits
9	What methods have been used to evaluate the service?	Supporting evidence
10	What are the future plans?	Duration
11	What lessons are there for others?	Types & Duration
12	Contact details	N/A

Table 11: CHA I&BP Proforma Questionnaire

The programme was open to all 471 community hospitals in the UK. The panel made

visits to 87 shortlisted services in the first six years of the programme in order to verify

the information in the applications, assess the service and then grade services as either

award winners or highly commended. The Chair of the I&BP panel noted in her

foreword in 2004 that the panel membership had been consistent over the period (Jones

et al. 2004). Of the 296 applicants over the six years, 54 services were deemed to be

award winners. In keeping with the scope of this study considering integrated care in

community hospitals in England, the services that were submitted from Wales, Scotland

and Northern Ireland were excluded from the analysis. The table below illustrates the

number of applicants overall, and the subsequent grading by combining data from the

CHA publications (Jones *et al.* 2003; Jones *et al.* 2004; Jones *et al.* 2005).

Year	Awards England	Awards rest of UK	Highly Commended	Not Shortlisted	Total Applicants
2000	10	1	9	51	71
2001	9	0	3	38	50
2002	8	1	7	40	56
2003	7	1	4	22	34
2004	7	2	5	28	42
2005	7	1	7	28	43
Total	48	6	35	207	296

Table 12: CHA Submissions and Awards 2000-2005

The 48 questionnaires concerned 60 community hospitals and were completed by 68

staff individually, in pairs or in one case by three staff together. 78% of the staff who

completed the questionnaires were either nursing staff, managers, or nurse-managers

(Table 13).

Designation of Staff in Surveys	Number	%
Nurse	28	41%
Manager/Nurse Manager	25	37%
Doctor	3	4%
Therapist	8	12%
Not Known	4	6%
Total	68	100%

Table 13: Designation of Staff Completing I&BP Proforma Questionnaire

The Proforma Questionnaire was in the public domain, and I concluded that many of the

data fields could be interrogated in order to help me to answer questions about the types

of integrated care in community hospitals (Appendix C). The CHA publications of the

questionnaire included those services that were highly commended as well as those that

met the criteria and were given an award. As I wanted to research those that had

reached the agreed standard, I chose to analyse only the award winning services. I

therefore "sorted" a subset of the full data set (Heaton 2004:59).

The next section details the steps taken by the CHA in the process of collecting, collating and verifying the primary data, including data quality checks, interviews and verification using documentation so that the level of data trustworthiness may be established.

Primary Data Collection – Community Hospitals

In order to have confidence in the "trustworthiness" of the primary data (Robson 1993:66), it is necessary to know the source of the data, type of data, and the aim of the original data collection (Heaney 2004:104).

The data was sourced from questionnaires completed by staff in community hospitals. The CHA designed the questionnaires in order to capture quantitative and qualitative data in order to answer the question "does this service meet explicit CHA criteria to enable it to be considered an example of innovation and best practice."

The process adopted by the CHA for determining which services would be given the I&BP award is described in the CHA publication (Tucker *et al.* 2000). The process was applied throughout the 2000-2005 period of the programme, and primary data was generated from a questionnaire in order to assess services for an award. As the designer of the process and a member of the panel in the first two years, I undertook visits to community hospitals within the programme.

CHA Innovation and Best Practice Award Process
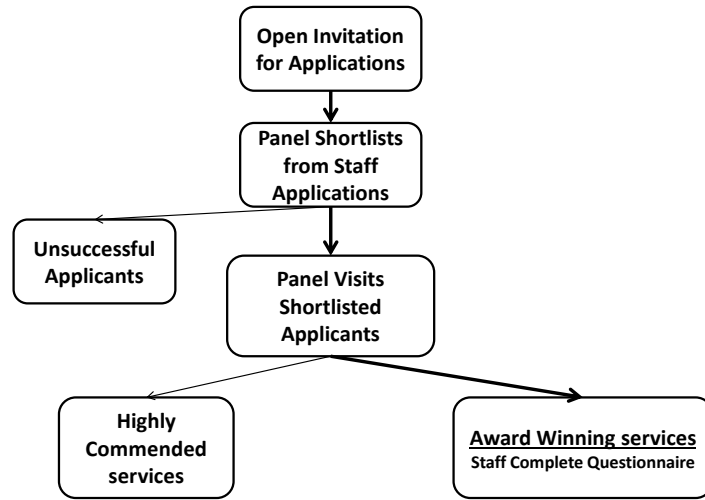
Figure 3 CHA I&BP Award Process

The table below sets out the stages in the process which were in place to provide verification of the data using empirical evidence from independent parties as well as triangulation with several sources of data including documentation. The presentation of the collection in tabular form below describes the stages and offers a view on the advantages and limitations and scope for improvement in the process.

CHA Award Process	Strengths of data collection process	Limitations of data collection process	Scope for Improvement in data collection to optimise trustworthiness of data
1. Open Invitation to Apply CHA advertised the programme through their website, newsletter and conference. Criteria were published and awards categorised by type of service (i.e. rehabilitation and palliative care). Applications forms available through the CHA.	Applicants volunteered to be part of the process and there was a high level of co-operation.	Applicants were self selecting, and this introduces a potential bias and reduces the extent to which findings may be considered generalisable (Bowling 1997:211)	Would consider ways of categorising awards by geography, and size of hospital in order to encourage diversity and comparisons (Tucker *et al*. 2008).
2. Shortlist by Panel CHA panel shortlisted from application forms, assessing compliance with criteria. The panel was 5 members consisting of 4 CHA committee members and an independent member from the Queens Nursing Institute (Tucker *et al*. 2000)	Panel had range of skills and experiences and provided consistency throughout the programme. Independent member offered external verification.	Reliance on skills of a small panel, given the diversity of services in community hospitals.	Consider accessing a wider membership as required, such as for social care and specific clinical skills.
3. Visit to Community Hospital Service by Panel members Panel (up to 3 members per visit) met	A planned meeting so that team members could be present. In tone a friendly exchange of	Visit was planned so staff could prepare evidence to support	Unannounced visits and spot checks may have provided a further level of validation.

staff concerned as a team, and interviewed collectively and individually in order to clarify and verify the application	information rather than a formal interview	their claims. Interview could be more formal and recorded.	Recorded interview notes would enable further checks.
4. Verification by Observation and Documentation Panel provided with supporting documentation which provided evidence of way of working. Panel requested copies of any evaluations of the service. Also panel were shown accommodation, facilities and equipment to support the service.	Documentary and empirical evidence to enable the panel to verify the content of the application, assess the context of the service and ensure there was data by which to measure compliance with each of the 17 criteria.	Not all services were being formally evaluated or monitored outside of this process, and therefore the availability and quality of supporting documentation varied.	CHA could offer further advice on standard documentation required.
5. Assess Service Against Criteria by Panel Using a scoring system, panel determined services that were deemed to be either highly commended or worthy of an award.	Clear criteria in the public domain and included evidence of partnership working and evidence of team work	The scoring system was not weighted, so each criterion given equal standing (Robson 1993:67)	Additional questions could be included on the specific types and levels of integrated care. Criteria could be weighted, to give more weight to agreed criterion (Tucker in Meads and Meads 2001:108).
6. Questionnaire Submitted by Award Winners and Validated by Panel Those winning the award for their category were asked to complete a questionnaire with open questions enabling the service to be assessed in context. The content was checked by the panel and by the submitting organisation in preparation for being published.	Staff completed a questionnaire following the visit, reflecting the application form, the measures against criteria, the panel visit and discussion and the learning from the overall process.	There are challenges to accuracy in self completed questionnaires (Robson 1993:243) although this process incorporated checks by the panel and the submitting organisation	The timing of the completion of this questionnaire may be improved if done before the visit
7. Dissemination of Innovations and Best Practice Staff whose services attracted the award were asked to give a presentation at the CHA national conference. The questionnaire was published verbatim in an annual publication.	Staff agree to complete the questionnaire and speak at the conference at the start of the process therefore were open to questions and discussion.	The dissemination is focused on the CHA community hospital network and is not shared within a wider audience	Scope to open the award-winning services to further scrutiny and learning if shared with a wider range of audiences

Table 14: CHA I&BP Strengths & Limitations of the Data and Potential Improvements

The process adopted by the CHA was one which had a number of checks and verification stages, and therefore the data can be considered to be "trustworthy," within limitations (Heaney 2004:66).

The data set also needs to be shown to be "suitable" in order to answer the research question. In the secondary analysis, the data from the CHA questionnaires has been used to answer a different although supplementary question. The question posed in the primary data collection was whether the service met criteria for innovation and best practice, such as evidence of integrated care. This data set has been further analysed to

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try and answer supplementary questions specifically focused on integrated care, namely whether it is present, what is its nature and how is it being developed. As confirmed by Heaney (2004:59) data fit is more likely to be appropriate for supplementary analysis of primary data, rather than supra analysis, re-analysis, amplified analysis or assorted analysis (Heaton 2004:38).

The process described above was deemed to be appropriate by the CHA for the purposes of assessing services against award criteria, and provides a level of confidence in the primary data for secondary analysis. However, it is recognised that the primary data was not collected for the purposes of research, but was collected as part of a process of evaluating the service against set criteria (Bowling 1997:372). Although this is a limitation, I believe that there are sufficient checks on the accuracy of the data to merit further analysis for this research study. As Bowling has advised, data from documents for secondary analysis cannot be relied upon to be a completely accurate representation, but if the process of construction is taken into account as well as the context, such data can be a valuable source about society (Bowling 1997:372; Kiecolt and Nathan1985:75).

A further check on the quality and accuracy of the data was the involvement by the researcher in both the primary and secondary analysis of a data set, which was in depth in the first year as a member of the panel. This is perceived by Heaton as a positive attribute, as researchers had "firsthand knowledge of the context in which the data were originally collected and analysed" (Heaton 2004:36). The explicit methodology and acknowledge of shortcomings means enables the data and findings to be considered accordingly and in context (Coxon 2005).

I considered the ethical implications of using this data. Although the data is in the public domain, I wrote to the Chief Executive of the CHA requesting support for the research, which was given (Appendix A). Community hospital staff had been advised that one of the aims of the programme was to encourage research and evaluation, and to disseminate information on community hospital services, and therefore this research would be in keeping with the original aims of the programme on terms that staff had agreed to (Tucker 2000:7). The data provided an insight into the work of staff in community hospitals and their partnerships, and this had not been recorded in this way before. I therefore considered, on balance, that I would re-use the data in the questionnaires to pursue my research questions on integrated care (Heaton 2004:42).

In summary, the primary data available in the public domain from the CHA I&BP has been assessed regarding access, quality and suitability and considered to be appropriate for secondary analysis to help answer questions on integrated care in community hospitals. Staff views on community hospital services in England have been collected for previous research (Tucker 1987) but has been rarely undertaken. The availability of this data represents an opportunity to contribute new knowledge from the perspective of those working in the service (Coxon 2005).

5.5 ICON – Community Health Services Programme

The ICON programme was designed to promote integrated primary and community care, including social services, in the Midlands area of Ireland, to build on existing levels of integration, and address areas where integration was less developed for its population of 225,000. This programme was unusual in that it was organisation- wide

and involved a range of services for a range of client groups. Therefore knowledge

gained form researching this programme would represent a new contribution to the field,

in an area where integrated care is typically located in discrete projects for specific

clients. The programme was supported by the author acting as a management

consultant, and was reported in full in a series of management reports written by the

author, which were published online and are therefore in the public domain (Midland

Health Board/Secta Consulting 2003a; Midland Health Board/Secta Consulting 2003b;

Tucker for Tribal Secta2005). The programme was also published in a series of articles

in the Journal of Integrated Care and the International Journal of Integrated Care

(Tucker *et al*. 2004a; Tucker *et al*. 2004b; Tucker *et al*. 2005). The following

description of the programme and the source of the primary data for secondary research

is taken from these reports and papers.

The Midland Health Board (MHB) was prompted by the need to improve the quality and

consistency of care, and by the requirements of the Freedom of Information Act 1998

and 2003 which exposed the lack of systematic care management and recording.

Another driver was the pressure to develop information technology systems to support

clinical work, and their initial specifications illustrated the disparate ways of working

(Tucker 20064b). The MHB formed a project board and project team, and started the

programme with the circulation of a discussion paper on integrated care (Tucker 2003).

In phase 1, a questionnaire was designed by the project team to assess staff's

understanding and experience of integrated care, identify good practice, and stimulate

some interest in partnership working. The questionnaire was piloted, refined and

finalised (Bowling 1997:242). The questionnaire was circulated by members of the

ICON project board to managers and practitioners, and was available to download online from the MHB website. 63 questionnaires were received setting out staff views and experience of integrated care in Phase 1, the start of the programme. A summary of the data fields in the questionnaire is shown in Table 15.

Ref	Question	Detail
A	Interviewee details	Contact
B	Service Responsibility	Scope
C	Current Service	In particular teams, partnerships, links and collaborations
D	Team working	Examples of teams or service links: inter-professional, multidisciplinary, multi-agency, academic and any other
E	Good practice	Up to 3 local examples of good practice and planned service developments
F	Integrated Care	What does integrated care mean to you?
G	Models and Features	Any models of good practice?
H	Key Features	Key features of integrated primary and community care
I	SWOT analysis on integrated care	Up to 3 examples of the strengths, weaknesses, opportunities and threats of integrating care in your service
J	Implementing models of integrated care	What would you need in place to develop integration further?
K	Additional considerations	Additional comments, evidence, documents, models etc.

Table 15: ICON "Baseline" Questionnaire 1 at start of programme

The project team were available to answer queries on the questionnaire, and the questionnaire had clarifications and guidance notes (Appendix D). In the primary study I analysed the questionnaires in order to establish a baseline of practice which would then provide a measure for any progress within the programme. The questionnaire was analysed within the "7S" framework (Iles and Sutherland 2001), and reported that the staff viewed that the strategy, staffing and style of the organisation was appropriate for integrating care, but that systems and structures were most frequently referred to as either weaknesses or threats. This led to a focus on processes and systems (MHB/Secta Consulting 2003b). The results of the analysis of the questionnaires were shared with 119 staff in 6 workshops (Table 16), giving an opportunity for discussion, validation and interpretation. The workshops had a representation for each client group and staff

group. Staff gave presentations in these workshops of their view of fragmentation and

integration using patient case studies, within a pre-determined framework (MHB/Secta

Consulting 2003b).

Staff	No.	%	Client Group	No.	%
Managers	44	37%	Primary care	30	25%
Doctors	10	8%	Mental health	21	18%
Nurses	29	24%	Disabilities	19	16%
Therapists	30	25%	NGOs	18	15%
Social workers	6	5%	Children	13	11%
			Older People	18	15%
Total	119	100%		119	100%

Table 16: Attendees at Workshop by Position and By Care Group

Question F was phrased *"What does integrated care mean to you?"* and the responses to

this particular question were analysed and the results used to help frame a definition and

description of integrated care for the MHB (Tucker for Tribal Secta 2005). In view of

the importance placed on the responses to this question, I have chosen to re-analyse the

data from this question.   In keeping with the findings of the literature review on

integrated care, I have categorised the staff responses to the meaning of integrated care

in three ways: by values, process and outcomes.

In phase1 of the ICON programme, I developed the ICON diagram (Figure 14) which

was a visual representation of the most frequently referred to components and definition

of integrated care recorded by staff in Question F (Tucker for Tribal Secta 2005). In the

secondary analysis I have undertaken a more systematic secondary analysis of the data

from this question and coded each of the responses by content. This data provides an

insight into the question of what integrated care means to staff, which is an important

perspective for this research. This is particularly so given that efforts internationally to

identify a universally applicable definition of integrated care have not succeeded (Leichsenring and Alaszewski 2004:15). A re-analysis of the primary data using a different methodology has been undertaken to make full use of the staff contributions and to consider whether the ICON definition, description and diagram is fully representative of staff contributions. This analysis will be an important contribution to the question of what integrated care means to those working in the services.

Phase 2 of the ICON programme was concerned with improving internal systems and preparing the way for Phase 3, such as by designing and agreeing a data sharing protocol for the MHB (Tucker for Tribal Secta 2005).

Once preparations were complete, phase 3 was launched with an invitation to staff to consider joining the ICON programme. The focus of this phase was to support staff in the re-design of their services in order to further develop integrated working. Staff attended a workshop where the opportunities, benefits and implications of being a part of the programme were discussed. 18 teams volunteered to take part. Directors and senior managers agreed to "sponsor" a team which meant that they would take a personal interest in particular teams and become a link between the teams and the project board (Tucker 2005).

A programme of work had been devised by staff and the ICON project team. They identified eight components (systems and processes) that, if re-designed and aligned, would facilitate integrated working. These were: open referrals, common assessments, care plans, outcome measurements, a single file for clients, shared information protocols, service information in directories and training to support team working. The team leaders were invited to monthly seminars which were designed to be educational,

participative and supportive (Tucker for Tribal Secta 2005). Team leaders completed the following questionnaire at the start and end of the nine month programme of Phase 3. Staff recorded their views on their progress with implementing the systems in questions 6-16 in Table 17.

No.	Questionnaire for Team Leaders	Research Question Processes to support IC
1	The name of the team	Service Defined
2	The team leader	Team leader
3	How long the team has been in operation?	Sustainability
4	Does the team have its own cost code?	N/A
5	Who are the client group seen by the team?	Client and Age Group
6	How are people referred into the team?	Referral process (1)
7	Are there clear referral procedures?	Referral process (2)
8	How are client notes maintained?	Single file (1)
9	Does the team have a common assessment process?	Common assessment process
10	Are client reports multidisciplinary or unidisciplinary?	Single file (2)
11	Does the team use a data sharing protocol?	Information sharing protocol
12	Does the team agree a care plan with the client/carer?	Care planning
13	Does the team measure outcomes?	Outcomes measurement (1)
14	Has the team attended team building training?	Team building
15	Has the team carried out a patient satisfaction survey?	Outcomes measurement (2)
16	Does the team have an information brochure for service users?	Service Information

Table 17: Questionnaire for Team leaders in ICON teams

At the end of Phase 3 I analysed the responses to the questions and carried out a simple evaluation of staff-reported progress in tabular form in the report (Tucker for Tribal Secta 2005). This was reported back to staff, and discussed and validated within the monthly team meetings (Tucker for Tribal Secta2005).

I considered that there would be new learning if I re-analysed the primary data in more detail using a systematic approach, utilising staff comments within the questionnaires in order to contextualise their responses. I also wanted to analyse data on a sample of teams as embedded case studies in order to explore more fully the issues of putting

processes and systems in place and developing integrated working (Yin 2003:40). The

report evaluating the ICON programme analysed progress made collectively, rather than

studying teams individually (Tucker for Tribal Secta2005). I wanted to consider more

carefully the impact of changes in processes and systems on the way of working for staff

working in these teams. In order to verify my findings, I have cross referenced using

nine sources of primary data including questionnaires, reports and records (Table 18 and

in Appendix E).

Records	Type	Date
Q1	Baseline questionnaire Phase 1	
Q2a	Questionnaire 1 Phase 3	Nov-04
Q2b	Questionnaire 2 Phase 3	Jun-05
ALS	Action Learning Set Records	May-05
TR	Team records	May-05
P1	Presentation by team leaders	Nov-04
P2	Presentation by team leaders	Jun-05
MHBa	MHB/Secta Consulting 2003a	2003
MHBb	MHB/Secta Consulting 2003b	2003
TS	Tucker for Tribal Secta 2005	2005

Table 18: Sources of Data for ICON

Within the ICON programme there were other datasets for the evaluation of the ICON

programme that I considered accessing and analysing in order to help answer my

research question. For instance, questionnaires had been completed by senior executives

on the project board. However I wanted to research the views and experiences of

practitioners and local managers, and did not want to lose that focus. There were also

data within systems maps which were diagrams staff created in order to visualise

integrated care. These proved to be a creative way of exploring the service

improvements required (MHB/Secta 2003). I undertook data analysis of the systems

maps by coding content and analysing the content of each diagram (Holliday 2007:66).

The visual systems maps reflected relationships and priorities that were difficult to

capture in an analysis. My initial findings from this analysis however did not add any

new knowledge to my study, and I have excluded this from my thesis. I have provided

the rationale for this for a sample of documents in Appendix E.

Overall, the ICON programme was carried out in an open and transparent way, with

reports and documents disseminated widely and available online (Tucker for Tribal

Secta 2005). This open sharing of the work of the teams and their progress with

integration has enabled access to datasets and supporting documentation, either within

my own records or online. With regard to ethical considerations (see 1.9) permission

was sought from the Chair of the ICON project board, who wrote supporting my

research (Appendix B).

The ICON programme was designed to generate knowledge whilst stimulating change

and improvements and as such could be considered to be social action research (Iles

2001:66). The data from staff questionnaires provide a primary data source for

secondary analysis, whereby data on the definition of integrated care and understanding

the processes and systems to support integrated care could enable my research questions

to be more fully explored.

5.6 Analytical Framework for Research Question

The research questions and data sources are shown by programme in Table 19 below.

No	Question	Topic	Data source data for secondary analysis	Programme
1	What is the definition and meaning of integrated	Presence	63 "baseline"	ICON

	care?		questionnaires	
2	What are the types of integrated care?	Nature	48 questionnaires	I&BP
	What are the component parts and processes?		36 questionnaires (18x2)	ICON
3	Which factors helped or hindered service development?	Development	48 questionnaires	I&BP
4	Who is Integrated care for?	Inclusivity	48 questionnaires	I&BP
			36 questionnaires (18x2)	ICON

Table 19: Research Questions and Data sources from ICON and I&BP Programmes

This table summarises the questions and sources. This is also shown in the flow chart in Figure 1.

- **Analytical framework - Types of Integration**

The analytical framework for the community hospital study was a typology that I have developed for this study based on the findings from the literature review and from experience. I was unable to find any publications that combined the types of integration into a single framework for understanding community hospital services and their networks, and therefore designed this framework for this study. My research was designed to examine which actors and agencies work together, both within and around the community hospital, focusing on eight types of integration. Many research studies focus on one specific type of integration but this study is unusual in that it examines eight types of integration simultaneously. The eight types are shown by code and description, with key sources from the literature (Table 20).

No	Types of Integration with CHs	Code	Description	Source
1	Multi-disciplinary	MDT	Two or more professions or disciplines working together	Ritchie 1996; Seamark *et al*. 2001; Heaney *et al*. 2004; Tucker in Mead and Meads 2001:111.
2	Social Services	SS	Practitioners in health and social care working together	Heaney *et al*. 2006 ; Higgins 1993:40.

3	Multi-agency/third sector	MA	Third sector partnerships such as voluntary agencies and private companies in health and social care	Wilce 1988:127; Higgins 1993:40.
4	Local Authority	LA	LA services such as housing, transport & leisure	Wilce 1988:66 ; Emrys-Roberts 1991
5	Patient	PT	Proactive partnership with patients and clients	Ahgren 2003; Leutz 1999; Wilce 1988:6;
6	Community	COM	Proactive role for community collectively such as through Leagues of Friends	Higgins 1993:40 ; Meads 2004; Wilce 1988:127; Tucker and Bosanquet 1991; Higgs 1985.
7	Primary care	PC	GPs and primary care team working with community hospital staff	Heaney *et al.* 2006; Higgins 1993; Dawson 1920; Bennet 1974; Cochrane 1972; Seamark *et al.* 2001;
8	Secondary care	SC	Specialist staff based in acute hospitals working with community hospital staff	Hadridge 1997; Wilce 1988:43; Higgins 2003:40; Heaney 2006

Table 20 : Eight Types of Integration in Community Hospitals

The analytical framework for types of integrated care is shown below in figure 4.
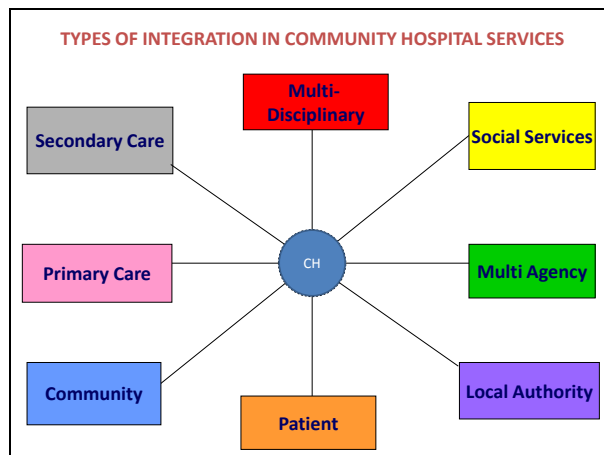
Figure 4: An Analytical Framework for 8 Types of Integration

The diagram is colour coded, for ease of identifying patters although is limited in that it does not show relationships or interdependencies, and simplifies the complex team working across services.

– **Analytical Framework - Processes Facilitating Integration**

Eight processes focused on point of care make up the analytical framework for the study and were identified as a priority by practitioners and local managers as important to supporting integrated working in Irish community health services (Tucker 2005). Processes identified within the programme that staff chose to try and develop reflected those in the literature. The sources for each process are shown below.

Processes Facilitating Integration	Code	Description (Processes developed from literature review findings and also ICON programme priorities defined by staff)	Source
Referral	REF	Open referral between patients and practitioners	Nies and Berman 2004:120-121; Drumm 2008
Assessment	ASS	Common assessment process for professionals from different disciplines to share	Lloyd and Wait 2005; Nies and Berman 2004:120-121; Alaszewski *et al.* 2003
Care Plan	CP	Care management process with a care plan	Thistlethwaite 2008; Oewens *et al.* 2005; Kodner 2004; Green *et al.* 2005; Lyon *et al.* 2006
Outcome measurement	OUT	Processes for measuring outcomes including patient/client experience and health outcomes, staff satisfaction and service improvements	Green *et al.* 2005; Bernabei *et al.* 1998; Kodner and Kyriacou 2000; Leichsenring and Alaszewski 2004:88-89.
Single File	SF	A single client record combining multi-disciplinary input	Nies and Berman 2004:120-121; Thistlethwaite 2008
Data Sharing System – client	DS	A process or protocol for sharing client data	Lloyd and Wait 2005; Kodner 2002; Grone and Garcia Barbero 2001
Service Information	SI	A process for sharing information on services – availability, eligibility, access etc.	Oewens *et al.* 2005; Kodner 2002; Leutz 1999
Team working	TM	A process to support teams and team working, such as training	Kodner 2004; Audit Commission 2002; Freeman 2003; Drumm 2008

Table 21: Eight Processes Facilitating Integrated Care

The processes prioritised by staff provide a basis for developing systems for care management, information management and team building in order to facilitate integrated care, and are shown in the framework below.
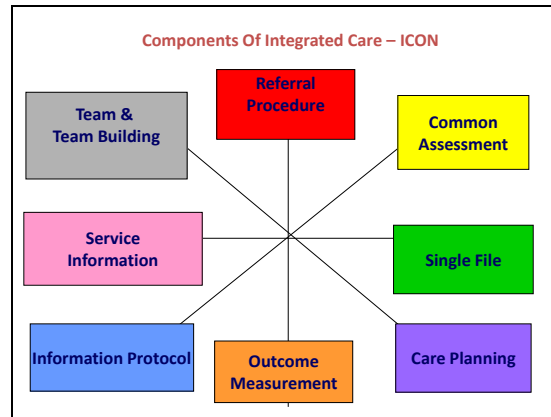
Figure 5: An Analytical Framework for 8 Processes in Integrated Care

The diagram provides the basis for an assessment tool and is developed later in this study.

5.7 Assessment of Methods

I considered a number of research approaches before designing the method for analysing the data in the questionnaires. In particular, I wanted to assess whether the programmes would be appropriate as case studies, and whether it was appropriate to carry out secondary and retrospective analysis on data collected for another purpose. I reviewed the literature on research methods, and considered how best to analyse survey data on staff views using qualitative and quantitative analysis. I considered other research studies and their approach to analysing staff perspectives, and their use of methods such as pattern matching. Finally, I looked at the value of triangulation, whereby different data sources and multiple methods can be linked in order to improve the quality of analysis and findings.

– **Case study**

I wanted to explore whether a case study approach was appropriate for the two programmes. Case study is a strategy for research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence (Yin 2003; Robson 1993:5). Each case study requires a defined and delineated setting, bringing together factors such as values and social cohesion (Holliday 2007:34). The two programmes could be considered to be bounded systems, as they are delineated (Holliday 2007). Multiple sources of evidence are considered to improve case study research (Yin 2003:93), and the two programmes have drawn on multiple sources for validating the primary data including staff surveys, records, presentations and reports. The 66 teams and services within the two programmes provided embedded case studies which can be used in order to contextualise the findings (Bowling 1997:362). Case study data brings together different forms of data and permits the study of subjective experiences of staff and users as well as objectively identifying characteristics (Yin 2003:109). Studies that have adopted a case study methodology in order to determine staff experiences and knowledge have provided a useful basis on which to design an appropriate methodology for this secondary analysis (Coxon 2005).

– **Secondary analysis**

Data were available for re-use or secondary analysis from questionnaires that had been completed by staff in both the ICON and I&BP programmes. Secondary analysis has been termed an approach that uses old data to test new ideas and test new frames of

reference (Hakim 1982; 16), or to re-examine data using new techniques (Hakim 1982:149).   It can be the further analysis of an existing data set with new questions that differ from the primary study (Bowling 1997:282). In a literature review of 65 studies of secondary qualitative analysis, 60% of the studies were defined as carrying out supplementary analysis, which was defined as being closely related to, and extending, the analytical remit of the primary study (Heaton 2004:42).

The focus for the primary analysis was to evaluate services against criteria (I&BP) and teams against objectives (ICON) and disseminate the learning on a local and national basis. Within the evaluation of services and teams in both studies, an analysis was made regarding the presence and development of integrated care. For this study, the focus for the secondary analysis is to answer specific research questions on the types and components of integrated care, and to consider the concept of inclusivity.

Secondary analysis of primary data is a method adopted in quantitative studies such as from Government surveys and population census data (Hakim 1982:6). Secondary analysis of qualitative data is becoming more widely used (Conti 2006). Some of the most successful health studies rely purely on existing data sets and do not require the collection of any new data (Hakim 1982:152).   Advantages of carrying out secondary analysis of available data are cited as saving time and effort, avoiding duplication, and enabling money to be channelled into other unexplored fields (Moser and Kalton 1971:43). Optimising the utilisation of the data by re-analysing it from the perspective of new or additional questions can prove to be very productive, and in the context of health care services has avoided unnecessary disruption to patients and public services.

The benefits of carrying out secondary analysis on data that are already available are becoming more widely appreciated, as data sources are becoming more accessible, although there is a concern that this is leading to research being studied extensively where data sets are available, whilst other areas are ignored (Moser and Kalton 1971:43). There is a view that the inherent difficulties in utilising survey data collected for another purposes is outweighed by the opportunities presented by pre-existing data Kiecolt and Nathan (1985:75). Advantages of primary research include the opportunity to design the study to answer the research question, use pre-coded themes and tailor the study appropriately (Bowling 1997:255). Therefore the research can be designed specifically to answer the research question. When using pre-existing data for analysis for another purpose, this can present a compromise in the study. For ICON and I&BP, the source, method and validity of the primary data were known, and data were readily available. The advice given on secondary analysis is to be aware of data limitations, keep an open mind, be creative in approach, and design a research approach that is appropriate (Kiecolt and Nathan 1985: 76).

There is increasing interest in utilising primary data for secondary analysis. The UK data archive contains both quantitative and qualitative data that are accessible for researchers (Heaton 2004:21). There is also interest in the methods, resources and tools for re-analysing qualitative data (Conti 2006). The ESRC requires applicants for research funding to demonstrate that they have considered utilising existing data rather than collecting new data, and therefore secondary analysis is being encouraged (Heaton 2004:23). In an earlier paper, Heaton set out four methodological and ethical considerations: the compatibility of the data with secondary analysis, the need to report

both the original and the subsequent analysis in full, the appropriateness of consent given in the primary study that can apply to the re-use of the data, and the position of the secondary analyst who is preferably a researcher who was involved in the primary study (Heaton 1998).

 The availability of data in questionnaires and associated documents from the two programmes presented an opportunity to explore new research questions. I have chosen to carry out qualitative and quantitative secondary analysis as a supplementary analysis to the primary study, using data in the public domain that is also within my personal collection (Heaton 2004:12).

- **Survey Data**

The questionnaires were completed by staff without any interviewer present, using a method that represented a non-intrusive and non-reactive approach, limiting any negative impact on staff time and services (Robson 1993:272). The lack of an interviewer reduced the risk of bias (Bowling 1997:230), although this limited opportunities for staff to expand on their answers in essentially a very complex area of health and social care. A number of open-ended questions without pre-coded response choices were used, a technique applied when replies are unknown, too complex or too numerous to pre-code (Bowling 1997:245). Moser and Kalton identify limitations and challenges with posing open ended questions, pointing out that respondents will provide different amounts of information and different items which is a challenge to compress qualitative data into a code category (1971:343).

- **Staff Views**

Studies of service initiatives to progress integrated care have been undertaken (Bernabei *et al*. 1998, Hebert *et al*. 2005, and Kodner and Kyriacou 2000), but few research the perspective and views of staff (Billings *et al*. 2003, Coxon 2005, Workman and Pickard 2008). Staff experiences and perspectives were drawn out in a study which presented issues within the themes of service development and service-specific issues. These identified factors in the development and staffing of intermediate care services using themed content analysis of factors identified by 160 staff from workshops (Nancarrrow 2004). Coxon makes the case for these types of studies "it remains important to examine the views and experiences of front line staff who are in daily contact with service users and whose insights can help inform the development of stable and sustainable integrated services" (Coxon 2005). Coxon's study was a comparison of staff views of the advantages and disadvantages of working in an integrated service model in nine countries, identifying benefits and disadvantages and stratified by models of cross-agency integration and single organisation integration models (Coxon 2005). The methods adopted for these studies have provided a useful precedent for the design of my study.

- **Content Analysis**

According to Heaton, whilst secondary analysis in respect of increasing knowledge has received attention, there has been little attention on methods for re-using qualitative data (Heaton 2004:89). In Heaton's research of 65 health and social care studies, the most frequently recorded method used was content analysis (Heaton 2004:97).

Content analysis (or textual analysis) was undertaken of the survey data, using thematic coding (Flick 2009:319). The research questions and analytical frameworks for each of the programmes were defined in such a way that the data could be analysed selectively for the questions being posed. For instance, survey data in the CHA programme were analysed for the presence of each of eight types of integration. This complied with the findings of Bowling, who advised that objectivity could be enhanced by having a coding system that had explicit rules and set out which data were to be included or excluded according to categories of interest (Bowling 1997:378). In the example of the I&BP programme, terms or phrases staff recorded to describe integrated care were recorded, and these were pre-themed into eight categories, referred to by Bowling as recording units (1997:378). The verbatim reference to a type of integration was recorded, reduced to a term and then categorised in one of the eight categories. Electronic records were available for cross checking and validating, with terms and phrases for integration being used being recorded as data units, and coded accordingly (Flick 2009:318). Thematic coding of data was undertaken, requiring several steps of checking and cross checking, carried out through repeating the coding, checking accuracy and assessing any anomalies (Flick 2009:319). Credibility checks include prolonged involvement with the subject matter and triangulation (Robson 1993:404). For ease of visualising patterns, colour coding was adopted (Robson 1993:401). Verbatim extracts were recorded and utilised in the findings where appropriate to contextualise findings (Bowling 1997:302). Embedded case studies illustrated the findings of the study (Bowling 1997:362) following Yin's guidance that they must be significant, complete, consider alternative perspectives, display sufficient evidence and be engaging (Yin 2003:165). Documents

were available for each programme and sourced to check and interpret findings (Flick 2009:255). This multi-method approach, as advocated for case studies, helps to illuminate the topic of integrated care and can crystallise a rich picture, particularly in complex situations (Thomas in Kernick 2004:328). Therefore the content analysis of the data provided a method for recording and analysing types and processes of integrated care, as well as staff views of the meaning of integrated care and the factors influencing its development.

Content analysis was a method adopted for carrying out an international comparison of staff views of the advantages and disadvantages of working in an integrated service (Coxon 2005). In this study, coding for types and processes were deductive, whilst the themes identified in the survey accounts of factors helping or hindering the development of integration were inductive. Bowling makes the case that one of the advantages of inductive coding is that categories can be developed that reflect the richness of the data, rather than trying to fit data into predetermined categories (Bowling 1997:296).

In order to demonstrate the method I adopted for identifying and interrogating the data, I have taken two services and described the process for content analysis. The method is described as a procedure for analysing textual material, using categories and reducing the material to enable qualitative analysis (Flick 2009:321).

In order to illustrate the method I employed to identify and categorise the eight types of integrated care, I have written a synopsis of services as recorded by staff in the questionnaire using their words and terms as far as possible in Figure 6 and 7. These

synopses serve to illustrate the methodology for identifying community hospital services and partnerships.

For the research, I analysed recorded data in full from the 48 questionnaires and not from a synopsis. The first service is a community hospital in Cheshire, described as a Health Promoting Hospital. I coded each reference to any of the eight types of integration in the framework, marking the code in the hard copy in the publication, and also recording it on an excel spreadsheet. The types of integration as coded are given in the box below (Figure 6). The staff's account of the service provided examples of each of the eight types of integration being studied, which were the themes being identified and recorded. All questionnaires were given a unique code, and the example below is 36/04/H, which is the number of the award (36), the year (2004) and the category (health promotion).

Health Promoting Hospital (36/04/H)

The community hospital aimed to build health promotion into all activities for patients, local residents and staff and gave many examples of joint working in order to promote a public health agenda in the hospital and the community. Community hospital nurses, specialist nurses and physiotherapists provided post-operative breast-care hydrotherapy *(multidisciplinary integration).* Courses were run for the community by St John's Ambulance service with hospital staff, such as baby safe courses for new parents in order to prevent accidents *(multi-agency integration).* An "Exercise on GP Prescription" initiative was supported by GPs *(primary care integration).* There were a number of community support groups initiated and supported by local people and staff working together, such as for Back Pain, Multiple Sclerosis and Lymphoedema and carers supported through a new Carers Centre *(community integration).* Patient involvement was promoted through the expert patient programme, and services influenced by patient satisfaction surveys and discovery interviews *(patient integration).* The questionnaire described partnership working with the local borough council such as linking with local leisure facilities and planning "vintage leisure" and programmes for physical activity for older people *(Local Authority integration).* The staff recorded the role of external partners in

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planning and developing the service such as social services *(social services integration).* The service is described as enabling local access to primary, secondary and voluntary agency services, and is a community hospital that is managed as part of an Acute Trust enabling specialists to provide information and advice to both staff and patients *(secondary care integration).* Staff recorded the importance of developing "partnership links with health, social and Local Authority and outside agencies, to set priorities and work together in achieving goals to improve holistic care."

Figure 6: Illustrative Example of Method for Content Analysis (1)

The second example given to illustrate the themed content analysis method is a minor injuries service (Figure 7) which provided evidence of integration in four of the eight types of integration being studied. The service is coded 33/03/E which was the number of the award (33), year (2003) and category (emergency care).

Telemedicine within a Minor Injury Unit (33/03/E)

The Minor Injuries Unit was described by staff in the questionnaire as "a remote self-referral unit for unscheduled care for ambulatory patients, more akin to A&E than to primary care but which overlaps the two." The service was a collaboration between the community hospital staff and the Acute Trust A/E staff which led to the establishment of a telemedicine facility to enable community hospital staff to access a specialist opinion remotely *(Secondary care integration).* The Acute Trust attracted an educational grant to help to fund the initiative. Emergency Nurse Practitioners and GPs worked in the minor injuries unit *(multi-disciplinary integration)* and GPs had access to specialist advice from consultants and worked within the community hospital *(primary care integration).* The equipment was actively supported by the community and funded by the local community through the League of Friends *(community integration).* Staff recorded in the questionnaire that "The project has created an excellent working partnership between an acute trust and a primary care trust for the benefit of patients and attempting to keep care as local as possible."

Figure 7: Illustrative Example of Method for Content Analysis (2)

The method was applied to each of the 48 questionnaires, data interrogated and results summarised in tabular form. Each questionnaire was categorised by year, care pathway, client group, region and service to enable the research questions to be explored.

This method was also applied to Question F in the 63 ICON baseline questionnaires, in which staff recorded their view of what integrated care meant to them. Responses were recorded and patterns of recurrent themes identified. Responses were coded and grouped into themes and counted, so that terms most frequently applied to integrated care could be identified. The method of themed content analysis was also applied when assessing the content in question 4 and 5 of the I&BP proforma questionnaire which asked what helped and hindered the development.

- **Pattern Matching**

The method of data analysis used is a "pattern matching" approach that enables data sources from different types and levels of data to be triangulated and validated. Yin describes pattern matching as one of the most desirable techniques for case study analysis, particularly when anticipated patterns or outcomes are defined prior to data collection or analysis (Yin 2003:116). This is a similar approach to the one adopted by Billings as described in their empirical research methodology for the PROCARE programme (Billings *et al*. 2003). This research into views of staff working in integrated care settings across nine European countries utilised a case study approach using questionnaires and focus group methodology. This method was used in order to generate insights from the perspective of staff and managers and common themes were identified and grouped. Questions included whether staff could say what joint working (seamless

care or coordinated care) meant to them. Responses were coded subsequent to collection

and analysed by themes in order to assess knowledge and attitudes of staff. I have used

pattern matching to anticipate the predominance of services for older people with

complex needs as a client group in both programmes, and also to anticipate the high

level of integration between health and social care in community hospital services (Yin

2003:116, van Raak *et al*. 2005).

− **Triangulation**

Triangulation is considered to be a strategy that improves the quality of research and

may be applied to multiple researchers, methods, data sources or theories (Flick

2009:405). Triangulation was originally designed to compare multiple independent

measures for verification (Heaton 2004: 104). Each research method has its weakness,

but triangulation provides an opportunity to combine methods that may have different

methodological weaknesses (Bowling 1997:180). Triangulation requires the sources of

data to be linked, and the 9 source documents used for the ICON study (as detailed in

5.4) provide an opportunity to carry out further validations on the findings of the study.

− **Thick Description**

In order to provide context for the services and teams in the study, I have adopted a

research method of writing "thick descriptions," a method that was developed by Geertz

in 1973 to illustrate different and complex facets of particular phenomena (Holliday

2007:74). Geertz uses the example of the difference between a "twitch" of an eye (a

thin description) or a socially charged "wink" of an eye (a thick description) (Holliday

2007:76). This method is considered suitable for descriptions of bounded social settings,

such as anthropological studies of communities in villages when connections and collective representations can be shown (Holliday 2007:75). This is particularly relevant to illustrate the complex working arrangements of staff working in teams and partnerships, as factors such as culture, values and social context may not otherwise be illustrated. According to Heaton, this method has been adopted to enable researchers to strengthen their claims (Heaton 2004:100). I have used thick descriptions for embedded case studies, using multiple sources of data (Yin 2003:40). The method is considered to be applicable to case studies, when it is the researcher's responsibility to provide sufficient data and context in detailed descriptions to enable the reader (or potential applier) to make a judgement about transferability (Robson 1993:405).

5.8 Benefits and Limitations of the Research Approach

The methodology that I considered to be appropriate for this study is a retrospective, secondary analysis of data using content analysis. The study requires qualitative and quantitative analysis of staff views and experiences, utilising multiple data sources and methods to triangulate the findings. The ICON programme and the I&BP are two case studies, and within that teams and services have been analysed and written as embedded case studies to provide an opportunity to illustrate and contextualise the findings (Holliday 2007:76).

I have considered the benefits and limitations of this research approach. Benefits of re-using existing data include that it is less costly in terms of resources and staff time, it has facilitated the elaboration of earlier findings and it has provided an opportunity to compare two studies (Heaton 2004:27). With respect to this study, it has enabled an

analysis of data that would not have otherwise been available.   The process for obtaining the primary data for evaluation in both programmes incorporated validation checks so there was a level of confidence in the quality of the primary data. The opportunity to analyse data that could not be readily accessed in this way across two countries in local community services, without creating considerable workload and disruption to staff and services was valued.

The research approach is limited in a number of ways, particularly concerning the way that the primary data were collected. One of the considerations was the focus on promotion and supporting good practice, and this may have provided an incomplete picture emphasising the positive aspects of the programmes. The survey material was drawn from self-selecting volunteer staff and teams, who may be presumed to have an interest in integrated care and this would need to be taken into account when considering whether the findings can be generalised. The I&BP questionnaires are from award winning services which are, by definition, distinctive services, and cannot be taken as being representative of community hospital services overall. The I&BP services cannot be considered to be a representative set of services in community hospitals, as there was no management of allocation by geography or type of service. Staff volunteered to be part of this programme if they believed that their service could be considered innovative or an example of good practice and this also needs to be taken into account when considering the findings. Similarly, staff in the Irish community services volunteered to be part of the ICON programme. Bowling cautions against using volunteers as a way of creating a sample, as volunteers may be different from non-volunteers which may create a bias and reduce external validity (Bowling 1997:211). Another limitation to the study

was that there were not opportunities to record the views of staff or agencies who are partnered with the services in both programmes, and only the views of staff within the programmes on partnership and integration were analysed.

A limitation in the community hospital case study was that staff were required to answer predominantly open questions. This presented a challenge in the analysis and presented difficulties in making comparisons. Although staff were advised that the criteria included demonstrations of joint working, partnership and team work it is possible that types of integrated care may have been present but not recorded. A similar limitation in the ICON programme was that a number of the questions were open, although open questions may have been appropriate in that they would not have restricted or limited responses (Bowling 1997:245).

For social research there is often a balance to be struck between what Holliday calls creative opportunity and scientific principle (Holliday 2007:9). As the researcher, I was required to be objective and a "stranger to my data" (Holliday 2007), and yet recognise my role in the design, implementation and evaluation of these programmes. Finding a way to draw a distinction between the objective analysis of the data, and contributing the contextual understanding from my own experience and knowledge of the programmes has been a challenge (Holliday 2007:20-21.)   There is recognition of a researcher being a participant in a study, particularly for social action research (Holliday 2007:21; Flick 2009:111), undertaking activities that promote change through the cycle of planning, acting, observing and reflecting (Robson 1993:438).

The decision to research two case studies rather than focus on one of the programmes in depth presented some challenges and opportunities. There has been a risk that the study loses focus and does not allow for sufficient consideration of two highly complex services. Overall, the research into the two programmes enriched the learning and enabled the experiences of teams to be compared and contrasted. The use of short descriptions of the services and the staff views and experiences provided a context to the data analysis, by adopting the "embedded case study" or vignette approach (Yin 2003:46). This helped in interpreting the data analysis, and it was noted that with case studies and embedded case studies, Bowling urges caution in the interpretation on the basis that the findings may not be generalisable (Bowling 1997:360).

Robson proposes that the two key fundamental issues for research studies are validity and generalisability (Robson 1993:66). Validity includes reliability, construct validity (minimising bias) and internal validity (having a causal link between treatment and outcome with a design that limits the impact of potential extraneous variables). The ability to make generalisations from a study which is also referred to as external validity may be demonstrated either by statistical analysis when using a representative sample of a defined population or by making a case on the grounds of the group being studied (Robson 1993:72). The validity of the data from the I&BP surveys has been shown through the multi-method approach used to verify the accuracy of the questionnaire responses, which included an independent assessor. The case for the generalisability of the findings may be made from detailed exploration of 48 case studies, although there is also a case for considering the findings in terms of utility or transferability (Kernick 2004:328).

Heaton makes the point that there is an issue of understanding the context in the secondary analysis of qualitative data, although this can be offset if there is continuity of primary and secondary researcher. This enables a contextualising of the findings and an understanding of the issues (Heaton 2004:37).

I acknowledge a limitation to my research study in chapter two, concerning my methods for carrying out three literature reviews. When starting the study, in 2005 I was not familiar with the critical appraisal method. It has not been possible to revisit all three literature reviews using this method for this study. However, I have reviewed the references I have used, and carried out an internal check on the quality and appropriateness of references. I have used my knowledge and familiarity with studies to utilise and critique published evidence appropriately.

A major consideration in this study is the fact that staff volunteered to be part of each programme. As such were self-selecting and may have been attracted to the values and objectives within each programme. Therefore, the staff involved with each programme could not be considered as representative of staff working in community hospitals and community services as a whole. Once within the programme, there was also the impact of the "Hawthorne" effect, in which staff have been shown to change behaviour in response to the attention given to them (Bowling 1997:137). This reactive effect is well documented, where staff change their behaviour in response to being part of an experiment or innovation (Moser and Kalton 1971:219). Therefore, the staff who completed these questionnaires already had an interest in integrating care and their participation in the programme may well have changed their behaviour, although the

programmes were designed to stimulate change (Tucker 2005). Their responses have

been analysed and interpreted within this context. This limits the extent to which

findings can be generalised, although may help to suggest what can be achieved when a

systems approach is adopted and staff are part of a formal programme (Foote and

Stanners 2002:319).

In summary, there are benefits and limitations to this research approach. My rationale

for continuing with this study using the methodology described is that the availability of

the primary data for secondary analysis provides new learning with regard to staff views

and experiences of integrating care.

5.9 Method for the I&BP Programme

Before designing a method, I undertook an analysis of the questionnaires as data sources

in order to become familiar with who completed them, where they came from, and

which hospitals across the country were included. As described in the previous section, I

gave a unique reference for each questionnaire. I numbered them according to the order

in which they appear in the publications (number), the year of publication (number) and

the care pathway classification (letter). For instance, a questionnaire from staff working

in a day centre offering rehabilitation for older people is 1/00/R signifying that is the

first in the publication, in the year 2000, and concerns rehabilitation services (Tucker *et

al*. 2000).

The questionnaires were already categorised by care pathways that had been defined by

the CHA panel for the programme and I adopted these categorisations with a small

adjustment of incorporating a staff category into general services. The table below

shows how integrated care was analysed by type, care pathway, age, service and region.

No.	Types of IC with CH	Care Pathways	Age	Services	Region SHA
1	Multidisciplinary	Palliative Care	Children	Ambulatory	East Midlands
2	Social Services	Long Term Conditions	Adults	Bed-based	East of England
3	Third sector	Health promotion	Adults & Older People	Hospital-wide	London
4	Local Authority	Maternity	Older People		North East
5	Patient	Rehabilitation	All ages		North West
6	Community	Intermediate Care			South Central
7	Primary Care	Diagnostic/Clinics			South East
8	Secondary Care	General Services			South West
9		Emergency			West Midlands
10					Yorkshire & Humberside

Table 22: Categories for Analysing I&BP Questionnaires

The review of the literature in the previous chapter informed my design of an analytical

framework of eight types of integration. These were integration between the community

hospital service and secondary care, primary care, social services, Local Authority

services, the patient and the community as well as multidisciplinary and multi-agency

integration (Column 2, Table 22). The data were interrogated in order to determine

which types of integrated care were evident in each of the community hospital services

in the programme according to staff, and the frequency of occurrence overall.

The CHA categorised each community hospital service into a category for the I&BP

programme, and I have called these care pathways. This is not to indicate that they have

formally adopted systems of care pathways for managing services, but is a term to

indicate a form of care. I have adopted the CHA categories with minor adaptations for

consistency. The nine care pathways are shown in Column 3, Table 22. Care pathways

such as mental health and learning disability were not utilised by the CHA, as none of

the services in the programme were categorised in this way. An analysis was undertaken of the types of integration for each care pathway to determine whether there was a pattern, and to consider the appropriateness of types of integration for care pathways.

One of the ways of determining whether integrated care is inclusive or exclusive is to assess the number of types of integration by client age group. The conceptual framework has been developed to challenge the findings in the literature review that integrated care is predominantly for older people with complex needs. The description of the service profile for each questionnaire provided the information necessary to categorise each service by client age group. I identified five client groups by age: older people, adults and older people, adults, children, and the whole community (Column 4 Table 22). The analysis was undertaken to determine whether there was evidence of a high frequency of type of integration for services designated for older people, as identified in the literature.

Another way of distinguishing services within a community hospital is to categorise services as to whether they are ambulatory services, such as clinics, minor injuries units or day centres; bed-based services such as intermediate care beds; or hospital-wide services such as health promotion initiatives. I adopted this simple categorisation to help determine whether the number of types of integration differed accordingly, and whether there was any discernible pattern.

The analysis of the types of integration by community hospital service was undertaken by geographical region, in the categories of the ten Strategic Health Authorities, in order to determine how many community hospitals in the programme were from each region

Column 5, Table 22). For instance, a recent profile of community hospitals across England shows a high concentration of community hospitals in the South West, and it may be argued that in regions with many community hospitals there is a potential for a further developed networks and joint working (Tucker 2008).

These areas of investigation or lines of enquiry (Robson 1993:11) are pursued in the next section.

I marked copies of the questionnaires with codes for each data field and these were recorded on an excel spreadsheet. Content analysis was carried out in order to identify examples of integrated care throughout the text, and also record staff views of the development of integrated care. If one type of integration was referred to on more than one occasion, only the first record was coded as its presence had already been established. Terms such as joint working, linking, coordination, networking, collaboration, partnership and shared practice were recorded as examples of integration, and these were consistent with terms recorded in the literature (Thistlethwaite 2008). I did not attempt to discern purpose or the level of integration as this was not consistently recorded, although this would have provided useful contextual information (Leutz 1999). Any forms of integration that were not included in the eight-dimension typology were recorded separately, but not counted in the results. The method of themed content analysis was also applied to the staff responses to the questions regarding what helped or hindered the development of their service and assessed within the 7S framework (Iles and Sutherland 2001:27). Quotes from staff illustrate the findings and provide

descriptions of services in order to provide a context and an overview (Holliday 2007:46).

5.10   Method for the ICON Programme

I undertook an analysis of the questionnaires in order to ascertain which staff had contributed their views and experiences, so that I could become more familiar with the data sources. The questionnaire in Phase 1 of the programme was completed by 63 staff respondents in what was described as a baseline questionnaire in the consultancy report (MHB/Secta Consulting 2003) and was available in electronic form. A Steering Group for the ICON programme selected a sample of staff to send the questionnaire to, and staff could request a copy to complete. The staff selected to complete this questionnaire were managers and senior practitioners employed within the Midland Health Board in February-March 2003 working in the Primary, Community and Continuing Care sector (PCCC). The questionnaire was completed only by employees of MHB, and not external contractors such as GPs and staff working in voluntary agencies and the independent sector (MHB/Secta Consulting 2003).

Profession	No.	%
Doctor	10	16%
Nurses	8	13%
Social workers	5	8%
Therapists	12	19%
Nurse Managers	6	10%
Managers	21	33%
Ambulance	1	2%
Total	63	100%

Table 23: Respondents to ICON Questionnaire 1 by profession

The respondents were asked to provide their job title, and this analysis shows that 57% of respondents were practitioners. 43% of respondents were either nurse managers, or managers of services, as shown in Table 23.

The respondents were also classified by the client group that they were working within as shown in Table 24. The highest level of response was from mental health and primary care. Respondents were included in the generic category if they worked across client groups, such as finance staff.

Ref	Client Group	No. Responses	%
O	Older People	4	6%
C	Children	6	10%
M	Mental Health	10	16%
L	Disability	4	6%
P	Primary Care	10	16%
G	Generic	29	46%
	Total	63	100%

Table 24: Respondents to ICON Questionnaire 1 by client group

The analysis shows a wide range of professions and client groups represented in the staff that completed the questionnaires, with a high proportion of staff who were managers of services.

In Phase 1, staff recorded their views in response to the question *"What does integrated care mean to you?"* (Question F, Appendix D). Responses were coded according to themed content analysis, in order to analyse the views and perspectives of staff at the start of the programme.

 In Phase 3, team leaders from 18 teams completed questionnaires at the start and end of Phase 3 of the programme with questions to be completed on team profile, and whether

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they had processes in place. Each of the teams was given a unique reference for their two questionnaires, coded by location, age group of clients, and type of service. The eight processes in the analytical framework were colour coded, and a record was made of whether the process was in place or pending. The data were coded and included both qualitative and quantitative data. Free text responses in the questionnaires, as well as data in supplementary documents were coded using themed content analysis.

No.	Processes for IC	Care Groups	Age	Services	Location
1	Referral	Primary Care	Children	Ambulatory	Laois Offaly
2	Assessment	Community services	Adults	Bed-based	Longford Westmeath
3	Care Planning	Disability services	Adults & Older People	Hospital-wide	Midlands
4	Single File	Mental Health	Older People		
5	Service Directory	Health promotion	All ages		
6	Outcome measures				
7	Information Sharing				
8	Team Building				

Table 25: Categories for the analysis of ICON Questionnaire 2

The data fields are summarised in above. Column 2 lists the processes that staff agreed to focus on developing, and Column 3 lists the MHB care groups. Column 4 provides the categories of ages and Column 5 categorises types of services. The final column lists the three locations in the MHB.

Quotes and vignettes provided an illustration of the findings and were selected to illustrate the shared experiences or range of experiences expressed by staff (Bowling 1997:362). Five teams were selected as embedded case studies in order to represent a range of services, locations, client groups and progress made. They were written to show the team profile, the development of integration, future plans and lessons learnt. There were nine sources of data available for analysis, enabling a triangulation of the evidence.

The documents were questionnaires (2), presentations by staff (2), reports (3) action learning set notes and team records.

5.11 Conclusion

The research questions concerning the presence, nature and development of integrated care may be answered by analysing the data in the questionnaires from staff in the two programmes. Whilst not every question can be answered by each programme, in combination the programmes provide a source of evidence from practitioners and managers working in community services on the types and components of integrated care. My approach to interrogating the data is to use an analytical framework for types of integration for the I&BP programme, and processes in the ICON programme. Further detail on methods adopted for each of the specific programmes is set out in each of the subsequent chapters. The quantitative analysis of data by percentage is shown throughout the study in rounded percentages. The use of graphs, colour coded summary tables have been applied where I have considered it to be appropriate.

6   INTEGRATED CARE IN COMMUNITY HOSPITAL SERVICES

6.1 Introduction

In undertaking research into the I&BP programme, I hoped to learn about integrated

care from the perspective of those working in local community hospital services.

Integrated working can be shown in the origins of rural cottage when first developed

150 years ago (Burdett 1882), with most pre-dating the NHS (Heaney *et al.* 2004).

There is an impetus for integrated working and sharing in remote and rural areas where

there are scarce resources (Freeman 2003). The data in the I&BP programme provides

an opportunity to research whether integrated care is taking place now in community

hospitals, and to provide new knowledge on working practices and partnerships.

As described in Chapter 5, the research questions to be explored are:

- − Is integrated working present in community hospitals?

- − What types of integrated care are present in community hospitals?

- − In which services is integrated care present?

- − What helps or hinders the development of integrated working?

I have designed my analytical framework around eight types of integration, with the

rationale for this typology provided from the review of the literature in chapter 4. My

conceptual framework concerns the extent to which integrated care can be considered as

exclusive, as shown in the literature in chapter 3, or whether it is a way of working that can be offered on a more inclusive basis to a range of patients and services.

I have analysed the data from questionnaires to explore staff views and experiences of integrated care. This analysis would answer the question of whether integrated care was taking place, and, if so, in which type, in which service, for which patients, and in which regions in the country. The data were also analysed to determine whether there was any pattern of integration or correlations. Staff views and experiences of what helps and hinders service development and joint working were analysed in order to identify factors that impact on the development of integrated care. This study would provide a new contribution to the evidence on integrated care and community hospitals. The review of the literature revealed that there are no such studies currently published.

6.2 Overview of the Community Hospital Services and I&BP Programme

As explored in the literature review in Chapter 3, community hospitals can be defined as small local hospitals with a range of services and facilities: *"A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources"*(Ritchie and Robinson 1998). Community hospitals can include services such as inpatient beds, outpatient clinics, day care centres, minor injuries units and outreach services, diagnostic services, maternity, day surgery, rehabilitation services and many other services and facilities (Tucker *et al*. 2000). I have taken three verbatim descriptions of community hospitals from the staff questionnaires, selected to illustrate a rural, coastal and urban community hospital.

"North Cambridgeshire Hospital is situated in the capital of the Fens, a small Georgian market town. Services provided include a dedicated Endoscopy Unit, Day Surgery and Pre-Assessment clinics, Care of the Elderly Ward and Day Rehabilitation Unit, a busy Out-Patients Department, Minor Injuries Unit, Palliative Care Day Centre and both Inpatient and Day Care for the Elderly Mentally Ill" (24/02/D).

"The location of Whitby Hospital is on the North East coast surrounded by the Yorkshire moors and the North Sea. It serves a population of 29,000 spread across a geographically isolated area covering 400 square miles" (6/00/D).

"The 18 bed inpatient unit provides nurse-led rehabilitation and palliative care to a locality population of 140,000, of whom 70,000 are South Asian" (14/01/I).

The descriptions of the three types of community hospitals above show a hospital serving a population in small market towns of up to 15,000 people, a hospital serving a population of nearly 30,000 and an urban hospital which may be accessed by a population of 140,000. This illustrates the diversity of community hospitals (Cavenagh 1978; Tucker *et al.* 2008, Heaney *et al.* 2006).

Staff questionnaires reflected the diversity of community hospitals. 40 of the questionnaires described a specific service within a community hospital, such as a dermatology clinic or a day hospital. Five of the questionnaires described services across the hospital, such as in a health promotion initiative and a GP staff training scheme. Three questionnaires covered more than one community hospital, such as in the clinical programmes for rehabilitation and strokes.

I have selected quotes from three services to illustrate the range and type of services and the linkages that have been described by staff, as a way of introducing the context for

the data analysis. These quotes are from staff working in health promotion services, emergency care and palliative care.

One of the services was described as a community project for health promotion which was managed within the voluntary sector involving individuals and agencies such as Age Concern, a local GP, NHS staff, and the Local Authority Libraries service: "*The aim of the Patient Information Point is to provide a central resource for patients, their carers and staff, where information about health conditions, healthy living and most importantly local support can be held*" (45/05/H)

One of the community hospital services provided a rapid response service by developing a Minor Injuries Community Outreach Team linking primary care, home care and community hospital staff. "*The team was designated as a night crisis management team with close links to local GPs and district nursing service, offering short term intensive nursing care to patients in the community who might otherwise require hospital admission or have their discharge from hospital delayed*" (7/00/E).

In a palliative day care service, staff describe their service as a one stop centre where Macmillan nurses, the community hospital multidisciplinary team, GPs, social services staff, and specialist oncologists collaborate to provide a locally based service. Staff describe the service benefitting from volunteer input from the community, offering health, social care and alternative therapies as well as giving advice to patients, carers, relations, friends, healthcare professionals and the general public: "*....an all purpose centre of excellence where advice, care and treatment could be given along with more efficient utilisation of resources*" (4/00/P).

The short descriptions of the type and range of services, and also the individuals and

agencies involved in the services, help to place the data in context (Holliday 2007:46).

The services illustrate the diversity of interests of stakeholders including primary,

secondary and community care staff, practitioners across different professions, staff in

the voluntary and third sector, those working in social services and the Local Authority,

and also those in the community and those using the service. These stakeholders make

up the eight types integration in my analytical framework.

As described in my research approach in chapter 5, I have created a unique code for

each community hospital services based on the sequential numbering from publication,

the year of award and the category of care pathway. For instance, the first entry in

Table 26 is 1/00/R which is the first in the publication (1) for the year 2000 (00) and is

categorised as rehabilitation (R). I categorised each service by type of integration,

patient, service, care pathway and location.

6.3 Types of Integrated Care

Content analysis was used to identify which of the eight types of integration were

evident in each of the services. The results are shown in the Table 26, with each types of

integration recorded as being present in each of the services being colour coded:

multidisciplinary (MDT), secondary care (SC), patient (PT), primary care (PC),

community (COM), multi-agency (MA), social services (SS) and Local Authority (LA).

Table 27 provides a key to the table, where a block of colour indicates a type of

integration is present in the service.

Ref	Name	MDT	SC	PT	PC	COM	MA	SS	LA	Total
1/00/R	Day Centre	1	0	1	1	1	1	1	0	6
2/00/I	Intermediate and Community Care Facility	1	1	0	1	1	0	1	0	5
3/00/R	Gym for Older People	1	1	1	0	1	0	0	1	5
4/00/P	Palliative Care Centre	1	1	1	1	1	1	1	0	7
5/00/D	Ophthalmology service	1	1	0	1	1	1	1	0	6
6/00/D	Nurse-led Haematuria Clinics	1	1	0	0	1	0	0	0	3
7/00/E	Minor Injuries Unit Community Outreach Team	1	0	0	1	0	0	0	0	2
8/00/D	Mobile Gastroscopy Service	1	1	0	1	1	0	0	0	4
9/00/M	Birth Centre	1	1	1	1	1	1	0	0	6
10/00/H	Nursery	0	1	1	0	1	0	1	1	5
11/01/C	Clinical Programme Team for older people	1	1	1	1	0	1	1	1	7
12/01/C	Domiciliary Visits - Satellite Renal Unit	1	1	1	0	0	0	0	0	3
13/01/P	Terminal Care Pathway	1	1	1	1	0	1	0	0	5
14/01/I	Culturally sensitive intermediate care	0	0	1	0	1	0	1	1	4
15/01/I	Promoting intermediate care	1	0	1	0	0	0	0	0	2
16/01/M	Improved midwifery services	1	1	1	0	1	1	0	0	5
17/01/E	Minor Injuries Development	1	0	0	1	0	1	0	0	3
18/01/D	Day surgery audit	1	1	1	1	0	0	0	0	4
19/01/D	Orthopaedic Nurse Practitioner Service	1	1	1	0	0	0	0	0	3
20/02/C	County Stroke Service	1	1	1	1	0	1	1	0	6
21/02/I	Step down beds	1	1	1	1	1	1	1	0	7
22/02/S	GP Registrar Attachment Scheme	1	1	1	1	1	0	0	0	5
23/02/D	Thrombolytic Therapy	1	1	0	1	0	1	0	0	4
24/02/D	Fast track rectal bleed clinic	1	1	1	0	1	0	0	0	4
25/02/D	Gynaecology services	1	1	0	1	1	0	0	0	4
26/02/M	Shared training for midwives and paramedics	1	1	0	1	0	1	0	0	4
27/02/I	Transfers of patients with joint replacements	1	1	1	1	0	0	0	0	4
28/03/D	Nurse-led dermatology clinics	1	1	0	1	1	0	0	0	4
29/03/I	Intermediate Care Unit	1	1	0	1	0	0	1	0	4
30/03/C	Rehabilitation and housing service	1	1	1	0	1	1	1	1	7
31/03/R	Rehabilitation service	1	0	1	0	1	0	0	0	3

32/03/D	Nurse-led pigmented lesion clinic	1	1	1	0	1	0	0	0	4
33/03/E	Telemedicine within a minor injuries unit	1	1	0	1	1	0	0	0	4
34/03/C	Care monitoring system	1	1	0	1	0	0	0	0	3
35/04/E	Minor Injuries Unit Standardised Care	1	1	1	1	0	0	0	0	4
36/04/H	Health promoting hospitals	1	1	1	1	1	1	1	1	8
37/04/S	Employee Rewards	1	0	1	0	0	0	1	0	3
38/04/H	Arts for Health - Garden Project	1	0	1	0	1	1	0	1	5
39/04/P	Care Pathway for the Dying	1	1	1	1	0	1	0	0	5
40/04/D	Orthopaedic Pre-assessment service	1	1	1	1	0	0	0	0	4
41/04/D	Fracture risk assessment clinic	1	1	1	1	1	1	0	0	6
42/05/D	Nurse-led diagnostics/haematology service	0	1	1	0	1	0	0	0	3
43/05/I	Patient Discharge	1	1	0	0	0	0	1	0	3
44/05/S	Generic Worker Project	1	0	1	1	0	0	0	0	3
45/05/H	Patient Information Point	0	0	1	1	1	1	0	1	5
46/05/S	Ward based Pharmacy Technician Project	1	1	1	1	0	1	0	0	5
47/05/E	Nurse Practitioner Minor Ailment service	1	1	0	1	0	1	0	0	4
48/05/H	Hygiene in the community	1	0	1	0	0	0	0	1	3
	Total	44	37	33	31	25	20	14	9	213

Table 26: Types of Integration in 48 community hospital services

Key	Description
Colour (1)	Blocked colour indicates process in place
White (0)	Process not in place

Table 27: Key to Table of Types of Integration

All of the 48 community hospital services had integration in place according to staff. Not only did they all have integrated working recorded, all services had multiple types of integrated working with staff recording two or more of the eight types of integration. Overall, there were 4 types of integration reported (median). This finding is important, as many of the studies in the literature concerned only one type of integration for a service or project (Leichsenring and Alaszewski 2004; Van Raak *et al.* 2003).

Type of Integration with Community Hospital services	Code	Number of Types of Integration per questionnaire N=48	% of Total for each type of integration per questionnaire N=48
Multidisciplinary	MDT	44	92%
Secondary Care	SC	37	77%
Patient	PT	33	69%
Primary Care	PC	31	65%
Community	COM	25	52%
Multi-agency	MA	20	42%
Social Services	SS	14	29%
Local Authority	LA	9	19%

Table 28: Number of Types of Integration for Each Service

The table above shows that multidisciplinary working and integration between the community hospital and secondary care were most frequently reported. The least frequently reported partnerships were with social services and the Local Authority.

I have considered the findings by each type of integration by order of frequency, and provide a quotation from staff where this helps to illustrate the way that this type of integration is evident.

Multidisciplinary working was recorded in just over 9 out of 10 services (92%). In one of the services, staff described the establishment of a gym for older people and illustrated the development of trust, transferable learning and communication systems through regular meetings: *"The working of the multi-disciplinary team and attendance at the wards weekly discharge planning meeting has encouraged the sharing of knowledge and skills amongst all staff and an excellent relationship has been built up"* (3/00/R). 4 services did not record multidisciplinary working. One of these was a community-led initiative offering patient information which was a service staffed by community volunteers (45/05/H), and another was a nurse-led diagnostic service offering a discrete service (42/05/D).

Integration with secondary care was recorded in 3 out of 4 services (77%). Integrated working with secondary care was featured in all diagnostic/clinics, maternity, palliative care and long-term conditions. This type of integration also featured in the majority of emergency care and intermediate care services, but was not evident in a number of rehabilitation services or certain health promotion services. To illustrate this type of integration, staff have described the role of an Emergency Nurse Practitioner within a MIU with specialist support provided through a telemedicine link to A/E: *"...the close working relationships which developed between the Acute Trust and the Community Hospital" (33/03/E).*

The third most frequently recorded type of integration was between the community hospital service and the patient. Integration with patients and the community was recorded as being present if there was evidence of proactive engagement, with examples such as patients determining their care, forming self-help groups, and taking part in patient education and empowerment. Proactive involvement of patients as partners in team working was recorded in 7 out of 10 services (69%), and in particular health promotion, palliative care, rehabilitation and general services. Patient groups were recorded in a number of the services, such as the Stroke Interest Group (SIG) in East Devon (21/02/C), a Joint Action Group (JAG) (27/02/I) and a Birth Unit Babies Support (BUBS) (9/00/M). The importance of working with patients as partners is shown in this extract from a maternity service questionnaire: *".... bring the users into the heart of the planning from day one, and keep collaboration a principle" (9/00/M).*

Integration with primary care, whereby community hospital staff work with GPs and the primary care team, was explicitly recorded in 2 out of 3 services (65%). In particular, primary care staff were recorded as providing palliative care and working with emergency care services: "*The MIU development involved a close partnership between the Unit and the GPs and credit is due to all staff in the unit who embraced the need for change*" (17/01/E).

Community integration was typically recorded when communities worked with staff to plan, promote or fund community hospital services. Proactive involvement of the community was recorded in just over half of the services (52%), with examples given of joint working (45/05/H), planning (9/00/M) volunteering (45/05/H) and fundraising (41/04/D). One of the health promotion schemes illustrated the positive impact of working with communities, and this was echoed in many of the questionnaires. "*The fact that the whole community took ownership of this project contributed to this achievement*" (38/04/H).

Joint working with the third sector was recorded in just over 4 out of 10 services (42%). Multi-agency working was recorded in all of the maternity services and palliative care services, and in the majority of services for people with long term conditions. Multi-agency working also featured in the majority of the health promotion services, as described in this example from a questionnaire: "*Partnership working with the PCT, Local Borough Council, Carers centre, Stroke Association and other voluntary organisations has fostered good working relations and enhanced holistic care*" (36/04/H).

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Integration of health and social care was recorded in 29% of the services. Intermediate care and care for people with long term conditions accounted for 8 of the 14 examples of this type of integration. An example is a service which created Stroke Interest Groups of practitioners and service users who worked on improving practices in stroke care in Devon: *"The joined up approach with social services and colleagues in the acute setting have encouraged better stroke care in all environments"* (20/02/C). Social service staff did not feature in emergency care services, maternity services or general services, and in only one of the clinic services.

1 in 5 services involved the Local Authority (19%). All of the health promotion services involved joint working with Local Authorities, and other examples of joint working were with intermediate care and rehabilitation services. One example is a rehabilitation service for patients who have had amputations, linking rehabilitation in the community hospital to an extra care housing scheme, whilst patients wait for permanent accommodation or adaptations to their homes: *"The housing project is a joint venture between Norwich Primary Care Trust, South Norfolk District Council and Social Services"(30/033/C).*

The graph in Figure 8 illustrates the frequency of occurrence of the eight types of integration studied, ranging from multidisciplinary integration at over 90%, and Local Authority integration at less than 20%.
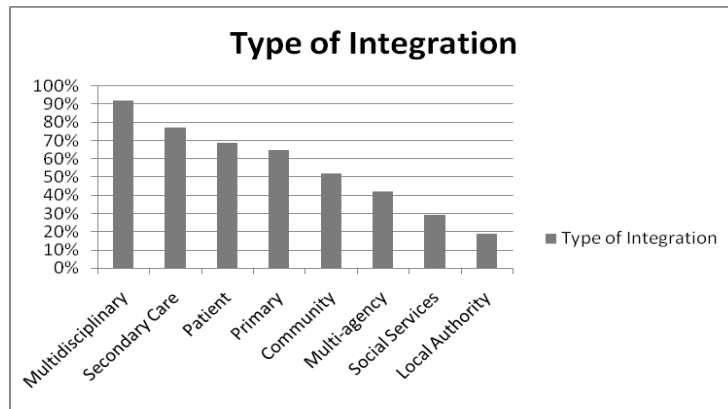
Figure 8: Number of Types of Integration in 48 community hospital services

Staff from one hospital encapsulated the interdependent types of integrated care, and the focus on people who use the service. *"The aim of the Unit is to work as an integral team, providing inter-disciplinary goal led patient centred care, in line with the philosophies of intermediate care and with a rehabilitation focus. Patient care is team led, with medical cover provided by a local GP practice with access to medical assessment by a consultant physician as required. The project has been guided throughout by a multi-disciplinary / multi-agency project group"* (29/03/I).

As described in chapter 5, there is no assumption made that it is appropriate for all services to develop integrated working in all of the eight types of integrated care being studied. This study has shown that all of the community hospital services had multiple types of integrated working in place, with some with as many as 7 or 8 types within one service.

In the following sections I consider which types of integration are present in which care pathways, in which services, for which clients and in which locations.

6.4 Types of Integrated Care by Care Pathways

I have analysed the number of types of integration by each care pathway, using the

categories developed by the CHA and described in my research approach chapter 5.

Care Pathway	No. of Question naires	% Questionnaires	Total Number of Types of IC	% Types of IC	Average number of Types of IC
Palliative Care	3	6%	17	8%	5.67
Long Term Conditions	5	10%	26	12%	5.20
Health Promotion	5	10%	26	12%	5.20
Maternity	3	6%	15	7%	5.00
Rehabilitation	3	6%	14	7%	4.67
Intermediate Care	7	15%	29	14%	4.14
Diagnostic/Clinics	13	27%	53	25%	4.08
General	4	8%	16	8%	4.00
Emergency	5	10%	17	8%	3.40
Total	48	100%	213	100%	4.44

Table 29: Types of Integration by Number, Percentage and Average by CHA Categories of Care

Pathways

Staff working in palliative care services recorded an average of 5.67 types of integration

which was the highest number of types of integration. The staff working in emergency

services recorded the lowest average with 3.4 types of integration. 4.4 types of

integration was recorded for the services overall.

Over 5 types of integration were recorded for palliative care, long term conditions and

health promotion, in which, arguably, a continuity of care is required. Between 4 and up

to 5 types of integration were recorded for maternity, rehabilitation, intermediate care

and diagnostics/clinics, in which care may be considered episodic and time limited. Up

to 4 types of integration were recorded for general services and emergency care, which

may be services provided "as required". Therefore there may be a correlation between

the types of integration and relationships and the types of care pathway in respect of

whether they represent a services required on a continuous, episodic or "as required"

basis.

Type of Integration	Palliative N=3	Health Promotion N=5	LTC N=5	Maternity N=3	Rehab N=3	Interm N=7	Diagnostics/ Clinics N=13	General N=4	Emergency N=5	Total N=48
Multidisciplinary	3	3	5	3	3	6	12	4	5	44
Secondary Care	3	2	5	3	1	5	13	2	3	37
Patient	3	5	4	2	3	4	7	4	1	33
Primary Care	3	2	3	2	1	4	8	3	5	31
Community	1	4	1	2	3	3	9	1	1	25
Multi-agency	3	3	3	3	1	1	3	1	2	20
Social Services	1	2	3	0	1	5	1	1	0	14
Local Authority	0	5	2	0	1	1	0	0	0	9
Total	17	26	26	15	14	29	53	16	17	213

Table 30: Number and Type of Integration by CHA categories of Care Pathway

As described in chapter 5, I have adopted a colour-coded ranking system in order to help

illustrate the most frequently occurring types of integration. Types of integration are

included in the table if they are present in all (or all but one) of the services being

considered. This provides an alternative way of assessing the results and helps to show

the consistency of integration by type of care and service.

The table shows that the widest range of types of integration is evident in palliative care

services. The majority of the care pathways had multidisciplinary working as their most

frequently recorded type of integration, followed by their relationship with secondary

care. The table illustrates the distinct difference in the patter of integration of health

promotion, where integration features with the patient, the Local Authority and the

community. This presentation of the findings by colour coded ranking provides an

opportunity for pattern matching using a visual representation of the results. For instance, social services only features in intermediate care services and is ranked third in frequency in that service. This shows that community hospitals and social services are not working consistently across care pathways, as types of integration are only included if they are in all (or all but one) of the care pathways listed.

Care Pathway	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Palliative Care	MDT	SC	PT	PC	MA
Long Term Conditions	MDT	SC	PT		
Intermediate Care	MDT	SC	SS		
Maternity	MDT	SC	MA		
Clinics/Diagnostics	MDT	SC			
Rehabilitation	MDT	PT	COM		
General	MDT	PT	PC		
Emergency	MDT	PC			
Health Promotion	PT	LA	COM		

Figure 9: Ranking of Types of Integration Care Pathway

In a palliative care service where staff had recently been co-located, staff reported that: "*The continuing success is dependent on the commitment and support of the integrated team which provides an all-encompassing holistic service"(4/00/P).* A health promotion service described their integration with a different orientation outside of the hospital into the community: *"...promotion of best practice to our local community, linking and building partnerships between education and health"* (48/05/H). Staff describe their public health agenda and a personalised service: *"In the community hospitals we are very proud of the way that health promotion has become an integral part of care. We believe that we now provide South Asian patients with truly holistic person-centred care and peace of mind" (14/01/I).*

6.5 Types of Integration by Service

In order to examine this further, I have categorised each service according to whether it is a bed-based service (in-patients), a walk in service (ambulatory), or a service that covers one or more community hospital (hospital-wide). Inpatient services include ward-based intermediate care, maternity birthing units and palliative care beds (e.g. 21/02/I; 16/01/M; 13/01/P). Ambulatory services include services such as diagnostics/clinics, unscheduled care and day care (e.g. 24/02/D; 17/01/E; 1/00/R). Services that are hospital-wide include clinical programmes and health promotion (e.g. 11/01/C; 22/02/S; 36/04/H)

Type	Inpatient n=16	Inpatient %	Ambulatory n=22	Ambulatory %	Hospital-Wide n=10	Hospital-wide %	Total n=48	%
Multidisciplinary	15	94%	21	95%	8	80%	44	92%
Secondary Care	13	81%	19	86%	5	50%	37	77%
Patient	11	69%	12	55%	10	100%	33	69%
Primary Care	11	69%	15	68%	5	50%	31	65%
Community	7	44%	13	59%	5	50%	25	52%
Multi-agency	8	50%	7	32%	5	50%	20	42%
Social Services	6	38%	3	14%	5	50%	14	29%
Local Authority	2	13%	1	5%	6	60%	9	19%
Total	73		91		49		213	
Average	4.56		4.14		4.90		4.44	

Table 31: Number of Types of Integration by Service Types

The analysis in Table 31 shows a distinct difference between hospital-wide services and inpatient and ambulatory services. Hospital-wide services record a proactive engagement with patients in all services, and are much more likely to have the involvement of Local Authority and social services.

Types of integration recorded for inpatients and ambulatory care are predominantly multidisciplinary working and integration with secondary care and primary. Community engagement is recorded more frequently for ambulatory services.

I have adopted the colour-coded ranking system to present the results, and included those types of integration that are present in all (or all but one) of the three types of services: inpatient, ambulatory and hospital-wide services (Figure 10).

Using this ranking, four types of integration were consistently recorded for inpatients namely: multidisciplinary teams, secondary care, primary care, and the patient. Ambulatory care services recorded the same four types of integration and in addition staff recorded integration with the community. The services which were hospital-wide, such as those concerning health promotion, information and training, showed a very different pattern, with integration involving patients, the multi-disciplinary team and the Local Authority.

Services	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Inpatients	MDT	SC	PT	PC	
Ambulatory	MDT	SC	PC	COM	PT
Hospital	PT	MDT	LA		

Figure 10: Ranking of Types of Integration by Service Categories

The graph below (Figure 11) illustrates the pattern and frequency of types of integration.
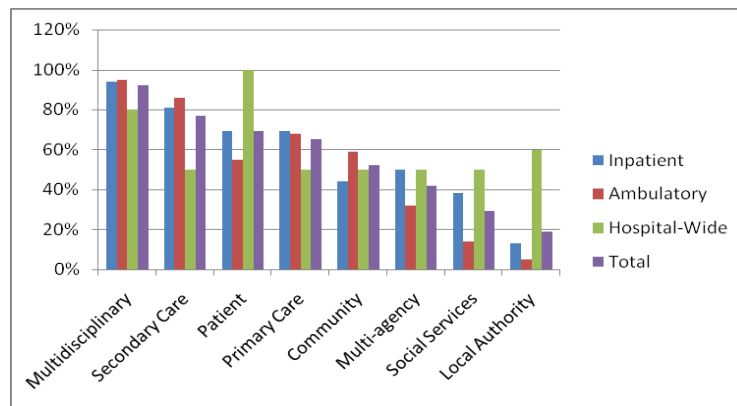
Figure 11: Types of Integration by Service Categories

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The table below shows that integration in ambulatory services was less than average at 4.14. This may be understood in respect of ambulatory care services being primarily self-contained episodic visits, diagnostic tests of clinic appointments. Hospital-wide services recorded the highest average at 4.90, which may be explained by the service scope in promoting health, educating and providing information with patients, the community and a range of partners. Inpatient services recorded above average for the types of integration and these were predominantly relationships within the NHS such as multidisciplinary secondary care and primary care.

Service	No. Types	No. Services	Average Types
Ambulatory	91	22	4.14
Hospital-wide	49	10	4.90
Inpatient	73	16	4.56
Total	213	48	4.44

Table 32: Number of Types by service categories

6.6 Types of Integration by Age of Client Group

In order to answer the question of whether integrated care is predominantly focused on older people in these programmes, I have undertaken an analysis by client group by age group (Table 33). I hoped that this analysis would help test the idea in my theoretical framework developed from the literature which was to assess the extent to which integrated care was exclusive to older people.

Client Group	Example	Number of Questionnaires	% of Questionnaires	Number of types of integration	Average Types of Integration
Older People	Day Centre	3	6%	18	6.00
Adults	Maternity	3	6%	15	5.00
Children	Nursery	1	2%	5	5.00
Adults and Older People	Rehabilitation	29	60%	125	4.31
Community – all ages	MIU	12	25%	50	4.17
Total		48		213	

Table 33: Number of Types of Integration by Age Group

29 services (60%) were described as for adults and older people, such as intermediate care, rehabilitation and clinic services (e.g. 2/00/I; 31/03/R). 3 services were recorded as being designated for older people (e.g. a day centre 1/00/R, a gym 3/00/R and a clinical programme for rehabilitation 11/01/C). 3 maternity services were designated for adults (9/00/M; 16/01/M; 26/02/M). One service, a nursery, was designated for children (10/00/H). 12 services for all ages included MIUs and health promotion services (e.g. 36/04H; 7/00/E).

Services for older people recorded an average of 6 types of integration which was the highest number of the age groups. Services for adults (maternity) and children (nursery) recorded an average of 5 types of integration. Services for adults and older people averaged 4.31 types of integration and those categorised for all ages recorded an average of 4.17 types of integration, both of which were below the average of 4.4.

The findings show that services designated for older people record a high number of types of integration. Services for older people recorded the highest number of types of integration, although only 3 of the 48 services were designated solely for older people. There was evidence of integration in services for each of the age groups such as maternity services for adults. This therefore challenges the idea that integration is exclusive to older people.

6.7 Types of Integrated Care by Region

I have categorised each questionnaire according to each NHS SHA region in Table 34 in order to explore whether there is a pattern of increased levels of joint working in those regions with proportionately more community hospitals. The data on the number of community hospitals by region is taken from a survey undertaken for the DH (Tucker *et al.* 2008).

Code	SHA Region	No. Questionnaires	% Questionnaires	No. of English Community Hospitals*	% CH
EM	East Midlands	6	13%	29	10%
EE	East of England	9	19%	35	12%
L	London	1	2%	5	2%
NE	North East	1	2%	17	6%
NW	North West	3	6%	22	7%
SC	South Central	2	4%	34	11%
SE	South East	2	4%	34	11%
SW	South West	13	27%	80	27%
WM	West Midlands	8	17%	22	7%
YH	Yorkshire & Humberside	3	6%	18	6%
	Total	48	100%	296	100%

Table 34:Questionnaires by Region and Community Hospital Distribution

The South West records the highest number of community hospitals in the country, and also had the highest numbers of community hospital services within the programme accounting for 1 in 4 of all community hospitals and 1 in 4 awards. SHAs in South Central and South East have proportionately less awards per number of community hospitals. The West Midlands region attracted 17% of the awards and has 7% of community hospitals. The two regions that have the fewest community hospitals, London and the North East, also had the lowest number of community hospital services in the programme, with only one each.

Code	SHA Region	No. Questionnaires	Types of IC	% Types	Average Number of Types	Difference from Average 4.44
EM	East Midlands	6	25	12%	4.17	-0.23
EE	East of England	9	45	21%	5.00	0.60
L	London	1	6	3%	6.00	1.60
NE	North East	1	3	1%	3.00	-1.40
NW	North West	3	15	7%	5.00	0.60
SC	South Central	2	10	5%	5.00	0.60
SE	South East	2	9	4%	4.50	0.10
SW	South West	13	57	27%	4.38	-0.02
WM	West Midlands	8	32	15%	4.00	-0.40
YH	Yorkshire & Humberside	3	11	5%	3.67	-0.73
	Total	48	213	100%		

Table 35: Number of Types of Integration by SHA Region

The range of types of integration across each of the SHA regions is 3.00-6.00. The

South West has the highest number of community hospitals in the country and had just

under the average number of types of integration, whilst London which has the least

number of community hospitals recorded the highest number (although for one service

only). There was no discernible pattern in types of integration across the country by

region in the proportion of services to the number of community hospitals, or to the

frequency of types of integration. Those regions with a relatively high number of

community hospitals may have been expected to record a high frequency of types of

integration, as joint working and networking may reasonably be expected to have

developed more fully in these SHAs. However, a correlation has not been shown. This

may be understood in part by observations that that regional health strategies have not

given attention to community hospitals in the past, and that many develop according to

local circumstances (Tucker 1987; Tucker *et al.* 2008, Heaney *et al.* 2006).

6.8 Results of Types of Integration in Community Hospital Services

I have summarised the findings in the table below, showing the number of types of integration by care pathway, service, age of client group and region and grouped them in three levels: low (less than 3.99 types), medium (4.00 to 4.99 types) or high (5.00 types and over).

Category	Types of Integration Low (Average 3.00 to 3.99)	Types of Integration Medium (Average 4.00 to 4.99)	Types of Integration High (Average 5.00 and over)
Care Pathway	Emergency Care 3.40	Rehabilitation 4.67 Intermediate Care 4.14 Diagnostics 4.08 General 4.00	Palliative Care 5.67 Long Term Conditions 5.20 Health Promotion 5.20 Maternity 5.00
Service		Hospital-wide 4.90 Inpatient 4.56 Ambulatory Care 4.14	
Age/ Client Group		Adults & Older People 4.36 All ages 4.17	Older People 6.00 Adults 5.00 Children 5.00
Region	Yorkshire & Humberside 3.67 North East 3.00	South East 4.50 South West 4.38 East Midlands 4.17 West Midlands 4.00	London 6.00 East of England 5.00 North West 5.00 South Central 5.00

Table 36: Summary Results of Average Types of Integration

The summary of the findings shows that none of the categories averaged any less than 3 types of integration taking place. This therefore demonstrates multiple partnerships in place. The highest average number of types of integration was 6 for services designated for older people, although services for adults and children recorded an average of 5 types indicating multiple types for all ages.

The summary shows that care pathways such as palliative care had a high number of types of integration (5), whilst emergency ranked low in relation to other care pathways (3). Health promotion and maternity averaged just over 5 types of integration.

The three service types showed an overall medium level of integration, with inpatient, ambulatory and hospital-wide services all showing between 4.1 and 4.9 types of integration.

There is evidence of a lower number of multiple types of integration in parts of the north of England. The SHA with the highest number of community hospitals is the South West SHA, and contrary to expectation did not demonstrate the highest number of types of integration in its services.

The table above shows that there is multiple joint working across a wide range of care pathways, age groups and services across community hospitals across the country.

6.9 Analytical Framework and Assessment Tool

The results of the analysis of the types of integration in the 48 services are shown in the analytical framework of the eight dimension typology of integration providing a visual representation of the results.
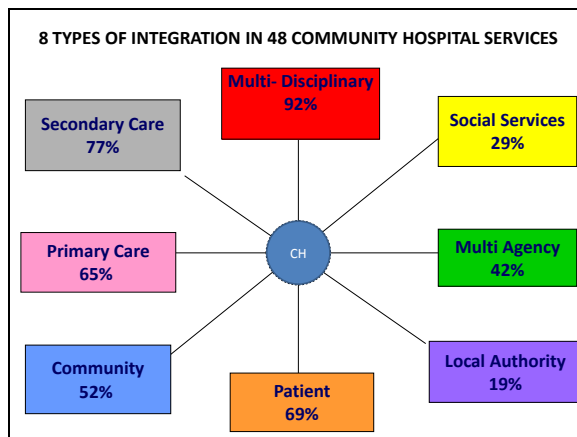
Figure 12: Analytical Framework for8Types of IC in CHs

I have further developed the analytical framework to incorporate assessments on levels as well as types of integration as shown in the diagram below (Leutz1999).
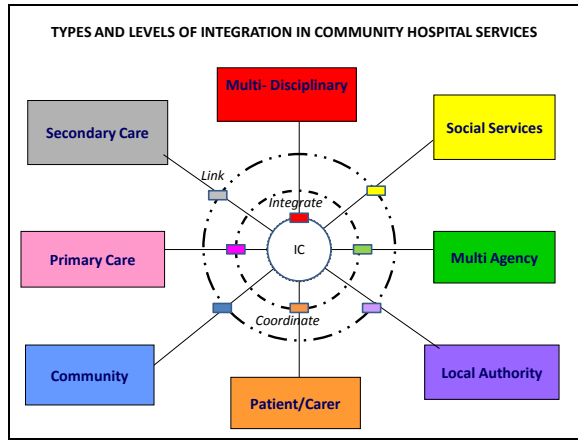
Figure 13: Analytical Framework for Types and Levels of IC in CHs

The colour coded boxes for each of the eight types of integration are blocked in colour according to the type and level of integration present. The circles in the centre of the diagram represent the three levels of joint working, namely link, coordinate or integrate (Leutz 1999). This has the potential to be used as a self-assessment tool within community hospitals. This has not been tested on services within the study, as the data from the questionnaires did not allow for levels to be measured or reported.

6.10   Discussion of Findings

Before proceeding with the discussion, it is important to emphasise that it is possible that the results of this study may overstate the presence of integrated care as I set out in my research approach in chapter 5. The data was taken from self-selected services put forward for an award on the understanding that the criteria included a demonstration of partnership working and integrated care. It is not possible therefore to be confident

about the generalisability of these findings. My discussion on the findings is considered within this limitation. Further research to test these findings in a random sample of community hospital services is warranted.

Presence of Integrated Care

Staff have given evidence of multiple types of integrated working in all of the 48 community hospital services. Community hospitals had 4 types in place (median), and this ranged from 2 to 8 of the 8 studied. As has been shown in the literature review, many studies of services focus on one type of integration at any one time so this is an important finding (Nies and Berman 2004, Thistlethwaite 2008). The explanation of the presence of integrated care may lie in their origins (Burdett 1882), their rurality which encourages sharing scarce resources (Freeman 2003), and their generalist role (Meads 2001).

Multidisciplinary Working

Multidisciplinary working was described by staff in almost all community hospital services, which may be expected in a community service which is provided by nursing staff, therapy staff and local GPs working flexibly and creatively for the benefit of the patient (McCormack 1993). It may be argued that autonomous or uni-professional would be rare, and that there may have been an under-reporting of professionals working together in four of the questionnaires. Follow up interviews would have added to the validity and understanding of the data, but this was not undertaken due to the elapsed time period as explained in chapter 5.

Secondary Care and Primary Care

In the literature, community hospitals are characterised by being predominantly extensions of primary care (Meads 2001, DH 2006a, DH 2006b). These findings show that the relationship with secondary care is more frequently recorded than with primary care. This raises questions about the role and function of a community hospital, and whether it is an extension of primary care (Cavenagh 1978), a satellite of District General Hospitals (Hadridge 1997; Higgins1993:66), or a multi-provider unit offering a wide range of services (Tucker 2006).   The lack of clarity on the role of community hospitals is discussed by Heaney in his systematic thematic literature review who comments on the ad hoc nature of their development (Heaney *et al.*2006). There is a view that they are best understood as community resource centres with roots in primary and social care (Higgins 1993:67), although this is not borne out by the primacy of relationships shown by types of integration in this research.

Social Services

The lack of joint working with social care is another finding that is contrary to expectation. Community hospitals have often been described as integrated health and social care units (Meads 2004, Balcombe 2008, DH 2006a, DH 2006b). However integration with social services was only present in 1 in 5 of the services studied. There are few studies on this way of working, although the challenge of integrating health and social care was illustrated in the Limes Project in Livingstone community hospital (Leichsenring and Alaszewski 2004:465; Coxon and Billings 2004). Higgins observed

that community hospitals were most successful when they blurred the role and function between health and social care (Higgins 1993:67).

Internal and External Integration

Difficulties of cross-agency and multi-agency working, such as health and social care, are recognised. A European study concluded that "single standalone" services reported more integration than "cross-agency" models (Coxon 2005). My research supports this finding, demonstrating that those types of integration that were cross agency or external to the NHS (community, third sector, social services and local authority) were recorded less frequently than those internal to the NHS (multi-disciplinary, secondary care, primary care and the patient). Factors to be considered may be different funding and systems (Higgins 1993:67) and different roles and functions (Tucker *et al.* 2008).

The Community

Integration between the community hospital and its local community is demonstrated in over half of the services studied. Community hospitals have been described as hybrid organisations that may be considered as network organisations, with multiple roles and sources of funding, with strong financial support from the local community (Meads 2001). Community engagement has been discussed as one of the most critical factors in developing community hospitals with communities feel a strong sense of ownership of "their" hospital (Tucker in Meads and Meads 109:2006). Higgins noted from her study that small hospitals meant much more to communities were much more than simply a place to receive health care, and she discusses the sense of community solidarity (Higgins 56:1993). The literature reveals few discussions of the wider role that

community hospitals may play in their communities (Heaney 2006) and so this finding of community engagement and involvement is an important discovery, and merits further investigation.

Appropriateness

As set out in my research approach, it is not assumed that the more integration the better, but is a question of appropriate relationships according to the services. For instance, it may be appropriate to have fewer partnerships in episodic services (such as clinics and diagnostics) than those that require an ongoing relationship with the patient and offer continuity, such as for those with long term conditions. The findings support this distinction, and this important question of appropriateness merits further research.

Older People

The study has shown that it is not just services for older people that demonstrate integrated care. This is an important finding in exploring the idea that integrated care may not be exclusive.

Pattern matching has provided a new insight into the dominant relationships in community hospitals, and shown that integration in practice in 48 community hospitals does not always reflect how community hospitals are represented in the literature.

Integrated care or partnership working was described by staff as having a positive impact for the patient in terms of experience and outcome, as shown by the two quotes.

> *"This project has demonstrated that partnership working with other agencies can be a powerful force in improving service and care to patients"* (46/05/S).

"All schemes involve active partnership with outside agencies such as social services and

leisure services, to offer an integrated care package for the user" (11/01/C).

The analysis of types has focused on staff reported experiences of integrated care and partnerships, which has been presented in the questionnaires in positive terms where it has been present. The following section analyses the staff views of what has hindered or helped integrated working, which gives an indication of some of the difficulties as well as the opportunities within the service.

6.11   What Helped and Hindered Integrating Care

The question of how integrated working is developed has been considered by analysing the data in the questionnaires recorded by staff on their view and experience of what helped or hindered the development of their services. The rationale for the research approach and method was presented in chapter 5, setting out how content was coded, themed and analysed (Flick 2009: 322). A total of 306 comments were recorded by staff. Multiple recordings were made under a number of themes in questionnaires. For instance, the reference to the importance of commitment may have been made in a number of ways with reference to different manifestations of commitment by different stakeholders and so each comment was recorded and coded distinctly. The results are summarised in Table 37. I have totalled all of the comments, combining the views of what staff believed were significant factors in either helping or hindering the development of their services and integrated care.

	What Helps		What Hinders		Total	
Measures	**No. of Comments**	**% Comments**	**No. Comments**	**% Comments**	**No. Comments**	**% Comments**
Staffing	20	10%	41	41%	61	20%
Systems	23	11%	23	23%	46	15%
Funding	26	13%	15	15%	41	13%
Facilities	6	3%	12	12%	18	6%
Education & Training	28	14%	8	8%	36	12%
Commitment	87	42%	0	0%	87	28%
Management	17	8%	0	0%	17	6%
Total	207	100%	99	100%	306	100%

Table 37: Staff Views on What Helps and Hinders Integrated Working

Staff recorded twice as many examples of what had helped them (average 4.31; range 1 to 7) than what had hindered them (average 2.06; range 1 to 4). Staff gave an average of 6 factors in each questionnaire. I have presented the findings in the order of the table above and have selected extracts from questionnaires to illustrate the theme.

- **What Helped**

Staffing was considered to be an important factor and this included the importance of having a multidisciplinary team, successful recruitment to the team, and capacity within the staff for workload and time (43/05/I). The composition of the team, and the description of co-location of the team, were frequently recorded, such as in this rehabilitation service : " *The team comprises Nursing Staff, Physiotherapy, Occupational Therapy, Rehabilitation Consultant, Staff Grade Doctor, and social workers all based on site*" (30/03/C).

Staff recorded their views on the importance of **systems** in place, such as integrated care pathways (13/01/P; 23/02/D) and shared policies and procedures (15/01/I; 33/03/E).

Staff described the value of having integrated care pathways in a number of services in a palliative care service: *"It organises care in a more structured way but also clearly identifies the desired outcomes of care during the terminal phase. It promotes multidisciplinary discussion and provides a format through which care can be given evaluated and audited" (*13/01/P).

Funding for the service development was cited as a factor that helped, with reference to community contributions and grants as well as internal funding (44/04/5) as shown in the extract from a questionnaire describing a day service: *"Multi-disciplinary and multi-agency joint working and funding worked well in the development of this integrated day care centre* (1/00/R).

Having the appropriate **facilities** was considered an important consideration, such as in a unit in one of the hospitals which was small and considered ideal for piloting a new way of joint working:*"The ward chosen for the pilot changed its function"* (39/04/P).

The importance of **training and education** was given as an example of what helps by staff (22/02/S; 26/02/M). In a rehabilitation service, staff recorded that: *"The nursing auxiliaries were all very keen to undertake some new form of education" (31/03/R).*

The most frequently recorded factor that helped staff to develop the service was **commitment** which included all references to support from interested parties including patients, staff, the community, management, GPs, and acute hospital staff (29/03/I; 30/03/C). This theme accounted for 2 out of every 5 examples given of what helped develop the service: *"The commitment and enthusiasm of all involved in the multidisciplinary team taking this new initiative forward was the most important driving*

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force" (32/03/D). An extract from a questionnaire describing a step down service for people recovering from joint replacements recorded: *"Commitment from all staff, including the General Practitioners, nursing, physiotherapy, occupational therapy and clerical support"* (27/03/I).

Staff said that they recognised the value of the **management** of the service development which was typically described in terms of vision, leadership and being in keeping with the national agenda: *"having a shared vision that both managers and clinicians could sign up to"* (35/04/E).

Overall, service development and joint working was considered to be helped if there was a strong commitment by all concerned, appropriate training, sufficient funding, and systems in place to facilitate a new way of working. Having clear leadership, vision and management was considered by staff to be helpful and also having facilities in community hospitals to accommodate service development and joint working.

– **What Hindered**

The most frequently recorded factor that hindered service developments was **staffing**, and this included a lack of staff, high workloads of existing staff and some resistance or anxiety from some staff concerning service changes An example was a rehabilitation service which was hindered due to the *"lack of nursing/occupational therapy input due to problems with staffing levels and inability to release staff to participate in the programme..."* (31/03/R).

The lack of **systems** was another factor that was considered to have hindered developments, such as systems for information and finance as well as systems for managing care such as care pathways (28/03/D). One of the services described their efforts at integrating their service and systems and their decision to develop systems to overcome difficulties: *"the development of a joint referral system for all our services will make it easier for all users to link into the service"* (11/01/C)

In the examples given by staff, there were 15 comments on how **funding** was hindering the further development of their service (47/05/E). *"Monies were not made available.... for a ...falls assessment clinic planned to run alongside the fracture clinic"* (41/04/D)

Staff recorded the lack of **facilities** as a hurdle, such as space and equipment, such as described by staff offering a rehabilitation service for patients recovering from joint replacements requiring specialist equipment: *"...having the beds available, and difficulties with the availability and delivery of equipment"* (27/02/I).

Another hurdle was the lack of **education and training** required for staff to have the competency to progress developments. One of the palliative care services encountered this difficulty among others: *"There was no money for the project and time constraints were and still are a major hindrance. For example, finding space to teach the pathway is difficult and we had always felt that it was important that clinicians should not use the pathway without suitable training..."* (13/01/P).

There were no specific comments on a lack of commitment hindering development, or any comments or the role of management hindering development. It is possible that

these factors were understated, as the questionnaires were being completed to illustrate innovation and good practice.

Overall, service development and joint working was considered to be hindered by staffing considerations such as numbers of staff and attitude of staff, a lack of systems designed for the service, and a lack of resources such as money and facilities. Where there was insufficient training for staff, this was considered to be a hurdle to the development of the service.

The most significant factor recorded by staff overall was commitment, believed by staff to be the most important consideration in developing good practice and integrating care.

6.12   Discussion on what helps and hinders

I have considered the responses from staff using the headings of the 7S framework as described previously in Chapters 2 and 5 as a way of assessing organisational balance (Iles 2001:27). The 7 factors are categorised as shared ethos, skills, style, systems, staff, structure and strategy.

The factors recorded by staff in the questionnaires concern predominantly staff attitudes and commitment, described as **shared ethos**, and the commitment to working together to improving the patient experience is referred to more than any other factor in the questionnaires. Another positive factor was the **skills** shown, supported through education and training, and the style of the organisation, through devolved management and a culture of innovation. Factors that were recorded as a hindrance were **staffing**, and this concerned either the limited staff resource in terms of level or time. The

development of **systems** to support integrated working, such as care pathways, was recorded as a help where they were in place, and a hindrance where they had not been developed. None of the staff recorded the organisational **structure** as a factor in either helping or hindering service development. The overall **strategy** was not referred to explicitly, and this may have been because there was an assumption about the national policy direction, although there was some reference to a local shared vision. Overall, the "soft" factors (as described in the literature review in the earlier chapter) such as shared ethos and style were considered to be helpful, and the "hard" factors such as structure and systems were considered to be hindrances (Iles 2001:27).

The classification of factors into the 7S framework, also concurs with a six dimension typology developed by Fulop, citing integration of systems, services, clinical practice and functional as well as what they refer to as normative (shared values) and organisation (structural or virtual) (Ramsay and Fulop 2008). The findings are also in keeping with a review of the evidence on integrated care, which noted that a lack of staffing, funding and information were typically recorded as hurdles, and that commitment and supportive management were often identified as factors that helped integrated care (Ling 2009).

6.13   Conclusion

The study was undertaken in order to establish whether integrated care was present in community hospitals, and this was confirmed in all cases. This study has shown that integrated care was taking place in established services rather than in new, time-limited short-term projects that dominate the literature (Leichsenring 2004).

The multiplicity of partnerships was illustrated, illustrating what Meads has called community hospitals as "network organisations" (Meads 2001).

The question of which types were most frequently reported gave some results which were contrary to expectation from the literature review. In particular, integration between health and social care was only present in 20% of cases.

The question of which services featured integrated working was answered in the study, showing that palliative care and services for people with long term conditions requiring a continuity of care involved multiple partnerships. Services requiring episodic care had relatively fewer examples of joint working. Contrary to the message given by Leutz (1999), the services with the highest numbers of types of integration were not for older people or people with high and complex needs, but was found to be in health promotion services. This finding contributes to the debate on the inclusivity or exclusivity of integrated care. Integrated care services were provided not just to older people in the study, but to whole communities of all ages.

Overall, the study shows that there are examples of integrated working reported by staff in the community hospitals in the I&BP programme. Given that the community hospital services put forward for the programme were services deemed suitable for a I&BP award with criteria including partnerships and joint working, this finding may be expected. The evidence of multiple and simultaneous types of integrated care illustrates the range of partnerships in these small predominantly rural hospitals, and this is worthy of further research in community hospitals outside of the I&BP programme. I have also suggested further research on levels of integration (Leutz 1999).

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In conclusion, this research shows that integrated care may be considered inclusive in the community hospitals in the programme, as the services are offered to patients of all ages, incorporate multiple types of partnerships, and have been shown from the literature to have a long tradition of joint working.

In the analysis of what helped and hindered the development of innovative services and best practice with regard to integrating care, staff held the view attitude and cultural were factors that impacted on the development of integrated care more significantly that systems. This finding leads on to the next section, where staff working in the ICON programme chose to focus on systems. This difference of approach will enable me to compare and contrast the experiences and views of staff in each programme.

In this next chapter I analyse the reported views and experiences of staff in the second case study, the ICON programme, to assess the systems and processes in place to support integrated care and consider how integrated working was developed using a systems approach.

7   INTEGRATED CARE IN COMMUNITY HEALTH SERVICES IN IRELAND

7.1 Introduction

This chapter sets the context for the ICON programme and defines the research question to be addressed. The question of the meaning and definition of integrated care was asked of staff, and the analysis of the data in the questionnaires by themed content analysis of values, processes and outcomes and provided evidence of a common understanding of a person-centred approach that, through managing care, improved care to patients. The question of whether integrated care was present in 18 services within phase 3 of the ICON programme was addressed by studying the processes in place to facilitate integrated care at the start and end of the programme. The questions of who integrated services were provided for and in which services have also been addressed. Five of the services provided embedded case studies, and the thick descriptions were analysed to illustrate factors influencing the presence and development of integrated care.   Factors influencing the development of integrated care and types of integrated care are taken from the data on these five services.

7.2 Context for Researching the ICON Programme

The ICON programme was established by the Midland Health Board (MHB) as an organisation-wide structured approach to facilitating improving integrated care across primary, community, and continuing care services. The MHB, one of ten Boards in Ireland, was responsible for providing, or contracting for, health and social care services

for a population of 225,000 in four rural districts of Laois, Offaly, Longford and Westmeath located over 50 miles from Dublin (Tucker *et al*. 2004a). MHB employed over 3,000 staff in primary, community and continuing care. The ICON programme was designed to support staff to work in an integrated way, building on good practice, and piloting new ways of working (Tucker *et al*. 2004a).

As described in chapter 5, the programme was resourced over a four year period (2002-2005) with a project board, project team, and external consultancy support. The programme was designed in three phases, with a project agenda that included attention to the local strategy, management systems, and communication systems. This research study is concerned with the elements of the programme that involved staff at an operational level in phase 1 when staff were asked what integrated care meant to them, and phase 3 when staff recorded their views and experience of the implementation of processes and systems to support integrated working. I wanted to analyse the data from the questionnaires to help illuminate the experience and views of staff of the presence, nature and development of integrated care.

Phase 1 of the programme was designed to develop a definition and model of integrated care with staff, and to identify processes to facilitate integrated working (Tucker *et al*. 2004a, MHB /Secta Consulting 2003a, MHB/ Secta Consulting 2003b).

Phase 2 was designed to pilot integrated working in two teams, prior to the launching of Phase 3 and is not reported on in this study. Phase 3 of the programme was designed to support 18 teams in integrated working, through the development of eight processes that were identified by staff as required to facilitate integrated working. A consultancy

report for Phase 3 of the programme recorded the work of implementation teams over the nine month period across the MHB and progress made with developing integrated working (Tucker for Tribal Secta 2005).

The ICON programme attracted interest internationally, and papers were presented at the International Journal of Integrated Care conferences (Tucker *et al*. 2004a; Tucker *et al*. 2004b; Tucker *et al*. 2005). The programme was considered to be distinctive by the MHB as it involved teams from all client groups working across a wide geographical area and covered the whole health and social care system across primary and community care (Tucker *et al*. 2005). The Steering Group recorded that *"integrated care has moved on from being a project and is now becoming our established way of working"* (MHB/Secta Consulting 2003b).

The rationale for selecting the ICON programme is that there is data from the phases of the programme that can be interrogated and analysed to help answer questions on the presence, nature and development of integrated care. Primary data are available for retrospective secondary analysis from staff questionnaires, with other sources of data being available for triangulation namely reports, presentation material and action learning set records. The primary data was used in an evaluation of the programme and the service (MHB/Secta Consulting 2003a; MHB/Secta Consulting 2003b; Tucker for Tribal Secta 2005). The programme was designed to support staff at service delivery and practice level, and to record their views and experiences within the programme which also helps in addressing the research question. Therefore, I have analysed the ICON primary data using retrospective secondary analysis in order to consider the

evidence for the presence, nature and development of integrated care in community health services in Ireland. The specific research questions are:

- What do staff understand by integrated care?

- Is integrated care present in community services?

- What processes have staff implemented to support integrated working?

- Who is integrated care for?

- What helps or hinders integrated working?

7.3 National Policy and Context

This section describes the national context at the time of the start of the ICON programme. In Ireland there was an emerging priority for integrating care, although a lack of direction regarding how this might be achieved. The national plan "Quality and Fairness" promoted *"a new comprehensive model of care to meet the needs of patients and clients in an integrated way based on close teamwork between health professionals and direct access to service"* (DOHC 2001b). Integrated care was heralded as the key to successful primary care, *"leading to better outcomes, better health status and better cost-effectiveness"* in the primary care strategy, described as a "new direction" (DOHC 2001a). There were a number of challenges to the integration of care in Ireland. The Irish Health system is one of mixed private and public funding, which limits access to services with 30% of the population being eligible for state support through medical cards, and 90% of those not eligible only insuring for hospital care (DOHC 2001a).

Charges are made for GP services and there is no registered list for GP practices, many

of which are single handed. The primary care strategy described the system as one of

fragmentation and of disparate personnel which was to be replaced by a team-based

approach with community networks (DOHC 2001a).

The health service is a multi-provider system, with a well developed market of Non-

Governmental Organisations (NGOs) which presents a further challenge to integrated

and seamless care. Another factor that supported the ambition to integrate services was

the statutory requirement to account for care that exposed the lack of cohesiveness in

practice and record keeping, and the lack of a national system for care management

(Tucker *et al*. 2004b). In a report published by the MHB and written by Secta

Consulting Ltd, the Board cited the requirement to develop an appropriate information

technology system that was service-led, and that facilitated future integrated care

practice (MHB/ Secta Consulting 2003a).

One of the few examples found in the literature regarding integrating care in Ireland was

Home First. Ireland was participating in the European programme, CARMEN, and

cited an example of good practice as their Home First scheme which was described as a

collaboration between primary care, social services and secondary care services

whereby older people were provided with individualised care packages to enable them

to have care at home (Nies and Berman 2004:116).

The primary care strategy described one of the objectives to provide an *"integrated,*

inter-disciplinary, high-quality, team-based and user-friendly set of services for the

public" through establishing primary care teams and primary care networks (DOHC

2001a). Therefore the national strategy gave a priority to integrating care, and this set a

context for the ICON programme to be developed. The Chief Executive of the Health Service in Ireland stated: *"I know that if people experience the benefits of team working for themselves and patients, they will wonder why they ever worked in any other way"* (Tucker for Tribal Secta 2005).

7.4 Classification and Interrogation of Data

At the start of phase 1 staff were asked to record what integrated care meant to them in question F of the baseline questionnaire (Q1).   I interrogated the data from 63 staff questionnaires, and coded their responses by theme using content analysis using the method set out in chapter 5. Questionnaires were received from a wide range of staff (Table 23) and were received from staff working in all care groups (Table 24).

Responses were placed in three categories adopted from the literature review namely: the values, processes and outcomes of integrated care (Thistlethwaite 2004, Grone and Garcia- Barbero 2001). The analysis of the 63 staff's responses contributed to the discussion on the definition of integrated care and the ICON diagrammatic model.

In Phase 3, 18 teams were supported over a nine month period to develop processes to facilitate integrated care. Team leaders completed questionnaires at the start and end of this phase, recording progress made. An analysis of the 36 questionnaires was undertaken to assess what progress was made with eight of the processes, and consider views and experiences of staff in developing integrated care. Staff recorded their experiences of changing practice in documents such as action learning set notes, presentations and team records thereby enabling a triangulation of the data. I also

assessed the inclusivity of integrated care by analysing the client groups by service and age group catered for in the teams across the organisation. The data from the questionnaires at the start and end of Phase 3 were available for secondary retrospective analysis, in a longitudinal study measuring progress over the nine month period.

The eight processes that made up the components selected by teams for development were: open referral, common assessment, care plans, an outcome measurement system, single client file, an information sharing protocol, a system for sharing information on services, and processes for team building (Tucker for Tribal Secta 2005*).* These are shown in the analytical framework described in Chapter 5.

7.5 Definition and Model for Integrated Care

The data in the 63 questionnaires provided 309 terms or phrases recorded by staff when stating "what does integrated care mean to you." The terms used were categorised as a value, process or outcome, using the framework identified in the literature review in chapter 4. The term or phrase was recorded on an excel spreadsheet, and consolidated into themes using deductive analysis. Staff recorded on average 4.9 terms or phrases in their response to the question. 138 (45%) terms were classified as values, 131 (42%) as processes and 40 as outcomes (13%). This proportion reflects definitions within the literature, where integrated care is less frequently defined by outcome (Kodner and Spreeuwenberg 2002; Nies and Berman 2004).

– **Values**

The value that staff recorded most frequently was that of integrated care as being person-centred (or an equivalent term such as client focused or user-orientated) and a

service designed according to the needs of individuals, such as reflected in the following comment: *"Integrated care is a system of providing care where the patient is at the centre of the process" (Q6).* Another member of staff recorded that:*"Integrated Care means nothing if it is not needs-led."* One member of staff described integrated care as being led by service users who are empowered *"A unified approach to treatment encompassing a holistic approach with the patient as an active participant" (Q36).* The categories for contributions that were coded as 8 values are shown in Table 38 below.

Values	No	%
Person centred/appropriate to need	55	40%
Seamless/ Holistic/Continuity	37	27%
Accessible/Timely	15	11%
Efficient /Effective	14	10%
Partnership	6	4%
Quality	5	4%
Equality	4	3%
Vision shared	2	1%
Total	138	100%

Table 38: Staff Definition of Integrated Care – Values

The term "seamless" was used by 14% of respondents: *"Very simple – cradle to grave – all services provided to a client should be totally integrated and seamless irrespective of the type of care, the care provider or the location" (Q44).* A frequently used term was holistic (9%) such as expressed in the two following extracts: *"Services working closely together to provide a holistic, coordinated and easily accessible service where the service users best interests are paramount" (Q29); "A group of professionals coming together to contribute to the holistic care of the person"* (Q26). Values are considered

fundamental to creating an appropriate culture for joint working (Freeman *et al*. 2001) and welcoming differences (Graham 1991:52) : *"It means communicating clearly and honestly with people, trusting others and being clear on agreements. It means looking beyond your professional stomping ground and encouraging others to provide the best service solutions with you" (Q31).*

– **Process**

A total of 131 terms were coded under the category of "process", and were themed as terms for systems, care management and care providers as shown in Table 39.

Process	Examples	No.	%
System	Finance, Information, Communication	12	9%
Care Management	Referral, Access, Care plans, Outcome measures	63	48%
Care Providers	Training, Education	56	43%
Total		131	100%

Table 39: Staff Definition of Integrated Care - Processes

Nearly half of the terms used concerned how integrated care is delivered (48%), and just over one third (35%) used terms to indicate who provides the service. With regard to how integrated care is delivered, "care management", "coordination", "communication" and "information on clients" featured strongly in responses. *"Fully integrated care to me means that a patient entering the system (regardless of where in the system) has a continuity of care based on their needs as identified by the appropriate assessment. This care would be delivered in a way which is user and family friendly, not duplicated or fragmented in the simplest and most appropriate means possible regardless of what field of services through proper linkage and coordination" (Q37).* 41% of respondents referred to horizontal integration with "multidisciplinary" or "interdisciplinary"

working, with only 16% referring to integrated working across agencies. Respondents described the vertical integration across primary, community and acute care. 2 respondents gave views on how preventative care needs to be integrated. "*Between acute and community that everyone knows what is going on. All information is conveyed in a seamless fashion. The multi-disciplinary needs of the client are met. The professionals involved meet with the appropriate people with the client at the centre*" (Q33).

– **Outcomes**

40 items were classified as outcomes, where staff described the impact or benefit of working in an integrated way (Table 40).

Outcomes	No	%
Patient benefit	28	70%
Maximise quality	2	5%
Reduce duplication/gaps	8	20%
Benefit to MHB & Providers	2	5%
Total	40	100%

Table 40: Staff Definition of Integrated Care – Outcomes

Nearly half (48%) of the respondents specifically recorded that integrating care was carried out in order to benefit the patient. The benefit to patients may be viewed as implicit in many of the staff responses, but is not always articulated as such and cannot be recorded. Therefore there is likely to be an under-recording of patient benefit as an outcome. The response below draws attention to benefits to staff and the organisation. "*The bringing together of all relevant services provided by the Board in a structured manner so that the appropriate service providers see the patient. Patient/client benefits. The Board benefits. Service providers benefit*" (Q39). 8 responses were concerned the

avoidance of duplications or fragmentation in services: *"All services working together with the client/patient so that there would be no gaps or duplication in service provision and no passing the problem from one care group to another…."* (Q52).

7.6 Results of Staff Views on the Meaning of Integrated Care

In the response to the question of what integrated care meant to them, staff focused on principles and values, and how integrated care was developed, rather than what it was intended to achieve. This lack of focus on outcomes and benefits reflects the findings in the literature review (Reed *et al.* 2005). The most frequently recorded contributions from staff were that integrated care is person centred, supported by care management systems and integrating care is for the benefit of the patient.

The data in the questionnaires were used to inform the development of a definition and a model for integrated care that was relevant to the context of the MHB. The themes from the analysis show that staff view integrated care as person centred and appropriate to need. Integrated care is described as an approach, requiring care management processes involving care providers working in multi-disciplinary and multi-agency teams. The main outcome of integrated care is the benefit to the patient. This secondary and retrospective analysis is a more systematic analysis of the data than my analysis as a consultant. I developed a formal definition to guide the programme based on staff contributions (MHB/Secta Consulting 2003a). *"Integrated care is care which is person-centred offering a readily accessible and seamless service based on the needs and preferences of people who use the service."*

I designed a diagrammatic model representing the contributions from staff as a guide to integrated working which was adopted (Tucker 2004a). The importance of a brand to signal a new way of working has been acknowledged in the literature (Thistlethwaite 2008).

ICON

A structured approach to facilitate and support the development of integrated care.
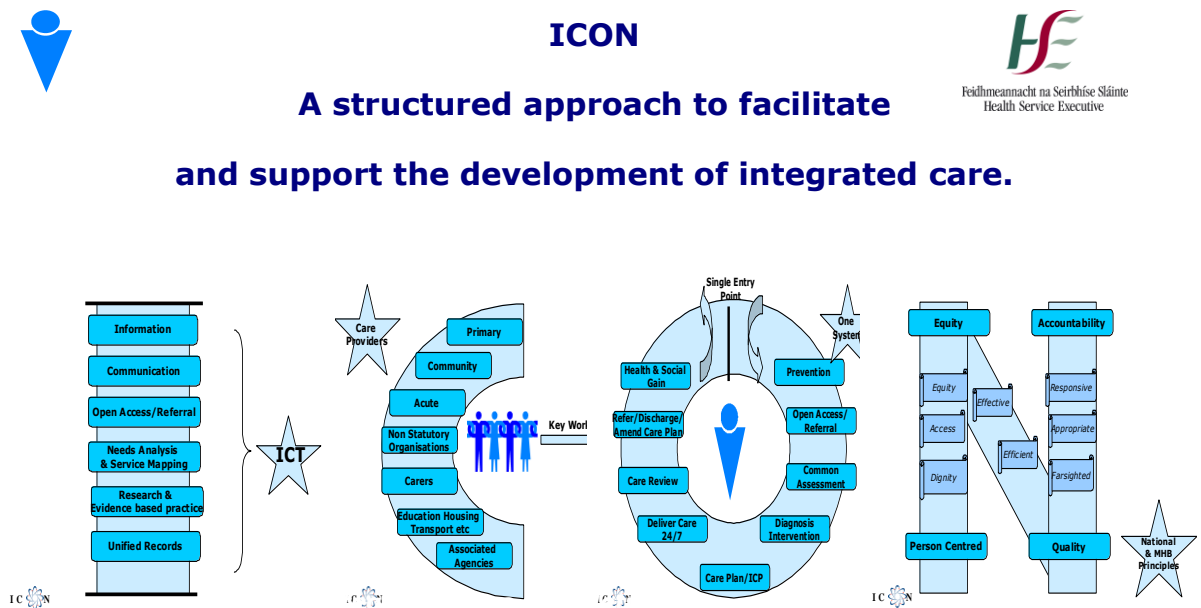
Figure 14: The ICON Model

In the ICON model, the letter "I" represents information, the letter "C" is care providers coordinated by a key worker, the letter "O" is one care management system, and the letter "N" is national and local values and principles (HSE Health Matters 2005). *"It was agreed that a brand for integrated care would help achieve a common understanding of integrated care and its component parts"* (Tucker *et al*. 2004a). The model provided a diagrammatic representation of the components and values of integrated care and was created from the contributions that staff made in the questionnaires as well as the systems maps and action plans from the workshops

(Tucker *et al*. 2004a). The processes that staff chose to focus on are contained in the ICON diagram and shown in the table below.

ICON	Processes
Information	Service Information
	Single file for clients
	Information sharing protocol (ISP)
Care providers	Team building
One care management	Common referral
	Common Assessment
	Care Plan
	Outcomes

Table 41: Processes in ICON Diagram

7.7 Identification of Processes

Staff designed action plans for progressing integrated care by choosing 8 processes that they considered would have most impact with regard to changing practice and improving integrated working. Staff recognised that joint working needed to be formalised, and designed a programme of work that was focused on implementing systems and processes that required, supported or facilitated integrated working. This approach mirrored the approach taken by the EPICs programme, when staff agreed to rewrite or align systems and processes between agencies so that staff from different agencies and professions could work together using a common approach (Foote and Stanners 2002).

7.8 The Development of Processes to Support Integrated Care

The MHB Steering Group, consisted of senior managers of the organisation representing all care groups. 18 teams for phase 3were made according to criteria which included the

willingness of teams to join the programme, the identification of a team leader, and the support of the local manager (Tucker for Tribal Secta 2005).

– **The Teams**

The 18 teams were diverse, and included teams supporting people of all ages and providing services including health promotion and early intervention services, rehabilitation and respite care, clinical treatments and continuing care. There were also teams that provided clinical support functions, such as those supplying aids and appliances, those managing discharges from hospital and a team assessing older people for nursing home arrangements. The teams are detailed in the table below by code, team name, and description.

Ref	Team	Description provided by team leaders
1/LO/PCT	Primary Care Team Portarlington	A GP surgery which was national pilot for developing a primary care team with a project leader
2/LW/EIT	Early Intervention Team Mullingar	A specialist service for children with developmental delay
3/LW/SP	Springfield Centre	A rehabilitation service based at Springfield for adults and older people
4/LO/EIT	Early Intervention team Laois	A specialist service for children with developmental delay
5/LO/RP	St Paul's Ward	A service for older people offering respite care
6/LO/AD	Admissions & Discharge Team	A team coordinating the admissions and discharge of people with complex conditions
7/LW/MH	Mental Health	A mental health team in Mullingar
8/LW/CRT	Community Rehabilitation Team	A team offering community based rehabilitation
9/LO/NH	Nursing Home Subvention Team	A team assessing older people for the entitlements to nursing home care
10/LO/AA	Aids and Appliances	A newly designed service led by OTs offering aids and appliances
11/LW/LU	Nurse Led Leg Ulcer Clinic	A nurse-led service treating and monitoring people with leg ulcers
12/MHB/OH	Occupational Health	An organisation-wide service for staff, offering occupational health service
13/LO/FC	Falls clinic	A service for older people aimed at crisis prevention and minimising falls

14/LW/ID	St Hilda's	A service for children and young people with intellectual disability
15/LW/PCT	Primary Care Team – Newtown	A GP practice extending to a primary care team
16/LW/TS	Travellers Service Longford/Westmeath	A general service supporting the health and welfare of travellers
17/LO/TS	Travellers Service Laois/Offaly	A general service supporting the health and welfare of travellers
18/LO/YS	Le Cheile	A service for vulnerable young people aimed at averting crises

Table 42: Teams by code, name and function

I gave each team a unique reference number as described in the research approach chapter based on a sequential number, location and a code for the service. The team name, location, client group by age and the care group directorate were recorded in the questionnaires by staff and were the fields for data analysis as shown in Table 43.

Ref	Team Name	Client Age	Care Group
1/LO/PCT	Primary Care Team – Portarlington	All	Primary
2/LW/EIT	Children's Early Intervention Team Mullingar	Children	Disability
3/LW/SP	Rehabilitation, Springfield Centre	Adults	Disability
4/LO/EIT	Children's Early Intervention Team L/O	Children	Disability
5/LO/RP	St Pauls respite for older people	Older People	Community
6/LO/AD	Admissions & Discharge Team	Older People	Community
7/LW/MH	Mental Health	Adults	Mental Health
8/LW/CRT	Community Rehabilitation Team	Older People	Disability
9/LO/NH	Nursing Home Subvention Team	Older People	Community
10/LO/AA	Aids and Appliances	All	Community
11/LW/LU	Leg Ulcer Clinic	Adults	Community
12/MHB/OH	Occupational Health	Adults	Health Promotion
13/LO/FC	Falls clinic	Older People	Health Promotion
14/LW/ID	St Hilda's Intellectual Disability Service	Children	Mental Health
15/LW/PCT	Primary Care Team – Newtown	All	Primary
16/LW/TS	Travellers Service L/W	All	Primary
17/LO/TS	Travellers Service L/O	All	Primary
18/LO/YS	Le Cheile youth service	Children	Community

Table 43: Profile of Teams in ICON Programme by client age and care group

I have selected verbatim extracts from four questionnaires from team leaders to describe teams supporting children, young people, adults and older people respectively, as a way of contextualising the data analysis.

- Children and Young People

  "The Early Intervention services can help the child and family learns the best ways to care for a child, support and promote development and inclusion in community life. The team provides assessment and treatment aged 0-5 yrs 11 months with difficulties in overall development" *(2/LW/EIT).*

Le Cheile was a team that provided support to young vulnerable adults and described their role as "*to provide therapeutic and preventative work via 1:1 work and group work, utilising key work sessions and activities that are client centred*" (18/LO/YS).

- Adults

A team catering for adults of working age was the occupational health team, which recorded that their role was to *"provide a comprehensive high quality health, safety and welfare at work service to the workforce"* (12/MHB/OH).

- Older People

One of the teams supporting older people was the Community Rehabilitation Team which was described as a "*community based service for selected elderly who are identified in hospital to have the potential to rehabilitate. Service is provided in the home following discharge up to a 12 week period"* *(*8/LW/CRT)

Teams were asked to record when their team had been established and results are in Table 44. Two thirds of the teams had been established for more than three years, showing that these were established services.

Duration	Number	%
Up to 2 years 11 months	6	33%
3 years to 5 years 11 months	6	33%
6 years and over	5	28%
Not given	1	6%
Total	18	100%

Table 44: Duration of Services Provided by Teams

– **The Processes**

Team leaders recorded whether processes were in place to support integrated working at the start and the end of Phase 3, so that progress could be assessed. These 8 processes which were identified by staff as facilitating integrated working were also identified in the literature review (Kodner 2003; Thistlethwaite 2009).

Team leaders completed the questionnaires and submitted these to the project team who validated and interpreted the responses in the questionnaires, through their knowledge of the operation of the service. As described in Chapter 5, the project team were working closely with the teams within the programme of seminars, action learning sets and ongoing support and could verify the data in the questionnaires regarding the status of systems and processes in place within the organisation.

The questions in the questionnaire concerning care management were: "*Are there clear referral procedures between team members?*"; "*Does the team have a common assessment?*"; *"Does the team agree a care plan with the client / carer?"* and "*Does the team measure outcomes?"* which refer to open referral, common assessment, care plans and outcome measurement respectively.

The questions categorised as information processes were: "*Does the team use a data sharing protocol?*" "*Does the team have an information brochure for service users?*" referred to as sharing information on services and "*Are client notes multidisciplinary or separate unidisciplinary files?*" referred to as a single file. The question which concerned care providers working as teams, and whether there was anything in place to support this such as training: "*Has the team attended team building?*"

The responses in the questionnaires were coded and themed and results tabulated below.

7.9 Frequency of Processes in Place

The results have been recorded in the table below using colour coding to assist with a visual appraisal of the results and to help with identifying any patterns or trends. Where a team has recorded that they have a process in place, the square is blocked with colour. Any changes from the start of Phase 3 to the end of Phase 3 is shown by either a "+1" in the event of the process now being in place, or a "-1" if the process has been deemed by the staff to no longer be in place. The use of the letter "P" shows where staff have recorded that their process is pending. The final column in the table shows the number of processes in place at the start of the programme in brackets, and the number in place at the end of the programme in bold. Therefore, the analysis of the data is summarised in the table by process, by team and over the period of time from the start to the end of Phase 3. Each team has a unique code (number, location and service code) and the key to Table 39 is provided in Table 40.

Ref	Referral	Service Info	Care Plan	Out Come	Assess	Single File	Data Share	Team Build	Total End (Start)
1/LO/PCT						-1			**6** (7)
2/LW/EIT		+1		+1					**7** (5)
3/LW/SP							+1	P	**5** (4)
4/LO/EIT		+1		+1		+1			**5** (2)
5/LO/RP		+1		+1					**5** (3)
6/LO/AD							+1		**4** (3)
7/LW/MH					P				**6** (6)
8/LW/CRT						+1			**7** (6)
9/LO/NH							-1		**5** (6)
10/LO/AA									**3** (3)
11/LW/LU		+1	+1			+1	P		**5** (2)
12/MHB/OH					-1 P				**3** (4)
13/LO/FC			P	P					**2** (2)
14/LW/ID				-1 P					**2** (3)
15/LW/PCT									**4** (4)
16/LW/TS							+1		**4** (3)
17/LO/TS						+1			**8** (7)
18/LO/YS									**8** (8)
Total **End** (Start)	**16** (16)	**14** (10)	**14** (13)	**12** (10)	**11** (12)	**9** (6)	**8** (6)	**5** (5)	**89** (78)

Table 45: Processes in Place in ICON Teams at the Start and End of Phase 3

Key	
Colour	Blocked colour indicates process in place
White	Process not in place
+1	Process implemented during programme
-1	Process no longer considered in place
P	Process pending

Table 46: Key to Table - ICON Processes

The analysis shows a median of 4 of the 8 processes in place at the start of the programme, increasing to a median of 5 of the 8 processes in place at the end of the programme. Teams also recorded that 7 processes were pending.

Table 45 shows that teams recorded a total of 78 processes in place at the start rising to 89 at the end of Phase 3. Processes considered to be already in place in the majority of teams were those concerned with referral, assessment, care planning, outcome measurement and service information. The processes to support how professionals

share client information, and how they hold a single client file were in place in one third of teams. The processes to support team building, such as induction and training, were in place in 5 of the 18 teams.

No.	Process	In Place at Start n=18	%	In Place at End n=18	%	Difference	%
1/O	Open Referral	16	89%	16	89%	0	0%
5/O	Care Plan	13	72%	14	78%	1	6%
8/I	Service Information	10	56%	14	78%	4	22%
6/O	Outcome Measurement	10	56%	12	67%	2	11%
2/O	Common Assessment	12	67%	11	61%	-1	-6%
3/I	Single File	6	33%	9	50%	3	17%
4/I	Information Sharing Protocol (ISP)	6	33%	8	44%	2	11%
7/C	Team building	5	28%	5	28%	0	0%
	Total	78	54%	89	62%	11	8%

Table 47: Processes in Place at Start and End of P3

Sourcing data from the questionnaires completed by team leaders, and cross referencing with reports and documents, the presence of formal processes were evidenced as in place.   The graph below (Figure 15) illustrates the changes in processes in place from the start to the end of the Phase 3.
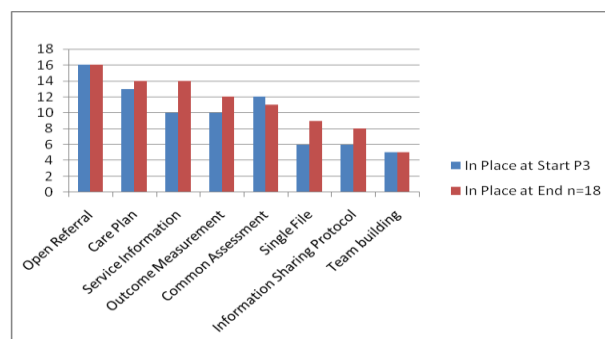
Figure 15: Processes Supporting Integration in Place

No progress was recorded by any of the teams on processes for training or supporting teambuilding. There was also no progress on referral processes, although 16 of the 18 teams had this in place already. Negative progress was recorded in the assessment

process, where a team leader considered it to be in place initially, and then revised the view by the end of the programme. The results are summarised in Table 48, categorised by three of the letters in ICON: O for care management, I for information and C for care providers.

Process in ICON	In Place at Start P3	%	In Place at End P3	%	Difference
Care Management (O)	51	65%	53	60%	2
Information (I)	22	28%	31	35%	9
Care Providers (C)	5	6%	5	6%	0
Total	78	100%	89	100%	11

Table 48: Processes in Place Categorised by ICON Model

During the programme, nine of the processes implemented were concerned with information systems: three teams implemented the single file; two teams implemented the protocol for information sharing and four teams implemented service information in a directory or brochure. Two teams implemented processes for measuring outcomes.

The progress in the implementation of processes is shown below (Figure 16) in the analytical framework. The first figure is the number at the start of the programme, and the second figure in bold is the number at the end of the programme.
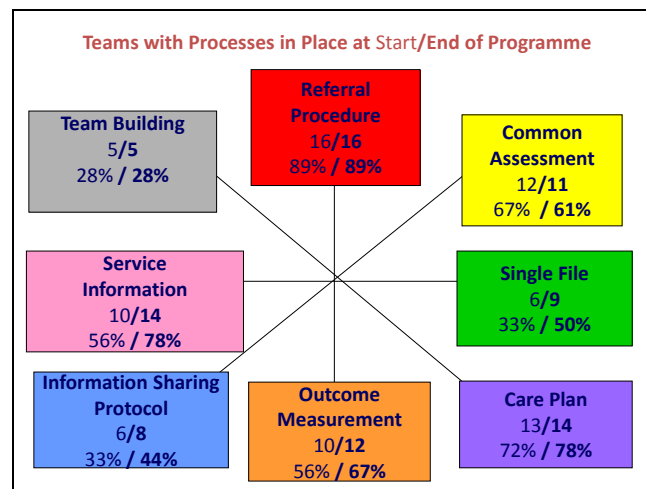
Figure 16: Analytical Framework for Eight Processes with Results

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Most progress was made in developing and sharing information about each service, which may be viewed as a first step to understanding how services may work together and in what way. Teams chose to focus on developing a recording system that was client-focused using a single file that required a clear understanding of what information could be shared. Team members recorded that without basic information on who they were working with, what the services had to offer, and how they would share information on patients, it was not possible to progress integrated working (ALS). This represented a strong message about getting the foundation for relationships and trust in place before making any changes in ways of working, which represented new knowledge (Tucker and Burgis 2012).

7.10   Processes in Place by Team

Teams recorded between two and eight processes in place at the start and end of the programme, averaging between four and five processes, as shown in Table 49.

Ref	Team	Start	End	New Processes
1/LO/PCT	Primary Care Team – Portarlington	7	6	-1
2/LW/EIT	Early Intervention Team Mullingar	5	7	+2
3/LW/SP	Springfield Centre	4	5	+1
4/LO/EIT	Early Intervention team Laois	2	5	+3
5/LO/RP	St Paul's Ward	3	5	+2
6/LO/AD	Admissions & Discharge Team	3	4	+1
7/LW/MH	Mental Health	6	6	0
8/LW/CRT	Community Rehabilitation Team	6	7	+1
9/LO/NH	Nursing Home Subvention Team	6	5	-1
10/LO/AA	Aids and Appliances	3	3	0
11/LW/LU	Nurse Led Leg Ulcer Clinic	2	5	+3

12/MHB/OH	Occupational Health	4	3	-1
13/LO/FC	Falls clinic	2	2	0
14/LW/ID	St Hilda's	3	2	-1
15/LW/PCT	Primary Care Team – Newtown	4	4	0
16/LW/TS	Travellers Service Longford/Westmeath	3	4	+1
17/LO/TS	Travellers Service Laois/Offaly	7	8	+1
18/LO/YS	Le Cheile	8	8	0
	Total	78	89	11

Table 49: Changes in processes in place during ICON Phase 3

I have analysed the progress by teams, to determine whether there was any pattern of progress by type of service. 2 teams increased their number of processes and systems by 3, teams by 2 and 5 teams by 1. 5 teams recorded no change. 3 teams reviewed their initial assessment of whether they had processes in place and considered that they did not. The teams that made the most progress were the two teams for children with developmental delay, and teams supporting older people providing a leg ulcer service and respite care. Teams making little or no progress with processes included the primary care teams, occupational health and the St Hilda's service for children with an intellectual disability.

7.11   Processes in Place by Client/Age Group

My analysis in table 50 shows that the 4 teams providing services designated for children made most progress with developing 4 additional processes over the programme and had more processes in place at the end (5.5) than the overall average (4.94). 3 processes were implemented by teams for adults and those for older people, and overall teams for these two client groups had less than the average number of processes in place. Little progress was made with the teams those serving all ages.

Age Group	No. Teams	No. Processes at Start	Average Processes in Place	No. Processes at End	Average no. Processes	Difference in Processes	Difference in Averages
Children	4	18	4.50	22	5.50	4	1.00
All Ages	5	24	4.80	25	5.00	1	0.20
Older People	5	20	4.00	23	4.60	3	0.60
Adults	4	16	4.00	19	4.75	3	0.75
Total	18	78	4.33	89	4.94	11	0.61

Table 50: Processes in Place by Client/Age Groups

7.12   Processes in Place by Services

I have analysed the progress made by the type of services, using the five categories that the MHB adopted in their care directorates (Tucker for Tribal Secta 2005). The teams that made the most progress in developing processes were the teams providing disability and community services, accounting for a combined increase of 12 processes within their 10 teams. Disability services accounted for an average of 6 processes per team. Negative progress was recorded by the teams in health promotion and mental health. Teams working in primary care averaged 5.5 processes for their 4 teams, although only increased their number of processes by one (Table 51).

Service	No. of Teams	No. Processes Start P3	Average	No. Processes End P3	Average	Difference in processes
Community	6	25	4.17	30	5	5
Disability	4	17	4.25	24	6	7
Health Promotion	2	6	3.00	5	2.5	-1
Mental Health	2	9	4.50	8	4	-1
Primary Care	4	21	5.25	22	5.5	1
Total	18	78	4.33	89	4.94	11

Table 51: Processes in Place by Service

7.13   Processes in Place by Location

The analysis of teams by location has been undertaken to determine whether there were differences in developing processes across the MHB by area (Table 52). There were eight teams in Longford/Westmeath and nine teams in Laois/Offaly, which was how the MHB was divided in the management structure. There was a marginal difference in progress, with Laois/Offaly recording five processes and Longford /Westmeath recording seven processes. The team working across the MHB was health promotion, who recorded negative progress. This may indicate that teams providing local services were able to progress more quickly than those which provided MHB-wide services.

Area	No. Teams	No. Processes Start P3	Average Processes in Place	No. Processes End P3	Average no. Processes	Difference in Processes	Difference in Averages
Laois Offaly	9	41	4.56	46	5.11	5	0.55
Longford Westmeath	8	33	4.13	40	5.00	7	0.87
Midland Area	1	4	4.00	3	3.00	-1	-1.00
Total	18	78	4.33	89	4.94	11	0.61

Table 52: Processes in Place by Location

7.14   Staff Changes in Phase 3

Over the course of Phase 3, the core team membership increased by 10%, with 15 members of staff, increasing the number of staff in the 18 teams from 141 to 156 (Tucker for Tribal Secta 2005). This increased the average by 8 to 9 in a team. The increase was by headcount, and not by whole time equivalent measures and staff did not record if the posts were substantive, full time or sessional (Table 53). The Action Learning Notes records showed that team leaders had made the case for additional administrative support, so that clinical staff could increase the proportion of time they

spent on clinical tasks, resulting in five additional administrative staff (ALS). Five

therapists were also recruited during this time. Three of the teams wanted to have a

social worker as part of their team, noting that some of these tasks were being

undertaken by the public health nurse, and three social workers were added during the

period. The increase in staffing was recorded by staff as helping to address some of the

concerns about completeness of the teams, and this was undertaken during a period of

recruitment freeze in the MHB (ALS).

Team Members	Start P3	End P3	Difference
Managers	5	6	1
Admin/Clerical	17	22	5
Therapy	35	40	5
Nursing	33	35	2
Medical	21	20	-1
Social Workers	1	4	3
Support workers	22	22	0
Other (not specified)	7	7	0
Total	141	156	15

Table 53: Development in Team Membership during Phase 3

The staff recorded that they had 15 more staff in post in their core teams in their

questionnaires at the end of the programme, and the records showed that teams had

either been recruiting to known vacancies, or were making the case for additional

resources (ALS). It is noted that 6 of the staff were in one team, namely the early

intervention team in Mullingar.

Ref	Team	No. in Team At Start	No. in Team At End	Additional Staff	New Processes In Place
1/LO/PCT	Primary Care Team - Portarlington	10	11	1	-1
2/LW/EIT	Early Intervention Team Mullingar	4	10	6	2
3/LW/SP	Springfield Centre	20	22	2	1
4/LO/EIT	Early Intervention team Laois	5	5	0	3
5/LO/RP	St Paul's Ward	2	2	0	2
6/LO/AD	Admissions & Discharge Team	7	7	0	1
7/LW/MH	Mental Health	15	15	0	0
8/LW/CRT	Community Rehabilitation Team	8	9	1	1
9/LO/NH	Nursing Home Subvention Team	4	4	0	-1
10/LO/AA	Aids and Appliances	8	8	0	0
11/LW/LU	Nurse Led Leg Ulcer Clinic	7	7	0	3
12/MHB/OH	Occupational Health	9	9	0	-1
13/LO/FC	Falls clinic	2	2	0	0
14/LW/ID	St Hilda's	4	4	0	-1
15/LW/PCT	Primary Care Team Newtown	14	15	1	0
16/LW/TS	Travellers Service L/W	6	8	2	1
17/LO/TS	Travellers Service L/O	11	11	0	1
18/LO/YS	Le Cheile	5	7	2	0
	Total	141	156	15	11

Table 54: Staffing Levels by Team Correlated with Processes in Place

I considered whether there was a correlation between the progress made by teams in implementing systems and teams that had additional staff appointed during the programme. The teams that made most progress did not record any new staff joining although three of the teams with additional staff also recorded additional processes. I concluded that there was no pattern overall.

I analysed the teams by size, to see if there was a correlation with progress. The size of the teams changed at the programme as staff were recruited. This shows that medium sized teams had the most processes in place at the start and end of phase 3. However, those teams that implemented most processes during phase 3 were the small teams of 8 or less staff and were responsible for 70% of the processes implemented.

ICON Team Size	No. Teams Start Phase 3	Av no Processes	No. Teams End of Phase 3	Av no Processes	No. Processes increased
Small (Up to 8)	12	3.6	10	4.3	+8
Medium (9 to 16)	5	5.8	7	5.9	+2
Large (17 to 24)	1	4	1	5	+1
Total	18		18		+11

Table 55: Size of Teams and number of processes in phase 3

This may suggest that there is a correlation between the size of team and the ability to implement changes within this timeframe. Jelphs and Dickinson (2008:6) refer to the view by Belbin that teams should be no more than 6-8 members and there is a view that relationships are more difficult to sustain in large teams (Leutz 2005).

7.15 Summary of Findings

The summary of the key findings above shows that integrated services are present in all services in the ICON programme, interpreted by the fact that they have implemented processes such as joint assessments, common referral and care plans. Teams recorded at least 2 processes in place to support integrated working, and 2 teams reported all 8 in place. Progress was recorded during the programme, particularly in processes that improved information on services and clients.

Most progress was recorded by teams working with children, and those working in disability services and community services. Less progress was recorded by teams working for adults and all ages, and with those providing mental health services, health promotion services and primary care services. The specific teams that increased their processes by two or more processes in the period were the two early intervention teams for children with a disability, and the teams for leg ulcers and the respite care service for

older people. The children's teams recorded the highest number of processes per team, with an average of 5.5 out of 8 of the processes by the end of the programme.

The tables below summarise the average number of processes in place by service, client group and location for the beginning (Table 56) and end (Table 57) of Phase 3, categorised by low, medium and high.

Category	Processes in Place Low (up to 3.99)	Processes in Place Medium (4.00 to 4.99)	Processes in Place High (5.00 and over)
Service	Health Promotion 3.00	Mental Health 4.50 Disability 4.25 Community 4.17	Primary Care 5.25
Client Group		All ages 4.80 Children 4.50 Older People 4.00 Adults 4.00	
Location		Laois Offaly 4.56 Longford Westmeath 4.13 Midland Area 4.00	

Table 56: Summary Findings for the Start of Phase 3

The table below shows a shift from "medium" to "high" for disability services, community services and primary care; for services for children and all ages; and local areas, but not ion those providing services on a MHB-wide basis.

Category	Processes in Place Low (up to 3.99)	Processes in Place Medium (4.00 to 4.99)	Processes in Place High (5.00 and over)
Service	Health Promotion 2.5	Mental Health 4.00	Disability 6.00 Primary Care 5.50 Community 5.00
Client Group		Adults 4.75 Older People 4.6	Children 5.50 All ages 5.00
Location	Midland Area 3.00		Laois Offaly 5.11 Longford Westmeath 5.00

Table 57: Summary Findings for the End of Phase 3

Services that were recorded as having a high number of processes in place at the end of the programme were primary care and disability services, and those services catering for children and those for all ages also recorded a high number of processes in place.

7.16   Team Experiences – Embedded Case Study

In order to explore the experience and views of staff in the ICON teams, I have analysed the data recorded by team leaders for five teams and summarised the recorded views and experience of the staff in the teams and written these as embedded case studies in order to describe features, context, and processes (Yin 2003). I wanted to provide some context to the findings on the changes to the increase in shared processes and systems, and by using data in source documents illustrate the way that working patterns changed and how integrated care was being developed. I have adopted a method of writing a "thick description," as described in chapter 5, as this process enables the context and interrelationships to be shown, and increases the trustworthiness of the research (Heaton 2004:100, Holliday 2007:76).

I have structured each description of the team experience in the following way:

- − Team profile

- − The development of integration

- − How the team wanted to further develop integrated working

- − Lessons learnt by the team.

The five teams were purposively selected to illustrate the range of experiences with changes in processes in services within the programme, with teams ranging from increasing their processes by three, to reducing their processes by one as shown in Table 58. Three of the teams were from Longford Westmeath and two were from Laois Offaly. The profiles may be considered to be embedded case studies (Yin 2003:40). The

teams provide services to a range of client age groups, including children, adults and older people.

Reference	Team	Age Group	Progress in Processes	Changes in Staff Team
11/LW/LU	Leg Ulcer Clinic	Adults	+ 3 (2 to 5)	0
2/LW/EIT	Early Intervention Team	Children	+ 2 (5 to 7)	+6
8/LW/CRT	Community Rehabilitation Team	Older People	+1 (6 to)	+1
13/LO/FC	Falls Team	Older People	= (2 to 2)	0
1/LO/PCT	Primary Care Team – Portarlington	All	-1 (7 to 6)	+1

Table 58: Five Teams and their respective progress in implementing processes

The source documents used to create these case studies are detailed in section 5.4 in research approach. The sources were: the team leader questionnaires at the start and end of the process used for the above analysis (Q1,Q2); presentations prepared by staff at the start and end of the process (P1,P2); consultancy reports (MHBa,MHBb,TS); recorded and shared notes from the monthly Action Learning Sets (ALS); and team records such as notes of meetings that were made available to the project (TR) as in (Appendix E).

The Action Learning Set meetings were used as a way for team leaders to share progress and good practice, as well as present challenges and request advice and support from other team leaders. Therefore any differences in opinion within the teams, or difficulties with agreeing and implementing changes were discussed within this forum.

The summaries of each team that follow provide a context for the findings of the data analysis.

– **Leg Ulcer Clinic Team**

The Leg Ulcer clinic was described as a nursing initiative with support from consultant medical staff and GPs and had been in operation for six years (Q2). The core team of 8 staff consisted of public health nurses, community nurses and therapists supported by clerical staff (Q2), thereby illustrating multidisciplinary working. The team had a role in health promotion and health education as well as treatment. The service offered was for adults and older people with recurrent leg ulcers or ulcers failing to heal. The team leader described *"the leg ulcer clinic which is one of the most advanced in the country provides an advice and treatment to clients with leg ulcers. Teaching to patients and students on leg ulcer care is also given"* (Q1).

The team developed a referral map which was used to identify who was involved in the process (P1). The team had recorded that they had a referral system in place at the start and end of the programme, although work was carried out to refine and develop the system (ALS). During Phase 3 the team added three further processes: service information, care plan and single file (P1). For instance, the team had developed an information leaflet (ALS). A protocol for sharing patient information was described as pending (Q2). Processes were not in place for measuring outcomes or team building, although staff recorded that one of the lessons learnt was the importance of all team members (P1). Factors that the team recorded as hindering development were the lack of IT and lack of access to the internet, lack of time and a high workload in a busy clinic, and insufficient team members and in particular clerical team members (ALS). Factors that helped develop the processes were the inclusion in the ICON programme that *"helped put a structure to our work"* and the availability of support to help develop

documentation, systems and processes (ALS). The team recorded that *"ICON encourages reflective practice"* (ALS). The team leader described operational difficulties prior to the ICON programme as the clinic's informal nature meant that clinical details were not always provided by referring GPs (ALS). The team designed and implemented a standard referral form, and concluded in their final presentation that one of the lessons learnt in ICON was to streamline and align processes (P2). The team gave an example of simplifying referral to a vascular clinic without having to refer the patient back to their GP (ALS). Other lessons included the necessity of clear information for the patients. The team set out their challenges for the future, including: *"further developing our core team to include a chiropodist, podiatrist, and dietician;"* as well as *"procuring increased administrative support,"* and an *"ICT solutions for our files."* The team presented a client benefit from the service and said that ICON has helped the team to *"consider all of the key people involved in delivering our services"* (P1). The team provided evidence of multidisciplinary working and integration between secondary and primary care.

My observation of the team leader and members of the team, as a consultant, was that being part of the ICON programme gave them confidence to be more proactive in their service, to provide more information about their service, and to manage the referral process more effectively.

– **Early Intervention Team for Children with Developmental Delay**

The Early Intervention Team was a multidisciplinary team of 9 staff, namely a

consultant paediatrician, a clerical officer, two nurses, a social worker, a physiotherapist,

a psychologist, a dietician, and speech and language therapist. The speech therapist was

the team leader for the ICON programme. The team described their services as offering

assessment, diagnosis, and treatment for children aged 0-6 with significant

developmental delay who met specified eligibility criteria (TR). The team was formed in

September 2003(Q1). At the start of the programme, recruitment was being carried out

for three posts (dietician, psychologist and nurse) and the OT was on maternity leave.

The posts were filled at the end of the programme (ALS).

The team described their common goal of streamlining and integrating their service

(Q2). The team wanted to improve access and referral to the service, and to develop a

common assessment process (P2). The team had developed a way of providing

information on the service through a leaflet, and had processes in place for sharing client

information between professionals. The team also had a care planning system in place

and developed a referral pathway (Q1). The team decided to work on their assessment

process so that all team members could use the Bayleys assessment tool, previously only

undertaken by the psychologist. The team reduced the number of appointments, from 7

to 1 with joint assessments and reports (TR). *"Reduction in duplication in taking client*

history and demo-graphic details with 1-2 composite reports now issued to client

instead of 7 which leaves more clinical time for patients" (ALS). The team provided a

patient case study illustrating how a link worker was the single point of contact and

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recording that *"Parents say that they have a better awareness of (their daughter's) overall needs and feel that everyone is working together for their child"* (TR).

The team presented some practical challenges to their way of working, such as the lack of suitable accommodation and space which was affecting their ability to store records and hold a single file (ALS). Other ICON team leaders offered support and temporary accommodation for meetings, illustrating a supportive network (ALS). Changes in team members and their roles meant that new staff needed induction and training in the way of working and teambuilding was delayed (ALS). The team described the challenge of maintaining cohesion when new members are joining and expanding the team (TR). The team was carrying out ongoing reviews of their standard operating procedures, and were involving families more directly in developing care plans (P2). The team identified the need for management support for their new way of working, and after some cancelled meetings, negotiated a six weekly support session with the manager to pursue some of the wider implications of integrated working (ALS). Factors that helped the development of integrated care were listed as having a common goal, having the flexibility to change, and having communication with mutual respect (Q2). The team recorded that they had benefited from resources and training from the ICON programme (P2). The learning from the team was the need to work with families more closely, and the need for flexibility (P2). Types of integration evident in the service were multidisciplinary working, integration with secondary and primary care, and integration with social services.

My observation of the team as a consultant was that they wanted to work more collaboratively so that the service was more focused. The team provided evidence of a

positive outcome for clients in reducing appointments and assessment, and a positive outcome for staff in job satisfaction by sharing roles and responsibilities.

- **Community Rehabilitation Team for Older People**

The staff described the community rehabilitation team as a multidisciplinary team of 10 members including nurses, OTs, physiotherapists, a rehabilitation assistant, a speech and language therapist, a manager and a secretary. The service was formed in November 2000 as a Community Rehabilitation Unit (CRU) for patients aged 65 years and over, taking referrals from acute hospitals and the community (Q1).   The service provides a multidisciplinary individualised rehabilitation programme to patients in their own home and provides education and support to patients and their relatives (P1).

The team described working with a wider network of professionals such as GPs, home helps, day care services, and respite care services (P1). The team also worked with external agencies such as the Irish Wheelchair Association and the Carers Association (P1).   This illustrated multi-agency integration as well as integration between community and primary care. The shared goal for the team was recorded as *"improving/achieving the greatest possible health and social gain for the client,"* and was described as being designed to empower patients and carers on their abilities rather than their disabilities (P1).   The team already had six of the eight processes in place that the ICON programme was focusing on, although some required updating such as the leaflet explaining the service (Q1). At the end of the programme the team had agreed an Information Sharing Protocol, and was still working on holding a single file (Q2). The team presented client outcomes to include less time in hospital, reduced hospital

admissions, and a long term set-up in place on transfer from the team. One of the

challenges described by the team leader was the lack of a social worker in the team,

which meant that staff from other disciplines were attending to people's social needs

(ALS). The team leader was asking for advice within the programme on how to

demonstrate a demand for social work support, and suggestions made by other team

leaders for making a case by recording and aggregating data on unmet need (ALS). One

of the weaknesses in integrating the service is described as the mixed funding system,

whereby the service is not means tested, whereas some associated services such as home

helps are means tested (P2). The team leader wanted to offer more training to the team,

including team building and information technology (ALS). The team leader presented

the three main achievements as the development of guidelines for a single file system,

the updating of a "user friendly" leaflet on the service, and the development of a referral

and consent form (P1). The team is recorded as meeting once a week to discuss each

patient on a structured and time-limited basis (ALS). The team leader recorded that she

had good support from her manager. The records showed that the lack of a social

worker, the introduction of new team members, the need for more training, and the

pressure of time on a busy team were all factors that were limiting what could be

achieved. The team gave evidence of multidisciplinary and multi-agency working, as

well as integrated working across secondary, primary and community care.

My observation of the team as a consultant was that the team were methodical in

developing processes and systems, and made more progress than the records would

suggest as not every process that they worked on was considered finalised and in place.

The team expressed their views that they believed that the lack of a social worker in a community rehabilitation service had a negative impact on the effectiveness of the team and the service.

- **Falls Clinic Team**

This service is described by the team leader as an integrated falls programme providing screening, health advice and rehabilitation for older people aged 85 years and over, many of which were recovering from strokes. The team had been established for less than one year. Those patients admitted to hospital for respite care were assessed for a risk of falling by a core team consisting of two nurses and three therapists (physiotherapist, OT and dietician). In listing the team members on the questionnaire, the team leader included the patient themselves and their families, other carers, and links to other agencies and professionals within the statutory and voluntary sector (Q1).
The core team was multidisciplinary, and the team worked with GPs, acute hospital staff, pharmacies, voluntary organisations and others, demonstrating multi-agency integration. The processes in place for this new service were referral and assessment (Q1) and the team leader chose to focus on developing a care plan and outcome measures as the priority processes to be established.
The team leader recorded that she wanted to further develop the referral pathway and develop a common assessment tool (ALS). Positive factors facilitating the development of integrated care were the access to support from a range of people including the team leaders in the ICON programme, the specialist in gerontology, a member of staff leading work on care plans and an OT providing risk assessment advice. Improvements in IT

and email connectivity also helped. Factors that hindered the development of integrated working that were recorded were the difficulties in engaging GPs which was addressed by having weekly multi-disciplinary ward meetings with the GPs (ALS). The team was working on developing an integrated care plan and measuring outcome, which they described as pending (P2). So although progress had been made during the nine months of the phase, the team leader did not record an increase in the number of processes formally in place. Types of integration recorded were multidisciplinary, multi-agency, between secondary, primary and community services as well as with patients and carers.

My observation of the team whilst working as a consultant was that there was an increasing awareness of the need to formalise systems and processes, and the new team had yet to develop their relationships.

- **Primary Care Team**

The primary care team in Portarlington was formed in 2003 as a combination of three small GP practices in separate premises and a nurse-led health centre. The team was one of the national pilots for the primary care strategy with a project manager. The practices served the population within a five mile radius, although without any formal registration to practices (P1). At the start of the ICON programme there were 10 core members of the team: 3 GPs; a GP administrator; 2 nurses; a physiotherapist; an occupational therapist, a secretary and the project manager. By the end of the programme a social worker had joined the team (Q1, Q2).

The team consisted of health and social care practitioners and staff working in a multidisciplinary way. The team recorded that *"integrated care needs a common vision in order to flourish"* (P2) and held values about a person-centred care, referred to as *"getting together around patient care"* (ALS). One of the priorities for the team was to carry out a health profile of the needs of the population, so that health prevention could be targeted appropriately (ALS). In order to develop a community-based approach to the service, an enrolment system was introduced where local residents could opt to enrol with the service which incorporated a consent form regarding sharing information (P2). The team agreed a protocol for sharing information across practices and staff as part of this process (Q2). The team held weekly clinical meetings, when individual patients were discussed, educational sessions were held, and systems and processes developed. Processes for referral and assessment were initiated, and open access to physiotherapy and occupational therapy was offered (P1). Team building was delayed to coincide with the recruitment of the social worker (ALS). Joint assessments by the GP, OT and nurse resulted in an agreed care plan (TR). The presence of a multi-disciplinary team working to a person-centred approach, developing processes, and providing examples of working together for the benefit of the patient and the community would indicate that this is integrated care.

Key factors hindering integrated working were the lack of accommodation for co-location and delays in recruiting all of the members of the team (ALS). The team leader described the different pace of change, with needing to allow for time for interpersonal relationships to develop and improve (ASL), whilst fast-tracking the introduction of new processes with support from the ICON team (P2). Positive factors supporting integrated

care were cited as communication (P2), a structured work programme, and support to speed up the development of processes and system (Q2). There was evidence of shared learning and support within the action learning sets, such as with support from other team leaders on the development of a single file (ALS). A referral pathway which showed access and referral routes through the service was described as a milestone and an achievement (P2). The teamleader recorded the presence of a single file at the start of the programme, and revised this following clarification showing negative progress by the team (7 processes to 6). So whilst there was much work on recruitment, relationships and processes, this was not evident in the data.

My observation of the team as a consultant was that progress was already being made in developing an integrated way of working at the start of phase 3 and therefore specific progress in the nine months was not easily defined. The team had developed new ways of working such as weekly clinical meetings across practices and joint assessments. The team had an ambitious programme for integration, which was not reflected in the data.

7.17   Discussion of Team Experience and Views

The questions posed in the analysis have been answered for each of the teams, and show a general pattern. The team profiles were between 4 and 10 staff who formed a multidisciplinary team, and included clinical staff, therapy staff, managers and administrators. There was a record of social workers joining three of the teams

throughout the programme. There were examples given of multi-agency integration and integration with secondary care.

From the records of the five embedded case studies, I determined the types of integration that were in place. Each of the teams described multidisciplinary working, and there was evidence of joint working across secondary care, primary care and community services in most of the teams. Social workers were appointed during the programme, so integration across health and social care was beginning. Only one team referred explicitly to working with the third sector, such as the Irish Wheelchair Association. One of the teams was encouraging proactive involvement of patients and carers, such as through open referrals and instigating care arrangements. It is likely that the range of types of integration for these five case studies is under represented, as there was a reliance on this being captured in staff records rather than being in response to a direct question.

Ref	Team	MDT	Health & Social	Secondary Care	Primary & Community	Third Sector	Patients /Carers	Total
11/LW/LU	Leg Ulcer Clinic	1	0	1	1	0	0	3
2/LW/EIT	Early Intervention	1	1	1	1	0	0	4
8/LW/CRT	Community Rehab	1	1	1	1	1	0	5
13/LO/FC	Falls Team	1	0	1	0	0	1	3
1/LO/PCT	Primary Care Team	1	1	0	1	0	1	4
	Total	5	3	4	4	1	2	19

Table 59: Types of Integrated Care in 5 services within the ICON programme

The predominance of types of internal integration, with multidisciplinary working and relationships across the sectors of secondary, primary and community services mirrors the findings in the I&BP presented in the previous chapter.

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The teams described the importance of agreeing a shared goal, which then served as a reference point for developing the way that the team worked. This was typically described as providing individualised or person centred care, such as in the community rehabilitation team. The teams recorded the importance of protocols and rules that could provide them with a framework for working in a different way.   The teams described how they adapted to working in a different way, such as the children's team undertaking training so that they were all able to assess children using the same assessment tool. Teams were self-organising and adapting according to their team membership, noting some of the challenges when team members were not in post and their roles were covered by other members.   The primary care team noted the pace of change, which was delayed at some points because of interpersonal issues that needed time to resolve, and at other times was accelerated when the ICON team offered support with processes.

Improvements in information flows helped in improving understanding and enhancing levels of cooperation (Workman and Pickard 2008). The importance of regular clinical meetings was recognised, such as in the primary care team and early intervention team, and the need to proactively promote the service, such as in the leg ulcer clinic and falls clinic. The need to formalise and regularise practice through implementing processes was recognised by teams, particularly where demand management was a challenge in busy services.   Teams worked on referral mapping, which identified the individuals and agencies involved in their service, either as part of the core team or network, which was used as a tool to illustrate the number of relationships that the team were involved with and where collaborative working could be further developed.

The teams worked on processes and also developed more collaborative joint working within and beyond the core team. Whilst it is recognised that mechanisms and processes are important to support integrated working, they are not in themselves sufficient to deliver integrated care (Freeman 2003). Participants need to "trust each other and the political framework" and to trust that their work to improve patient care is recognised and rewarded (Freeman 2003). Integrated working was facilitated by the teams working as a network, rather than through an organisational structure (hierarchy) or by contractual terms (markets) and record the value of sharing experiences and learning (Goodwin et al. 2004).

The descriptions of the teams and the staff reported experience of developing and aligning systems and processes to support integrated working illustrates the complexity of managing change involving multiple agencies, staff and services. This supports the view that integrated health systems are complex adaptive systems (Kernick 2003).

7.18   Review of Research Approach

The analysis of the data on the 18 teams in Phase 3 of the ICON programme provided an insight into the team's experience of being supported within a structured programme (Tucker for Tribal Secta 2005).   Team leaders recorded being within a network of teams piloting integration as a benefit, through shared learning, support and resources (P1, P2). Data were available for analysis from questionnaires, presentations, team records and

reports, much of which was in the public domain, and this access to documentation provided data that contextualised the findings of the implementation of processes.

There were a number of limitations to the research approach. The lack of guidance notes or clarity around some of the questions created some confusion for staff. In particular, staff who thought that they had processes in place at the start of the programme came to realise that this was not the case, and that their way of working did not qualify as one of the integrated care processes but needed to be more formalised or further developed. Whilst this was a useful learning experience, it meant that some of the responses in the questionnaire indicated that processes were in place when they may not have complied as a formal process. For instance the primary care team in Portarlington recorded that they had a single file in place as the doctor maintained a single record that was accessible to all of the primary care team and was an active record used by all doctors. However, in working through the programme, the teams developed a system whereby notes such as physiotherapy notes could be amalgamated into the file, making it a multidisciplinary record. This has drawn attention to limitations of the question, as it had not been fully explained. In respect of questionnaires completed by staff without an interviewer present, guidance notes or explicit criteria would have been helpful in clarifying what was being asked. However it was understood that this process was part of learning what constituted integrated systems and processes, and was a guide to teams and team leaders in assessing how well they believed their processes supported their objective of integrating care. During the programme, a system of formal adoption at Board level of processes and procedures was introduced using a suite of documents entitled "Standard Operating Procedures" (SOP) and some of the teams were waiting for

their processes to be formally endorsed at Board level before considering them operational (ALS).

The study was also limited by the scope and quality of the data that was available from the primary source, and this limitation compromised the validity of the study. It was not possible to carry out further interrogation of data, follow up on queries or lines of enquiry (Robson 1993), verify data or carry out new research to add to the data. The data was qualitative, concerned with staff reports of their views and experiences of progressing integrated care, and the validity and reliability of this data is compromised. However, safeguards and checks were in place in the ICON programme as part of the ongoing evaluation of the project, so that there was an audit trail of documents, records kept and shared, and a transparent process adopted (Tucker 2004).

The teams described the work that they were doing in order to progress the development of processes to support this way of working. The descriptions did not always match the records in the questionnaires completed (Q1 and Q2). For instance, teams recorded positive work on improving their systems of access and referrals, and yet the analysis of the questionnaires show that 16 of the 18 teams already had referral processes in place, and there were none added during the programme. This shows the limitation of the quantitative analysis, which did not identify improvements and enhancements to existing processes.

Data were not recorded in a consistent way, and was not recorded for the purpose of answering the research questions posed for the secondary analysis, which is a known and recognised limitation to carrying out retrospective secondary analysis (Moser and

Kalton 1971:43). The research approach, which was themed content analysis on data in questionnaires and documents, has identified some factors concerning an organisation-wide strategy for developing integrated care through a structured programme.

One of the limitations of this study is the use of survey data from staff who are working in a programme where there is an expectation of benefit and progress. There were possibilities that staff may have exaggerated their progress in order to build confidence in their service. They may also have changes their behaviour by being part of the programme, which may have been viewed as being in a prestigious position, such as in the Hawthorne effect (Bowling 1997:137). The Hawthorne effect, also referred to as the reactive effect, is shown when participants being studied change their behaviour as a response to the interest taken in them (Bowling 1997:137; Moser and Kalton 1971:219). The two programmes were designed to stimulate change and improve practice, so this was anticipated (MHB/Secta 2003a, Tucker *et al*. 2000). The findings from the study have been considered in this context. Therefore these considerations regarding the validity and reliability of the data need to be taken into account.

7.19   Conclusion

In answering the research questions of the presence, nature and development of integrated care, the reported experience of the teams in the ICON programme has shown integrated care was taking place in some of the services, and this was facilitated by new and aligned systems and processes such as a common assessment process undertaken by staff working jointly. The nature of integrated working has been shown in the systems

and infrastructure being put in place to support joint working. The embedded case studies illustrate the way that integrated working was being developed, and gives evidence of some of the difficulties and opportunities of this way of working.

The concept being challenged in this research is the one of exclusivity – that integrated care is being offered predominantly to older people in short term model projects. The study of the ICON programmes showed that integrated services were offered to patients of all ages, and that broadly two out of three services had been established for over three years, which suggests that these were not new model short term projects. The programme incorporated teams and services across the MHB, and so for this programme was not focused on one small area, type of service, or single client group. This suggests the start of an organisation-wide and whole system approach to developing integrated working.

The appraisal of progress made by teams in the eight processes was limited by the short timescale of Phase 3 which was nine months. Modest progress was recorded in terms of processes implemented, although the records in the embedded case studies show that progress was made in terms of awareness, confidence and relationships. Teams volunteered to be a part of the programme, and may this therefore be considered to be a positive approach to joint working.

The ICON programme was evaluated within the project team and through the consultancy commission. Subsequently the ICON model was adopted by other Health Boards in Ireland and shortlisted the programme for a national innovation award (Tucker for Tribal Secta 2005). The HSE promoted the success of the programme, such as in an article entitled *"ICON leads the way forward"* (HSE 2005).

In the next section, I consider the findings from the two case studies, compare and contrast the experiences and views of staff in integrating care, and reach some conclusions about how integrated care is identified and developed.

8   DISCUSSION OF RESULTS

8.1 Introduction

In this chapter I compare and contrast the findings from my analysis of qualitative data on the staff experience of the presence, nature and development of integrated care in two case studies. I have analysed the findings from the two case studies (ICON and I&BP programmes) and considered how far they have answered my research questions. I have framed the discussion of the results around factors that staff in each case study identified as influencing the ambition to integrate care, namely: context, systems and processes, staffing, funding and management and service users. I consider the staff's reported experience of the development of integrated care and managing change, and assessed the applicability of a systems approach and complexity theory to an embedded case study from each programme. I have compared these findings to the experiences of other studies from the literature. I conclude with a review of the limitations and benefits of my research approach and begin to consider areas for further research.

8.2 Comparing Results from the Two Case Studies

This research is seeking to answer three overarching questions regarding community hospitals and community health services concerning the presence, nature and development of integrated care.

- – Is integrated care present in community hospital and community health services in the two programmes?

- What is the nature of the integration present?

  o Which types of integrated care are evident?

  o Which processes are in place to support integrated care?

  o Which patients are receiving integrated care?

  o Which services demonstrate integrated care?

- How is integrated care being developed?

Table 60 gives an overview of the two case studies in terms of scale, timescale, geography and how the services were developed. Table 1 provides more detail on this.

Measure	I&BP	ICON
Services	48 services	18 services
Timescale	2000- 2005 Annual snap shot	2003 – 2005 Longitudinal
Geography	England	Ireland (MHB)
Development	Locally devolved	Structured approach

Table 60: A comparison of the I&BP and ICON programmes

Table 61 provides a high level summary of the key findings from the two programmes as a guide to the discussion on comparing and contrasting these two case studies.

Research Questions	I&BP	ICON
Presence of IC?	Yes, in all 48 services	Yes, in all 18 services
Nature of IC?	Multiple types of integration in all services	Multiple processes to facilitate integration in all services
	4 types (range 2-8) in each service	4 processes (range 2-8) in each service
	Multidisciplinary teams most frequently reported, health & social care one of least reported	Common referral, single assessment and care plans most frequently reported
	Services have more internal (NHS) types of integration than external (multi-agency) types	Most progress was recorded in improving shared information on clients and services
	Community hospital services are well established	Teams are predominantly established (2 out of 3 teams in place for over 3 years)
	Integrated services for all ages	Integrated services for all ages
Development of IC?	What Helps: Commitment; Education & Training: Funding	What Helps: Management support; Shared Learning & Training; Structured programme and Systems
	What Hinders: Staffing (Lack of staff); Systems (information, finance & care) and Funding	What Hinders: Staffing (teams incomplete or staff changes); Time; Facilities and Funding.

Table 61: High Level Summary Comparing Findings from the Two Case Studies

The findings from each case study in answering the research questions are discussed below.

- **Is integrated care present in community hospitals and community services in the two programmes?**

I am able to draw conclusions from the data that integrated care was present in all of the 66 services. My research has shown that staff reported multiple types of integrated care, such as multidisciplinary working. The staff in the ICON teams reported multiple processes in place to support integrated working such as joint assessments and a single file for clients, which I have taken as a proxy for integration in practice (Ramsay and Fulop 2008).

The answer to this research question needs to be tempered by the fact that levels of integration were not measured and it was not possible to establish the extent to which joint working was developed (Kodner 2000). It has been noted in my discussion on my research approach in chapter 5 that any findings would need to be considered within the limitation the staff for both programmes were self-selected and understood that there was an expectation of integrating care. I have outlined the steps taken to test the validity of the primary data (Table 14) and in my design of this research study in chapter 5.

- **What is the nature of the integration present?**

  o **Which types are evident?**

Multidisciplinary working was most frequently recorded by staff in the 48 community hospitals (Table 26) and by staff in the 5 embedded case studies in ICON.

Staff in the ICON teams reported that there were multiple component parts of integration (processes and systems) in place in each of the ICON teams.

They increased the number of implemented integration being present in the 18 community health services in Ireland, demonstrating this through the recording of the implementation of at least two processes to support integrated care. Therefore, according to the staff concerned, the question regarding the presence of integrated care is answered in the affirmative for the 66 services in this study.

I have considered the 5 types of integration that I was able to analyse in both programmes: multidisciplinary, community and secondary care, community and primary care, health and social services and integration with the third sector.   In the I&BP programme the most frequently recorded type by staff was multidisciplinary working (92% of services). Joint working was evident with secondary care, primary care in over 2 in 3 of the services, and multi-agency working in 2 out of 5 services. Less frequently recorded was integration with social services at just 1 in 3. In the ICON programme the types of integration recorded for the 5 embedded case studies demonstrated a similar pattern, with multidisciplinary working showing in all of the services, integration between community and secondary care and primary care in 4 of the 5 services, and less frequently recorded integration with social services (3 of 5) and the third sector (1of 5). It is noted that social workers had recently been recruited to two of the ICON services, which provides a context for this finding. For both case studies, inter-professional collaboration through multidisciplinary working is the most frequently occurring type of integration. Integration between NHS sectors such as primary community and secondary care ranked as the next most frequently developed. Less well developed were those with social services and the third sector. Staff therefore report a higher frequency of internal types of integration (i.e. multidisciplinary) than external (i.e. third sector).

o   **Which processes are in place to support integrated care?**

It is not possible to carry out a direct comparison on the two programmes with regard to the nature of integration in respect of processes in place, as data was only available to answer this question in the ICON programme. Staff in the community services in

Ireland reported at least two processes and as many as 8 processes in place in each service to facilitate integration. The staff focused on developing processes to support integrated working. Processes for managing care were already in place in some of the teams, and 4 of the teams chose to carry out work on care plans and outcome measures. Most progress was made in improving the sharing of information on services and patients through implementing a process for sharing information, developing process for profiling services and creating a single shared file for patients. Although systems to support team working were identified by staff as an important priority, there was no progress made on this during the programme, explained by staff as due to recruitment delays. The teams increased the number of processes in place from 78 to 89, with 9 of these 11 processes concerned with improving information on patients and services.

o **Which patients are receiving integrated care?**

In answering the research question of who was receiving integrated care, the data for both programmes showed that all services had evidence of integration and that they provided for patients of all ages. In community hospital services client group with the highest average number of types of integration was older people (an average of 6 of 8 types). In the ICON services, teams providing services for children had the most processes in place (an average of 5.5 of 8), having implemented an additional 4 processes during the programme. This finding for both studies demonstrates that integrated care is not exclusive to older people in these services, and there was evidence of integrated working in services for children, adults and those for all ages.

- o **Which services demonstrate integrated care?**

The question of which services demonstrate integrated care was answered by the extensive range of services in the two programmes. Services that had a high number of types of integration in community hospitals were those for palliative care, and those for community health services were disability services. Both programmes incorporated a range of services such as health promotion, rehabilitation and clinics.

- **The Development of Integrated Care**

Staff were asked to record their views on what helped or hindered the development of their services and integrated working. The community hospital staff (I&BP) cited commitment as the most significant factor in helping them to develop integrated working, referring to commitment from a wide perspective of staff, managers, the organisation and the whole community. Factors that were also recorded were funding, education and training. Community hospital staff said that care pathways and policies and procedures were helpful systems to have in place. The ICON staff said that the support that they had from management and the project team helped them to develop systems, and that they also appreciated the shared learning and communication in the action learning networks. These findings help to strengthen the view that leadership, management, communication and shared learning and important factors in facilitating integrated working.

Community hospital staff reported that the factor that hindered development more than any other factor was staffing (lack of staff, workload and attitude). The lack of particular systems, namely information and finance, also impacted in development. For the ICON

staff, the main hindrance was also staffing as a number of teams were incomplete, new staff were being recruited, and therefore teams members were changing. The lack of staff in ICON and I&BP impacted on workload and the availability of time to progress integrated working. Problems with facilities were also cited by staff in both programmes as a lack of space, inadequate accommodation and lack of co-location gave physical restrictions to the practicalities of meeting and working together.

My understanding of the staff's views is that a shared commitment to integration is an important factor and this concurred with findings in the literature (Hudson, B. (2006a). Staff also stated that they can be helped in their ambition to integrate care if they have appropriate training, sufficient staff and appropriate facilities, reflecting priorities set out in an international report described as a resource guide (Nies and Berman 2004).

The presentation of the findings of the two studies show some striking parallels showing common themes emerging which help to answer the research questions. The studies demonstrate that it is not just in new projects or pilots that integrated care may be found. In seeking examples of integrated care, it may be most fruitful to look in remote and rural areas where staff are working in partnerships in established services (BMA 2005, RCGP 1995).

8.3 Discussion of Themes from Case Studies

In drawing together the findings from the learning from the two programmes, I have compared the experiences described by staff in each programme, assessed its impact, and considered the application for transferable learning. I have also considered the learning from the study in the context of the literature and my experience. In order to

frame my conclusions, I have chosen to examine the factors that were identified by staff as important to helping or hindering integrated care. I also consider the theme of the service-user, given that integrated care is styled as person centred care (Thistlethwaite 2008).

- **Context**

In respect of context, national drivers in Ireland was to promote multidisciplinary working across primary, community and continuing care. The key emphasis on horizontal integration was to support the emerging primary care strategy which was based on a primary care team working in an extended network of community staff (HSE 2007).

The national drivers for England have been concerned with integration across health and social care, and also with the third sector as a plurality of providers has been encouraged (DH 2006a; 2006b). One of the strategies designed to encourage joint working across the statutory sectors of health and social care was the intermediate care strategy designed to reduce unnecessary admissions to acute hospitals and expedite discharges from the acute hospitals into the community (DH 2003). The role of community hospitals in intermediate care was not formally recognised by the Department of Health at the time because of the lack of research or evaluation (Hadridge 1997). The I&BP programme was developed to encourage staff to describe their way of working, and in particular their partnerships, networks and joint working, to demonstrate an evaluation of their service, and share lessons learnt (Tucker *et al.* 2001).

This therefore shows integrated care as context specific, according to the national and local political, social and environmental situation. In England and Ireland the national strategy set a direction that encouraged care to be integrated, and local conditions also influenced how well this was progressed. Whilst it may be argued that the different types of integration are relevant for all health care systems, the priority may be politically negotiated and be distinct. As has been shown in the literature review, multi-agency integration became a priority in the Netherlands whilst integration between formal and informal carers became a priority in Greece (Leichsenring 2004). The integration of systems and governance, particularly in finance, is particularly relevant to the American health insurance system (Gleave 2009).

Another aspect of context is the predominantly rural nature of the community services being studied, with community hospitals typically developed in remote, rural or coastal areas and the community services in Ireland in sparsely populated rural areas without any major towns or cities. Studies have shown that rural services cost more to deliver than in urban areas, and that there is an issue of the cost to service users in respect of time and travel. Policy initiatives such as "rural proofing" have had limited success (Pugh *et al*. 2007). Commissioning groups in England may take an opportunity to accommodate a premium for rural services, and encourage an increase in staff joint working, transferable skills and developing local capacity (Clewes 2006). A BMA report examining healthcare in rural areas concluded that consideration should be given to the expansion of community hospital services and facilities, and these would require joint working with sectors such as secondary care (BMA 2005). There is also attention

on the role that health professionals play in supporting the social sustainability of rural communities (Farmer *et al*. 2003).

The study has shown that multidisciplinary working, which is horizontal integration within services or community hospitals, was the most frequently described type of integration for both programmes. Although community hospitals are styled as integrated health and social care facilities in terms of the political and strategic representation, in fact this type of integration appears to be less well developed. As integrated care is a political discourse that is context specific, this may limit the transferable learning internationally (Leichsenring 2004).

– **Systems and Processes**

The process most fully in place at the start of the ICON programme was the referral process, although many of the teams recorded that they continued working on mapping, simplifying, aligning and opening up their referral processes. The processes that Irish teams made most progress with were those concerning improving and sharing information on clients and services. There were also examples of information systems within the community hospital programme being improved, such as involving the community in marketing and promoting new services as in the osteoporosis screening services (41/04/D). The examination of the presence and development of systems and processes to facilitate integrated care is a useful way of identifying how well supported the teams are in working in an integrated way (Kodner 2003). Staff in the I&BP programme recorded that systems and processes such as policy and procedures and care pathways were helpful, whilst there was a lack of appropriate information and finance

systems. Both teams recorded the need to formalise their ways of working with explicit systems.

- **Local Leadership**

The local leaders for the services within the community hospital programme were the staff submitting the questionnaires, and the majority were nurses or nurse managers, with only 3 doctors out of the 69 (4%) staff named as authors of submissions. This concurs with experience internationally, where evaluators of integration have noted a lack of medical participation or understanding (Leutz 1999). This raises questions about the clinical leadership of innovations in community hospitals, which, although they are described as extensions of primary care, have developed into nurse-led units with nursing staff leading innovation and changing practice (McCormack 1993).

The local leadership in the ICON programme were the team leaders, who emerged in the programme in an informal and locally negotiated way, often because of their interest in joint working. The team leaders were not always the most senior person within the team and did not therefore reflect the service hierarchy. For instance, the team leader for the children's team in Mullingar was the Speech Therapist, with team members who included a consultant paediatrician, psychologist and senior nurses. The team leaders were predominantly nurses and managers, and none of the teams were led by medical staff. Given that integrated care is about staff concerned with clinical health care and social care working together, ceding power, transferring skills, changing practice, and re-orientating their service around the needs of individual patients, the lack of medical input into each programme would appear to weaken the extent or potential of genuine

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integrated working. There are examples of schemes in England being medically-led, such as the Castlefields project (Lyon *et al*. 2006) and the Enfield project (Keating *et al*. 2008). Similarly, the EPICs programme in Buckinghamshire was led by a partnership of a Consultant physician in general medicine with an interest in the case of the elderly, and a medical social worker who worked as the EPICs project manager (Foote and Stanners 2002:371-372).   So whilst there are examples of services being led by GPs and Consultants, the services within the two programmes studied had few examples of medical leadership or input. This is in keeping with the studies, where physician engagement was limited to a reactive role at best (Leutz 1999).

– **Staffing**

The staff recorded the importance of commitment, relationships and the building of trust in their questionnaires in order to achieve a level of integrated working. Some of the services identified challenges this, such as the reticence of GPs to support the team approach in the "Falls" clinic in the ICON programme (13/LO/FC), the initial reluctance of GPs and some nursing staff to change practice when introducing an early warning system for in-patients at risk (34/03/C) and some resistance from Consultant medical staff in having an orthopaedic pre-assessment service locally combined with delays in GPs utilising a new local service (40/04/D). Staff in some of the services, including nurses and therapists, expressed anxiety about changes in practice and in services. Staff described the action taken to overcome this, such as improving information about the change and its anticipated benefits, and holding regular clinical meetings, such as in the community rehabilitation team in the ICON programme (8/LW/CRT). Other teams

described the difficulty of establishing continuity and cohesive team working whilst

there was a turnover of staff, periods of vacancies, and then new staff joining the team,

such as the Irish children's team (2/LW/EIT). Adaptations to ways of working had to be

made, such as when there were vacancies in the team proposed to provide an

ophthalmology service, and a medical vacancy was filled by a nurse practitioner who

had further training as a practitioner (5/00/D). Table 54 illustrates the increase in staff

in the ICON programme. It was noted that integration was reported as being hampered

by vacancies in both programmes.

The literature provides evidence that integrated care is about relationships and building

trust, finding ways of uncovering differences, using tension creatively, and evolving a

joint approach (Graham 1991:85). The staff in the EPICs programme in

Buckinghamshire concluded that the process of learning and training together was a

powerful level for change, and helped in improving joint working and cooperation

(Foote and Stanners 2002 :295). The importance of the education and training was also

stressed by staff in the community hospital programme, and there is increasing attention

being given to inter-professional education and developing collaborative capacities

(Carpenter and Dickinson 2008:36).

This study raises some interesting questions about why some teams develop integrated

working and others do not. The research on the ICON teams showed that the smaller

teams (up to 8 members) implemented more processes in phase 3 than the medium and

larger teams, suggesting that size was a factor (Jelphs and Dickinson 2008:6). This may

be explained by the number of staff negotiating changes in practice and the likelihood of

trust being established (Freeman 2003). Teams working in particular services made more progress with implementing processes than other teams. The team providing disability services for children implemented 4 processes during the period, and recruited 6 extra staff. Staff in these services recorded four types of integration (multidisciplinary, secondary care, primary care and social services), and noted that they were intending to have parents and children as more proactive partners in their care in the future. This may suggest that proactive teams who are prepared to be flexible may make more progress.

– **Funding**

Funding was described by staff in the community hospitals as an important factor in the success of the service initiative, and sources for funding were cited as from the local community, donations and grants, illustrating the constructive role that local people were playing in developing their local health care. Local NHS funds were also acknowledged, as well as the creative use of existing resources such as the shared use of resources and facilities that were available, such as in the creation of the gym for older people in a vacated area of the hospital in Surrey (3/00/R). None of the staff described locally devolved budgets, although a Day Centre in Suffolk was described as funded through pooled health and social care funding (1/00/R).

The ICON programme represented an investment by the organisation in respect of a project board and a designated project management team of six staff, including external resources of consultants. The approach at a local level was to encourage different work practices within existing resources, and there were limited funds available to support

changes at a team level. Staff described the value of the provision of laptops and support with information technology, and successful bids for additional clerical or new social work staff in the team. Financial support for the extension of the teams was recorded by staff as being highly facilitative with regard to integrating care, such as in the case of the administrative support that enabled new processes to be designed and implemented in the Travellers Health Team (17/LO/TS), and the social worker appointed to a primary care team (1/LO/PCT).

Staff in both programmes stressed the importance and value of training and education to support new ways of working. Evidence of staff attending training was more evident in the community hospital programme, whereas staff in the ICON programme recorded factors such as changes in team members and vacancies resulting in delays in organising training, such as in the community rehabilitation team (8/LW/CRT).

One of Leutz's laws is that integration costs before it pays, and staff in both programmes recorded the increase in time and resources required in order to support the redesigned ways of working, and these costs were met within existing resources or with contributions from the community or local management (Leutz 1999). One of the questions may be how well developed integration may have been if budgets and financial autonomy had been devolved to local teams and additional funds were more readily available.

Another factor is whether integrated care results in a more efficient use of resources, thereby reducing overall expenditure (Gleave 2009). None of the staff cited financial savings as an incentive for pursuing integration, and the financial impact of change was

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not measured. More recently the climate of recession and pressure on public spending is focusing attention on the potential for integrated care for creating efficiency savings such as through joint senior management posts, and employing staff to work across sectors (Carlisle 2009). The advice being offered in an analysis of the evidence on integrated care however is not to pursue integrated care primarily for financial savings (Ramsay and Fulop 2008). Budget constraints and a growing elderly population has led to the creation of a model in Canada to provide an integrated primary care-based service for frail elders, which combines health and social care, incorporates patient empowerment and is presented as a cost-effective model (Bergman *et al*. 1997). So in the Canadian model, whilst the drivers for the model were in part financial, it has also led to some quality and service improvements. The financial impact could have been usefully addressed in the two case studies, and there is scope for further research on this.

- **Management**

When embarking on managing change, it is understood that the creation of a vision that is shared is part of the process of commandeering support from stakeholders in working towards a new goal, and winning hearts and minds in working towards a change (Foote and Stanners 2002: 274). This fundamental step in change management is a challenge in integrated care, given the difficulty in visualising or articulating what integrated care might look like (Woods 2001). The ultimate achievement in integrating care has not been fully expounded, and many prefer to describe it as a journey rather than a destination (Nies and Berman 2004). Some prefer to talk of shared values and creating an ethos or culture, rather than setting out a blueprint for the service (Foote and Stanners

2002:275). Creating a shared vision when so many stakeholders are involved and the ultimate achievement is unclear is a challenge. The high number of stakeholders in a complex service such as health and social care, involving statutory and non-governmental agencies, as well as service users and communities also means that the traditional management approaches of command and control may not be appropriate.

The lack of consensus of what integrated care looks like is a recurrent theme in the literature, and a serious limitation to achieving stakeholder support for managing change. The staff views in both programmes is that staff recognise that whilst they are developing integrating care, there is further progress to be made, but they do not record that they have reached a state where services are fully integrated. There is confusion in some of the literature that integrated care means unification, where different parts are combined into one organisation or discipline. However in practice there will always be legitimate reasons for parts of the service to be separate, such as different legal entities and distinct professions (Thistlethwaite 2004).

Advocates of a systems thinking approach to change management suggest that a more flexible, locally devolved and enabling form of management may be more appropriate (Foote and Stanners 2002; Edgren 2008).   The teams in the ICON project were supported and enabled to develop their service within a model of integration which was defined both in terms of a formal and published definition (Tucker *et al*. 2005), and also in a visual logo or model. The programme was given a national as well as an organisational spotlight, through evaluations, conferences, and reports to the Board.

In contrast, the community hospital examples of integrated care evolved in a more informal and implicit way, in each of the localities. The literature review found evidence of the community hospital having a tradition of integrated working in terms of the roots of the creation of this model of care, and also in the way that this service developed. It has been argued that scarcity of resources creates the necessity for integration, and this may be the case for isolated rural and remote community hospitals (Freeman 2003). The literature showed that small rural hospitals had been ignored in the past in terms of national strategy and policy, in favour of the growth of secondary and tertiary hospitals and specialist clinical developments (Tucker 1987a). The lack of a formal model and the lack of inclusion in national strategy and policy meant that there was a degree of local autonomy in small hospitals. This freedom to experiment in a small facility arguably has created a service which is typically well networked, with well developed local partnerships as shown in the diagram designed by Tucker in a report advising how community hospitals prepared for the future (RCGP 1983) and reflected in a later paper in the series (RCGP 1990).

The explicit model in the ICON programme and the implicit yet traditional model of the community hospitals programme have both yielded examples of integrated care, and share the common factor of the opportunity for locally devolved management, where practitioners have been able to design and develop a way of working jointly that is appropriate for their service and their setting. This applies to local devolvement and self-managed teams, which is a recurring theme in how best to manage and develop joint working.

The leadership and management challenge in respect of fostering integrated care and team working requires a subtle and sophisticated approach, recognising the vital importance of relationships and the development of trust, the time required to align all stakeholders in a complex service, and the need to underpin the service with facilitating systems and processes.

– **The Service User**

Integrated care is often described as person-centred care, as the service is integrated around the needs of each individual service user. And yet the engagement of service users, individually and collectively, has continued to be a challenge ever since the principle was enshrined in the Alma Ata agreements (WHO 1978). Whilst there is support for the principle of increasing service user involvement by many national health strategies and policies (DH 2006a, DOHC 2006a) reforms have yet to result in significant improvements in the public and patient involvement in the running of health services (Gillam and Brooks 2001:17). A recommendation from the work by Leutz was to involve service users, carers and community service providers in the planning and oversight of integrated care, and suggests empowering representatives to be advocates of service user needs in professional meetings (Leutz 1999).

The Community Hospital programme provided evidence of some individuals proactively involved in directing their care and their service, and also provided evidence of the involvement of the community through volunteering, funding and campaigning for services, such as in the day care facility in Suffolk (1/00/R) and the osteoporosis screening service in Dorset (41/04/D). The history and tradition of community hospitals

is one in which local people feel ownership of their local facility, and this is expressed in their engagement in the proposals and delivery of their local service.

The ICON programme had fewer examples of engagement with service users individually or collectively. One example was the recruitment of travellers as community support workers who were helping to design and implement a model of integrated care across all of the services that travellers required (17/LO/TS).   Services where service users and their families were asked their views on service changes, such as in the Springfield rehabilitation service for people with disabilities (3/LW/SP), and the team offering early interventions for children with developmental delay (2/LW/EIT) showed that views were being taken into account, and outcome measures were considered.

However, the literature suggests that the role of the service user may be even more fully developed, so that individuals can help in a number of ways including having training and support to become an expert patient and manage their care such as in the case of people with long term conditions, and become their own care manager (Audit Commission 2002). There are examples of service users providing training to health and social care professionals and students in the experience of their condition, and also joining research groups and helping to identify priority areas as well as being able to commission and purchase their own health and care (Dickinson 2008:78). The role of community groups such as Leagues of Friends or community development groups such as social enterprises are considered to be important, and proposals to enhance their autonomy and encourage a participatory role rather than a consultative role (Gillam and

Brooks 2001:132). There is scope to engage more fully with service users in designing, developing and implementing models of integrated care, and this was not fully explored in either the CHA I&BP programme or the ICON programme where the emphasis was on preparing staff for changing their practice.

The most frequently recorded factor identified by staff as being helpful in pursuing integrated care was expressed as "commitment and this raises a question of whether people who use the service are committed to integrated care in the same way as practitioners and other staff. There is a view that service users have an expectation that their service will be "joined up" and may be unaware of the lack of communication and sharing of information between professionals who are involved in their care (Tucker and Burgis 2012). Studies have shown that service users value continuity of care, and this is often expressed as their relationship with a trusted professional (Freeman *et al.* 2001).

It is noted that there was an absence of service user representation in the design and management of the programmes (Tucker for Tribal/Secta 2005), and that there was scope for further engagement with people who use the services.

8.4 Change Management

In this section I explore theoretical frameworks in order to help understand the nature and development of integrated care not only in the case studies but also generally throughout health systems and services. I consider the findings of the analysis of the two case studies, and the further questions of managing change and service transformation that are raised through the research. In order to enhance my understanding of the way that integrated care takes place and how staff and services can

change to improve coordination and joint working, I have looked to other programmes that have adopted a systems approach. A key question at the start of the study was the one raised by Professor Baldock, which was asking why integrated care was not more fully in place given all that is known about it. The two case studies show that it is in place in some community health services in predominantly rural areas, although may not always be recognised. Integrated care is capable of being supported within a structured programme, but if integrated care is to be fully inclusive it needs a new approach to transforming services and changing ways of working, such as through a systems approach.

I have explored integrated care in primary and community services in two programmes in England and Ireland from the perspective of the practitioners working in teams. I designed the research method to deconstruct integrated care into types and processes in order to enhance the understanding of the presence, nature and development of integrated care. The study has provided new insights into the component parts of integrated care. In order to provide a context for this learning, a theoretical framework has been explored in which to help make sense of the essential elements of integrated care and how they manifest themselves within the two case studies. This is an important part of the process of interpreting the results, and without this the study would risk being reductionist by considering parts without considering the dynamics of the whole, and would therefore be limited in value in terms of new learning.

The deconstruction of integrated care into some of its component parts is helpful in assessing the extent of networks, partnerships and joint working. There is also scope for

gaining a deeper insight into the dynamics and relationships that take place between agents and agencies. The deconstruction of integrated care into component parts in isolation from its context may be viewed as reductionist and open to misinterpretation if not viewed in context and within a theoretical framework. Kernick has summarised why it is appropriate to take this learning and develop it further within a theoretical framework. *"The system is different from the sum of its parts. In attempting to understand a system by reducing it into its component parts, the analytical method destroys what it seeks to understand"* (Kernick 2004:28).

- **A Systems Approach**

Foote and Stanners provide a rationale for their decision for adopting a systems approach in their EPICS (Elderly People Integrated Care System) programme (2002:47). The authors describe their approach to designing and implementing an integrated care programme, and use system mapping to illustrate the interconnections of systems in multi-disciplinary and multi-agency care that has examples of both vertical and horizontal integration (Foote and Stanners 2002:48). Using a case study of an elderly patient, the authors illustrate the characteristics of a complex adaptive system such as adaptive, non-linear and self-organising (2002:59). The same case can be made for the community hospital services being studied, where there are teams working within teams and many interconnected and interdependent parts. In the 48 services studied services had four simultaneous types of integration demonstrated, which could mean that four different teams with multiple memberships were required to cooperate and contribute to the progression of a particular service. Staff working in the community hospitals were

working in an environment where there is a tradition and culture of integrated working due to factors such as scarcity of staff resources, where the term integration may not be used or recognised, but there is a tacit understanding of the need to work across disciplines and sectors and a tradition of staff working together, particularly in rural areas (Higgins 1993).

Staff working in the Irish case study worked to an explicit definition and model to guide them with the support of a programme with targets and resources. A feature of complex adaptive systems is the presence of simple principles. For instance, in the ICON programme the visual model of integration (the ICON logo) contained agreed principles such as services need to improve equity and access. These principles provided shared reference points for all staff working to improve or develop their service in collaboration with others (Tucker *et al*. 2004a). In some instances rules may be implicit or tacit rather than articulated, such as practitioners working to improve patient health, wellbeing and healthcare experience, such as in the community hospitals.

The multiplicity of agents within community hospitals, their interactions and their interdependencies are illustrated within the service case studies from the survey data within this study. Community hospitals have been described as a focus for community networks, and although they are typically small hospitals, they are multi-provider facilities with a range of interdependent practitioners and services. In order to provide integrated and seamless care, staff and services are required to cross many professional and organisational boundaries. For instance, in intermediate rehabilitation services a practitioner such as a physiotherapist may be a member of several teams which interact

and overlap, such as an intra-professional team of physiotherapists, a multi-disciplinary rehabilitation team, a multi-agency team for managing care placements, and a departmental or service management team. Similarly, the ICON teams collectively work across the whole organisation on a multi-client, multi-service and multi-organisational basis with many interconnections between staff working in more than one team. This is not unusual in health and social care, when staff will be working within several systems simultaneously (Plsek and Greenhalgh 2001).

– **Community Hospital Services as Complex Adaptive Systems**

In order to consider whether complexity theory helps in understanding and articulating change in health services, I have considered the data from one of the community hospital services. I selected the example of the development of ophthalmology services, as this was a clear explanation by staff of a change management process (Tucker *et al*. 2000:25-27). I have created a summary from the staff-reported data in the questionnaires in order to assess whether the service developments and change had characteristics of complexity adaptive systems (Figure 17).   The example shows the integration of staff and services within and across clinical, social and community care. Seven of the eight types of integration from the typology are present in this service: multi-disciplinary, health/social care, multi-agency, and integration between the community hospital and primary care, secondary care, patients and community.

In order to make changes and develop a cataract day case surgery service, a variety of health staff needed to cooperate and plan the clinical service including the community nursing and medical team, the Consultant and his team, the West of England Eye Unit staff, the GPs with their primary care team and local opticians. Other agencies involved included social services who organised support for the visually impaired through voluntary organisations such as the Partially Sighted Society. The community and the League of Friends contributed by helping to fund equipment and choosing to be referred to the service. The aims and objectives guiding the service were expressed as: increasing patient access, reduce the waiting list and reduce the number of appointments for patients. The ability and willingness of GPs to fund the service through their budgets could be considered as one of the positive factors in developing the service. Initially the progress of the implementation of the service was delayed because of the inability to recruit a medical clinical assistant, and the team adapted to this by training nursing staff to fulfil this role, thereby self-organising and adjusting to a different pattern of working. The development of the skills and competencies of the nursing staff meant that an alternative arrangement emerged and the services could be extended to biometric testing, monitoring stable glaucoma, and carrying out pre-and post operative checks. The range of conditions being treated was extended beyond cataracts to include glaucoma, lid surgery and cyst removal. The opportunities for innovation and creativity were exploited by the teams, who extended the service beyond day surgery into clinics and a minor eye injuries service. The development of the service was subject to delays due to recruitment difficulties, and at other times accelerated by decisions such as to extend procedures and to operate on a Saturday. Feedback on the service included patient surveys and clinical audits. The outcomes of the change were unpredictable, as expressed by one of the nurses in the team "the service today is very different from the initial concept" (Tucker *et al*. 2000:26).

Figure 17: Managing Change in the Ophthalmology Clinic

The care being offered at the community hospital would be considered as integrated as experienced by the patient, as they would be referred by their local GP who works as part of a team with the local community hospital nursing staff. The patient would require only one appointment, rather than having to travel to a DGH for an initial clinic appointment, have the surgery and then return for follow up. Local support from voluntary agencies and social services who are party to the design and review of the service means that it is a cohesive service addressing the many aspects and implications of eye surgery. The change described in the development of cataract surgery was non-linear and unpredictable and adaptations were required, such as the training of the nursing staff when medical staff were not available (Plsek and Greenhalgh 2001). It would be of interest to assess the progress of another community hospital wishing to develop cataract day surgery, where the initial conditions may be similar, but the

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changes may follow a different path due to the many agents involved and its unique context. The case study of Axminster Hospital Ophthalmology service shows how the services may be considered to have the characteristics of a complex adaptive system.

– **Community Health Services as Complex Adaptive Systems**

I have written a summary of the Children's Team in Mullingar, using data from questionnaires and records. The summary describes how a specialist team for children's services changed their practice to a more child-centred way of working. I have summarised the staff's account of the experience of the development of the Children's team, to identify characteristics of a complex adaptive system (Figure 18).

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ICON Team for Children with Disabilities - Early Intervention Team, (2/LW/EIT)

Health staff working with children with disabilities included the Consultant paediatrician, public health nurse, psychologist, speech and language therapist, physiotherapist and occupational therapist. Staff worked as individual practitioners in accordance with their professional standards and systems. The decision to make a change created uncertainty, as staff started working in an unfamiliar way. Team members changed their way of working by working jointly to assess children and plan their care, using transferable skills-sharing and coordinating appointments. The team jointly agreed on adopting the principle of enabling the parent and child to participate more fully in their care, which influenced the way that the service was redesigned, but also led to a higher degree of unpredictability than before. The team decided that the traditional role of the psychologist in carrying out assessments using the Bailey score could be undertaken by any member of the team and this resulted in a creative tension where practitioners negotiated roles which meant that any team member could lead a child's care plan on behalf of the team as a whole. This challenged clinical and managerial hierarchies, as well as professional autonomy and accountability. The team adapted to the new way of working, and organised into a new pattern of working such as holding regular clinical meetings, developing clinical guidelines, carrying out staff training and agreeing an information-sharing protocol. The speech therapist emerged as the team leader and this position became formally recognised by the team. The team reviewed its performance through family satisfaction questionnaires and performance measures, thereby providing systems of feedback. Satisfaction levels had increased, and the number of appointments per child had reduced. One of the unexpected consequences from the change was the implications for the different managers from different departments and/or organisations for each practitioner in the team, who were being required to review the organisational structure, service resourcing, and environmental facilities to support the new way of working. Another unexpected outcome was the shared learning and resulting change in other children's teams and other intra-professional teams, demonstrating the interrelationships between practitioners within a number of teams within the organisation. The team experimented with a new way of working, and took risks, but eventually self-organised and adapted into a new way of working, and continuously reviewed their performance through feedback from those using the service.

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Figure 18: Managing Change in a Team for Children with Disabilities

The embedding of integrated working was achieved through new patterns of working, which were supported by revised and aligned policies and procedures. The case study of the children's team shows how the team travelled from relative certainty and agreement into complexity and towards uncertainty, where creative tension enabled a major shift in the service. The team self-organised into a new pattern of working, and then were able to move towards restoring their previous position of certainty and agreement as they created the systems to support integrated working. The team implemented all but one of the processes, and that was the process concerned with formally supporting team building. The team had recorded changes in staffing, and therefore this may not have been appropriate until the staff team had become established.

– **Managing Change in the Two Programmes**

The two programmes, ICON and CHA, illustrate how staff working in teams and in services within health and social care operated within a network for mutual support and development. Kernick suggests that an informal network that enables self-organising and spontaneity may be more effective that formal organisational structures that are based on rationale, planned activity organised around goals and targets (Kernick 2004:88). In the ICON teams, there was often an experience of little or no progress for some time, followed by a significant change in context which created the appropriate environment for rapid progress (bifurcation) which could not have been predicted or

planned. Factors viewed as helpful were the shared vision of the many interdependent staff, and the determination to make improvements for people who use the service.

The CHA programme showed the impact of team working in developing innovative services, and how this good practice may be disseminated and shared, thereby contributing to learning. The case study on the community hospital programme shows how local autonomy and initiative has led to improvements in services, and disseminates this experience to encourage transferability. The ICON programme showed how processes were developed within a structured approach and how these were shared and adopted locally and nationally. The two programmes that are the case studies in this study provide examples of teams that have carried out self-organisation and teams have demonstrated some of the precursors outlined by Kernick such as shared principles, connectivity and feedback, dialogue and inter-dependency (Kernick 2004:29). In both programmes, the theoretical framework offered through a systems approach has been helpful in illuminating the experiences and views of staff who were part of services where partnership working and integrated care were being pursued.

This study focuses on those who work in health and social care rather than those who use the services. However, it may be appropriate to support staff to prepare for working in an integrated way, so that they are able to meet client expectations in the future. It may be argued that staff need to develop their shared understanding and systems as a prelude to enabling the patient to lead their care and be pivotal to integrating their own care. One of the priorities in developing integrated working is to create readily

accessible services, such as through single entry points which would transform complex and confusing systems and make them more user-friendly (Leutz 1999).

– **Applicability of a Systems Approach**

A systems approach has been described as a major tool for reform in the programme for integrating care for older people in Buckinghamshire (Foote and Stanners 2002:15). There are diverse views on how useful it is to consider health care and in particular integrated health care as a complex adaptive system.

There are those that believe that viewing integrated health care as a complex adaptive system can only provide a way of describing, and that it is enough to observe and not to understand given its nature of unpredictability (Kernick in Sweeney and Griffiths 2002:108). Alternatively there are those who believe that by understanding the characteristics of a complex adaptive system, strategies can be adopted that manipulate attractors in order to manage health systems (Wilson *et al*. 2001). Rather than using systems thinking to aid understanding and observing, some authors suggest that it can be applied more proactively and can assist decision-making by provocative questioning (Wilson *et al*. 2001). A systems approach can facilitate an understanding of what creates patterns of order and behaviour, and may at least offer an expanded explanatory model which might assist in interpretation (Sweeney and Griffiths 2002:32). Kernick advises that complexity does not offer a solution to managing change, but suggest another way of looking at change based on relationships (Kernick 2004:83).

The importance of an appropriate management approach and understanding of how complex adaptive systems work have been explored. Failures in partnership working have resulted in tragic consequences (Glasby and Dickinson 2008: xi). Therefore, the need to appreciate what integrated care is, and how best to enable staff and services to work together is critical for improving the way that appropriate person-centred services are provided in the future.

- **Considering Heath Services as a Complex Adaptive System**

The context for this study is the priority being given to integrating care in health services across the world, driven by factors such as an increasing specialisation of services requiring coordination, the increasingly complex needs of an ageing population, and the increasing number of organisations involved in health and care. This means that agents and agencies need to change the way that they provide services, and understand how this change may be effected. Health services are continually changing as services adapt to health and care needs, clinical developments, political priorities and national strategies. The structure of the health service in England is changing to differentiate between commissioners and providers of services in a competitive market economy. The ongoing changes to funding, systems and structures, set within a policy of personalised care, creates a situation of multiple simultaneous and systematic changes, and there is a risk that collaborative working between practitioners and agencies is a challenge to sustain in this competitive environment. Securing sustainable integrated care across professionals and organisations requires cooperation between sectors,

services, and modes of governance (Hardy *et al*. 1999), and requires appropriate legislation, governance and funding as well as competence (van Raak et al. 2003:12).

The framework that a systems approach offers may help in understanding how the different types, processes and levels work together within a health care system.   There is increasing interest in viewing health systems as complex adaptive systems and in particular because of the recognition of the limit of the "cause and effect" theories of causation and the need for a more sophisticated theory-led model which accommodates the lack of predictability and concepts of emergence (Dickinson 2008; Hudson 2004).

The English and Irish governments, as are many governments throughout the world, are exploring ways in which individual patients experience an integrated service, supported by teams of professionals who understand their needs, provide a coordinated service, and are focused on agreed outcomes together with the patient. The English Government has enshrined some of the requirements for health and social care agencies to work together in legislation and policy, with a combination of financial incentives and sanctions and performance measures (DH 2006a, DH 2006b). The Irish Government has redesigned its health care system and incorporated integrated care as fundamental to its strategy (HSE 2009).

Whilst the principle of integrated care is simple, the implementation is highly complex and far-reaching. Governments may expect a linear and predictable change following on from setting the policy direction for integrating care, although a prescriptive approach of setting rules, regulations and standards with targets and performance management systems may not be conducive to the dynamic nature of integrated care.

There is often a disconnection between policy makers and healthcare practitioners, with policy makers being *"oblivious to the fact that organisations do not do as they are told"* (Kernick 2004: xv). There needs to be an appreciation of the fact that everything within the NHS is connected, and that action and change in one area has repercussions for another, creating unintended as well as intended consequences, making a prescriptive approach with an expectation of linear progress unrealistic.

The English Government funded a programme for 16 integrated care organisation pilots (Ling 2009). The design of the programme mirrored features of the ICON programme in that development was devolved to local teams and services over a year three year period, the services formed a learning network and a management approach that is not overly prescriptive (DH 2008). This programme mirrors some of the learning from the case studies with respect to the design of a formal programme over a three year period, with an explicit vision of person-centred care, freedoms to operate according to local circumstances, and an evaluation process with ongoing feedback. The pilots are being encouraged to experiment and test new ways of working, which may help to create an evidence base and explore employment issues (Carlisle 2009). Integration is referred to by the Department of Health on their website and guidance to pilots as appertaining to partnerships, systems and models as well as organisations, and crossing boundaries across primary, community, secondary and social care. The majority of the sixteen pilots have chosen to focus on older people with long term conditions. One of the largest and most ambitious ICO pilots covers the County of Norfolk and involves 32 GP practices and 300,000 in six localities, and I have used the opportunity in working as a consultant to this ICO to build on the learning from this study and support the

development of integrated working in a new context (Tucker 2010, Tucker *et al*. 2011, Tucker and Burgis 2012).

8.5 Review of the Research

I have reviewed the design and implementation of the research. Having considered options in approaching my research to answer my research question, I decided not to carry out primary research but to carry out secondary analysis on existing data. I chose to utilise data from consultancy commissions thereby using existing data rather than collecting new data. My rationale was that the availability of the data in questionnaires provided me with an opportunity to study the experience of staff in a way that could not be readily achieved in any other way. The two programmes contained questionnaires completed by staff working in community-based services that provided an insight into a highly topical aspect of healthcare, namely integrating and coordinating highly complex and specialist services in a way which is orientated around the needs of the patient. Both programmes represented a financial investment from health organisations in England and Ireland, and could be considered bounded systems, and therefore were researched as case studies (Yin 2003). Rather than a retrospective research study carrying out secondary analysis on data, it would have been possible to design a new research study to try and answer the research questions. If that had been the case, the services to be studies would have been derived from a sampling process, and may not have identified services where staff had such a direct focus on the task of integrating care.

It is clear from the increase in archiving of qualitative data in health and social care for the purposes of data sharing for re-use and secondary analysis, that there is a growing

interest in optimising the learning from primary data, which is supported and encouraged by the ESRC (Conti 2006).   The scope of the interrogation of the data is necessarily compromised by the fact that it is data collected for another purpose, and further expansion or further collection of data is not possible. However, by "sorting a subset" of data to answer new research questions, it is possible to supplement the original study with additional analysis with a new focus (Heaton 2004:59).

The research process drew to light the importance of distinguishing between the role of the consultant, as constructive facilitator, and the role of researcher, as critical appraiser. This change of role brought new insights into the programmes, their processes and outcomes. Familiarity with the teams, services and data was a factor that was both a positive and negative value to the research study, with a view that an understanding of context was helpful in interpretation, particularly in supplementary analysis (Heaton 2004:41).   A large quantity of documentation generated by the two programmes was held by the researcher, and a considerable time was taken to assess which documents contained data suitable for analysis in order to help answer the research question and to help explore the concept of inclusivity of integrated care. There were examples of unproductive analysis, or analysis with limited value which were not finally included in the study, such as the staff records of systems maps that they used to help create the ICON model (MHB/Secta consulting 2003a). There were examples of primary data that were incomplete, inadequately or inconsistently recorded that would have compromised the quality of the data and the analysis and so were excluded, such as the records of levels of integrated care (Tucker *et al*. 2000). The decision to explore integrated care using staff voices, and analyse the questionnaires completed by staff meant that,

although questions were not framed precisely to answer the research questions, the staff views and experience provided a valuable insight into integrating care.

Another key decision was to research two programmes as case studies rather than one. This created an ambitious scope for the research project, although enabled comparisons to be made between the two programmes and the staff's experience of developing integrated care in different contexts and countries.   Each of the programmes provided data that when analysed, provided an insight into the characteristics and components of integrated care, and the experience of staff in practice. There was learning across the two programmes as I developed my research method and analysed findings across the two case studies.

Within this research study, I wanted to gain some insight into staff's views of what it means to integrate care, and determine when integrated care was taking place, what was the nature of integrated care, and how it was being developed. My experience and observation was that practitioners delivering care would be able to contribute to the debate about the presence, nature and development of integrated care. The research has provided evidence of staff working in an integrated way, and provided an insight into the multi-faceted nature of integrated care.

8.6 Implications of Research

One of the issues in policy is the lack of a common definition of integrated care, and what constitutes integrated working (Leichsenring 2004). The study has deconstructed components and types of integrated working, to illustrate its many facets.   Many countries have integrated care as a desired objective, perceived as improving efficiency,

cost and appropriate care (Nies and Berman 2004). These objectives are particularly explicit in those countries with health care systems that are based on competition rather than collaboration (Van Raak *et al*. 2005).

This study contributes a deeper understanding of the complexity and fragility of team working and integrated care, and adds new knowledge from the perspective of front line staff. This may help take the policy aspiration of integrated working and create a clearer focus.

The study has illustrated the issues that staff face when trying to improve integrated working, and these have included staffing levels and funding (Coxon 2005). Staff commitment and vision has been shown to be critical in each of the programmes, as well as management support. This research has shown that the management of change that needs to be negotiated between professionals, agencies and sectors is highly complicated, and that health systems may be usefully considered as complex adaptive systems. If there is an understanding of the way that staff change and adapt in a complex environment, new management and support systems may be put in place accordingly (Kernick 2003). An appreciation of dynamic, interrelated health systems may also help in managing expectations with regard to making changes in respect of timescale and size of change (Plsek and Wilson 2001). The evidence is that there are typically small changes that are made but that because there is the involvement of many parties, the impact can be extensive (Plochg 2006). Progress made in the ICON programme was described by the project manager as "small steps" but with a far reaching impact (Tucker for Tribal Secta 2005).

The implications of the study on professional development and education is considerable. The voice of staff reporting their views and experiences has illuminated the process of integrating care, and through the embedded case studies in particular has shown the adjustments that need to be made by staff. There is a recognition that the training of health and social care professionals needs to incorporate team working as well as individual professional autonomy (Leathard 2003). The deconstruction of integrated care has shown the interrelationships between staff and services, and the vital importance of working on a whole system basis on a patient-centred way (Gray 2002). This represents a new approach to health care, and is distinguished from the specialist, fragmented and separate services for health and social care across the statutory and voluntary sectors.

There is scope for further research into integrated care in practice, and in particular within the current context. These include research into: empowerment of service users and integrated care; new management models to support integrated care; commissioning and performance management; implementing a whole system approach to integrating care, and the impact on communities and community infrastructure. There is also a need to research integrating care in different health systems, different political and funding systems, and different economic and social systems given one of the findings is that integrated care is context specific.

The question of the increasing empowerment of service users and what this means for integrating care could usefully be researched, given the priority being given choice, personal budgets, and developing the role of services users as consumers. There is also

scope to explore new management models in order to support teams to work in innovative ways in the context of highly regulated and complex health care systems that are publicly accountable. Attention may also be usefully given to researching the role of commissioning for integrated care, and how this way of working may be funded and performance managed. Finally, the literature identified gaps in the research with regard to the patient and community involvement in community health services, and the impact of health care developments to communities and their infrastructure, particularly in remote and rural areas. Research into these areas would provide further contributions to the ongoing debate about what integrated care is, what it looks like, how it can be supported, and how it contributes to social cohesion and social inclusion.

The interest in the topic of integrated care is increasing, for reasons of improving quality and an ambition for an improved patient experience and outcome as well as efficiency and cost-savings. The lack of evidence on the nature of integrated care, limited recorded success in managing and developing integrated care, and the benefits of transforming services in order to work this way means that there is interest in studies where learning can be shared. There is scope for further research into the wider implications of joint working across practitioners and organisations.

There is a need to research integrated care on an international basis, given that it is context specific. Countries such as the Netherlands with an insurance system (Bismark) face different issues than England that is mainly tax-based (Beveridge), as illustrated in a pan-European study of six countries (van Raak 2003). This study found that all countries focused mainly on the chronically ill elderly, and used the same organisational

tools such as multidisciplinary teamwork and case management, protocols, although their type of fragmentation differed (van Raak 2003). Further studies comparing the experience of frontline staff in different countries and settings could illuminate this further, and build on the learning from experience of staff in England and Ireland in this research. In my concluding chapter I make specific recommendations on priorities regarding further research.

8.7 Conclusions from Research

Systems and processes were identified by staff as requiring alignment, adjustment or re-developing. None of the services reported by staff required structural change, and the literature suggests that this is not the place to start (Hudson 2006a). The style and shared values, which may be considered elements that make up the culture of the organisation and service, supported joint working in each programme, and were more explicit in the ICON programme, and more traditional and inherent in the community hospital programme. The staffing, in terms of commitment, levels, skills and competencies, were identified by staff in both programmes as being crucial to the success in transforming services to benefit the patient.

The staff experience in the two programmes has shown a collective commitment and enthusiasm for change, and support for the benefits of joint working. This was shown in staff satisfaction, as practitioners valued sharing, learning and providing services as a team. Staff were empowered to develop a new way of working. In the case of the ICON programme, teams were given permission to experiment and were supported accordingly within an intensive programme designed to meet their needs as a team, with

designated project managers to assist with the networking and developing of facilitative processes. In the case of the community hospitals programme, staff described their efforts as a locally generated initiative where local autonomy was devolved in an informal way.

The lack of medical involvement, either proactively or within each team may have compromised the extent to which teams could be genuinely integrated.   The lack of involvement of service users, either individually or collectively, was a limitation in the ICON programme, although less so in the community hospitals case study, but would appear to contradict the strongly expressed value statement of integrated care being person centred, which is echoed by staff in Ireland as well as in the literature. The lack of financial devolvement may also have restricted the scope of each of the services, particularly where this may have released staff time and facilities.

This research has focused on the experience and perspective of staff as they explored changing practice in order to improve services for the patient. The staff worked in teams and explored ways of improving their level of joint working, not only between practitioners but across the wider system of health, social care and associated community services. Overall, staff have expressed their support and enthusiasm for this way of working, although recognised the challenges for the organisation and the service. The study has shown the multidimensional nature of integrated care, its far-reaching impact, and the attention that needs to be given to managing change in order to support teams to explore, adapt and develop new ways of working.

This study has examined the experience of staff at an operational service delivery level, and has not focused on the commissioning of services, although it is noted that a key driver for change may well be the change in commissioning and procurement for services which will require providers to cooperate in order to bid for contracts to manage integrated services.

This research study explores integrated care in community services, and complexity theory helps to provide a framework for appreciating the interconnectedness and the considerations when making changes and improvements within a complex healthcare system that affect so many agents who are in turn affected by their context and environment. This study deconstructs integrated care into some of its component parts, such as processes and types, in order to try and bring new knowledge to the nature of integrated care and how it is manifested in practice in two case studies. This study is concerned with exploring the concept of the "inclusivity" in integrated care, that is to say that it is appropriate for all service users, across a whole system and is sustainable. Complexity science, and in particular the study of complex adaptive systems, helps in understanding the impact of the dynamics of multiple actors and agents who are interdependent, and thereby design an appropriate management style and create an optimum environment to enable integrated care to flourish.

Making changes and improvements in health services, given the context of integrating care, requires a novel approach and a new understanding. It will not be appropriate to make detailed plans, and expect progress to be made in a linear fashion to an outcome that is certain, given the high number of variables in individuals and teams as well as

context. A whole system approach is required, with recognition of the self-organising

ability of teams given a clear vision and simple rules. The development of integrated

working if the nature of the interdependencies is not understood, and the external

governance is too prescriptive, will be stifled. Where teams are able to adapt and

develop, they make progress through a negotiation focused on service users, are self-

organising, acknowledge a dynamic system of constant change, and are sensitive to local

circumstances.

9 CONCLUSION AND REFLECTIONS ON INTEGRATED CARE

9.1 Introduction

In this section I summarise my research approach and findings, consider their application to my conceptual framework, and offer a framework of five principles. I suggest implications for policy, service development, education and training and international developments and make recommendations for further research. I also provide examples of how I have applied the learning from this research in each of these areas. I conclude this chapter with the challenge to health services to provide services that patients experience as integrated.

9.2 Reflections on Research

Literature Reviews

I carried out literature reviews on three topics: Research and Management, Integrated Care and Community Hospitals (Table 62). The research questions I sought to answer through my review of the literature are set out below in column 2. Following my critique of the literature I refined these questions as shown in column 3.

Topic	Research Questions for Literature Review	Research Questions Refined After Literature Review
Research & Management	How are management consultancy and research defined? What are the similarities and differences between management consultancy and research? How may the identification of these similarities and distinctions be used to inform the design of this research study?	Learning including the need to adopt a critical approach and explicit methodology
Integrated Care	What is IC? What is the social theory for integration? What is the health theory for integration? What are the characteristics of IC? What is the rationale for IC? Why is IC a global priority? How is IC developed? How is the development of IC managed? What is the impact of IC?	Is IC present in community hospitals and community health services in the two programmes? What is the nature of the integration present? Which types of IC are evident? Which processes are in place to facilitate IC? Which patients and services are receiving IC? How is integrated care being developed?
Community Hospitals	What is a CH? What is the history of CHs? How have CHs developed? What is the role and function of a CH? What is the international experience of CH hospitals? Is integration evident in CH?	Is IC present in CH? Which types of IC are evident? Which patients and services are receiving IC? How is IC being developed?

Table 62 Research Questions Before and After the 3 Literature Reviews

My overarching research question was the presence, nature and development of integrated care in community services. On the nature of integrated care, I defined this as: who was receiving integrated care, in which services, which types of integration were evident, and which processes were in place to support integrated working. In reflecting on these questions, I have concluded that the focus of my enquiry was appropriate and gave me an opportunity to carry out new research. In retrospect, the question of the extent to which integrated care was present, using measures such as levels (Leutz 1999) would have been more meaningful, added context and informed my interpretation of integrated working. However this was not recorded in the primary data.

I defined integrated care as "actors and agencies working together for the benefit of the patient" for the purposes of this research, and conclude on reflection that this simple definition continues to encapsulate the essential process and purpose of integrated care.

Research Approach

I considered whether to carry out primary research or to carry out secondary research and utilise questionnaires and documents that I had collected during my work as a management consultant. My decision to carry out secondary analysis on qualitative data presented a challenge, but on reflection this approach has been productive as it has provided data from staff in two programmes enabling a comparison of views and experiences and a meta-analysis of the data from the two case studies. I managed the potential risk of subjectivity and bias by designing robust and explicit methods and by adopting an impartial perspective on findings (Robson 1993:66; Heaton 2004). The interrogation of the data from questionnaires in 66 services provided an overview of integrated care in a network of services across an organisation (ICON) and across England (I&BP). This approach is new and in contrast to the literature that considers single isolated model projects that are not readily assessed in the context of other teams, services and organisations (Billings 2005).

My analytical framework deconstructed the component parts of integrated care into types and processes and was informed from the literature. The 8 types defined from the literature were partnerships and examples of joint working such as between professionals and sectors (Heaney *et al.* 2004; Higgins 1993). The processes to support integrated working represented a proxy for integrated care in practice (Ramsay and

Fulop 2008). I was concerned that the deconstruction of integrated care into component

parts risked being reductionist, and there would be a loss of seeing the system as a

whole (Senge 1994) and I therefore considered my findings within complexity theory

(Kernick 2004:28). This helped to provide a context for interpreting the data (Tilley

2000).

My conceptual framework was the positioning of integrated care on a spectrum of

inclusivity and exclusivity, reflecting the debate on whether integrated care should be

targeted to certain patients such as older people (Leutz 1999, Keating *et al.* 2008) or

whether it has a wider application as a model of social inclusion (Godfrey In Van Raak

et al. 2003:151).

Research Findings

My findings need to be considered within a number of limitations as discussed in my

research approach, and in particular that the staff volunteered to be part of each

programme, that each programme was in place to encourage good practice, and that the

data was collected for a purpose other than answering my research question (Tucker *et*

al. 2005, Tucker 2006). I put safeguards in place to help minimise the risk of bias, such

as reviewing the systems and checks in place for the primary data, designing a robust

methodology, and being a "stranger to my data" (Heaton 2004; Holliday 2007:20). The

limitations and safeguards are presented in full in chapter 5 of this study.

As shown in the previous chapter, staff in both programmes gave evidence of integrated

working. A high level summary of key findings is given below in table 63. Staff in

community hospitals gave evidence of multiple and simultaneous types of horizontal

and vertical integration. Factors influencing this way of working were cited as having a

shared commitment, being local, having devolved authority, and being supported

through education and training although limited by staff resources and finance. The

staff working in community health services in Ireland gave evidence of some progress

towards implementing processes to facilitate integrated working, such as joint

assessments, and made particular progress in improving information systems. The staff

in Ireland said that the management support and the creation of a network of services

helped them to develop integrated working. I have carried out a comparison of the

findings from each programme, and have summarised the learning from staff in the two

programmes.

Summary of New Knowledge	
Learning from the I&BP study	Reference
IC is present in all of the services in the I&BP CH programme	Table 26
IC is present in all services for all ages in the services studied	Tables: 26; 33; 36
There is evidence of multiple, simultaneous types of integration in the services studied	Tables: 26; 29; 30; 36
The most frequently reported type of integration was multidisciplinary	Tables: 26; 28; 36 Figure 12
CHs in this study show evidence of proactive partnerships with patients and communities	Tables:26: 28; 36 Figure 12
Joint working with social services and Local Authority was least frequently reported in the CH studied	Tables: 26, 28,36 Figure 8,12
The individual services in the programme with all reported types of integration was health promotion (36/04/H)	Table 26
The services with the most frequently types of integration were palliative care and long term conditions	Table 36
Staff cite cultural factors (commitment) as more important in developing IC than funding and systems.	Table 37
Internal integration within the NHS (multidisciplinary, and between the CH and secondary care, primary care and the patient) was recorded more frequently than external integration (third sector, social services, Local Authority and the community).	Figure 8
Learning from the ICON study	
Staff defined IC by 3 components: person centred (values); care management (process) and patient benefit (outcome).	Tables: 38 39, 40
IC is present in all of the community health services in the ICON programme, as demonstrated by processes in place	Table 45 Figure 16
IC is present in all services for all ages in the services studied	Tables: 50, 57
There is evidence of multiple processes of integration in place in each of the services studied	Tables: 50, 57
Teams chose to implement processes to support sharing information on services and clients during the programme, increasing these processes more than those concerned with care management or team building	Table 48
Most progress was made in implementing processes in disability services	Table 51

Small teams (up to 8) progressed changes more quickly than larger teams	Table 55
The most frequently reported type of integration was multidisciplinary and least frequently was multi-agency (third sector).	Table 59
Learning from the ICON & IBP case studies	
Integrated care can be found in existing and established services (rather than model projects and pilots)	Table 44
Re-using existing qualitative data for secondary analysis from sources such as research, evaluations and management consultancy (such as questionnaires) provides a way of generating new evidence and making a contribution to knowledge in areas that are currently under-researched	9.8
The management of change in terms of integrated care may be understood within systems theory (complexity theory)	Figure 17 and 18

Table 63: High Level Summary of Learning from the Case Studies

I have applied the learning from this study to the development of new framework, and also in the formulating of implications and recommendations.

9.3 A Framework of Five Principles

The diversity of definitions has led to confusion further complicated by the differences internationally in context (Alaszewski *et al.* 2003). It has been suggested that without clarification on the meaning, landscape and language of integrated care it will be increasingly difficult to advance strategies and polices (Goodwin *et al.* 2008). In order to answer the question of what is integrated care, I have considered an alternative approach to using a definition and applied my findings from my conceptual framework to develop a framework of five principles.

Inclusive IC	Is Integrated Care Inclusive?	Spectrum	Is Integrated Care Exclusive?
1. Everyone	For all patients/clients or services	⟵⟶	For some people or services
2. Extensive	Multiple simultaneous types		In one form at a time
3. Enduring	Sustainable		Short term projects
4. Enabled	Capable of being developed		Difficult to implement
5. Essential	Critical and essential		Optional

Table 64 Conceptual Framework of Exclusivity/Inclusivity and Five principles

The data sources and/or literature that have enabled me to assess where integrated care sits on the exclusive/inclusive spectrum is shown in the table below. I have framed each principle to reflect each measure, and pose the principles as questions to consider whether integrated care is for everyone, is extensive, is enduring, can be enabled and is essential.

Principles	Measure	I&BP Examples	ICON Examples
Everyone	For all patients/clients	All ages: MIU (35/04/E) Children: Nursery (10/00/H) Adults: Maternity(16/01/M) Older People: Day Centre (1/00/R) (Higgins 1993)	All ages: Traveller service (16/LW/TS) Children: Early Intervention (4/LO/EIT) Adults: Mental health (7/LW/MH) Older People: Nursing Home Team (9/LO/H) (Hudson 2006b)
	For all services	Rehabilitation: Health and housing (30/03/C) Health Promotion: Health promoting hospital (36/04/H) Clinics: Haematuria clinic (6/00/D) Long Term Condition: Stroke (20/02/C) (Ritchie 1993)	Rehabilitation: Community team (8/LW/CRT) Clinic: Leg Ulcer clinic (11/LW/LU) Health Promotion: Falls service (13/LO/FC) Primary Care: GP practices (1/LO/PCT) (Nies & Berman 2004)
Extensive	Multiple simultaneous types	7 types: Palliative Care (4/OO/P) 4 Types: Day Surgery (18/01/D) (Meads 2001)	5 Types: Rehabilitation (8/LW/CRT) 4 Types: Early Intervention (2/LW/EIT)
Enduring	Sustainable	Community hospitals established services with a long tradition (Higgins 1993; Heaney *et al.* 2004)	2 out of 3 teams established for 3 years and over (Tucker 2005)
Enabled	Capable of being developed	Integration demonstrated and evidenced when staff encouraged to record the service and submit for independent appraisal (Marriot *et al.* 2002)	Increase of 11 processes to support integrated working following a systems approach in a 9 month programme (Tucker 2005)
Essential	Critical and Essential	(Glasby and Dickinson 2008:xi)	(Carpenter and Dickinson 2008:xiii)

Table 65: Evidence for the 5 Principles of Integrated Care

The five principles represent a new perspective on integrated care, and have been developed based on reflections on the views, experiences of the staff in this study.

Is Integration for Everyone?

This research has shown that integrated care is being provided for service users of all ages, with a wide range of conditions, illnesses and disabilities. There was no evidence in my research of any patients being excluded from integrated care for reasons of age,

level of disability, condition or service. The 66 services included those for people with mental health needs, people with a learning disability and those who had age-related illnesses or conditions.   The literature is dominated by models of integrated care designed for older people, particularly those with complex needs and/or long term conditions (Leichsenring 2004, Nies and Berman 2004).   Leutz makes the case that the higher the dependency and level of need, then the more need there is for an integrated care approach (Leutz 1999). Whilst there is clearly a challenge to integrating care for older people with complex needs who may be major users of a wide range of services, the benefits for all patients receiving coordinated and integrated care cannot be underestimated. Examples include integrating efforts in screening and health promotion in particular, in following a public health model of service (Tucker *et al.* 2011).

In questioning whether integrated care is for everyone, I have widened this question to consider social inclusion, whereby members of society who have previously not been included in services can be brought together. This has been described as repairing social fragmentation, whereby marginalised individuals and groups are integrated into communities and services (Godfrey *et al*. in van Raak 2003:151). The lack of social cohesion, the fragmentation of society and the disruption to traditional connections have been shown to have created a context where integration needs to be actively pursued in terms of social and systems integration (Giddens 2009:100). This is discussed more fully in section 3.5. The use of the term integrated care has been considered to be too narrow, as the full implications of fostering integration in society on a whole systems approach involves not only health and care, but also social, economic and environmental concerns (Godfrey *et al*. in van Raak 2003: 151) and this would apply to community

health services in predominantly rural and remote areas. A systems-wide approach is advocated in policy (DH2006a) and also in the literature (Hudson 2006a). Terms such as social action and social inclusion more fully represent the wider impact of integration.

– **Is Integration Extensive?**

Integrated care comes in many forms. The literature shows many types of integration (Nies and Berman 2004; Thistlethwaite 2008; Van Raak *et al.* 2003). A key finding of this study is that multiple types can be present simultaneously within services. This research demonstrated that staff in local rural hospital settings were working in partnership with a range of staff, services and sectors across the statutory and voluntary sector and that staff in Irish community services were formalising their way of working together for a range of clients and services across the organisation. This deconstruction of integrated care into component parts is useful, but risks being reductionist (Kernick 2003). It is helpful therefore to consider integration within theoretical models such as network theory as discussed in section 3.5 (Goodwin *et al.* 2004).

Clarification is needed on the nature of integration being pursued so that the teams and types are identified and supported in the context of the whole system and network. There will always be distinct professionals, services and organisations, and it is important to recognise the reasons for the differences (Meads 1997).   Integration will continue to be a process whereby separate entities work together and the numbers of individuals and agencies concerned with health, illness, welfare, public health and well-being are increasing (Thistlethwaite 2008). Terms for integration across Europe include "shared care", "transmural care", "intermediate care" and "seamless care," and these

vary in scope with regard to integration between professionals, services and sectors *(*Grone and Garcia-Barbero 2001). Integrated care is context-specific, and will mean different things to different people within different setting and circumstances. This multi-faceted nature of integration demonstrates that it is extensive.

- **Can Integrated Care Endure?**

This research has shown that it may be more fruitful to examine existing services in order to assess the presence and sustainability of integrated care. Cottage and community hospitals have featured joint working from their inception as shown in the literature review and the history of this model of service. Most of the community services studied in Ireland had been in place for over three years and could therefore be considered to be established. This is in contrast to the findings in the literature that integrated care is characterised by short term innovative projects that are not sustained (Leichsenring and Alaszewski 2004; Nies and Berman 2004; Van Raak *et al.* 2003). In England, the progress on integrated care has been described as patchy, and most progress made where the focus is on people, relationships and trust rather than structure and systems (Carlisle 2009). There is a challenge to sustaining partnerships in a context of competing forces, such as localisation versus centralisation and collaboration versus competition (Peck and Exworthy 2003:1999). When looking for evidence of integrated care, researchers and policy makers have been drawn to new projects, rather than existing practice (Nies and Berman 2004). The ICON programme was extended to 72 teams following phase 3, and has provided the basis for the model of integration adopted by the Irish Government into their primary care strategy (Drumm 2008). Therefore, it is

possible that integrated working need not be constrained to short term innovative model projects, but be present in established services, may be sustained and may endure.

Can Integrated Care be Enabled?

The two programmes show two different approaches to enabling staff to work in an integrated way. The staff in community hospitals describe a devolved management system, whereby they design ways of working that are appropriate to local circumstances. In the ICON programme, the systems approach provided an explicit model, a definition, a project plan, funding and project management support. So whilst the approach was different, staff demonstrated integrated working in both programmes.

One of the conclusions from one of the European programmes was that integrated care is too difficult to define, and too complex to implement (Leichsenring 2004). The literature records a frustration with the slow progress of integrated care, and major hurdles identified such as poorly aligned systems (Kodner 2002). However, it is suggested that it is not enough to address structures and systems in order to encourage integrated working, and that an appropriate management approach is needed to enable and support a change in culture and working (Edgren 2008). The conventional model of management and leadership, is not considered to be appropriate for integrated care services. A team-based service with collective responsibility and accountability requires a different approach. There is evidence of benefit from a systems approach with a locally devolved authority with self managed and self-organising teams (Foote and Stanners 2002: 318). The research has demonstrated two distinct approaches to enabling integration, both of which have demonstrated the development of integrated

care. The attention given to staff in these programmes (known as the Hawthorne effect) may have impacted on the way of working of staff (Kilduff and Tsai 2003:14; Bowling 1997:137). Overall, teams in both programmes may have been encouraged to develop integrated working as part of a network of services (Goodwin *et al.* 2004).

– **Is Integrated Care Essential?**

Although a global priority, studies in literature have shown integration in stand-alone services as innovations. This suggests that this way of working is not integral to the service. The evidence shows that poorly coordinated services have created unsafe services with catastrophic implications (Glasby and Dickinson 2008:xi). The essential nature of integrating care is in respect of safety, clinical effectiveness and quality (DH 2008; Dickinson 2008: xi).   Given the priority given to integrated care, it is surprising that there are so few measures of effectiveness of integrated care, although there are some systems emerging (Ahgren and Axelsson 2005; Ramsay and Fulop 2008). It is clear from the services in the case studies, that many of the services being described would not have been developed at all had they not been a result of collaborations between different practitioners and organisations. Teams of staff need to work interdependently in order to meet the demands on health care services, with driving forces for change including patient expectation, numbers of people requiring care, increasing specialisms and new technology (Grone and Garcia-Barbero 2001). Ensuring that everyone concerned with the care and support of service users has the information that they require in order to plan and provide an appropriate service in partnership with the service user and all of those concerned with their care is becoming a fundamental requirement (Gray 2002). Although the case for fragmented care in appropriate

circumstances (Freeman *et al.* 2001), there is a growing case for improving in the way that services are planned, managed, coordinated and integrated for the benefit of those who use the service. As one of the staff recorded, *"it is now hard to imagine working in any other way,"* and the ICON managers who declared *"this is now our way of working"* (Tucker for Tribal 2005).

In the following section I consider the implications of my research in respect of policy, service development, education and training and international developments. I provide evidence of how I am applying my research in practice, and how this has added value and enhanced the work that I do. I conclude by making recommendations on further research.

9.4 Implications for Policy

Policy implications have emerged from this study and the literature as being important in setting strategic direction and creating a context for integrating care. I consider four implications: aligning policies, commissioning for integrated care, incorporating person-centred care and integrating health and social care. I also offer an example of how my research has been applied to inform national Parliamentary debate when asked to write a ministerial briefing.

Aligning Policies

Many health service policies require integrated working to enable successful implementation, such as the policy of "care closer to home" in England (DH 2006a; DH 2006b) which requires a high level of co-operation between third sector home care providers, informal carers, primary care, community health services and social services

(Ling 2009). A call has been made for more "joined up" policies (Jelphs and Dickinson 2008). Also, a more explicit recognition of the collaborations required may be helpful in framing policies (Lloyd and Wait 2005). This may be viewed as giving a mandate to local staff to pursue further joint working, thereby creating an appropriate culture as set out in staff views in sections 6.11 and 6.12.

Commissioning for Integrated Care

A policy on commissioning in a way that supports integrated working would facilitate partnership working, recognising the tension between competition and collaboration in a market system (Ham 2008, Peck and Exworthy 2003:1999). There is a debate on whether this creates a healthy tension, or is a genuine disincentive to integrated working (Rosen and Ham 2008). Commissioning integrated care pathways rather than individual specific services is considered a way in which cross-boundary working is encouraged, and this is considered requires support and development (Jelphs and Dickinson 2008:106). Attention to joint commissioning is considered a priority (Kodner 2002)and some of the issues that staff have identified regarding what helps and hinders integrated care (Section 6.11 and 6.12) may be assisted by joint commissioning. Research on commissioning integrated services could consider factors such as professional and team accountability.

Incorporating Person-Centred Care

Policies are being orientated around "person-centred" care, and is in keeping with the view of integrated care as being designed around the needs of individuals (DH 2008, DOHC 2001). Staff in the ICON programme described integrated care as person-centred care, described as care orientated around individuals (Section 7.5). This research has

shown that patients as proactive and as members of the team in some of the services but that there is scope for patients to be more involvement in the design, delivery and monitoring of services, and become "resourceful patients" who have a more proactive role (Gray 2002).

Integrating Health and Social Care

Health policies have yet to address the lack of alignment of systems and funding of health and social care, referred to as "Berlin walls" (DH 1998), whilst at the same time encourage integration through incentives and sanctions. This is what Leutz describes as a "square peg in a round hole" (Leutz 1999). This study has shown that, although there are some examples of integration between health and social services, there are still significant challenges (Section 6.3, 7.7 and Table 26). Arrangements such as joint appointments (Leathard 2003:347) and structural changes such as combining a local NHS and council into a Care Trusts are some of the ways that these challenges are being addressed (Thistlethwaite 2011). This study shows that this remains one of the more difficult types of integration to implement, and is one of the most common "fractures" in services (Freeman *et al.* 2001).

Ministerial Briefing

I was invited to provide a ministerial briefing to an MP on the Health Select Committee in preparation for her leading a debate in the House of Commons on the role and future of community hospitals, in which she advocated promoting improving information on community hospitals and encouraging the need for improved collaboration. My briefing drew on my review of the literature as well as my research and was evidence-based. The

motion was passed without opposition. (Wollaston in Hansard 2012)

9.5 Implications for Service Development

Staff reported on factors that impacted on how they developed their services, and this was also explored in the literature. The learning from this study has led me to examine three implications for service development: managing change, allowing time and measuring integrated care. I provide four examples of how new knowledge and learning from this research has been applied in practice: Measuring component parts of integration using my analytical framework as an assessment tool; Measuring types of integration using my analytical framework as an assessment tool; Contributing to the design of a programme to improve integration, and helping to develop DH guidance on the design of community hospitals.

Managing Change

Integrated care has been described as a change management process, and there is an increasing interest in the learning from systems theory and complexity theory to inform ways of supporting integrated working (Edgren 2008; Foote and Stanners 2002). I have analysed two embedded case studies using the learning from complexity theory and found this to be a helpful way of determining how changes in services with multiple actors and multiple variables were made (Section 8.4; Figures 17 & 18). This may be applicable more widely, and may help inform future management approaches (Kernick 2004:83).   Systems thinking has been described as a way of seeing the whole in terms of inter-relationships and patterns (Senge 1994). Whole system working, as described by

the Audit commission, reflects integrated care in that it is designed around individuals, parties are interdependent and hold a shared vision (Audit Commission 2002).

Allowing Time

Many studies have cautioned that sufficient time needs to be allowed for team members to be identified, relationships to build between team members, and an understanding to develop on respective roles and responsibilities (Ramsay and Fulop 2008, Jelphs and Dickinson 2008:107). The need for time to build trust between parties has been emphasised (Freeman 2003). This was illustrated within both programmes (Section 7.1) as well as in other studies (Tucker 2010; Rosen and Ham 2008).

Measuring Integrated Care

Given the difficulties in defining integrated care and clarifying expectations, the application of measurement tools may assist in assessing the presence and extent of integrated care (Browne *et al.*2004, Ahgren and Axelsson 2005, Kodner and Kyriacou 2000). There are a number of models and measurement tools that help to assess partnerships and team working which can be usefully applied (Dickinson 2008:82). I have designed an analytical framework which is a diagrammatic tool for types, processes and levels of integrated care that may be utilised as a self assessment tool (Figures 4; 5 &13). There are benefits to being able to compare and contrast services, and add to the learning regarding patterns of integrated care and what is appropriate in which context (Ling 2009).

Measuring Component Parts of Integration Using my Analytical Framework as an

Assessment Tool

My learning from this study was applied in a community hospital study in Scotland. I was commissioned by two neighbouring community groups working together who wanted to review the role and potential of their respective community hospitals in Scotland. The study had a high degree of involvement of patients, carers and wider community, with public meetings attended by 250 people. Local people completed questionnaires and offered suggestions such as: *"there is an opportunity for innovative links between the GP practice and the community hospital."* By applying my analytical framework of processes (as shown in Figures 5 and 16) I identified scope for improvement in sharing information between all stakeholders in all sectors. The recommendations in the report were formally accepted (Tucker 2012a). The research had provided me with a clear framework and I could apply the additional knowledge I had gained from my studies.

Measuring Types of Integration using my Analytical Framework as an Assessment

Tool

A study was commissioned by a proactive local community in Dorset who wanted to work with staff, patients and other stakeholders to develop a vision for the hospital. The analytical framework on types of integration developed in my research (as shown in Figures 4; 12 & 13) proved to be a useful tool when I applied this to help structure discussions in focus groups involving over 100 stakeholders. This provided a visual display of the network of relationships and identify where partnerships might be

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strengthened. In discussion, an additional type of integration was added to the framework, namely integration with other community hospitals. The agreed vision set out that the hospital would be "*vibrant, innovative and forward-thinking, offering a wide range of services through its many partnerships across health and social care*" (Tucker 2012b).

Contributing to the Design of a Programme to Improve Integration

I was commissioned as an external consultant to a programme, "Integrating Care in Norfolk" (ICN), to support the improvement of integration across primary, community and social care working with 5 localities with 33 GP practices. I advised on the design, management and evaluation of the programme over a three year period. From the learning in the ICON and I&BP programmes I designed and facilitated a learning network, and helped to identify the scope for aligning systems and processes such as joint assessments. One of key findings from my evaluation of the programme was that there were pressures (not least of which from patients) to develop integrated working on a whole system basis. These include integration with informal carers, private homecare providers and housing agencies. The programme was one of 16 pilots in England funded by the DH to develop integrated working and share the learning from this. I have had seven articles published on the three programmes: ICON (Tucker et al 2004a; Tucker et al 2004b; Tucker *et al.* 2005); I&BP (Tucker 2006) and ICN (Tucker 2010, Tucker *et al.* 2011, Tucker and Burgis 2012).

Helping to Develop DH Guidance on the Design of Community Hospitals

The DH set up a team to develop a design guide for community hospitals and facilities for primary and community care services. I utilised my learning from my study to contribute evidence as a team member on the role, function and potential of community hospitals, and in particular how the design of new or refurbished buildings could facilitate integrated working. The Health Building Note 11-01 has been adopted (DH 2009c).

9.6 Implications for Professional Development and Training

Staff in the study rated education and training as an important factor in developing integrated care which is supported in the literature (Carpenter and Dickinson 2008). From my findings and the literature I have considered four implications for professional development and training: creating the culture, establishing peer support, promoting joint training and supporting team building. I also present as an application and dissemination of my research my role in supporting and contributing to a national community hospitals conference.

Creating the Culture

One of the findings from the literature and from this study is the importance of "commitment" to integration (Section 6.11) whereby there is a willingness to integrate and a shared motivation (Ramsay and Fulop 2008). Culture is described as one of three critical dimensions to multidisciplinary working along with processes and structure (Jelphs and Dickinson 2008:81). The culture is considered to be a barrier in developing

interprofessional education and training (Carpenter and Dickinson 2008:58). Therefore an interprofessional education and training programme would need to consider the culture and motivation for pursuing integrated care (Audit Commission 2002:32).

Establishing Peer Support

Staff in this study found it helpful to have a network of peer support, such as the Action Learning Sets in ICON (Section 7.17) and the sharing of good practice across community hospitals (Jones *et al.* 2004). Designing programmes with networks of peer support have helped elsewhere (Tucker 2010) and may have wider applicability.

Promoting Joint Training

Staff in the two programmes recorded that they valued the education, training and support offered (Section 6.11; 717). Joint training and learning together is considered crucial for inter-professional collaboration (Leathard 2003:355) and may be pursued proactively and systematically. Evidence of joint training has been shown in community hospitals, and this could be further extended (Tucker 2006). Researchers reviewing the evidence on integrated care advocated an evaluation of the education and training offered in integrated care pilots in England (Ramsay and Fulop 2008). An implication from this study would beto highlight the need for joint training to staff working in the statutory and voluntary sector on a range of topics relevant to the health and social care services being provided.

Supporting Team Building

Staff reported experiences in both programmes of staff changes and vacancies which impacted on the completeness of teams and ability to carry out team building (Section 7.15:7.16). The embedded case studies provided more context to this (Figures 17 & 18).

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In developing integrated services, this research contributes to the understanding of the need for complete teams and the need to enhance and sustain team working as a continuous process and not as a one off activity (Jelphs and Dickinson 2008). Interprofessional education is considered to have the potential to make an important contribution to developing multi-disciplinary team working in multi-agency settings (Carpenter and Dickinson 2008:10). Therefore an implication of this study is to consider the benefits of team building within a programme of interprofessional education and development.

Contributing to a National Community Hospitals Conference

In my role as Vice President of the CHA, I have contributed to the design of the annual national three day conference that is focused on integrated care. The conference has attracted speakers from academia, policy and practice, and it is hoped that this national platform will encourage further research and evaluation. The Chief Executive of the RCN will be speaking on working in integrated care across professional boundaries. I will be speaking on "discovering integrated care in community hospitals" when I will share and discuss my analytical framework, conceptual framework, my findings and new knowledge which will enable the research to be disseminated and discussed (CHA 2013 http://www.communityhospitals.org.uk/2013ConferenceAgenda.pdf)

9.7 Implications for International Developments

In considering the potential application of this study to international developments, I have considered four implications: sourcing the data, determining perspectives,

deconstructing integrated care and considering context. I also provide examples of how my research has been applied in contributing to international conferences.

Sourcing the Data

It is appropriate to review the availability of data sources on this important topic, and consider carrying out secondary analysis on existing data as has been carried out in this study. There is an increasing recognition of the benefit of utilising existing qualitative data for research purposes (Conti 2006). Data is available from evaluations and consultancy that may be suitable for re-analysing (Kubr 2002:58). Although there are challenges to re-using data collected for another purpose, there are safeguards that can be put in place (Heaton 2004:59). This approach represents an alternative to primary research, and is being encouraged by national bodies funding research as well as through the creation of data banks for qualitative data (Conti 2006).

Determining Perspectives

This study has explored the views and experience of those who are providing services, and captured staff views of what type of integration is in place, what systems and processes they have to support it, and what their views are with regard to what helps or hinders development. There is a view that practice and ideas on integrated care are more likely to be rooted in service delivery (Thistlethwaite 2004). This suggests that there may be scope to carry out further research on the views and experiences of those staff who are concerned with delivering the service in a range of settings and countries (Coxon 2005, Workman and Pickard 2008).

Deconstructing Integrated Care

The measurement of component parts of integrated care, namely types and processes, has helped to demonstrate the multi-faceted nature of integrated care (Ling 2009). Researching evidence of processes in place to support integrated care, such as joint assessments, provides a proxy for integrated care in practice (Nies and Berman 2004). Looking for evidence of types of integration helps to illustrate the partnerships that are in place. This study has shown that, although the integration of health and social services is a priority nationally (DH 2006a; DH 2006b; DH 2008), in practice this type of integration was not as frequently observed as other types of integration studied. There may be scope for studying other correlations internationally, to determine the match between strategy and practice.

Considering Context

The importance of context in evaluating services has been recognised, and such as in realistic evaluation when determining what works, for whom in which circumstances (Tilley 2000). The findings of the study regarding the multiple simultaneous types of integration in community hospitals and the development of processes in community health services are context specific, and relevant to multiple factors. It may be helpful to consider contexts such as rurality and scarcity as encouraging partnerships (Freeman 2003, BMA 2005). This has been shown in this study, in the small rural hospitals in England and the community health services in Ireland (Tucker 2006, Tucker *et al* 2005). Further studies on context and integrated care, and in particular the development of integrated working in rural areas, may be worthy of consideration internationally. This

study has also helped to demonstrate the value of researching existing and established services rather than focusing on special projects (Leichsenring and Alaszewski 2004).

Contributing to International Conferences

I have presented papers and given presentations with colleagues at international conferences as a way of disseminating findings and benefiting from questions and discussions with those attending. These conferences have been: the PROCARE conference in Venice 2004, the International Journal of Integrated Care (IJIC) in Dublin 2005, the CHA conference in York 2006, the primary care network conference in Utrecht in 2006 "Towards Unity for Health", the IJIC conference in Vienna (presented on my behalf due to ill health) and the IJIC conference in San Marino in 2012 (The International Journal of Integrated Care http://www.ijic.org)

9.8 Recommendations for Further Research

Throughout this study I have identified areas for further research, and I have summarised these into seven areas: carrying out primary research, considering the perspective of service users, considering a whole system perspective, widening the geography, measuring levels of integration, utilising existing data on established services and testing the framework of five principles. I also provide an example of my contribution to the drafting of a national call for research into community hospitals from the National Institute for Health Research (NIHR).

Carrying out Primary Research

There is scope to carry out primary research to answer the research question which explores the presence, nature and development of integrated care in community services further. For instance, the research questions could be addressed to a random sample of community hospital and community health services that have not been part of any formal programme. This would allow for a comparison to be made of findings in different contexts, illustrating what works for whom in which circumstances (Pawson and Tilley 1997). This would allow a comparison with those in the I&BP and ICON programmes and may provide results that may be generalisable (Bowling 1997:221). Such research could be designed to seek the views and experiences of staff, as in thi s and other studies (Workman and Pickard 2008, Coxon 2005).

Considering the Perspective of Service Users

The experience and views of staff in the study has shown that in some services patients and the community have been partners in managing their health and care.   Given that the model is one of person-centred care, it may be the patient who is best placed to assess whether their experience of health and care is one of an integrated service (Tucker and Burgis 2012). There is scope to pursue what Gray calls "the resourceful patient" and carry out further research for the perspective of those who use the service (Gray 2002).

Considering a Whole System Perspective

The study is concerned with partnership working across professionals, organisations, sectors, and there would be a benefit in widening the research so that all agents and agencies concerned with a service could contribute their views and experiences. Whilst staff in this study contributed their views of their partnerships, it would be of value to incorporate the perspective of all of the actors and agencies involved in a service and research their views on extent to which they are working in an integrated way (Hudson 2006b).

Widening the Geography

This research has studied services in England and Ireland, and there would be a benefit to extending the geographical scope. The community hospital model features across the UK (Ritchie 1993; Cavenagh 1978; Emrys-Roberts 1991; Seamark et al 2001), as well as internationally (Charante *et al*. 2004, Aaraas 1998). There have been a number of European and international collaborative studies such as the CARMEN programme (Nies and Berman 2004) the PROCARE programme (Leichsenring 2004) and these suggest the scope for research studies in different geographical contexts (Billings *et al.* 2004).

Measuring Levels of Integration

This study did not consider levels of integrated and this would have contributed an important dimension to understanding staff practice (Leutz 1999; Thistlethwaite 2008). The question of whether integrated care is present may be further substantiated if there

was evidence of the level of integration between actors and agencies, using measures such as links, coordination and full integration (Leutz 1999). These measures have been applied in some studies (Kodner and Kyriacou 2000, Ahgren and Axelsson 2005). Further research on measuring levels of integrated care is merited (Ling 2009, Thistlethwaite 2008).

Utilising Existing Data on Established Services

This study has shown the benefits and challenges of carrying out secondary analysis on data that has been collected for another purpose (Heaton 2004). This study has also shown that there may be benefit to researching integrated care in existing and established services such as community hospitals (Wilce 1998) rather than investing in special projects (Nies and Berman 2004, Billings 2005). The view that there is more partnership and team working in existing services than is recognised (Jelphs and Dickinson 2008:107) and therefore this would be a fruitful area to research.

Testing the Framework of Five Principles

There is scope for further research to test out the framework of five principles that I have been developed from my research questions. This would enable an assessment to be made on the extent to which integrated care may be considered as appropriate for everyone(patients of all ages and or all services), is extensive (multi-faceted), is enduring (sustainable), can be enabled (using change management approaches such as a systems approach) and may be viewed as essential (rather than optional). This may be carried out by primary research, or by reviewing data on existing services. There remains some important questions about what a fully integrated health and care system

may look like (Woods 2001), and whether integrated care is appropriate to implement on a whole system basis (Hudson 2006b).

Providing Advice on Draft Call for Research

I applied my learning when I was invited by the National Institute for Health Research (NIHR) to comment on their draft commissioning brief for research into community hospitals in September 2012. My commentary and advice was based on the findings in my review of the literature for this thesis, illustrated by case studies, and informed by the findings of my research. I identified scope for extending the brief to include integration and in particular community engagement. This is the first funded programme of this size and scale that is specifically focused on community hospitals. Following the call for research, I was invited to be part of a University team bidding for this funding and we have been invited to submit further details of our proposed study in the second stage of our application (National Institute for Health Research 2012).

9.9 Concluding Remarks

This research has demonstrated that there is a benefit to exploring the presence, nature and development of integrated care in existing and established services, rather than focusing on model projects and pilot studies. The study has also demonstrated the value of utilising existing data, sourced from studies such as evaluations and commissions by management consultants. This research has demonstrated the insight that can be given into integrated care in practice by the staff who deliver the service. The study has also

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shown the potential for considering integrated care in terms of change management and systems theory, and assessed how this may influence the management and development of integrated working.

This research has presented new knowledge on the presence, nature and development of integrated care, and shown that, by deconstructing integration into component parts (types and processes) it can be shown to be present.

The availability of data in questionnaires from two existing programmes offered a unique insight into staff views and experiences of what helped or hindered them in working in this way. The ability to compare and contrast the findings from these two programmes further added to the generation of new knowledge on the experience of integration at a service delivery level, and showed parallels between the staff experiences.

My findings are tempered by the limitations of my research, which I have discussed throughout this thesis and in particular in the design of the study (5.7), in the review of the research (8.5).

There are few studies on community hospitals and in particular partnerships and integrated care, so the findings from this study will contribute to the evidence base of the extent to which community hospitals are networked within whole systems (Meads 2001). The presence of multiple types of integration in all community hospital services was a significant finding.

Integrated care was present in both programmes for patients of all ages in a wide range of services. Integration between practitioners, in multidisciplinary working, was the most commonly recorded type of integration in both programmes. Staff in the ICON programme chose to work on improving the way that they shared information on patients and services.

 Cultural factors such as commitment were considered by staff as helping in the development of integrated care, whilst staffing factors (lack of staff or changes in staff) hindered development. On reflecting on the outcome of this study from the findings and the literature, I have offered a new framework of five principles for integrated care, and questioned whether integrated care can be for everyone, can be considered as extensive, can endure, can be enabled and can be considered as essential. I have recommended further research to test these principles further.

These principles have emerged from my theoretical framework where I consider to what extent integrated care may be considered "exclusive" as is often portrayed. I conclude from my research that integrated care may be appropriate for a wide range of service users and services across a whole system and may be considered as potentially "inclusive."

The challenge facing health and care services is to provide a service that all patients experience as integrated.

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10.   APPENDICES

Appendix A   Approval I&BP

Community Hospitals Association

Meadow Brow, Broadway Road,
Broadway, Ilminster,
Somerset TA19 9RG
Tel: 01460 55951
Fax: 01460 53207
Email: commhosp@gxn.co.uk
www.communityhospitals.org.uk

Helen Tucker
Briar Cottage
Half Moon Lane
Redgrave
Suffolk IP22 1RX

Dear Helen,

Research into Community Hospitals

Thank you for requesting support from the Community Hospitals Association for the research you are carrying out into integration in community hospitals. I understand that you are using survey data from the CHA Innovation and Best Practice publications which are readily accessible in the public domain. The surveys are the accounts by staff of their award winning services which we publish on a regular basis. The staff give permission for their accounts to be used in the publications and in our conferences. I understand that you will not be naming patients, staff or hospitals in your research and therefore anonymity is assured.

We would be very interested in seeing the outcome of your research.

Very best wishes

Barbara Moore
Chief Executive
Community Hospitals Association

supporting and developing a network of community hospitals and related services

Appendix B Approval ICON

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Dear Helen

Re PhD Warwick University

I have no objection in principle to your proposal to use data from the ICON programme for your research.

I would like to wish you every success in this academic challenge and if I can be of any further help, please do not hesitate to contact me.

Regards

Pat O'Dowd
Assistant Chief Executive Officer
Episodic Care
Chairman of the ICON Steering Group Midland Health Board, Tullamore

Appendix C Questionnaire and Application Form CHA I&BP

Application Form

COMMUNITY HOSPITALS ASSOCIATION

INNOVATIONS & BEST PRACTICE IN COMMUNITY HOSPITALS 2008

Please complete this form in BLOCK CAPITALS

Project Name:

Project Purpose:

A) HOSPITAL DETAILS

Hospital

Address

Address

Post Code Tel Fax

Name of Organisation responsible for hospital

B) How long has this project been running? Please state commencement date:-

C) Which healthcare Professionals are involved in the service? (please mark X in relevant boxes)

General Practitioners   Occupational Therapist
Consultant Medical Staff   Speech Therapist

Community Hospital Nursing   Pharmacist
Community Based Nursing   Dietician
Clinical Nurse   Specialist Podiatrist
Speech & Language Therapist   Clinical Psychologist
Physiotherapist   Others (please specify)
Others (please specify)

D) Which Agencies are involved in the project? (please mark X in relevant boxes)

NHS Acute Trust   League of Friends
Social Services   Charity
Housing Association   Voluntary Agency
Private Companies   Other (Please Specify)

E) Is this Service being Evaluated?   Yes   No

If yes please specify:-
Internal Review   Other
External Review   Other
Academic Research

Is there evidence of Audit/Evaluation?   Yes   No

F) Please supply supporting documentation - (please mark X for relevant enclosures)

Project proposal   Protocols
Grant application (if applicable)   Policies
Operational Policy   Brochure
Standards   Video (if applicable)
Other (please specify)

G) Description Please describe your Project in no more than 500 words
If insufficient space - please continue on a separate sheet of paper

H) Would you be prepared to have your service put forward for an Innovation Award?   Yes   No

Questionnaire completed by:

Title: Dr/Mr/Mrs/Miss/Ms
Position
Date   / / 200

Contact name for correspondence purposes (if different to above)

Thank you for completing this questionnaire. Please return with any supporting documentation to:-

Community Hospitals Association, Meadow Brow, Broadway Road, Broadway, Ilminster,Somerset TA19 9RG
Telephone: 01460 55951 Fax:01460 53207 e-mail commhosp@gxn.co.uk

website: www.communityhospitals.org.uk

CLOSING DATE

I&BP Questionnaire

COMMUNITY HOSPITALS ASSOCIATION

Innovations & Best Practice in Community Hospitals

Proforma (2000 words maximum)

1. Summary of the Project (background and purpose).

2. What did you hope to achieve?

3. How did you go about it and who did it involve? (professions/agencies/partnerships)

4. What helped?

5. What hindered?

6. What does the service offer?

7. Benefits to patients/carers?

8. Benefits to the organisation?

9. What methods to evaluate

10. Future Plans

11. What lessons are there for others?

12. Contact name/address/telephone/fax

Appendix D Questionnaires ICON

MIDLAND HEALTH BOARD

MODELS OF INTEGRATED PRIMARY AND COMMUNITY CARE

"Person-centred services delivered in a non-acute setting in a continuous way."

QUESTIONNAIRE

A. INTERVIEWEE DETAILS

Please give your name, job title, base of work, contact telephone number and email address.

B. SERVICE RESPONSIBILITY

Please provide a brief description of the service that you provide or are responsible for – the service provided by location & care group, staff employed, budget and activity data in broad terms. Please provide a broad outline of the size and scope of the service. Further detail is not required at this stage.

C. CURRENT SERVICE

Please describe how your service currently operates, and current ways of working with particular reference to teams and partnerships. Please describe any services that you provide in collaboration with, or within the following sectors – primary, community, acute, voluntary, private. Please describe links with other providers and cross referral systems.

D. TEAMWORKING

Please provide examples of any teams or service links that span the following: inter-professional, multi-disciplinary, multi-agency, academic and any other.

E.   GOOD PRACTICE

Please provide up to 3 examples of each of good practice and planned service developments.

F.   INTEGRATED CARE

What does integrated care mean to you?

G. MODELS AND FEATURES

Could you describe any models of good practice in your own discipline or elsewhere.

H. KEY FEATURES

Could you describe key features of integrated primary and community care (using the above models or others as a guide)

I.   SWOT ANALYSIS ON INTEGRATED CARE

How integrated is your service? Please provide up to 3 examples of where the service has strengths, weaknesses, opportunities and threats/challenges with regard to the level of integration.

J. IMPLEMENTING MODELS OF INTEGRATED CARE

What would you need to have in place to develop integration further. If possible please give 3 examples for ideas for immediate action.

K. ADDITIONAL CONSIDERATIONS

Please provide additional comments, evidence, documents or proposed models for how services can more fully integrate within and between primary and community care to the benefit of those using the service and their families.

Thank you for your co-operation in the completion of this questionnaire.

Questions for ICON Implementation Sites

1. Confirm the name of the team
2. Confirm the lead person for the team and how was that person agreed
3. How long is the team in operation?
4. Does the team have its own cost code?
5. Who are the client group seen by the team?
6. How are people referred to the team?
7. Are there clear referral procedures between team members?
8. How are client notes maintained?
9. Does the team have a common assessment?
10. Are client reports multidisciplinary or unidisciplinary?
11. Does the team use a data sharing protocol?
12. Does the team agree a care plan with the client / carer?
13. Does the team measure outcomes?
14. Has the team attended team building?
15. Has the team carried out a patient satisfaction survey?
16. Does the team have an information brochure for service users?

Appendix E   Programme Documents and Questionnaires

Documents Providing Data Sources for Research

Code	No	Title	Rationale for Inclusion	Date
CHAIBP00	10	I&BP Questionnaires	Staff describe service and practice	Tucker et al 2000
CHAIBP01	9	I&BP Questionnaires	Staff describe service and practice	Marriot et al 2001
CHAIBP02	8	I&BP Questionnaires	Staff describe service and practice	Marriot et al 2002
CHAIBP03	7	I&BP Questionnaires	Staff describe service and practice	Jones et al 2003
CHAIBP2004	7	I&BP Questionnaires	Staff describe service and practice	Jones et al 2004
CHAIBP05	7	I&BP Questionnaires	Staff describe service and practice	Jones et al 2005
Q1	63	Baseline Questionnaires	Views on Integrated Care	ICON 2003
Q2a	18	Team Questionnaire Start of Phase 3	Assessment of integrated working	ICON 2004
Q2b	18	Team Questionnaire End of Phase 3	Progress with integrating care	ICON 2005
ALS	18	Action Learning Set Records	Notes shared on progress	ICON 2005
TR	18	Team records	Collection of records for each team	ICON 2005
P1	18	Presentation by team leaders	Structured presentation	ICON 2004
P2	18	Presentation by team leaders	Structured presentation	ICON 2005
MHBa	1	Report on ICON Phase 1	Report to MHB including analysis of baseline questionnaire	MHB/Secta Consulting 2003a
MHBb	1	Report on ICON Phase 1 summary	Report to MHB - Appendices	MHB/Secta Consulting 2003b
TS	1	Report on ICON Phase 3	Report to MHB including analysis of questionnaires on team progress	Tucker for Tribal Secta 2005

Examples of Documents Excluded from Study

Code	No	Title	Rationale for Exclusion	Date
E001		Report on Seminar with Line Managers	Study concerned with practitioners rather than managers	2004
E007		Report on ICON Phase 2	Report has focus on IT and a Road Map	MHB/Secta Consulting 2004
D001		Discussion Document	Setting context for the programme by consultant	MHB/Secta Consulting 2002
Various		Policies, procedures etc.	Level of detail not required	MHB