'An exploration of health and social care service integration in a deprived South Wales area'

Volume 1

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Abstract

Frailty poses a complex challenge for some people through their experience of ageing. In Wales, devolution requires organisations to use a whole systems approach with a model of partnership to deliver public services. An integrated care approach is offered to meet the service user focus or 'value demand' which impacts on clinical, professional, organisational and policy levels within the system. Therefore, the aim of this study was to explore whether there was a difference between integrated health and social care day services and non- integrated health and social care day services. In doing so, answering the questions, how were these services different, what were the differences as perceived by the participants, why were they different, what could be learned from this study and how could health and social care services integrate in practice?

The study utilized Gadamer's interpretative hermeneutics with a single intrinsic case study design. Using this approach ensured that the unique voice of the individual lived experience was heard and interpreted within the whole system of the study. The participants were service users, carers and staff in a day hospital, an outpatient clinic, day centre, reablement team and a joint day care facility. The methods included a survey questionnaire (SF12v2 and London Handicap Scale), in-depth interviews, observations; and historical and service documents; and reflective diary. Data collection occurred January 2005 to December 2006. Quantitative and qualitative data were analysed separately. The qualitative data was analysed using Gadamer's five stage approach developed by Fleming et al (2003) and Nvivo 7.0. The embedded quantitative data was analysed using SPSS version 13.0. Triangulation was achieved through the use of a meta matrix which merged the qualitative and quantitative data.

The difference between integrated and non integrated services is expressed through the four themes, 'the study participants', 'commissioning and decommissioning integrated services', 'the journey within day services',

'navigating services and orchestrating care'. The four themes were developed through a strategy used for interpreting the findings, which was to follow the study questions, propositions and 'emic' questions. The differences between the integrated and non integrated services were in the meaning of their purpose, culture, level of integration, team orientation of practice and the model of service user/carer relationship observed within the services. The thesis identified challenges in respect of integrated working such as concept confusion, negative experiences of care for frail or older people, a vertical gap in knowledge transfer between strategic organisation, the operational services and service users. Mapping each service level of integration and team orientation to the model of service user and carer relationship, found that the level of team orientation and integration does not appear to be proportionate to the service user and carer relationship.

The thesis concludes that in order to attempt to answer the question as to whether these day services can integrate in the practice, all levels of the system should focus on the service user/carer relationship. We need to understand service user diagnosis, how its characteristics and effect are interpreted by the service user, carer, professional and wider society in relation to independence and autonomy. It argues that knowledge emerges at this micro level (service user and carer relationship) and how we engage with this relationship and manage the knowledge we gain from it (both vertically and horizontally), will lead us to understand how we can ensure that integration occurs and that services in the future are person focussed.

TABLE OF CONTENTS – VOLUME 1

LIST OF FIGURES

Chapter 1 Introduction

1.1   Opening quotations and service user vignette

> *'I don't think people realize the overlap of how social care effects the healthcare and how health effects the social side…perhaps mental health would be a good example if you have mental health problems and you're depressed then the social side of your life goes down, you don't socialize and become unable to look after yourself.'(Int.5; Reablement team; staff)*

> *'When you need help you've got to change your attitude to life… A couple of months ago I had to go to the toilet and I couldn't get back into bed. That's when I start getting my tablets and of course when you need help you've got to be.. All the carers I have I can't say nothing I have wonderful carers. But you've got to be a bit patient and wait for them to do things their way. That's when you need help. When you can do it yourself that's a different thing. But when you've got to have help you've got to alter your outlook on life. Don't demand you can't demand nothing, be a bit kinder. Well it's a bit like that here!' (Int. 14; Joint day care; service user).*

These first quotes, provided by two participants give differing perspectives of day services; a professional perspective of the impact of health and social care upon one another and the latter a personal perspective of what it means to receive the services as a passive user. The second quote, by a frail older person, describes the impact that taking prescribed medication can have on personal dignity and the need for prompt, discrete carers (whether at home or attending day services) who will still value you as a person. This quote highlights that we are a long way from delivering person-focussed care either at home or in day services. The two quotes were chosen because day services are complex and when we contemplate service integration there are multiple opinions, various levels, different forms and several mechanisms and techniques of integration to consider from service user, professional and organisational perspectives. However, when we consider systems theory as our conceptual framework for developing this way of working, the dominant feature which drives integration is service user 'value demand' and its impact on the system through clinical,

professional and organisational integration. This is the service users' perspective of their need which as a result demands integration if their needs are to be met holistically (Seddon, 2008). A vignette, 'Mrs Mary Williams' is provided in Appendix 1. Mary Williams is a pseudonym (Data Protection Act 1998) and is a précis of the main parts of the journey experienced by the participants within this case study. It is a journey through time and gives an insight into increasing individual needs over a period of eight years. [This vignette has been used by the New Frailty Programme in 2009 to support the development of their Frailty journey].

1.2   Background

This thesis is a single intrinsic exploratory case study of day services for frail or older people in a 'welsh borough'. It links theory and policy to practice whilst considering the real world of the day service user, the carer and the staff who work within the services. As a result the focus is on clinical, professional and organisational integration, but in particular clinical integration and the meaning and impact that the service users and carer relationship has on the whole complex adaptive system.

The aim of this introduction is to introduce the case study and set the scene. It will achieve this by at first describing the demography of Wales and the 'welsh borough' within the UK context, defining concepts such as ageing and frailty, then setting the political devolved health and social care scene in Wales (in order that the reader can fully appreciate the case study). Finally it will introduce the aim of the case study and the significance of this study for older people not only in the 'welsh borough' but also for the geographical locality and Wales itself.

1.2.1   Demography

The World Health Organization (2008) has predicted that the world will have over 2 billion people living over the age of 60 years of age by 2050. The United Nations (2002) in its Second World Assembly on Ageing outlined the impact of the demographic transition the world expected to see by 2050 as the number of older people (people over sixty years of age) were expected

to exceed the number of younger people for the first time (Kalache et al, 2005). The 'old old'(75-84 years) were seen as the fastest growing age group in the world growing at 3.8% per year with one fifth of the older population envisaged to be eighty years and older by 2050 (United Nations, 2002). The projected world parent support ratio for 2050 is predicted to be 11 people aged 85 years or older per 100 as opposed to the actual 4 persons per 100 in the year 2000. Gruber & Wise (2002) envisaged that these demographic changes in conjunction with the Vienna International Plan of Action on Ageing (United Nations, 2003) and United Nations Principles of the Older Person (OHCHR, 1996-2007) would undoubtedly have an effect on the expectations and demand for health and social care services in the future. The impact of these projections as we move towards 2050 has been the realisation that 25% of 65-69 year olds and 50% of 80-84 years olds experience multiple co-morbidities i.e. they have two or more chronic conditions at the same time (WHO, 2009).

The UK population on the whole is growing quickly by an annual growth of 0.7%. It is projected to reach 71 million by 2031 due to more births than deaths and an inflow of immigrants. In addition, our population (aged 65 years plus) is projected to increase to 22% of the population by 2031 (ONS, 2007). Children born in the UK in 2006 would expect (on average) to live to 76.9 years (boys) and 81.9 years (girls). As a result the chances of a child born in the UK in 2006 of reaching 65 years is projected at 91% for boys and 94% for girls compared with 74% for boys and 84% for girls born in 1980-82. However, whilst more women survive and live longer, they can also expect to spend more years in poor health and with a disability.

In Wales although the population increased from 2.89 million (1997) to 2.98 million (2007) the number of people aged 65 years and over has increased by 5.5% whilst those under 35 years has decreased by 4.5% over the same time period (WAG, 2009a). By 2031 the total population is projected to increase to 3.3 million with 24% being older people of pensionable age. A report of Welsh statistics on older people (based on the Census in 2001, the Labour Force Survey and the Welsh Health Survey) states that nearly one

in four people in Wales are over sixty years of age (WAG, 2008b). Whilst life expectancy is comparable with that of the rest of the UK, in Wales the proportion of people over eighty years of age is slightly higher (4.9%) than the rest of the UK (4.5%) and most of the European Union with the exception of Italy and Sweden. The anticipated arrival of a 'greying world' has been expected for some years, not just for Wales, UK and Europe but also for the rest of the 1st, 2nd and 3rd world where the impact of a changing family construct and lifestyle has anticipated a need for services which care holistically for its frail and vulnerable people (Tout, 1993; Alvarez, 1993; Apt,1993; Reban & Bayer, 1993; Achenbaum, 2005).

The report of Welsh statistics on older people gives us a more detailed picture of the older people most likely to require health and social care services (WAG, 2008b). People aged over seventy five are twice as likely to use social services day care and three times as likely to use homecare or meals on wheels compared with people aged sixty five to seventy five years of age. Whilst a third of people over 70 years had been to outpatients, they are also twice as likely to be an inpatient as the under fifties. The numbers of people over the age of sixty-five years requiring homecare services per week are higher than those under sixty five years of age (WAG, 2008b).

Subsequently it's not surprising that UK health and social care policy for older people has been developing and changing to manage the care and wellbeing of its growing 'silver' population (WAG, 2002a; WAG, 2004; WAG, 2005a; WAG, 2006a,b,c; WAG, 2007a,b,d,e; WAG, 2008e). Nevertheless in 2008, the World Health Organization stated that they had concerns that health systems across the world were being allowed to drift towards the continued delivery of hospital acute care. They were not showing any signs of preparing and adapting for the changes ahead and the demands from population expectations of health promotion, people focussed care, reliability, equity, solidarity and social inclusion (WHO, 2008).

1.2.2   The demography of a 'welsh borough'

The 'welsh borough' is situated on the edge of the South Wales coalfield, historically an industrial town which never recovered economically after the closure of the steelworks in the 1980s. It has three valleys and five main towns. Long term unemployment is well above average and so the council and NHS are major employers. In 2004 the 'welsh borough' had a population of approximately 68,838 people in a Welsh population of 2,958,600. It is a small unitary authority which was coterminous with its Local Health Board (LHB) until October 2009 when the LHB merged with the local NHS Trust and other local health boards (WAG, 2008a). During the lifetime of this research study, the 'welsh borough' LHB commissioned primary and secondary services for its local population (on the whole) from the local NHS Trust and tertiary services as appropriate from other Trusts such as Felindre NHS Trust for oncology services. It had approximately £92million per year to spend on the health of the local population (HIAT, 2006a).

In 2005 the population of the 'welsh borough' was approximately 5.4% lower then it had been in 1996. Although an average decrease of 390 people calculated across all age groups, the differences varied across the groups, with large and substantial decreases in population seen from 0-44 years and 65-84 years but an increase in 45-64 years and 85 years plus (HIAT, 2007). Male Life expectancy (72.1 years) at birth (2002-2004) is well below the welsh average of 75.8 years and females below the welsh average of 80.3 years (HIAT, 2006a). On the Townsend Deprivation Score seventy five percent of this 'welsh borough' scores 1 (most deprived) and on the Welsh Index of Multiple Deprivation fifty per cent of this 'welsh borough' scores 1 (most deprived) (HIAT, 2006a).

Its population has a 21% disability which is the highest in Wales, a reduction in perceived mental and physical health with age and above Welsh average use of hospital services (HIAT, 2006 a,b,c). Forty three percent of people over the age of 75 years live alone, which is higher than the welsh average.

This 'welsh borough' County Borough Council supports 32.80 people (per 1000 population) over 65 years in a care home. The welsh average is 26.87 people per 1000 population (HIAT, 2006 a,b,c).

Intermediate care provision is changing quickly within the borough with the development of a new community hospital in one of its valleys and two health and social care units each in the other two valleys. The number of community beds will remain at 96 in total in the locality. Its intermediate care provision includes a nursing Rapid Response team, reablement team, mentally ill liaison and joint day care services which have contributed to the reduction in emergency medical admissions, overall length of stay and delayed transfers of care experienced by the borough (BGLHB, 2009)

1.2.3 Definitions of old age and frailty

1.2.3.1 Old age

What we should remember whilst reading this section is that most of us grow to be older people but only few of us experience frailty and vulnerability whether that's through physical or mental health problems (Peace et al, 2007). The concept of old age is defined by its multi-dimensional biological, psychological, social and cultural dimensions and depending upon where you live in the world the biological dimension may be less important (WHO, 2009). An early biological perspective of ageing sees it as associated with deteriorating change and death (De Beauvoir, 1970). Associated with those ideas are disease, illness and disability,

> *'the transformation of the human organism after the age of physical maturity so that the probability of survival constantly decreases, and it is accompanied by regular transformations in appearance, behaviour, experience and social roles* (Birren, 1988 cited in Burke & Walsh, 1997,p80)

Kalache et al (2005, p30) define older people as '*60 years of age and over.*' Sixty or sixty-five years is generally the given age at which we define the onset of old age in the western world (WHO, 2009; WHO, 2002a). Nevertheless there are some countries and continents such as Wales and Africa where it is felt to be more appropriate to include people aged 50

years and over within their strategies for older people (WAG, 2003a;WAG, 2008e; WHO, 2009). The World Health Organisation (2004, p42) defines an older person as

> *'a person who has reached a certain age that varies amongst countries but is often associated with the age of normal retirement.'*

It further categorises old people as 'young old' (60-74 years), 'old old' (75-84 years) and 'oldest old' (85 years and older). However, people generally cannot be neatly packaged into these categories because of their bio-psychosocial life experiences which may impact on their own perception of how they should age (Westerhof & Tulle, 2007). Fry (1996) has argued that this form of categorization is a very negative perception of age and has offered another definition, '*age is the unfolding of life and the meaning to be found in the continuities and discontinuities with self and context*' (Fry, 1996, p129)*.* This definition speaks of a personal change throughout a lifetime which we as society have called ageing. A social construction with certain features that society finds acceptable such as retirement from paid work, low incomes, gate keeping of certain services for submissive and inactive people who use them (Townsend, 1981). This approach of using age to categorize old age as opposed to stages of life has also been criticized as ageist and an economic approach to the life stages is suggested as an alternative (Midwinter, 2005).

This period of time in later life after retirement age has also been called the third and fourth age. The third age signifies an autonomous and independent individual with material wealth, economic security and consumer choice, whilst the fourth age signifies dependency, illness, frailty, disability, restriction of choice and lifestyle (Midwinter, 2005; Gilleard & Higgs, 1998; Bond et al, 2007). A period of active ageing defined by the World Health Organization (2002 p12; 2005b) as *'the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age'* has the purpose of trying to delay the onset of the fourth age for as long as possible. Its purpose is also to maintain individual participation in society, family and community for all older people

in order to maintain quality of life through preserving autonomy and independence (WHO, 2002). Research in recent years acknowledges that the very old are healthier than predicted and the basis for that is thought to be a healthy lifestyle along the lifespan (Ljubuncic et al, 2008).

1.2.3.2   Frailty

Frailty is an old and common problem where there is health deterioration which may be considered as a natural part of the lifespan (Ferrucci et al, 2006; Steinhagen-Thiessen &Borchelt, 1999). It does not have a standardised definition and has been predominantly researched in recent years by biomedical researchers (Fairhall et al, 2008;Barrett, 2006; Walston et al, 2006; Bandeen-Roche, 2006; Rockwood, 2005; Fried et al, 2001; Rockwood et al, 2000). It is defined more recently by Topinkova (2008, p6) as a

> *'status of global impairment of physiological reserves involving multiple organ systems.'*

Fried's (2001, p M146) definition of frailty from a physical perspective has a set of recognizable signs and symptoms which has been increasingly accepted by the health community (Bandeen-Roche, 2006).

> *'a clinical syndrome in which three or more of the following criteria were present: unintentional weight loss (10 lbs in past year), self-reported exhaustion, weakness (grip strength), slow walking speed, and low physical activity'*
> *(*Fried, 2001,p M146)

The social and environmental aspects of frailty are equally as important as the physical and physiological (Barrett, 2006; Walston et al, 2006; Woo et al, 2005). A definition from social gerontology is given whereby the process of frailty, and frailty itself, is seen as negotiated changes to the individual and not a set condition.

> *'Frailty is an outcome of the relationship between the individual and his or her environment. Becoming frail is that process that occurs within the context of encounters between the older person and the individuals, agencies and institutions responding to the 'lived with' problems of old age. The transition can be thought of as a 'frailty process' (Barrett, 2006, p116)*

This identifies the association between frailty and socially constructed disability (Rockwood et al, 2000; Foote & Stanners, 2002; Topinkova, 2008). Frailty generally consists of individual vulnerability, disability/dependency, anorexia, sarcopenia, osteoporosis, fatigue, slowness, risk of falls, poor physical health and the increased risk of death (Strandberg & Pitkala, 2007; Walston et al, 2006; Rockwood, 2005; Song et al, 2004; Foote & Stanners, 2002; Fried, 2001; Rockwood, 2000). Chronic disease such as diabetes, heart disease, stroke, back problems, but more specifically arthritis and rheumatism in older age are another aspect of frailty. These are the most common chronic diseases in the UK (ONS, 2008) and increase with old age (Fried et al, 2004; Topinkova, 2008). Older people are likely to report to having two or more chronic illnesses (NPHS, 2005a; WAG, 2007a). More recently, the Welsh Health Survey (including the SF-36 short form questionnaire) found that the extent to which health and pain limited people's physical activities got worse as people grew older (WAG, 2008). Physical health scores also worsened with age but their mental health improved slightly between 50—80 years but worsened after eighty. Therefore people in Wales are more likely to be treated for mental illness as they grow older (WAG, 2008b).

Sensory deficits have an impact on independent living and in the 70-80 year olds, one in fourteen had eyesight problems and a third had hearing problems. These problems which impact on mobility and functional independence increased with age, in the over eighty year olds (WAG, 2008b). Therefore, they affect an individual's ability to live independently.

Disability, frailty and chronic illness are seen by some as distinct but interrelated; one may exacerbate the other and so build on the picture of complexity (Fried et al, 2004). Rockwood (2005) suggests that from the age of 95 years frailty is inevitable and at that time, both frailty and age are intertwined. However, this has more recently been found in 20-30% of people over the age of 75 years (Topinkova, 2008). Frailty has also been defined as a phenotype or cluster of traits and not a single syndrome, with

possible interventions such as exercise used to improve physical function and quality of life (Walston et al, 2006; Rockwood, 2005;Butler, 2000).

Summary

Old age and frailty are multidimensional concepts that need to be considered from bio-psychosocial, cultural and environmental contexts. Although old age is defined from the age of 50 years in some countries the accepted chronological age at which old age traditionally commences around retirement, and then categorized accordingly. For some people encountering longevity within a fourth stage of life brings with it the negative experience of disease and disability. Therefore, people who are frail can present with chronic and functional problems with stressed social networks. All of which impact onto health and social care services (Johri et al, 2003). The challenge is how we as a society care about and with people facing these experiences when they need an increasing amount of care; and whilst trying to maintain wellbeing, autonomy and independence.

1.2.4   Devolution and its impact on service delivery in Wales

Since the election of the Welsh Assembly Government (WAG) in May 1999, activities which include health, social services and housing have been devolved to WAG from the UK government in London. These intended activities were outlined in the White Paper 'A voice for Wales' (Secretary of State for Wales, 1997). Devolution has influenced health and social care policy in Wales in the last 10 years through its focus on inequalities in health and a partnership model. Its solutions increasingly influenced from European welfare policy and the Welsh Assembly Government's need to provide tailor made services which satisfy the needs of the citizens of Wales.

Two early key developments have influenced how society is trying to define old age and develop active ageing policies: The Vienna International Plan of Action on Ageing which was endorsed by the United Nations General Assembly in 1982 (United Nations, 2003); and The United Nations

Principles of the Older Person were further developed and adopted by the UN General Assembly (resolution46/91) on the 16th December 1991. The Vienna International Plan of Action (United Nations, 2003) acknowledged that the bio-psycho-social and environmental factors of ageing were inter-related/ interdependent and required a coordinated approach to policies which should consider disability prevention, independence and the total wellbeing of the individual. In Wales they influenced the development of 'The Strategy for Older People in Wales' (WAG, 2003a) and the National Service Framework for Older People in Wales (WAG, 2006a).

The structure of Welsh health and social care services have altered since devolution (NAfW, 2001). Health Authorities were dismantled following the publication of the NHS Plan in Wales with their responsibilities devolved to Local Health Boards and Regional offices of the Welsh Assembly (NAfW, 2001). Whilst this case study was undertaken, the twenty-two Local Health Boards (LHB) and Local Authorities (LA) were coterminous (Welsh Office, 1998; Longley, 2004). The LHBs and LAs had responsibility for commissioning their respective local services. The former, commissioning services from local NHS integrated acute and community Trusts and national tertiary centres, the latter commissioning services from voluntary, independent and private organisations. Community Health Councils were retained within the NHS Plan in Wales (NAfW, 2001) providing the vital advocacy link between the citizen and the service (see fig.1).
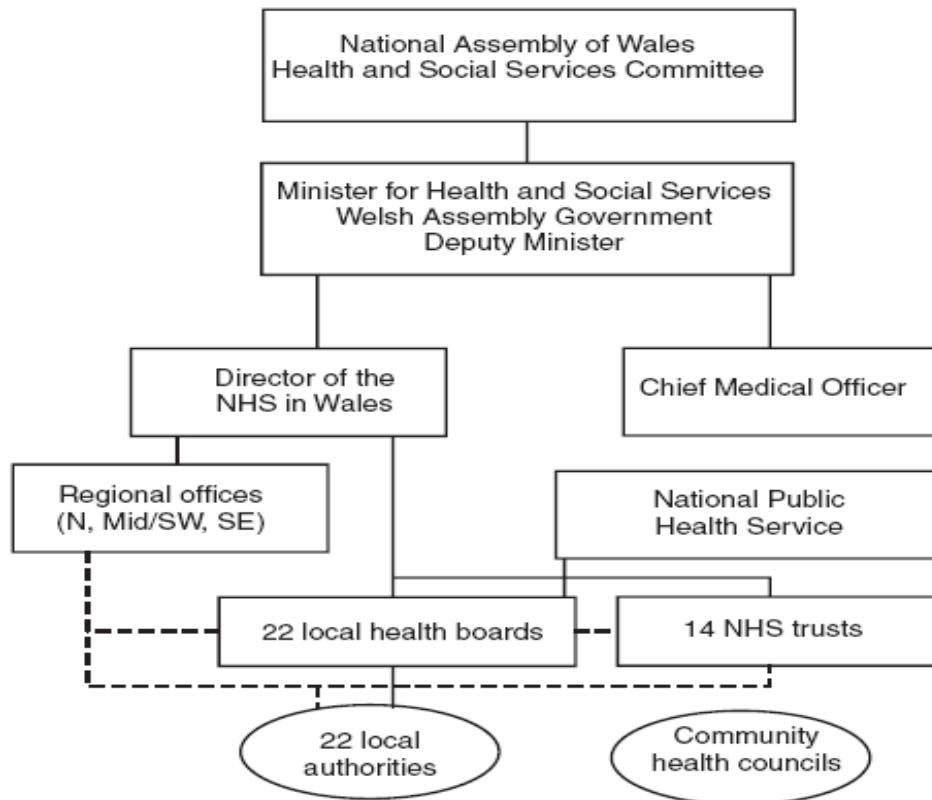
Figure 1: **Health service structure in Wales during the case study research until October 2009 (Longley, 2004, p4)**

Further changes within the Welsh National Health Service occurred on 1st October 2009. Following the Labour and Plaid Cymru coalition document 'One Wales' (WAG, 2007c) the twenty-two local health boards and seven NHS Trusts have reduced to seven integrated Local Health Boards and three NHS Trusts (public health, specialist cancer services and Welsh Ambulance Services) (WAG, 2009d) in addition to the abolition of the internal market and the development of a National Health Service Board for Wales (WAG, 2008a; WAG, 2009d). These changes may signal a move from a locally commissioned and delivered NHS to an NHS which is Welsh nationally planned with a local flavour and emphasis on changing behaviour, whole systems working together, clinical engagement, 'wellness not illness' (WAG, 2009d). Nevertheless, this signifies another structural change which may have an impact on the way service users access their acute and community services (Jones, 2009).

Devolution has provided WAG with an opportunity to deliver a potentially different and radical health policy in Wales to that delivered in England, Scotland and Northern Ireland (Tewdwr-Jones, 2001). This difference WAG acknowledges within many of its documents is the emphasis on public/preventative health, self care with citizen involvement and a partnership model as opposed to a combination of targets, inspection, choice and competition as in England (Andrews & Martin, 2007; Jones, 2009; WAG, 2003a; WAG, 2006a; Welsh Office, 1998; NAfW, 2001). The long term aim has been to promote health and independent lives in order to tackle the key determinants of health (Beddow & Cohen, 2003; WAG, 2003). This came partly from the Health Planning Forum (NHS Directorate, 1989), the Acheson Report (1998), 2001 Census and publications by the National Public Health Service for Wales including Deprivation and Health (NPHSfW, 2004) Needs Assessment (NPHSfW, 2006): Older People (NPHSfW, 2006) and A Profile of the Health of Older People in Wales (NPHSfW 2005b) (Drakeford, 2006). These reports have demonstrated that people living in the most deprived areas of Wales have worse health than those living in affluent areas. Health problems include higher levels of mental health, hearing and sight problems, chronic illnesses combined with the trend for obesity. As a result policy needs to promote the maintenance of mobility, independence and social contacts which rely on functional capacity, tackling ageism, cost and equity of access to all public services (Acheson Report, 1998; WAG, 2003a).

In acknowledging that health inequalities are not just the responsibility of the health service but a broader responsibility of the whole system including individual lifestyle, economics and wider public services; the WAG has created Local Service Boards to strengthen collaborative leadership (WAG, 2008f). Its message to public bodies whether statutory or third sector is to focus on the needs of individuals and communities. It requires openness, partnership with cross boundary working, consistent communication, clarity of purpose, with identified outcomes in order to achieve its long term aim

(WAG, 2002a,b; WAG, 2003a,b; Beddow & Cohen, 2003; WAG, 2005a; WAG, 2006cd; WAG, 2007abcde;WAG, 2008f)

A further challenge to the implementation of this policy has been the role of service user as citizen (rather than consumer) with a voice which is listened to (WAG, 2003; WAG, 2004; Drakeford, 2005; WAG, 2005a; WAG, 2006c,d; WAG, 2008f). The citizen model is presented as the first of the four principles to better services (WAG, 2004). It requires citizens to be at the centre of service planning and delivery in order to attain better value for money. This will be achieved through 'democratic accountability, better front-line access and support, greater responsiveness and stronger participation' (WAG, 2004, p9). In effect there is recognition that public services should be constructed by and around the people who use them and not only engaging passively when they are most vulnerable. This is not dissimilar to the personalisation agenda advocated by the Department of Health in England in the form of direct payments, individual budgets, health and social care reform (DoH, 2007c, 2009b,c). It aligns itself with 'self as subject', where the individual interacts with the environment and shapes it through his or her own behaviour. This is opposed to 'self as object' where the individual is unable to impose their will on his or her surroundings (Hoggett, 2001; Frost & Hoggett, 2008). This is a cultural change for professionals in practice who have traditionally been seen to know what's best for individual patients or service users. However in order to modernise and deliver public services for a changing older and knowledgeable population, the citizen's voice is a crucial ingredient.

Most recently Dr Chris Jones (Chair of Rhondda Cynon Taf LHB) (Jones, 2009) has been tasked by the Health Minister Edwina Hart to review primary and community care services and develop a '*Primary and community services strategic delivery programme'.* It criticises the current system as being an unsustainable acute, institutional and reactive 'push system' which needs to move towards being a primary care led whole systems approach to health and social care in Wales. It advocates *'an integrated model of highly organised community services that bridge the gap between primary and*

secondary care such that service provision is fully achieved' (Jones, 2009, point 5). This will utilise a whole systems approach with mechanisms such as generalist workers, partnership working, proactive care management, proactive prevention, common information systems, integrated multi-professional teams across health and social care, pooled budgets, joint management, which focus on service user need. Projects such as the New Frailty Programme (Appendix 2) have developed in response to Dr Chris Jones' review of North Wales Community Services (Hart, 2008).

Summary

Devolution's challenges have been to promote its population's health and independence whilst tackling inherent health inequalities and attempting to redesign services to meet those needs. The WAG has chosen to confront these challenges through developing policies which are based on identified individual need, and through developing prevention and public health through its public services in partnership with the citizens of Wales.

1.3 Chapter Conclusion

Our population is growing older and as a result a number of people who experience frailty as they age will require services which enable them to maintain their quality of life through acceptable levels of independence and autonomy. Complexity occurs in the presenting need which arises from the individual context of a combination of frailty, disability and multiple chronic conditions. Health and social care policy in Wales is redesigning itself to focus on an integrated model with a whole systems approach in order to satisfy the service user holistic needs or 'value demand' (Seddon, 2008; WAG, 2009d). Intermediate care services in the 'welsh borough' (within this case study) have developed over the last 10 years to include services which aim to meet the complex needs of people (who frequently live alone) in order to maximise their independence, i.e. a reablement team and joint day care facility (BGLHB, 2009).

Local initiatives such as these in combination with whole system theory led the researcher to consider a number of questions. This resulted in the design of an intrinsic exploratory case study. The aim was to explore whether there was a difference between integrated and non- integrated health and social care day services in the 'welsh borough' (Stake, 1995). This led to further questions:

- How were integrated services different?
- What were the differences in integrated and non integrated health and social care services as perceived by the participants?
- Why integrated services were perceived as different to non integrated services?
- What could be learned from this study of integrated and non integrated services?
- How can health and social care services integrate in practice?

In order to answer these questions, the following chapters are offered:

Chapter 2 Integrated Care for frail or older people - a review of the literature

This chapter is a review of the integrated care literature. It is divided into three sections and defines the concept of integrated care, its theories, models and mechanisms. Three frameworks have been used to analyse the findings that of Delnoij et al (2002) classification of integrated care and Leutz (1999; 2005) five laws of integration and Timms and Timms (1977) three level classification of theory.

Chapter 3 The context of intermediate care for day services: why use hermeneutic interpretative analysis and a case study?

This chapter sets the context of intermediate care for day services. It has two sections, the first critically analyses the definitions identified. The second section addresses how and why Gadamer's hermeneutic interpretative analysis with single intrinsic case study design evolved.

Chapter 4 The case study design and method

The purpose of this chapter is to convey the design and methods used within this research study. This chapter has been developed by using the five components of a case study as defined by Yin (2003a). The case study method has served to apply the whole systems approach, whilst the use of hermeneutic interpretative analysis explores the lived meaning of day services.

Chapter 5 Case Study Results

This chapter presents the results in themes to further define the case and answer the questions how and why were integrated and non integrated care services different. The four themes are the study participants, commissioning and decommissioning integrated services, the journey within day services, navigating services and orchestrating care. They include descriptive detail, quotations, qualitative and embedded quantitative results. It concludes with the meta matrix whilst answering what could be learned from this study?

Chapter 6 Discussion – how can health and social care services integrate in practice?

This chapter discusses the last question of the case study i.e. how can health and social care services integrate in practice? It also includes a discussion with regard to the knowledge of the case to date in respect of the new Frailty Programme and a reflexive account of the research process.

A conclusion and recommendations is given with a poem and quote which draws this thesis to a close.

This introduction has:

- Given the background to the single intrinsic case study of day services for frail or older people;

- Introduced its demography, concepts of frailty and old age;

- Introduced the policy expectations in respect of the partnership model and the wider systems responsibility for health in Wales;

- It suggests that integrated care is society's future for caring for frail or older people with complex needs whilst trying to maintain their autonomy and independence;

- The next chapter reviews the literature for integrated care.

Chapter 2   Integrated care for frail or older people: A review of the literature

Integrated care for frail or older people is seen as a way forward for health and social care services to manage the increasing numbers of people that require their complex needs to be met (MacAdam, 2008). It should not be considered as an easy option, because the combination of gerontology and integrated care brings with it complexity of many interrelating parts (Bravo et al, 2008). As a result there are many theories, models and mechanisms at different levels of the system to consider if we are to understand and translate the service user 'value demand' into services which meet that need (Hudson et al, 2004).

2.1   Introduction

The aim of this chapter is to review the existing literature from a variety of sources in respect of integrated care for older or frail adults. Its objectives are to demonstrate:

- An understanding of the existing knowledge,

- How the knowledge links together and

- Any existing gaps which lead to why the author has chosen to study integrated community day activities for frail people (Hart, 1998; Neale, 2009).

Integrated care is a concept that has been visible in day services for over twenty years (Smith & Cantley, 1985), it is a 'social' arrangement between agencies for maximising individual wellbeing, achieving acceptable quality of care within increasing cost constraints (Trice, 2006). Social arrangements to address social problems were once described by Pinker (1971, p7) as *'a study of human nature in the political context'* and social services as a form of negotiation between the individual and specific social groups in order to enhance wellbeing.   Leene & Schuyt (2008, p4) on the other hand may view integrated care as a social intervention which they define as:

> *'systematically planned and phased attempts to influence individuals groups, organizations and larger social units, with the aim of contributing towards preventing, easing and solving social problems.'*

When increasing numbers of individuals have complex needs and /or multiple needs with differing origins and require multiple provision from the wider health and social care sectors, then a variety of 'actors' are required to assess, prescribe and manage the evidence based care or cure that is required (Tout, 1993; Bigby, 2004; Loader et al, 2009). Otherwise, avoiding duplication, lack of ownership, poor communication and undermining or impacting on a parallel treatment or care becomes a reality (Lloyd & Wait, 2005). In order to understand a complex health and social care phenomenon such as integrated care it is essential to understand its theory, policy and practice contexts (Kumper, 2005).

Unfortunately the evidence base for integrated care is limited, the little evaluation that has occurred is found within a few large studies in Canada, USA and Europe and some small pilot work around the world (Ramsay et al, 2009; Ouwens et al, 2005).

Search Strategy

In order to define the selection of available documents which are pertinent to this research study the review of the literature within this chapter focussed on the key words "integrated care", "elderly", "older people" and "frailty". An initial search was undertaken on COPAC (including British Library) where forty-one (41) texts were found. Following removal of "physical therapy", "crime" and "music therapy" and removal of duplicates a final total of twenty-seven (27) texts resulted. A search on ZETOC using the keywords "integrated care" and elderly or "older people" or "frailty" not pharmaceutical not dental resulted in sixty seven (67) returns. The databases used for the initial literature search to inform this chapter included Assia (1999-2006), EMBASE, CINAHL plus with full text (1982-June week 5 2006), Journals @ Ovid Full text July 3 2006, International

Bibliography of the social sciences (1951-July week 1 2006), Ovid Medline (1966- July 2006) Mantis (1880-2006), Alt. Health Watch, SCIE. These were then revisited in 2008 and 2009. The terms 'Integrated Care' or 'Integrated services' and 'older persons' or 'older people' or 'elderly' were used as keywords or within the article title where refinement of the search was required. A total of 176 documents were initially retrieved. All duplicates were removed. Secondary references of importance were also included. The policy and guidance documents analysed within this chapter were obtained from the Welsh Assembly Government 'Health and Social Services' Department website, in addition to other relevant health and social care documents obtained from 'Older People', 'Care & Social Services Inspectorate Wales' (CSSIW) websites. Popular search engines such as Google were also utilised. As a result a total of 657 documents were identified. The methods of analysis used were summary records stored within Endnote with the development of content maps to understand the construction of the topic and sub topics of integrated care within the context of frail /older people (Hart, 1998).

Whilst reviewing this literature, three themes emerged; these form the structure of this literature review:

- Section 1 identifies a five part classification of integration (Delnoij et al, 2002).

- Section 2 introduces the three level classification of integration theories

- Section 3 finally introduces us to the mechanisms and techniques of integration whilst utilising Leutz (1999, 2005) laws of integration

This overall approach has been utilised because integrating services for frail or older people is a complex undertaking and consequently it is necessary to have an understanding of the theoretical concepts, models and mechanisms that underpin and deliver the various levels of service user, professional and organisational activity which is driven by service user need.

2.2 Section 1: Defining Integrated Care

2.2.1 What is integration?

During the last 25 years both the United Nations and more recently the World Health Organization have been requesting support for integrating the health and social needs of older people into community and other appropriate services (United Nations, 1992; WHO, 2003). Integrated care is developing across the world because of the fragmentation (duplication, service gaps, lack of continuity) experienced by a world aging population with complex needs and the fragmentation of professional roles and agencies (Tout, 1993; Minkman et al, 2009). There are two ways of working associated with integrated care, that of 'cross agency' working as in health and social care and the other within a single organisation 'under one roof' (Coxon, 2005).

The many names associated with the term integrated care across Europe and north America include managed care (USA), intermediate care (UK), shared care (UK), 'transmural' care (Netherlands), transition care (Australia) disease management (e.g. Australia, New Zealand, UK), continuing care and comprehensive care (van der Linden et al, 2001; Delnoij et al, 2002; Paulus et al, 2002; Van Raak et al, 2003; Clarke et al, 2003; Leichsenring & Alaszewski, 2004; Ouwens et al, 2005; Rygh & Hjortdahl, 2007; Hebert et al, 2008a,b; Australian Government, 2008; Minkman et al, 2009; Stein & Rieder, 2009). There are also many professions associated with integrated care such as medical and surgical care, nursing, social work, therapies (such as physiotherapy, occupational therapy, dietetics, podiatry) and domiciliary care (van Raak et al, 2003). There is a 'range' of providers, settings within which they deliver integrated care which includes service users own home, hospital (acute and community), primary care facilities (health centres and GP practices), day care, care home facilities (van Raak et al, 2003;Warner & Gould, 2003). Integrated care is described as a

'wicked' or 'fuzzy' concept (Hudson, 2006; Geyer, 2003; Fraser & Greenhalgh, 2001; Plsek & Greenhalgh, 2001).

Consequently integrated Care literature frequently describes and applies theories, 'laws' and frameworks to enhance its credibility and provide some answers for the increasing problems faced by service users, their families, professionals and the organisations that care for them (Leutz, 1999, 2005; Nies and Berman, 2004; Hebert et al, 2008a,b; Minkman et al, 2009). Publications have made comparisons between care systems, identifying the challenges and rewards of embarking on such a new approach to care (Kodner, 2006; Billings & Leichsenring, 2005; van Raak et al, 2003). In addition to studying its many mechanisms, types or forms such as networks, care pathways, integrated assessment, care settings, case/care management, (Loader et al, 2009; Wallace & Davies, 2009; Challis et al, 1995, 2002, 2006; Goodwin et al, 2004; Warner & Gould, 2003; Croucher, 2005; Atwal & Caldwell, 2002).

There are various definitions, classification, typology, laws and lessons offered by authors with different backgrounds who have studied and developed integrated care services across differing countries. They have exposed the differences which occur across Europe and the wider world (Stein & Reider, 2009). They have striven to identify essential laws and principles, question whether the definitions, principles and their models are transferable and ask us to consider whether we should be adopting an open and flexible approach to defining integrated care (Kodner & Kyriacou, 2000; Delnoij et al, 2002; Leichsenring & Alaszewski, 2004; Leutz, 1999, 2005; Billings & Leichsenring, 2005; Rygh & Hjortdahl, 2007; Minkman et al, 2009).

What is clear is that it is a composite term and in order to understand its meaning we need to direct ourselves to the themes which have been identified in relation to this concept (Wittgenstein, 1958). Therefore

integrated care requires defining prior to attempting to analyse the applied theories, models and mechanisms of this concept in the care of frail or older people. This is necessary if we are to understand how the service user 'value demand' is translated into services which meet their needs through clinical, professional and organisational levels (Pomerantz et al, 2009).

2.2.2 Rules, laws and classifications of integration

Plsek & Wilson (2001) cite 'simple rules for the design of the 21st century healthcare system in the United States' which move the service focus from being professionally driven and controlled to that of service user centre and control, evidence based and working together (Nies, 2006; Kodner & Spreeuwenberg, 2002). These in addition to Leutz (1999; 2005) five laws (and later six laws) of integration emerged as a frequently used set of statements which appear to influence local, national and international literature in addition to service and practice integration within modern services. The laws consider organisation, process, clinical and non clinical functions, culture, roles and relationships and service user need. The latter drives the level of integration, locality and empowerment. Over time, Leutz' Laws of integration have been used to evaluate integrated care whilst looking at the actual degree of evaluation and integration (Hebert et al, 2008a,b; Bravo et al, 2008; Nies, 2006; Ahgren &Axelsson, 2005; Nies & Berman, 2004; Kodner & Kyriacou, 2000).

In 2002 Delnoij et al (2002) had developed a classification of integrated care from previous work undertaken in the USA by Shortell et al (2000). The four types of integration within the classification (clinical, professional, organisational and functional) can be seen in Appendix 3 + 4. Billings and Malin (2005) then further developed the Delnoij et al (2002) classification by giving additional explanation for three of the classifications and evidencing them with a total of nine definitions:

- professional integration - *Frossard et al, 2004, p244; Colmorton et al, 2004, p144*;
- Organizational integration -*Ex et al, 2004, p415; Frossard et al, 2004, p244; Salonen & Haverinen, 2004, p187; Grilz-Wolf et al,*

2004, p117 cited in Billings & Malin, 2005. The last reference is not easily identified within the original text and so has not been utilised within this review*.*

- Functional integration- *Gritlz-wolf et al, 2004, p117;Ex et al, 2004, p415;Coxon et al, 2004 p465*

In comparison the NHS Confederation (2005) has adopted a typology of healthcare integration with six factors of integration and seven lessons for policy and practice (Appendix 3). This has been mapped to Leutz' (1999; 2005) six laws of integration (see figure 2).The similarities between the work undertaken by Leutz (1999; 2005), NHS Confederation (2005) and Delnoij et al (2002) are at defining clinical, organisational and functional integration. They also agree that integration is not easy, you have to invest in people, processes and money at various levels before you can appreciate any rewards, which takes time to achieve. The effort has been in developing common values, shared goals and balancing power relations in order to achieve co-operation and co-ordination.

The main differences between Leutz' six laws (1999; 2005) and the NHS Confederation (2005) six factors and seven lessons is that whilst the latter considers practical ways of connecting primary and secondary health organisation, the former uses the service user needs to drive and base the level of integration across health and social care systems. Both Leutz (1999; 2005) and the NHS Confederation (2005) have focussed on strategic and managerial organisational aspects of integration. As opposed to clinical integration which focuses on the fit between the clinical decision and the needs of the service user. Unlike Delnoij et al (2002) neither of them considers the delivery of clinical integration to the service user in addition to professional integration i.e. the act of working together in order to deliver seamless care. They have ignored the cultural differences of organisations across health and social care, professional groups and models of assessment and care which occur at service user, professional and organisational levels within the system. These are all integral to identifying service user need (Wallace & Davies, 2009; Hammick et al, 2009). For

these reasons Delnoij et al (2002) will be used to analyse the definitions found within this literature review.
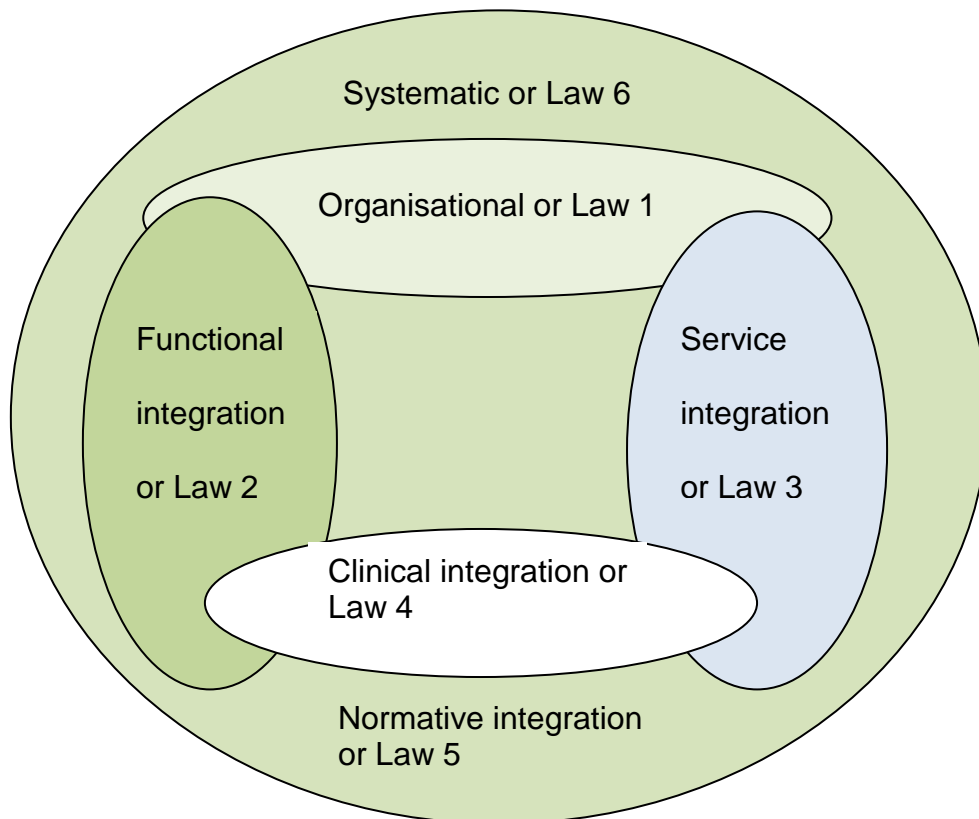
Figure 2: Typology of Healthcare Integration (NHS Confederation, 2005, p4, sourced from Mowlam & Fulop, 2005, adapted from Contandriopulos & Denis, 2001) mapped to Leutz (1999, p83-110; 2005p 3-12) six laws of integration.

2.2.3   Definitions of Integrated Care

There doesn't appear to be one standardised definition or one single model of integration (Stein & Rieder, 2009; MacAdam, 2008; Schultz, 2006; Leichsenring, 2004). A total of thirty-four definitions have been identified within this literature review (appendix 4). These have been added to the original four part classification developed by Delnoij et al (2002). In addition to a further classification identified, 'systems integration' (MacAdam, 2008)

Denzin (1989, p 56) states that *'definitions intervene between the perception of an instance of a concept and the operational process of acting on that instance'.* This is interpreted as meaning that a definition itself occurs between the impression or belief of a situation and its functioning series of actions within it. For integrated care the impression or belief of the situation is variable at different levels of the system by service users, carers, professionals, managers, commissioners or planners and policy makers. Its series of actions are its degrees of integration within its defined mechanisms, which all form part of the integrated model (Stein & Rieder, 2009; Warner & Gould, 2003). The keywords which further define the actions of integration include co-ordination, collaboration, co-operation and need (Stein & Reider, 2009; MacAdam, 2008; Schultz, 2006; Leichsenring, 2004). These are fluid within the parameters of the concept and so 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; Thistlethwaite, 2008; Stein & Rieder, 2009).

2.2.3.1   Clinical integration

Four definitions can be identified within this classification (Appendix 4). Its meaning is explained in the context of the interaction between professional and service user; and sometimes informal carer. The mechanisms to enable it are the acts and processes of cooperation, co-ordination and identification of individual need (Hebert et al, 2008a,b; Demers & Lavoie, 2008; Rygh & Hjortdahl, 2007; Van Raak et al, 2003; Delnoij et al, 2002). It is assumed that this is the co-ordination of assessment and services although the act and process of assessment are not mentioned but must precede the identification of need and the commissioning/ planning of services required (Wallace & Davies, 2009; Wilson & Baines, 2009).

The most straightforward definition is by Contandriopoulos et al (2001, cited in Veil & Hebert, 2008 p76) who describe the need for sustainability and an agreement or understanding between people before co-ordination can be engaged. Only Demers & Lavoie (2008 p6) and Van Raak et al (2003, p11) consider the service user and informal carer. Rygh and Hjortdahl (2007, p4)

assume a process of seamless continuity or 'chain of care' between clinician, health services, health plan and the patient.

A criticism of this clinical classification is in the interpretation of the micro level and the use of the words 'clinical' and 'patient'. Warner & Gould (2003) suggest practice as an alternative. In 2002 Delnoij et al described the micro level as *'continuity, co-operation and coherence in the primary process of care delivery to individual patients' (p2).* Cooperation is a word often used in the context of inter-organizational working but also used in respect of the caregiver relationship; it requires the minimum of communication and information exchange in order to enable people to work together (van Raak et al, 2003).

The act of co-ordination (often used as a blanket term for integration) is actively undertaken for the service user or patient who appears passive within these definitions. Instruments or mechanisms for co-ordination are organisational structuring, regular and planned multi-disciplinary team meetings, care protocols and pathways, guidelines, standards, information and communication technology and care or case management (van Raak et al, 2003). The mechanism of intensive case management is omitted within these definitions although this is also required when working with service users who have complex needs and require full integration (Latour et al, 2007; Nies, 2004).

Rosen and Ham (2008) define the micro-level as pertaining to the 'individual patient experience' and have shifted the interpretation of this level to considering the effect of integration on the receiver, an experience of 'being' a 'patient' which is seen as separate from the whole person. This is in contrast to the general understanding of the micro-level as 'being' and 'interaction between individuals' (Feuerstein, 1993 cited in Peinhaupt, 2004; Grone & Garcia-Barbero, 2001).

As a result the act of coordination remains in the domain of the professional and their teams who co-ordinate the delivery of their planned treatments.

Coordination, reciprocity and interdependence are not considered in the domain of the service user and carer or between service user, carer and professional (Roberts et al, 2005; Plickert et al, 2007). Professionals continue to dominate the negotiation of the relationship with individual people they work with in traditional hierarchical relationships, as individual people move from grateful and compliant receivers and users of services to patient experts, collaborative partners with increased personal control through direct payments and individual budgets (DoH, 2005; Gottlieb et al, 2006; Glasby & Littlechild, 2009; Loader et al, 2009). The act of negotiated collaborative partner with valued personal autonomy (and the structures to support it) should be reflected in this classification through the personalisation of clinical integration (Dworkin, 1988; Gilleard & Higgs, 2000; Peinhaupt et al, 2004; Gottlieb et al, 2006; Sang, 1998, 2006, 2007). After all, service users should be empowered to co-ordinate their own care whenever possible (Trummer et al, 2002 cited in Peinhaupt et al, 2004). This would support and sustain independent living and the status of service user as citizen through valuing (acknowledging, including and developing) the individual contributions; of informal carer and service user (van Raak et al, 2003; Clark et al, 2004; Plickert et al, 2004; Roberts, 2005; Glasby & Littlechild, 2009).

2.2.3.2   Professional Integration

Five definitions have been identified within this form of integration (see Appendix 4). Professional integration is initially referred to as the act of working together within organisations (Delnoij et al, 2002; Billings and Malin, 2005). However, Rosen & Ham, (2008) have again shifted this understanding to include professional integration across primary and secondary care; and across health and social care. Therefore professional integration can be across teams and/ or cross agency, co-located or virtual act (Coxon, 2005; Abendstern et al, 2006). The integration mechanisms or operational processes to enable this type of integration include clinical pathways, shared information technology with information and process sharing (Loader et al, 2009). What is not considered here is, the different

types of professions working in integrated care, the impact of the service user and/or carer subsystem on the role of the professional and how they work together. Occupational groups such as professionals are dynamic organisational sub-cultures and strive to achieve a core culture for themselves in which they have control over their unique body of knowledge, education, their work and their evaluation (Trice, 1993). Therefore they are likely to clash with those they interface for fear of deskilling or diluting their uniqueness e.g. joint assessment (Trice, 1993).

There is some contradiction on the understanding of the meso-level. To some authors it means organisation (Hebert, 2008a,b; Feuerstein, 1993 cited in Peinhaupt, 2004; Grone & Garcia-Barbero, 2001). To Rosen and Ham (2008, p2) it's where professional integration is found and is known as 'a clinical structure and process' which requires collaboration with a common purpose i.e. individual needs or objectives.

Many authors have written on the act of working together and have highlighted the many difficulties (including language barriers) that arise through the many forms of doing so (Glasby & Dickinson, 2008; Barrett et al, 2005; Coxon, 2005; Huxham & Vangen, 2005; Billings, 2005; Glasby & Littlechild, 2004; Weinstein et al, 2003;Sullivan & Skelcher, 2002; Glendinnings et al, 2002a; Hudson, 2002; Balloch & Taylor, 2001; Loxley, 1997; Leathard, 1994, 2003; Ovretveit, 1993). Essentially working together requires 'skill, knowledge, values and motives' and the right environmental ingredients within which it can be nurtured (Wallace & Davies, 2009).

A number of definitions emphasise collective skill, focussed purpose and role of the workforce (Billings and Malin, 2005; Stewart et al, 2003; Brown et al, 2003; Frossard et al, 2004; Colmorton et al, 2004) . Professionals mean both registered and non-registered people working within and across the services. The Department of Health (2009a) identified the link between the act of working together and the quality of care i.e. receiving services which meet identified need.

Pahor and Domajnko (2008) identified three levels of working which has been compared in table 1 with Boon et al (2004) conceptual framework. Boon et al (2004) describe seven models of 'team-oriented health care practice' on a continuum from parallel working through to integrative working. Parallel/disciplinary and integrative/ interdisciplinary are similar in their interpretation but the middle range of working together does not appear to match. This lack of standardisation with the meaning of words leads to '*positively valenced concepts*' that is confusion and loss of meaning for students, researchers, educationalists and practitioners alike (Cowen, 2001; Scott & Hofmeyer, 2007).

Boon et al, 2004	Pahor and Domajnko (2008)
Parallel- independent workers in a 'common setting' performing their jobs in accordance with own professional range of practice	**Disciplinary level**- considers the physical, psychological and social in the parallel context of working, with the physical aspect dominant with their reviewed publications
Consultative- 'expert' advice given to one professional from another	-
Collaborative- professionals who normally practice in parallel, share information about a common patient.	-
Coordinated- a formally gathered team of professionals with a common purpose who have an agreed structure for communication and information sharing. A care co-ordinator has information sharing responsibilities.	-
Multi-disciplinary- teams (may be virtual) managed by a non-physician. The team member integrates the decisions and recommendations made by the individual members of the team.	**Multi- disciplinary** (but not collaboration) **and inter-professional** (meaning 'joint action') level identified quality of life as its main feature and it included independence, technology, healthy lifestyle, housing, education, diet and nutrition, medication, social networks and social support, violence and discrimination.
Interdisciplinary- professionals practice consensus decision making and have regular 'face-to-face meetings'.	
Integrative- team with non-hierarchical members who practice person-centred care, with consensus decision making, mutual respect, shared vision, joint care plan	**Transdisciplinary/ transprofessional level** of working is where the holistic and integrated view of health and treatment for older people is observed. Although professionals/disciplines remain separate they are able to substitute one another when appropriate.

Table 1   A comparison of Boon et al (2004) conceptual framework and Pahor & Domajnko (2008) levels of working.

Within all of these definitions the purpose of working together in whatever form is to deliver a seamless, gap-free approach to care which is otherwise known as 'collaborative advantage' (Huxham & Vangen, 2005). Teams are a social phenomenon and so have an individual culture, characteristics which depends on the team players, the way in which they act, live (co-location) and learn together (Cornes & Clough, 2004; Brown & Cullis, 2006; Billings, 2005; Coxon, 2005; Hammick et al, 2009). The power base within a team which focuses its work on a person or service user usually comprises of a collection of individual expert people. These expert views and experiences are accepted as really important in interpreting individual clinical need and translating that into integrated services (Coxon, 2005). However, the danger is that the focus of the individual experts may not be the service user's but the enhancement of their own individual careers (Handy, 1999). In order to act together they need a shared vision, shared trust, team goals, all of which impact on decision making i.e. power and control (Sullivan & Skeltcher, 2002; Senge, 2006). That shared vision for the future involves a cultural shift which bases the individuals prescribed care on the individual expected outcomes (DoH, 2006a; Seddon, 2008).

Brown and Cullis (2006) argue that securing sustainable co-operation and co-ordination in a team may be difficult and is dependent upon team culture which is the build up of tacit knowledge (non transferable) within the team. An integrative approach to culture will enable a team to develop team capital through a facilitative team leader and so enable professional integration. Although this doesn't guarantee that a greater number of older people will live independently at home, it does enable teams to offer greater accessibility to assessment, care planning and carer support services (Brown & Cullis, 2006; Abendstern et al, 2006; Coxon, 2005).

2.2.3.3 Organisational integration

This is the most commonly defined form of integration identified with twelve definitions found within the literature review. The earlier definitions focused on integrated care within the health system only (de Jong and Jackson,

2001; Grone and Garcia-Barbero, 2001; 2002). Although the definition used by the World Health Organisation also used the wider concept of health which included social care (Grone and Garcia-Barbero, 2001, 2002).

Organisational integration is seen as having the purpose of improving quality, market share and efficiency (Henrard *et al, 2006; Thistlethwaite, 2004, 2008*; *Alexander, 2001;* de Jong and Jackson, 2001; Grone and Garcia-Barbero, 2001; 2002). This innovative type of organisation relies on 'adhocracy', the ability of its members to problem solve, coordinate, have the ability to bring different experts together, remain flexible in their approach to information and process flow, avoiding standardisation wherever possible (Mintzberg,1989;6 P et al, 2002; Ling, 2002). De Jong and Jackson's (2001) 3C's of effective integration are 'communication and access', 'culture, values and teamwork'; and 'commitments and incentives to deliver'. Failure to deliver on integration and gain organisational improvement is usually as a result of neglecting one element of this list.

Whether at the 'meso-level' or 'macro-level' (Hebert et al, 2008a,b; Feuerstein, 1993 cited in Peinhaupt, 2004; Grone & Garcia-Barbero, 2001; Delnoij et al, 2002; Rosen & Ham, 2008), the mechanisms of integration found in organisational integration are shared strategic planning, partnership, leadership, care trusts, pooled budgets, integrated payer and provider organisations (e.g. Kaiser Permanente), shared performance management such as the standards within the National Service Frameworks for Older People, information sharing protocols, managed network or merging organisational structures which are targeted at a given population, care trusts, care pathways, 'boundary spanning' roles which cross organizational barriers, inter-organizational training and education which all support the development of an integrated culture and values (Kodner and Kyriacou, 2000; De Jong & Jackson, 2001; DoH, 2001a; Glendinning et al, 2002b;Atwal & Caldwell, 2002; Mur-Veeman et al, 2003a, cited in Ouwens, 2005; WAG, 2006a; WAG, 2008c; Hebert et al, 2008).

Again a criticism of this classification is its lack of engagement with the service user which has been barely heard (Glendinning et al, 2002b; Midgley et al, 1997). In the past organisations have been criticised for developing services in their own interests and at a cost for service users (Dill, 1993; Vesperi, 1985 cited in Fry, 1996). The organisational classification and its definitions do not consider the service users and informal carer role as co-creator in developing and commissioning person-centred integrated organisations (Peinhaupt et al, 2004; Sang, 1998, 2006, 2007). Service user involvement and understanding how they want to be involved is necessary if organisations wish to be responsive to service user needs and deliver the key principles of access, choice, information, support and representation (Midgely et al, 1997; Abelson et al, 2004; Reed et al, 2008; King & Farmer, 2009; Andrews et al, 2004).

2.2.3.4   Functional integration

Functional integration gives a practical perspective of the *'cure, care and prevention aspects'* which enables clinical, professional and organisational integration (Billings and Malin, 2005, p53). Only four definitions were found in respect of this form of integration (Appendix 4). Very little information is given to support and evidence the perception of concept and its operational process in order to differentiate it from the other forms of integration as they all refer to quality of care, working together in some form and demand through expressed or assessed need. Delnoij et al (2002) suggest that this form of integration is on the 'macro-level' and involves policy and regulation (e.g. NHS (Wales) Act 2006, Data Protection Act, 1998). Veil and Hebert (2008, p76) describe it as a cluster of *'informational, organisational and financial dimensions'*. Its purpose is to create the conditions for clinical and professional integration.

Functional integration then enables organisational demand to be recognised from clinical level data e.g. the collection of assessment information at clinical level can be collated and translated into commissioning and planning data. As a result person focussed planning has the potential to be realised

through an evidence base which explains how and why services are required and whether they work (Wells, 2007; Loader et al, 2009; Wallace & Davies, 2009).

2.2.3.5   Systems integration

Systems integration is an additional classification which has been identified from this literature review. This form of integration is based on systems theory (Bertalanffy, 1968; Checkland, 1993) and nine definitions were identified (Appendix 4). It has the goal of achieving quality of life, quality of care, individual satisfaction and system efficiency (Veil & Hebert, 2008). This means that the organisational strategies are matched with people's needs and problems and as they alter the strategies must also change (Veil & Hebert, 2008).

Systems integration is person-focussed, and often provides a proactive approach to care and agency development. The language within the definitions move from a health service label of 'patient' to 'people', 'citizens' and 'individuals' giving the impression of autonomous beings (appendix 4) (Lloyd and Wait, 2005; Kodner & Spreeuwenberg, 2002). Both the Audit Commission (2002) and Nies & Berman (2004) acknowledge the complexity of need and the complexity of the flexible individual solutions required by people in order for them to attain and build independent living within their families and communities. It's their expressed needs and goals which bind the part of the system together and promotes positive results (Hebert et al, 2008c; Rosen and Ham, 2008).

Van Raak et al (2003) has argued that clinical and functional integration are the basic requirements for any system integration. However, Leutz (1999) explicitly states that the connection between the health system, care system and wider public services is education. He also identified that integration cannot be undertaken at one level but must consider all levels which impact

upon the whole system (Hebert et al, 2008). All of the definitions within this classification refer to what Hebert et al (2008c) would consider local and regional levels implying that there is a 'knock on' effect from one level to another. Therefore the strategies developed should reflect needs and their solutions which bind the micro, meso and macro levels together. They should also consider the impact of the carer, care giving and its cultural system of dependency and obligation (Fry, 1996). The techniques or mechanisms to achieve that are vertical and horizontal integration through networks, pathways, collaboration and coordination.

2.2.4   Vertical and Horizontal integration

An understanding of vertical and horizontal integration is essential when describing and defining integrated care. MacAdam (2008) describes these as forms whilst Warner & Gould (2003) describe them as the 'degree' or 'extent of integration'. Vertical or 'deep' integration is the bringing of different levels of the hierarchical care organisation together (Glasby, 2007; NHS Confederation, 2005; Woods & McCollam, 2002); or increasing the range of *'an organisation's activities by moving up or down the 'value chain'* (NHS Confederation, 2005,p3); or *'the delivery of care across service areas within a single organizational structure'* (MacAdam, 2008, p3).

Most recently Ramsay et al (2009) have described two main types of vertical integration

1. '*where agencies involved at different stages of the care pathway are part of a single organisation* (Meeks & Depp, 2003; Woods & McCollam, 2002)

2. *Where payer and provider agencies are part of a single organisation'* (NHS Confederation, 2005; Wilson & Baines, 2009),

Examples of mechanisms or techniques used are the standardised frameworks for sharing assessment information such as Single Assessment Process, Unified Assessment, Single Shared Assessment which promote integration between statutory agencies, chronic disease management, discharge planning and their associated care pathways (Strosahl, 2001;

WAG, 2007a; DoH, 2007a; NLIAH, 2008; DoH, 2003b; DoH 2007d; Wilson & Baines, 2009; Wilson et al, 2007; DoH, 2002; WAG, 2002b; SE, 2001; DoH, 2004). The focus for managers in the development of vertical integration is the management of costs, which may be at the expense of quality (Flynn, 2007).

Horizontal integration is considered to be the most basic form of integration which maximises the potential of service delivery within a targeted population (Cummings et al, 2001). It is '*the bringing together of professionals, services and organisations that operate at similar levels within the care hierarchy*' (Woods & McCollam, 2002, p2). It requires *'improved coordination of care across settings'* (MacAdam, 2008, p3). This would require collaborative working for example older people's services with services for people with lifelong disabilities (Bigby, 2004) and mental health services; and is common practice especially in primary care (Macadam, 2008; Woods & McCollam, 2002; Chew-Graham et al, 2008; Cohen, 2003; Strosahl, 2001). Horizontal integration is person focussed with a focus on quality as perceived by the service user (Flynn, 2007).

2.2.5   Section Summary

The reality is that there are multiple definitions which reflect the authors' differing perspectives of integrated care. Organisational integration is the most defined form with eleven definitions found within the literature review. The least defined were clinical and functional integration (four definitions each). The latter form requiring further clarification in respect of perception of concept. The former highlighting a gap in which the voice of the service user is barely heard although systems thinking warrants a view on the needs of the service user in order to integrate.

Stein & Rieder (2009) report that the integrated care fraternity agree that a single definition of integrated care should be developed from the most commonly used definitions. Although MacAdam (2008, p3) has said that *'the form, level or type of integration depends upon the desired outcome'.*

Difficulties will arise whilst trying to define a perception of the concept and operational processes which acknowledges all forms and levels of integration, as opposed to a linear definition.

The only agreement that appears constant across all forms of integration is in the form of outcomes i.e. quality of care, quality of life and satisfaction. All of which are the result of some mechanism or technique of continuous care e.g. care co-ordination. This deduction in itself identifies the word 'care' as the most commonly accepted term across systems which envelopes all its forms. How care in itself is operationalised depends on who perceives that care, how they perceive it and where (within or outside) of the system(s) or subsystems they stand. Should the most commonly used definitions form the foundation of a single definition, then the perceptions of the service user and carer may not be heard. As a result the link or 'fit' between the micro and the macro will not be accurately made as integrated care fails to recognise the importance of the individual presenting the need (or 'value demand') for services within the whole system (De Beauvoir, 1970; Warner & Gould, 2003; Ray, 2008). Service users and carers are not currently actively present within the majority of definitions published, as integrated care as a concept is perceived by those working within systems and organisations. The proactive citizen as care co-ordinator or the informal carer only appears within some of the definitions in the additional 'systems integration' added to this classification.

The next step is to clarify some of the terms identified such as systems, value demand, need and 'fit'. To do this we need to consider the theories of integration when working with older or frail people before we consider mechanisms, techniques, models or types used to deliver the concept of integrated care.

2.3   Section 2: Theories of integration in the context of working with frail and older people

2.3.1   What is a theory?

Theories provide competing explanations as to what is being observed which can be applied in some cases and tested through research as to whether they are viable (Thompson, 2000). They challenge professional practice, structures and principles which can lead to re-modification and remodelling (Wadensten & Carlsson, 2003). Theory is defined as:

> *'A set [or network] of ideas linked together to help us make sense of a particular issue or set of issues'* (Thompson, 2000,p 22).

Social theory is set in the belief that human beings have developed social patterns which have properties and processes which explain society and its events. Theory in this context is defined as:

> '*a statement that proposes to explain or relate observed phenomena or a set of concepts. Theory involves a set of interrelated arguments that seek to describe and explain cause-effect relationships'* (Delaney, 2005).

Therefore it could be argued that *'theory building is reality building'* (Argyris & Schon, 1974, p18) but perhaps reality only from the perspective of defined social groups that provide impartial meanings to their real existence (Berger & Luckman, 1966).

Therefore a service user's age is also viewed as a fundamental factor in determining how individuals should be cared (Wadensten & Carlsson, 2003; Grossman & Lange, 2006; Johnson et al, 2005; McCormack, 2005). Nies (2006) argues that an understanding of the behaviour of the individual service user will help us to further our knowledge in respect of individual and service outcomes (Nies, 2006). By adapting Timms & Timms (1977) three level classification of theory, we can explore the theories which give meaning to integrated care for frail or older people i.e. those that explain integration, those that show us how to integrate and those that give meaning to the world of the service user of integrated care (see table 2). This section of the chapter will be organised using this classification as sub section headings. Professional theory (such as nursing theory) is not discussed within this

context because their theories and models do not necessarily consider the implications of ageing and how to care for frail older people (Wadensten & Carlsson, 2003). However, they should be considered in the context of professional integration and undertaking interdisciplinary assessment (Wallace& Davies, 2009; Grossman & Lange, 2006).

Classification levels	Theories	Key points
Theories which give meaning to Integrated Care	Systems	- There are open and closed systems. An open system is in constant exchange with its environment. - Neither the system nor its external environment are, or ever will be constant - Individuals within a system are independent and creative decision makers - Uncertainty and paradox are inherent within the system - Problems that cannot be solved can nevertheless be 'moved forward' - Small changes can have big effects - Behaviour exhibits patterns (that can be termed 'attractors') - Change is more easily adopted when it taps into attractor patterns
	Complexity	- There is a tendency for uncertainty and unpredictable change. - Complex systems are a complex web of interacting relationships and patterns i.e. pattern seekers - Managers and leaders cannot predict on the basis of previous experience - There are local and global structures which interact
Theories which show us how to integrate care	Network	- A web of relationships either individual or organisational - Coordination is the dominant behaviour
	Collaborative	- Active engagement between people - Defining collaborative opportunities are essential - Collaborative advantage and collaborative inertia - Joint activity, joint action - Organised practical-moral settings
	Contingency	- A theory of knowledge management - Concerned with organisational effectiveness and the fit between task differentiation and current environment conditions - Resolution of conflict and mistrust is key
	Configuration	- Knowledge management theory - Networks of interrelationships are key - Core themes or 'gestalt' emerge
Theories that give meaning to the service user world	*Biological, psychological and social theories of ageing (see table*	*See Appendix5*

Table 2 Adapted Timms & Timms (1977) three level classification of theory in the context of integrated care

2.3.2 Theories which give meaning to integrated care

There are two theories which help us generally give meaning to integrated care. They are systems theory and complexity theory. Both of which have been interpreted within the functionalist tradition (Burrell & Morgan, 1979 cited in Jackson, 2000).

2.3.2.1 Systems theory

System's theory is a grand theory in that it has certain claims of universality with 'guiding differences' which direct the way in which information is processed (Luhmann, 1995). This is a theory where organizations are perceived as machines (Lars, 2008). Where a scientific reductionist approach to control, rules and processes are adopted (Haynes, 2003). In this section systems theory will be discussed in order to understand cause and effect and its relationship to the past, present and expected behaviour in public services (Weber, 1947; Seddon, 2008).

Bertalanffy (1968) defined a system as 'a set of elements standing in interrelations'(p38) or 'interaction'(p83). He went on to say that *'the whole is more than the sum of parts'* (Bertalanffy, 1968, p55), meaning that you can explain the behaviour of a complicated whole system by looking at how the separate parts interrelate with each other (Checkland, 1993). The behaviour itself may have originated from a subsystem or the whole system (effecting one another); and may have an effect on the behaviour of individuals within the subsystems (Checkland, 1993; Haynes, 2003). Bertalanffy (1968) saw his study and general principles of 'wholeness' as relevant to all systems regardless of their inner construction and interacting boundaries and environments.

There are both open and closed systems. A 'closed system' is a system which is solitary and cut-off from its environment. The environment itself is not generally significant (Luhmann, 1995). The system relies on something called 'entropy' (a measure of probability) to be at its highest for the system to achieve a state of predictable 'equilibrium' (Luhmann, 1995; Haynes, 2003). In closed systems order is always destroyed as opposed to open system

where entropy is imported and so increasing order into parts ('differentiation') and organization is achieved and maintained (Bertalanffy, 1968).

*An 'open system' (such as a human be*ing or a social organisation, see figure 3) is in a constant state of equilibrium, where there are 'inflows' and 'outflows' (or inputs and outputs) i.e. an exchange between the system and the environment (Hudson, 2006). The individual behaviours within an organisation are interrelated with the organisation itself. As the open system enlarges and differentiates it needs order in the form of integration so that the whole system is able to maintain its ability to deliver the organisations purpose (Lawrence & Lorsch, 1967).
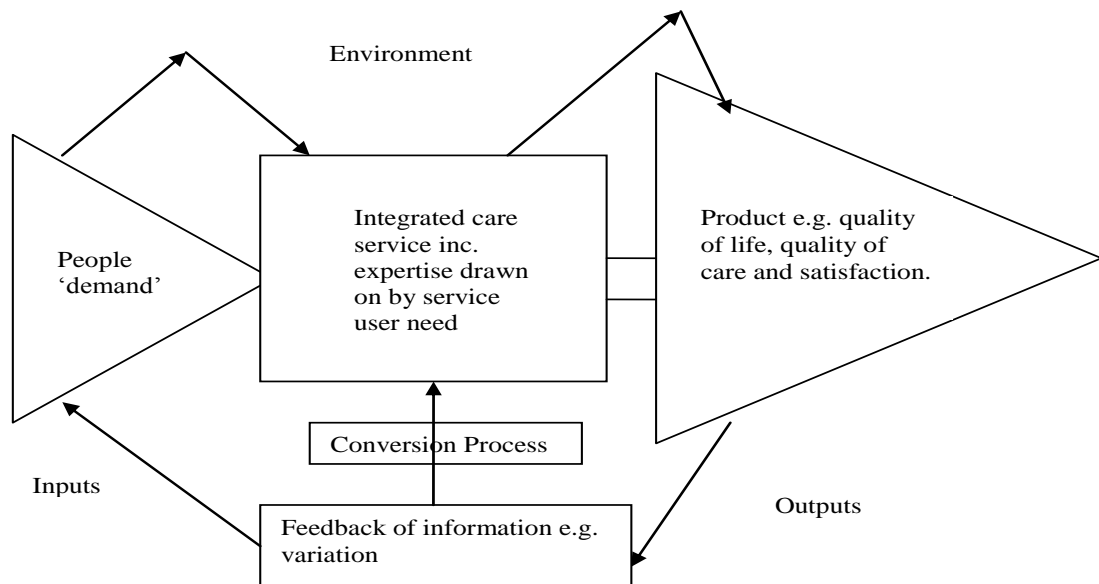
Figure 3: Example of integrated care as an organisational system which ensures survival through feedback and growth. Adapted from Cole, 1996 p73

Overall, there are three models within the open system that need to be considered:

1. The state of 'equifinality' (a 'steady state' or 'fleissgleichgewicht') (Bertalanffy, 1942 cited in Bertalanffy, 1968) .

2. Feedback mechanisms are usually fixed in nature and are essential to maintain equilibrium. Adding a feedback mechanism makes the system

self regulating and so forming a closed loop system (Katz & Kahn, 1966).

3. Adaptive behaviour to the external environment basically states that once a system has reached its 'critical state' it will alter into a new type of behaviour after a 'trial and error' phase in order to survive. (Bertalanffy, 1968; Lawrence & Lorsch, 1967; Luhmann, 1995). This is called 'systems differentiation' which occurs in time and through selection. The system uses only itself (self-reference and self observation) to manage an uncontrollable environment by increasing the order of its subsystems. It reproduces exact units of itself ('autopoiesis') through observing, creating and using a description of itself. As a result boundaries need to be defined between environment and the system. The role of the boundary is to separate the structures of the system from the environment but also to allow communications between environment and the system. Their performance is integral to the success of the whole system. Although there are times when the system must be prepared for the 'risk of noncorrespondence' (Luhmann, 1995).

Therefore, a systems organisation as a concept has to consider 'two pairs of ideas' around increasing organised complexity i.e. 'emergence and hierarchy' and 'communication and control'. The idea of organised complexity is that there is an order or hierarchy of organisation within any given whole. This hierarchy increases in complexity which needs investigating at all levels because it has a different language at each level (Checkland, 2006; Luhmann, 1995). Its aim is to provide an account of the relationship between different levels and an account of how observed hierarchies has developed. The three principles to consider are optimum size, constant state of instability and Voltera's law of oligopoly i.e. the smaller the number of organisations the greater the friction.

An alternative sociological viewpoint by Parsons (1991) defined activities as 'social systems of action' by 'interaction of individual actors'. The social system, personality system and cultural system were part of a 'system of

social action' and are crucial to each other's existence. He described social systems as a number of individual 'actors', working together in a' relational scheme' or 'unit', within which structures and processes are built. They could be scientifically analysed in the same way as other systems. There were three classes of interaction, 'social' (an actor), 'physical' (practical thing) and 'cultural objects' (symbols) which are shared within a 'system of interaction' and have a shared significance. In addition there are expectations especially in respect of the actors' interaction with one another. Their motivation was seen in respect of 'optimization of gratification', actions of 'gratification' and 'deprivation', that is the effective enhancement or withdrawal of self or group satisfaction (Parsons,1991). However, Luhmann (1995) has since argued that interaction is a different and separate system with occurs between people. Individuals within it participate through communication and within the rules (freedom and commitment) and its roles, values, programs and people that society produces and when differentiation occurs then conflict and indifference arises.

What does this mean for integrated care?

A health system was described by the World Health Organization (2000, p5) as '*all the activities whose primary purpose is to promote, restore or maintain health'.* Health included medicine, home care, health promotion and disease prevention, transport, environmental factors and specific health education Whole system approaches to integrated care are seen in North America in the form of PACE, SIPA and PRISM (Kodner, 2006) and also in the implementation of intermediate care services in the UK (Barton et al, 2006). Although the North American models have developed to be very successful over the last 20-30 years, Barton et al (2006) reported in their case study evaluation that although 54% of Primary Care Trusts indicated that their intermediate care services were fully integrated, in reality this was probably nearer to 11% with services operationally still working separately. Hudson (2006) has argued that there appears to be little theoretical underpinning of the discussion of whole systems. Therefore there is likely to be little difference in service delivery.

Alternatively the whole systems project in Scotland saw social factors as an issue in the increase of acute admissions by older people which required an intensive case management approach to care (Kendrick & Conway, 2003). More recently the Scottish Executive (2007) has used Joint Performance Information and Assessment Framework (JPIAF) to measure partnerships locally. JPIAF 10 is a whole systems indicator and is linked to the Joint Services Framework Better Outcomes for Older People (SE, 2007). Others include JPIAF 6 a Single Shared Assessment (SSA): waiting times and JPIAF 11 which focuses on measuring other outcomes in services for older people. In these experiences the whole systems measures consider system capability through waiting times and individual outcomes (SE, 2007; Andersson & Karlberg, 2001). These define 'value demand' (demand created by what the service user wants the service to provide) and 'failure demand' (created by not doing something for the service user) (Seddon, 2008). However, waiting times only provide a picture of one end of the 'end-to-end' time that's taken to provide a service. Understanding the demand which originates from the service user and the causes of variations would enable the manager to improve the service user experience.

Summary

Systems theory originates from a reductionist thinking but is now used within the functionalist tradition in the context of organization. Here it attempts to understand the origins of cause and effect in relation to predictable and unpredictable service user demand. However, there has been some recent suggestion that people engaged in integrated care should move to using complexity theory rather than systems theory to understand the effect of unpredictable changing demand and service user expectations (Lars, 2008).

2.3.2.2   Complexity theory

Throughout the 20th and now in the 21st century the human world of social interaction have developed systems of changing complexity, within which there is a lack of proportion between cause and effect (Urry, 2006; Geyer, 2003; Geyer, 1998; Gleick, 1988). Complexity theory applies to complex

adaptive systems which are 'organic, dynamic wholes' and are characterised by a tendency for emerging unpredictable change over time, whether in individual human or organisational contexts (Miles, 2009; Stevens & Cox, 2008; Halsey & Jensen, 2004; Haynes, 2003; Geyer, 2003; Wilson et al, 2001; Cilliers, 1998).

Jaafari (2003) explains that a complex society is created from '*a complex web of interacting open systems*' with '*an internet network of interconnections and interrelationships*' (p47). Stacey & Griffin (2005, p1) state that these *'complex responsive processes of relating'* are patterns of interacting relationships which include acts of communication, power relations and choice through values and norms. Plsek and Greenhalgh (2001, p625) define this in the context of health care 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 changes the context for other agents'.*

Therefore complex systems are such that relationships between people define how the system works because one person's behaviour affects another (Scott & Hoffmeyer, 2007; Griffin & Stacey, 2005; Plsek & Greenhalgh, 2001; Langton, 1992).

Complexity exists at the 'edge of chaos' (Stevens & Cox, 2008; Haynes, 2003; Langton, 1992; Gleick, 1988). Although it appears complex and disorganised on the surface, it may have a 'simple set of subsystems' beneath i.e. deterministic chaos or 'surface complexity arising out of deep simplicity' (Lewin, 1993, p12, 14). Therefore a society which is complex by nature is affected by uncertainty and unpredictability (Scott & Hoffmeyer, 2007; Jaafari, 2003). This may emanate from the behaviour of individuals (local interaction) which influences the 'emergent global structure'.

Langton cited in Lewin (1993, p 12) describes this as

> *'from the interaction of the individual components down here emerges some kind of global property up here, some thing*

54

you couldn't have predicted from what you know of the component parts.'

The global structures then provide positive or negative 'feedback' which influences the behaviour of the individuals down in the local interaction (Cilliers, 1998). Complex adaptive systems are 'pattern seekers' which learn from their experience of the environment and adapt accordingly (Lewin, 1993). Complexity theorists describe an autocatalytic process as one of the characteristics of complexity theory whereby growing open systems (dissipative structures) such as social systems change as a result of internal and external influences (Prigogine & Stengers, 1984; Kauffman, 1991, 1992, 1995; Geyer, 2003). This change leads to self organisation which is based on 'insight, competence of actors, synergy, flexibility and teamwork' (McMillan, 2008; Jaafari, 2003). These changes may lead to greater stability but the characteristics of the changing system are not predictable.

The interdependence of dissipative structures (growing new open systems) makes it impossible for observers to predict on the basis of previous experience (Scott & Hoffmeyer, 2007; Geyer, 2003). Prigogine (1997; Urry, 2006) argues that dissipative structures are local eruptions of order surrounded by disorder. Therefore reductionist linear model is not useful for forecasting future events. Dissipative structures such as professions are affected by their roles, the people they care for, responsibilities, culture in respect of knowledge, codes of conduct, individual and collective trust and values (Scott & Hoffmeyer, 2007; Geyer, 2003). Therefore, as the 'demand for care' increases due to 'poly-morbidities' in a growing elderly population within society, who choose to live at home, then this will effect the way in which professions and their agencies respond. Therefore synthesis is required to ensure that an overview of events and information is achieved (Haynes, 2003). Positively the response may be integrated through the emergence of professional and organisational integration in its many forms such as joint assessment, care co-ordination leading to blurring of boundaries across roles and agencies (Lloyd & Wait, 2005).

Emergence is defined by Langton (1992), Mihata (1997) and Stevens & Cox (2008) as

> ' the process by which patterns or global-level structures arise from inter-active local-level processes. This structure or pattern cannot be understood or predicted from the behaviour or properties of the component units alone (Mihata, 1997, p31)

Lewin's (1999) concept of behavioural 'emergence' suggests that although models of integrated care may have the same individual client groups with same conditions the people working within the teams may respond in different ways. Emergence cannot be controlled or predicted but needs to be facilitated (Stevens & Cox, 2008; McMillan, 2008).

What does this mean for integrated care?

In the context of integrated health and social care service users and/or carer behaviour occurs at the local level which then has an effect on the global structure of health and social care through its vertical working layers defined by professionals, organisations and national policy (see figure 4) (Haynes, 2003). Or indeed it may suggest that the professionals working at the local level are influenced by the policy feedback (global level) and so influences the way in which professionals assess older people. In the past an identified unmet need by a social work professional may have not been recorded because of a policy requirement to meet recorded needs. This may be interpreted as the global system adequately meeting all needs when at a local level it is not (Midgley et al, 1997). This interpretation means that all individuals working within the vertical and horizontal health and social care system need to have some understanding of each layer and the history of the context within which they work because structures such as individuals within systems have memories and a past through which development has occurred, the future influenced and planned (Cilliers, 1998). In order to create structured formal feedback there need to be processes within the organization (Haynes, 2003).

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┌─────────────────────────────────────────────────┐
│ Global structures / Policy level/ macro level   │
└─────────────────────────────────────────────────┘


  ┌─────────────────────────────────────────────┐
  │ Organisation and network level/ meso level   │
  └─────────────────────────────────────────────┘


  ┌────────────────────────────────┐  ┌──────────────────────┐
  │ Local interaction/ client level/ │  │ Carer sub- system   │
  └────────────────────────────────┘  └──────────────────────┘
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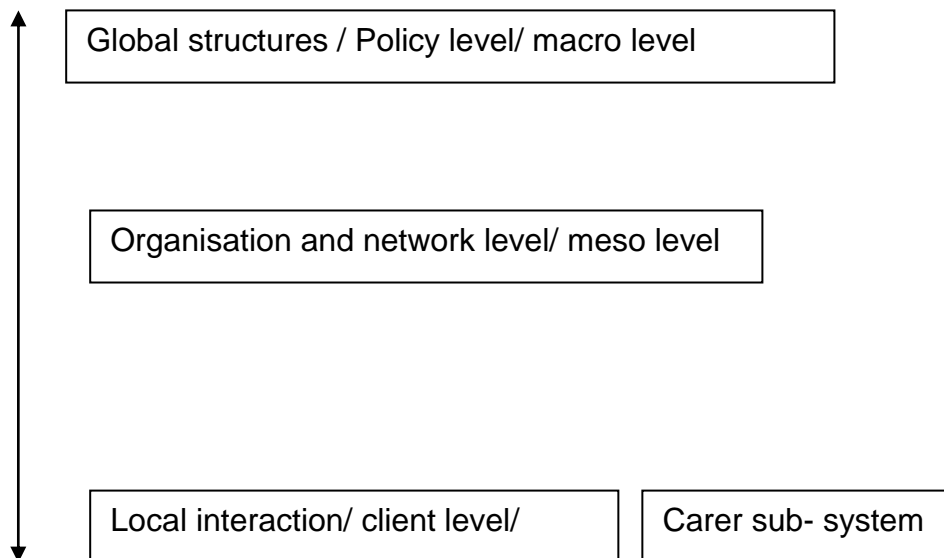
Figure 4: Combining complexity theory (Lewin, 1993) and management focus in integrated care (Nies, 2006) with levels (Peinhaupt et al, 2004).

Complexity theory allows the development of indicative models but not predictive models because although some events can be predicted with certainty, the detail cannot (Coveney & Highfield, 1995). This is because as time progresses individuals within systems can adapt and change their behaviour and so it is frequently seen as non-linear sometimes without cause and effect (Geyer, 2003; Plsek & Greenhalgh, 2001; Wilson et al, 2001). As a result the traditional ways of planning and management which rely on predictability cannot be assumed (Jaafari, 2003; Ivory & Alderman, 2005). Failure to manage complex systems derives from non-linear and linear interactions, over-centralised management and 'multi-nodality' (Ivory & Alderman, 2005). Understanding complexity offers an opportunity for individuals working within practice and management to solve those 'wicked', 'fuzzy' problems that are complex and difficult to explain (Geyer, 2003; Fraser & Greenhalgh, 2001; Plsek & Greenhalgh, 2001).

Summary

Complexity is characterised by complex adaptive systems which are unpredictable and suffer lack of proportionality between cause and effect. Due

to their complex patterns of interrelated relationships which emerge over time, they require facilitation and not traditional planning or management.

2.3.3 Theories which show us how to integrate

The theories which show us how to do integrated care are contingency theory, theory of collaborative advantage, configuration theory and network theory.

2.3.3.1 Contingency theory

Contingency theory has developed from an understanding that organisations are open systems and that there are links between the complexity and uncertainty of the technical and economic conditions in the environment (which put the system under pressure) and patterns of administration within the system (Lawrence & Lorsch, 1967;Galbraith, 1973; Goodwin et al, 2004; Demers, 2007; Macmillan, 2008). It is one of the explanations provided for knowledge management in areas of rapid change in organisations as they try to fit social patterns (Dufour & Steane, 2007; Greenwood & Empson, 2003). Contingency theory is defined by Donaldson (2001, p1) as

> *'Organizational effectiveness results from fitting characteristics of the organization, such as its structure, to contingencies that reflect the situation of the organization'*

Therefore, organizational effectiveness is the focus of contingency theory and includes efficiency, profitability, satisfaction, innovation and service user wellbeing. The most successful organisation is able to 'fit' its organisational strategy to the pressures from the environment which comes from varying factors such as other organisations, economy and market forces (Lawrence & Lorsch, 1967). As a result the organisation will alter its characteristics (adaptation) to avoid a 'misfit' which would result in reduced performance (Donaldson, 2001; Jansen, 2007). A misfit in a social system creates dependency through the inability of the social system to enable its citizens to effectively engage with society to maintain independent living (WHO, 2002a).

The main concepts within this theory are differentiation and integration. Differentiation is defined as *'the differences in attitude and behaviour, not just the simple fact of segmentation and specialized knowledge'* (Lawrence & Lorsch, 1967, p9). Integration is defined as *'the quality of the state of collaboration that exists among departments that are required to achieve unity of effort by the demands of the environment.'* (Lawrence & Lorsch, 1967, 11). Integration is achieved through the resolution of conflict by the managerial hierarchy, designated integrators who facilitate collaboration, informal managerial activity, routine structures for managerial control and planning. The fundamental question to ask is 'what business are we in? After which the characteristics such as structure of the chosen environment can be scrutinized and the conflict resolution practices used to improve the performance of the system (Lawrence & Lorsch, 1967). Therefore service integration depends on the fit between task differentiation and the current environmental conditions (Warner & Gould, 2003).

The behaviour of the manager is seen as interlinked with the behaviour of his colleagues and not just determined by personality, the task performed and his expected behaviour. The manager's orientation to goals, time, interpersonal and the formality of the structure of their units were of key importance (Cole, 1996). Leadership style used is based on achieving the best 'fit'. Perrow (1999) argued that people are logical and able to make decisions when faced with problems which require alteration to organisational design. However, key terms such as 'interactive complexity' (the tendency to make a technical interaction to avoid an accident) and 'tightly coupled' (fast process which can't be turned off and are not isolated from one another) are integral to understanding how 'system accidents' or 'multiple failures' happen (Perrow,1999).

Summary

Contingency theory has provided opportunities for systems and their organisations to consider their fit with the environment to ensure successful performance and satisfy their stakeholders. It has emphasised the importance of knowledge management, leadership, partnership membership and human

resources. However, it has yet to consider the service user and carer within the environment and the fit between service user needs and the services the system provides to ensure that people can live independently within their own homes.

2.3.3.2   Collaborative theory

Collaboration is '*an active process of partnership in action*' whereas partnership is '*a state of relationship, at organisational, group, professional or interpersonal level, to be achieved, maintained and reviewed*' (Weinstein et al, 2003). These definitions lead us to consider that collaborative theories are about the proactive interaction between people. Flynn (2007) discusses a collaborative spectrum which ranges from 'meetings, no action', joint bid, co-operation, collaboration, joint budgets to 'merger/acquisition'. Whilst Fritchie (2002) suggests that collaboration is a level of partnership.

Huxham & Vangen (2005,p4) define collaboration as '*as any situation in which people are working across organizational boundaries towards some positive end.*' They include partnerships, joint working, networks, alliances, collaborative contracting etc. It is a broad definition which lends itself to either strategic or clinical contexts.

Collaboration requires active management and it has two key concepts that of 'collaborative advantage' and 'collaborative inertia' (Huxham & Vangen, 2005). Collaborative advantage is the activity whereby '*partnerships between public organisations, and those with and between non-profit organizations, do tackle social issues that would otherwise fall between the gaps*' (Huxham & Vangen, 2005, p3). Collaborative inertia is defined as when *'collaborations make slow progress and that others die without achieving anything.'* (Huxham & Vangen, 2005, p3).

Andrews and Read (2009, p35) have linked collaborative theory with partnership working in their attempt to 'practice as lived theory' in order to interpret national policy and guidance into service delivery. They used a systemic approach to collaboration across agencies and professions as

opposed to a structural approach such as co-location. Key concepts were 'network dialogic' approaches to care and therapy, 'joint activity' and in particular 'joint action' (Seikkula & Arnkil, 2006; Shotter, 1993).). It suggests that 'joint activity' has dialogical characteristics. The human communication processes and the development of relationships are emphasised. There is an emphasis on linguistic skills (responsive listening and speaking, open attitude, respect, curiosity and linking with another person (Andrews & Read, 2009). Joint action has two main features that of '*unintended and unpredictable outcomes'* which occurs as the result of individuals coordinating their activities with each other, which results in '*an organised practical-moral setting*' (Shotter, 1993, p39). This 'situation' is owned by those who engage in coordination but to others it appears from nowhere. Secondly, its 'situation' has prospects which provoke possibilities for future action and encourage individuals to take action. After all, language is an interactive game between people within which there are rules and meanings (Wittgenstein, 1958). These collaborative skills are all necessary for integrative working together, not only within organizations but in sub-organizations and sub-systems such as informal carers.

Summary

Collaboration is an active engagement between people which occurs at different levels within the system and requires proactive management. It is perceived as an integral part of working together across organisations to achieve a positive end. Key concepts include collaborative advantage, inertia and joint action.

2.3.3.3   Configuration theory

Configuration theory is considered important in the development of knowledge management (Miller, 1996, Miller & Whitney, 1999; Mintzberg, 1989; Dufour & Steane, 2007). Definitions of configuration consider systems of interrelationships and themes (Mintzberg, 1989; *Miller, 1996)*

> *'constellations of organizational elements that are pulled together by a unifying theme, such as unequalled service or pioneering*

invention….The object of good configuration is always to develop a committed, enthusiastic cadre of people who collaborate shamelessly to get and keep customers who value their services.' (Dufour & Steane, 2007, p77; Miller & Whitney, 1999) or

'tightly knit mutually supportive elements put together into a thematic synergic whole' (Dufour & Lamothe, 2009, p97).

Miller (1996), Miller & Whitney (1999) and Mintzberg (1989) suggest that organizations should search for strategic themes or gestalts that bind systems together after which the detail of interdependency should be sought. There are three concepts

1. The environment will self select the successful organizational forms
2. Organizations are compelled towards a main theme which orchestrates the whole in order to gain success
3. Organizations only change under extreme conditions

(Dufour & Lamothe, 2009)

Miller (1996) suggests that there are advantages to high configuration, which are, synergy, clarity of direction and coordination, difficulty of imitation, distinctive competence, commitment, speed and economy. Although too much configuration can destroy innovation and discretion, create routine processes and become overpowering. Configuration in the context of integrated care is defined as *'an approach which addresses normative influences on inter-organizational fields and networks, as a factor for shaping and reshaping structures of organizations and society'* (Mur-Veeman et al, 2003b, p178). This is one single large study that considers configuration within the context of integrated care, and it does so in combination with institutional theory (Mur-Veeman et al, 2003; DiMaggio & Powell, 1983). Mur-Veeman et al (2003, p178) analysed the six health and social care systems with the themes of 'structure and power' and 'culture' and saw them as 'unique national configurations'. In their theme of 'structure and power', the UK had the most centralized system although health and social care is devolved to governments in Wales, Scotland and Northern Ireland. It was perceived as unresponsive to complexity within the systems, having a negative impact on communication and motivation. Spain, Sweden and

Finland were considerably independent of the central government, whilst Austria and the Netherlands were the most decentralized system, which slowed down the decision making process. The common theme across all countries was the professionalization of integrated care with problems of inter-professional working and service users perceived as 'highly dependent' on them. In addition to the changing power of older people and their care needs. The second theme of culture explored the national cultures in respect of the family, caring role and individualism.

Configuration theory could also be used in integrated care in the context of referral network systems, their capability and performance and in the form of co-configuration learning (Srai & Gregory, 2008). This is where the interdependency between the business and service user is explored. Service user- intelligent services are created and adapted to the needs of the service user (Engestrom, 2004). Person -centred care is the focus of good holistic quality care delivery and improvement of quality of life for frail older people which requires staff empowerment and the development of a 'transformational culture' (DoH, 2001a;Glendinning et al, 2002b; Audit Commission, 2002; Billings, 2005; Harrison & Zohhadi, 2005; Abendstern et al, 2006; Manthorpe et al, 2006; WAG, 2006a; Thistlethwaite, 2008). A person-centred approach or 'user focus' advocates steering the system through data based on the collective needs, values and understanding of quality of life of users, carers and the wider community' with an 'Easy flow of information' so that the service user is known within the system at all times (The Great Missenden Group 1998 cited in Plsek & Wilson, 2001; Casson & Skidmore, 2005; Lambert et al, 2007;DoH, 2007e; Loader et al, 2009). This also ensures that services are based and built upon the needs identified with and by the service users. However, the interdependency between service user, carer, professional and organisation is an area which may well need further research.

Summary

Configuration theory is integral to ensuring knowledge management within organisations and systems. Its key concepts are 'networks of

interrelationships' and core themes which bind systems together. However, configuration in some contexts can be destructive, such as the professionalization of integrated care.

2.3.3.4   Network theory

The literature identifies two forms of networks, those of social networks for individuals (Pearlin et al, 1996) and social networks for organizations (Kilduff & Tsai, 2003). The study of social interaction and the development of networks originates from the work of Kurt Lewin, Fritz Heider and Kapferer in the 1970s (Kilduff & Tsai, 2003).

There are a number of terms which need defining. Social networks are

> *'a web of relationships that can be described along such dimensions as its density, extensiveness, the frequency of interactions among its members, and the reciprocity, durability, and intensity of its interpersonal relationships'*
> (Pearlin et al, 1996, p284 developed from work by Cohen, 1988; House & Kahn, 1985, Pearlin, 1985; Turner et al, 1983).

Organizational networks are a:

> *'basic social form that permits inter-organizational interactions of exchange, concerted action, and joint production. Networks are unbounded or bounded clusters of organisations that by definition, are non-hierarchical collectives of legally separate units.' (Alter & Hage, 1993, p46).*

Whereas the act of networking is

> *' the act of creating and/or maintaining a cluster of organizations for the purpose of exchanging, acting, or producing among the member organizations'* (Alter & Hage, 1993, p42).

People who work across organisational boundaries and perform networking tasks and coordination are called '*Boundary spanners'* (Katz & Kahn, 1966 cited in Alter & Hage, 1993, p42). Actor-network theory states that an object

takes its shape and characteristic through and as a consequence of the relationships it has with other objects (Law, 1999). These networks have the purpose of engaging lasting symbiotic relationships between organizations in order to develop and produce 'products' as a result of economic and ethical interests or obligations. This involves interorganizational relationships (in a 'strategy of adaptation and survival') which problem solve across organizational boundaries, engage in team decision making within a flat structure, which results in higher performance, flexibility of decision making and faster problem solving (Alter & Hage, 1993; Goodwin et al, 2004; Warner & Gould, 2009). 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'*. They are affected by '*culture of trust, complexity of task, the existence of highly specialized niches and the emergence of small units'* (Alter & Hage, 1993, p42). Warner & Gould (2009) argue that in order to achieve the virtual space of interorganisational networks and a 'brockering white space' you need a coordinating role and coordinating behaviour (Alter & Hage, 1993).

Summary

There are two forms of networks those for individuals and those for organisations. Networks are formed through relationships which are coordinated and managed in order to achieve positive health outcomes for individuals.

2.3.4 Theories that give meaning to the service user world

An individual's pattern of life and experience of age occurs in a multi layered environment, within the micro (family and friends), meso (organisation service systems), macro (social structures of society) levels (Hooyman & Kiyak, 1999). Each level impacts on the person either directly or indirectly (Smith-Campbell, 1999). Hagestad & Dannefer (2001, p7) state that *'old age is part of lifelong journey, of individual lives embedded in changing social context hence of complex interplay between biographic time and historic time.'* The

length of this lifelong journey is pursued and highly valued even by people who have aged (Cowgill & Holmes, 1972).

There are many theories and associated theories of ageing (see appendix 5). Systems theory suggests that the same results can be obtained in humans regardless of age because of 'equifinality' (Betalanffy, 1968). Although complexity theory will suggest that emergence occurs in the clinical setting and so knowledge and context are required to monitor and respond appropriately for the unpredictable events (Holt, 2002).

Nevertheless, *'biologic, psychologic and sociologic process experiences during aging are shaped by historical factors'* (Burke & Walsh, 1997,p83). Therefore whether using the underlying theoretical concepts of systems or complexity theory; professionals, managers and researchers should understand individual local interaction or behaviour which may be as a result of or a combination of biological, psychological or sociological processes which have developed over a life time. Not doing so may result in professionals not understanding the impact of the aged care system on individual lives (Robinson & Street, 2004).

Key theories to be considered within the context of this case study are individual human need, autonomy, and successful ageing (Maslow, 1954; Cummings & Henry 1961, cited in Burke & Walsh, 1997; Baltes, 1987; Baltes & Baltes, 1990; Baltes & Smith, 1999).

2.3.4.1 Successful ageing and autonomy

The theory of successful ageing, aligns itself with agency, autonomy and empowerment, which are defined as the freedom to act independently against external constraints (agency), personal independence (autonomy) and

> *'the interpersonal process of providing the proper tools, resources and environment to build, develop and increase the ability and effectiveness of others to set and reach goals for individual and social ends' (empowerment), (Hawks, 1992, p609).*

66

Autonomy is the individual's right to his or her own existence as long as that right does not infringe on the rights of others (Beauchamp & Childress, 2001; Burke & Walsh, 1997). It is the individual's freedom of agency and political freedom which exists within societies minimal cultural goals of reproduction, system of authority and 'need satisfiers' which ensure a minimal level of health and survival (Doyal & Gough, 1991). Understanding autonomy is not only important in the delivery of individual care but also integral to how public policy is delivered (Le Grand, 2003). Autonomy is the supreme ethical principle, it requires rational decision making. It is *'a moral, political and social ideal'* to which there is a '*value attached to the reasons, values and desires of the individual and how those elements are shaped and formed*' (Dworkin, 1988, p10). A person is considered autonomous when he has the ability to choose and to act in a way that '*cannot be explained without reference to his own activity of mind*' (Dworkin, 1988, p6). When an individual uses capacity s/he also has the right to change that choice and act in a different manner. In some cases decision making may have to be assumed by another if individual is deemed as not having capacity (Mental Capacity Act, 2005). There are three key values which affect autonomy, an individual's personal understanding of him or herself, individual culture and mental capacity (Doyal & Gough, 1991). Professionals and carers must ensure that the right to self-determination is preserved. Bland (1999) argues that professionals and services should acknowledge independence as integral to an individual's autonomy and individual management of risk (Bland, 1999; Dworkin, 1988). There are core values of independence, privacy, dignity, choice and rights which should be a daily reality to service users (Bland, 1999).

Successful ageing is a bio-psychosocial construct (Baltes & Baltes, 1990; Fries, 1990; Featherman et al, 1990). In their psychological model of successful aging Baltes and Baltes (1990) specify three processes, that of selection (the active or passive adjustment to life domains), compensation (acquiring new skills or technical resources) and optimisation (enhancing and increasing individual reserves and resources). These ensure an individual's ability to adapt, come to terms with the self and cope with change (Baltes & Baltes, 1990; Wray, 2003; Baltes & Mayer, 1999). Fries (1990) discussed the

minimum morbidity model and the compression of morbidity through delaying the onset of chronic illness and shortening the period of illness at the end of life. This is achieved through preventative healthy and active living. Featherman et al (1990) argue that successful ageing is a socialpsychological transactional construct and occurs at the point of adaptation between the individual (mind and body) and society (environment). As a result in order to age successfully a person needs to draw on his or her own personal and environmental resources i.e. adaptive competence.

Godfrey (2001) argues that in order to understand how older people pursue goals, it is essential to grasp how their adaptive responses to managing loss and their perception of valued goals in managing old age are sculptured by individual bio- psycho socio-economic and cultural circumstances. Therefore, it is also necessary to consider the resources available to the individual and the constraints operating on the individual when evaluating the outcomes of preventative services (Godfrey, 2001). When working with people who are older the challenge is to clarify and understand the individual's underpinning concept of personhood i.e one's identity as a social person which is culturally viable (Armstrong & Fitzgerald, 1996). This is in order to understand their unique experience and facilitate rehabilitation or working with older people to enable them to adapt to their circumstances and so promote successful ageing (Dewing 2004; Mc Cormack, 2001).

Ageing successfully and increasing quality of life in older British white people is linked with the functionality of their bodies (Wray, 2003). Good health is seen as a priority in later life and is strongly linked to agency and empowerment as opposed to income and housing which was considered secondary to health (Wray, 2003). Good health is also associated with relationships with others, especially family and friendship networks (Armstrong, 2000), having a defined role and social position, religious beliefs, mobility and being with others (Afshar et al, 2002). Unsurprisingly, negative stereotyping held by health professionals about older people has an impact on their ability to access services (Victor, 1991). This is very often due to misperception and ignorance of the aging process and its consequences

(Lamb et al, 2002). Older people and especially women have a strong desire to maintain their bodies' functionality, which is frequently threatened by professional ageism (Wray, 2003). Having a body that is able to 'keep going' is important in the maintenance of agency and quality of life in all older people (Wray, 2003). A person is at risk of not experiencing successful ageing if he or she self assesses as having poor personal health (Roos & Havens, 1991; Walker, 2004).

2.3.4.2   Human Need

There have been a number of theories of human need within which there is a debate about its subjectivity (Maslow, 1954; 1970;Doyal & Gough, 1991; Pickin & St Leger, 1993; Bradshaw, 1972). Social needs have been defined as

> *'demands which have been defined by society as sufficiently important to qualify for social recognition as goods or services which should be met by government intervention*' (Nevitt, 1977, p115 cited in Doyal & Gough, 1991, p10).

However, if we consider that service users give meaning to their life experience then it is not the professional or society that defines need but the individual him or herself. Therefore, it's a concept which may be subjective and unpredictable in an older or frail service user due to its fluctuating intensity over time (Twigg, 2008).

Maslow's hierarchy of needs is the most commonly known theory of human need and is described as a 'motivational force' (Doyal & Gough, 1991). Whilst originally Maslow's hierarchy of need had five points of human need from biological and physical need, safety needs, belongingness and love needs, esteem needs and self actualisation at the top of the pyramid. In order to achieve self actualisation an individual had to meet all the other needs in their hierarchical order (Maslow, 1954; 1970). The concept has been further developed by Adams (2007) into seven needs which also include 'cognitive needs' and aesthetic needs'.

Doyal & Gough (1991p146) define human need as

'those levels of health and autonomy which should be – the extent that they can be- achieved for all people now, without compromising the foreseeable levels at which they will be achieved by future generations.'

The negative concept of health is utilised as they argue that it is in the individual's interest to avoid ill-health, promote an active and long life. Doyal & Gough (1991, p89) argue that there is an interdependence between *'individual need-satisfaction- societal preconditions'….* within which there are *'duties, rights and moral reciprocity'* which leads to a collective 'optimisation of significant choice' and 'optimisation of need satisfaction' for the population. In effect there is a moral code which suggests that meeting individual needs should be optimised. This is achieved through individual duties to one another through the relief of suffering. Therefore in the context of caring for a service user, professionals and carers should have an 'accurate' understanding of the individual's health and social environment, there must be opportunities for change within the environment and the individual virtues of *'reason, courage, truthfulness and willingness to sacrifice'* must be present (Doyal & Gough, 1991, p146).

In practice, recognising simple human need is accepted as being integral to the human trait of caring and thus achieving service user satisfaction (NLIAH, 2009a; Grossman & Lange, 2006; Liu, 2004; Smith-Campbell, 1999; Heidegger, 1962; Leininger, 1988 cited in Smith-Campbell, 1999). It is central to identifying patient or person centred care which is defined as *'a whole human being with wants, needs and fears that need to be addressed if healthcare is going to be effective'* (McCormack, 2005, p614). The concept of need has also been utilised within the standardised assessment frameworks and especially by the Scottish Government in their Indicator of Relative Need (SSA-IORN) (SG, 2004; DoH, 2001a; WAG, 2002b). Nevertheless, Cowden & Singh (2007) argue that policies in recent years have reinforced the *'commodification'* of human need rather than facilitating the integration of services.

2.3.5 Section Summary

In this section we have considered the theories in the context of integrated care and frail or older people whilst using Timms & Timms (1977) three level classification of theory. It considered theories which gave meaning to integrated care i.e. systems and complexity theories; theories that show us how to integrate i.e. contingency theory, collaborative theory, configuration theory and network theory. Finally theories that give meaning to the service user are many but those which are integral to this study are autonomy, successful aging and human need. This section has highlighted a variability in the theoretical underpinning of whole systems to service delivery (Hudson, 2006) and the need to understand service user demand with originates from the service user. The three level classification of theory enables an understanding of the differing levels and perceptions of integrated care.

2.4 Section 3 Integrated care models and mechanisms

Out of a total of twenty one projects identified, only seven large models were recognized as having been subjected to rigorous evaluation (see Appendix 6 for overview of models). The common themes across the models are that of improving health, quality of life, maintaining frail older people in their own homes whilst promoting their independence especially functional autonomy (Stein & Reider, 2009; Kodner & Kyriacou, 2000). Many researchers within integrated care have concluded that a systems approach is required if integration is to be successful (Johri et al, 2003). However, achieving effectiveness requires both linear and non-linear approaches to engage with whole system (problems and context) and to manage complexity (Leutz, 1999; 2005; Nies, 2006; MacAdam, 2008).

Continuity of care is an essential component to achieving quality of care (Nies, 2006). This is achieved by a number of mechanisms. The five types of organisational mechanisms that are essential in combination with each other at strategic, managerial and service levels which support effective and efficient ways of working together are multidisciplinary care management with a single entry point and coordination, planned provider networks with standardized protocols, standardised assessment frameworks and shared information systems, joint training with financial incentives for proactive prevention, rehabilitation and 'downward substitution' (MacAdam, 2008; Kodner, 2006; Rabner, 1999; Sinkkonen & Jaatinen, 2003). In order to analyse these models Leutz six laws of integration have been utilised (Leutz, 1999; 2005). However, law one is the most significant law in respect of the amount of evidence and the impact on clinical and professional practice.

2.4.1 Law One

'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.'(Leuz, 1999 p83).

Leutz further clarified this law by asking *'can we make integration easier?'(2005,p6).* This first law refers to a requirement to ensure that a whole systems approach to integration is adopted and proportionate to individual

and/or group needs. This means that combinations of levels of integration are needed within any one organisation of system in order to attain a multidimensional approach (Leutz, 2005). The identification of need is paramount to ensure that different levels of integration are adopted as appropriate. The greater the need the greater the degree of integration (Leutz, 1999, 2005; Newbury, 2001). Leutz (1999;2005) differentiates the 3 levels of integration as 'linkages', 'coordination' and 'full integration'. This approach has operational implications for services and their organisations (table 3).

Operational implications or service needs	Linkage	Co-ordination	Full integration
Severity	Mild-to-moderate	Moderate-to-severe	Moderate-to-severe
Stability	Stable	Stable	Unstable
Duration	Short-to-long term	Short-to-long term	Long-term to terminal
Urgency	Routine or non-urgent	Mostly routine	Frequent, urgent
Scope of service	Narrow to moderate	Moderate to broad	Broad
Self-direction	Self-directed or strong informal	Varied levels of self-direction	May accommodate weak self direction or informal
Screening	*Screen or survey population to identify emergent needs*	*Screen flow at key points (e.g. hospital discharge) to those who need special attention*	*Not important except to receive good referrals*
Clinical Practice	*Understand and respond to special needs*	*Know about and use key workers (i.e. discharge planners)*	*Multidisciplinary teams manage all care*
Case Management	-	Case Managers and linkage staff	Teams or case managers manage all care
Transition and service delivery	Refer and follow-up	Smooth transitions between settings, coverage and responsibility	Control or directly providing care in all settings
Information	Ask whether it is needed Provide when requested	Define and provide items or reports routinely in both directions	Use common record as part of daily joint practice and management
Finance	Understands who pays for each service	Decides who pays for what in specific cases, and in general guidelines	Pool funds to purchase from both side and new services
Benefits	Follow eligibility and coverage rules	Manage benefits to maximise efficiency and coverage	Merge benefits change and redefine eligibility

Table 3: Operational implications or service needs (adapted from Nies, 2004, p22 table 1 and p23, table 2 in addition to further adaptation from Leutz, 1999, 2005)

2.4.1.1 'Linkages'(Leutz, 1999; 2005)

This level describes a population's mild to moderate needs, stable and of a routine, non-urgent nature and self directed (see table 3). This form of integrated care is more appropriate for prevention and those people with single chronic diseases (McAdam, 2008; WAG, 2007a). Service user transition from one service to another occurs through referral and follow-up, as care and cure organisations work in 'silos' (Kodner, 2006; Kodner & Kyriacou, 2000). Cure meaning diagnosis and treatment and care *'a collection of tasks to be performed, services provided, and accommodations made'* (Binstock, 1996, p56). Organisation of roles, responsibilities and funding are separate and clear to all, good communication promotes continuity of person centred care from service to service (Nies, 2004). Prevention, education and person focussed care through the identification of need is considered important to avoid individual crisis but the population does not require any specialist services (The Great Missenden Group, 1998, cited in Plsek & Wilson, 2001; Leutz, 2005; McAdam, 2008).

However, a quasi-experimental design study of informal and formal care relationship in an integrated care home setting demonstrated that relationships change over time with the consequences of a complicated arrangement of linkages (Paulus et al, 2005). The study utilised Noelker & Bass (1989) model of four types of informal / formal relationship that of dual specialisation, substitution, independent formal activities and supplementation. A criticism of the Paulus et al (2005) study is that it used the formal carer as the starting point and not the informal carer as described in the original piece of work (Noelker & Bass,1989)

Mechanisms for Linkages

Mechanisms of integration are matched to the service user level of need (Nies 2004, see table 3). The Unique Care model utilised the EARL1 self assessment a seven-question tool but with scoring system to identify those service users within the practice who were at high, medium or low risk of admission to hospital (Keating, 2008; Adam, 2006). INTERMED (a decision

74

support system) (Latour et al, 2007)and PARR (predictive modelling case finding tool) (DoH, 2007a,b; Kings Fund, 2009) are more systematic approaches to identifying need. Programs such as PACE, On Lok and S/HMO I & II also use forms of screening to identify eligibility for services e.g. identifying risk for frailty and function (Wooldridge, 2001; Gross et al, 2004; Bodenheimer, 1999). The PRISMA service utilises the PRISMA-7 as its case finding tool and is undertaken by non qualified staff in public and voluntary agencies (Raiche et al, 2008). The emphasis is on the disability as perceived by the service user,

2.4.1.2 Coordination

There are two perspectives of this level to consider, that of Leutz (1999; 2005) and Nies (2004). Leutz (1999; 2005) argues that this is appropriate for those people who have moderate or severe conditions and who receive routine short –term or long term services (Leutz, 1999). The regulation of care coordination varies across Europe to a regulated coordination of services in Sweden to an inability of GPs to refer directly to hospital in Spain (Adamiak & Karlberg, 2003;Rico et al, 2003). The Australian Coordinated Care Trials based their integrated approach on targeting care coordination in primary care after recognising the work undertaken in the UK and New Zealand (Australian Government, 2007).

Coordination is the recognition that standardised processes, systems and relationships are required to be in place when an individual faces a crisis and doesn't have the ability to self manage or the family support to do so on the individual's behalf (Leutz, 1999). Alternatively, Nies' (2004) interpretation of this level is of 'coordination in networks'. This is where at organisational and clinical levels information is shared in a standardised and structured way, such as Unified Assessment (WAG, 2002b), Single Assessment Process (DoH, 2002) Single Shared Assessment (Scottish Executive, 2001) or Assessment Processes for Older People (New Zealand Guidelines Groups, 2003); care management, joint care planning, team care, disease

management (standardised protocols, care pathways) (Kodner & Kyriacou, 2000).

When services are coordinated, transitions between services are managed with a lead coordinator who establishes structures and processes for coordination (Nies, 2004; Kodner & Kyriacou, 2000; Newbury, 2001). It invariably leads to fewer admissions to hospital and less time between referral, assessment and service provision (Mayhew & Harper, 2008). PRISMA uses coordination at three levels of the organisation including strategic, management and clinical (multidisciplinary and case manager) (Bravo et al, 2008; Hebert et al, 2008a, 2008b; Kodner, 2006). This approach may include the development of networks at regional and local levels (Hedman et al, 2007).

Mechanisms for coordination

Three mechanisms for coordination are considered, pathways, the roles of care coordinator and case management. Disease or care pathways which are otherwise known as care protocols (Hammond, 2002) are for single disease management such as diabetes, fractured neck of femur, and acute stroke care, depression post stroke, end-of–life care (Sulch et al, 2000;Atwal & Caldwell, 2002; Turner-Stroke & Hassan, 2002; Roberts et al, 2004; Kwan et al, 2004; Nies & Berman, 2004; Mirando et al, 2005; Main et al, 2006; Nies, 2006 ;Latour et al, 2007). It is a single communication tool between professionals, patients and carers used in hospital of the community in order to improve the quality of care (IPCUS, 2007). Their original use was to promote cost effectiveness and are associated with improved service user outcomes (Roberts et al, 2004; Turner-stroke & Hassan, 2002; NHS Wales, 2005; ICPUS, 2007;Map of Medicine, 2009)

An integrated care pathway (ICP) is defined by the European Pathway Association (2005; Vanhaecht et al, 2006) as

> *' a methodology for the mutual decision making and organization of care for a well-defined group of patients during a well-defined period.'*

76

The many studies undertaken include randomised controlled trial, 'before and after' studies, 'discrete-event simulation', evaluation, survey, action research, case comparison (Sulch et al, 2000; Atwal & Caldwell, 2002;Kwan et al, 2004; Roberts et al, 2004; Katsaliaki et al, 2005;Croucher, 2005; Huby & Rees, 2005; Parker et al, 2005; Lhussier et al, 2007). They have had mixed results questioning the cost effectiveness of ICPs with increased length of stay, increased use of therapy services, not necessarily increasing inter/-professional relationships (Roberts et al, 2004; Atwal & Caldwell, 2002). However, the 10 year review of a three year project in Scotland which developed and implemented over 100 ICPs reviewed 1379 cases and 20 conditions. It highlighted the improvement in compliance with standards, evidence based practice was increased, patients valued ICPs because it gave them a better understanding of their care, there was an improvement in discharge planning but evidence on better outcomes experienced were not found (Kent & Chalmers, 2006).

The care coordinator is a role which is often interwoven with that of case manager or care manager or even at times intensive care coordination (Sinkkonen & Jaatinen, 2003; Newbury, 2001; Adam, 2006). However the care coordinator is often the role of the lead assessor who has an overview of the case (Stuck et al, 2000; NLIAH, 2008). It is a role which is defined by individual need (Stuck et al, 2000). In Scotland it is a recognized part of the Single Shared Assessment and is a role which is applied during the discharge process. This is usually straightforward for people with simple or stable needs (Scottish Executive, 2004).

The role of the care coordinator is to coordinate, implement and supervise annual multidimensional geriatric assessment, the multi-disciplinary care plans, to maintain communication with the service user and family, to improve post discharge compliance with medication and health promotion and maintenance instructions and to organise the multidisciplinary case conference when a service user is in hospital (Stuck et al, 2000; Latour et al, 2007; NLIAH, 2008). This is a role which is common across the Europe including Finland, Sweden, Austria, (Sinkkonen & Jaatinen, 2003; Adamiak &

Karlberg, 2003; Rondo-Brovetto & Krczal, 2003). S/HMO II uses a coordinated case management approach with an interdisciplinary team (Wooldridge et al, 2001). Its use can reduce the time taken for a MDT case conference from 90 minutes to 45 minutes (Latour et al, 2007). However, it requires further work in respect of use within integrated care settings, specialist expertise, training time and effort to implement (Latour et al 2007; Adamiak & Karlberg, 2003). A comparison of role characteristics can be seen in table 4

Challis et al's (2002, p1) view of care management is 'a field level mechanism for coordinating care, which links into the more macro issues of commissioning, service development and joint working'. It has also been defined as *'the process of tailoring services to individual needs. Assessment is an integral part of care management'* (Social Services Inspectorate and Social Work Services Group, 1991), this definition is still used in practice (Challis et al, 2002; The Scottish Government, 2006). Scottish Executive (2004) differentiates between care coordination and care management. This role is also sometimes known as an 'ambulatory case manager' (Latour et al, 2007). However, in Ireland a broader concept is used distinguishing it from case management (Challis, 2006). Challis has further described it as consisting of

> *'the integrated performance of a series of core tasks-case finding, assessment, care planning, monitoring and review- often undertaken by a designated worker for the most vulnerable individuals' (Challis et al, 2006,p336).*

It is a cyclical process within which assessment and identification of need and service provision occurs. Care Management is a term which is usually used for service users with complex needs. It is an activity which is often undertaken by a social worker but in certain cases (with appropriate skills training, competence and experience) can be undertaken by other appropriate health or social care professionals (Wallace & Davies, 2009). In the past care management had been provided for all but this wasn't considered appropriate. Therefore three levels of care management activity were identified,

Screening, Coordination, and intensive care management 'where a designated care manager plans and coordinates care, undertaking a supportive role for a much smaller number of users with complex and frequently changing needs' (Challis et al, 2002, p3) who have satisfied the local eligibility criteria. It also includes arranging the care plan, monitoring and review (Clarkson, 2006; WAG, 2002b; DoH, 2003a).

Care managers working in a single agency are not likely to be effective when working with people who have multiple problems because of the need for a robust assessment process (Challis, et al, 2002). The care management process includes the screening, assessing for need and problems in a network of community based care managers used for people whose independent living at home was deemed 'at -risk'(Rabner, 1999).

2.4.1.3   Full integration

'Full integration' suggests that close collaboration is required for usually a small amount of people. This close collaboration needs to be organised and structured around evidence on population need, the utilisation of services, public opinion on the quality of the services and systems used (Leutz, 1999). Full integration is required for service users with complex, multiple 'messy' problems including behavioural problems, severe levels of dependency, unstable unpredictable conditions, a need for a range of services, a need for high intensity of service provision, long term or terminal needs, a weak sense of self direction and a weak social structure, carer stress (Nies, 2006).

Mechanisms for full integration

The mechanisms or tools required to achieve full integration are achieved as a result of pooled resources such as interdisciplinary assessment, shared documentation, intensified forms of care/ case management, one-to-one care delivery, joint governance, 'fast track' access to services, close cooperation between people, co-location (Nies, 2004).

Responsibilities, resources and funding are combined to deliver a co-located and unified service such as PACE and SIPA (Kodner, 2006; Gross et al, 2004; Kodner & Kyriacou, 2000). Other mechanisms include 'unified service networks', pooled budgets, micro- management techniques to ensure appropriate care, multidisciplinary or interdisciplinary team care (Kodner & Kyriacou, 2000). The PACE model is a development on the UK traditional day hospital service and includes coordinated on-site primary care clinical cover, case management of services with a focus on prevention and rehabilitation (National PACE Association, 2002). Its service user group are 80 years and over, who have 7.9 identified medical conditions and restricted with three ADLs (Activities of Daily Living)(Gross et al, 2004). In order to enrol on the program the service users eligibility has to be agreed either by the state or the PACE team and the service user has to give all responsibility for their care (including medical responsibility) to the program (Gross et al, 2004).

Co-location is considered to be a positive approach to overcoming work related barriers such as inter-professional conflict (Cornes & Clough, 1999; Coxon, 2005). It has the advantage in delivering good quality case management as it enhances and supports good communication between professionals (Wright, 1995). Co-terminosity is the sharing of the same client groups. Co-location and co-terminosity lead to the development of shared cultures (Brown et al, 2003; Cornes and Clough, 1999, Hudson , 2006; Coxon, 2005).

Case management is a concept that is used across health services where there are complex needs to be managed (Mohamed et al, 2003). Defined as *'support provided to patients as they negotiate for the different services they desire'* (Mohamed et al, 2003, p207). The Gateshead study had a model of intensive care management which worked with 'highly vulnerable older people'. It included medical assessment at home with joint nursing and social work care management and rehabilitation in the community (Challis et al,

2002). PRISMA suggest that the ideal case load is about 40 service users although in the past the average has been found to be 45 (Hebert et al, 2008a; Phillips et al, 1988). The intensity of the role is related to the amount of time a case manager spends with a services user, which is dependant on the size of the individual case load (Phillips et al, 1988). The role of case manager in comparison with the role of the care manager and care coordinator can be seen in Table 4.

A full comprehensive assessment is the foundation activity for all the functions of this role and can take up to seven working days to complete (Phillips et al, 1988). One of the tools utilised by the case manager is the Individualised Service Plan (ISP). Its purpose is dual to identify the plan of care and treatment linked to goals and to empower the service user throughout the process. It's formed following MDT assessment, service user goals and identified need and services. This is also an output from the standard frameworks for assessment found in the UK (DoH, 2002; WAG, 2002b; Scottish Executive, 2001). However, in PRISMA the case manager leads the process of completing the ISP at an MDT meeting, the content is then confirmed by the service user and carer. Phillips et al (1988) identified two forms of case management, the 'financial control model' utilising pooled budgets and the 'basic model' using a brokering method to arrange services. The 'basic model' took longer to complete the care plan (22 days as opposed to 13) whereas the 'financial control model' required more supervisory time whilst initiating the first service visit (Phillips et al, 1988).

Role characteristics	Care coordinator (*NLIAH, 2008; Wallace & Davies, 2009;Adam, 2006)*	*Care manager (Challis, 2002; Wallace & Davies, 2009)*	Intensive Case manager (Hebert et al, 2008a; Mohamed et al, 2003,p208; Latour et al, 2007; Phillips et al, 1988; Challis, 2002)
Promote client wellbeing and maximise self care	√	√	
Sustaining and nurturing carers, client, family, formal and informal carers		√	
Undertake or enable a carers assessment	√	√	
Case finding and screening	√	√	
Connecting with service users, providing continuity of care across service providers such as acute and community services as a single stable member of staff as opposed to many undertaking this role for the service user.			√
Attending multidisciplinary case conference in hospital and liaising with the care coordinator in hospital in preparation for transition to the community	√		√
Supporting the service user in his or her transition back into social network		√	√
Planning for services strategically including monitoring costs of care packages		√	√
Service user satisfaction		√	√
Membership of inter-agency liaison groups		√	
Service and care planning required services for the service user and arranging admission to the services			√
Linking with service users and services, enhancing communication process. Providing a direct link for the service user to the services	√	√	√
Advocating for service improvement			√
Budget holders to purchase additional services required		√	
Advocating on behalf of the service user	√	√	√
Others such as crisis intervention, rehabilitation assessments, outreach services			√

Role characteristics	Care coordinator (*NLIAH, 2008; Wallace & Davies, 2009;Adam, 2006)*	*Care manager (Challis, 2002; Wallace & Davies, 2009)*	Intensive Case manager (Hebert et al, 2008a; Mohamed et al, 2003,p208; Latour et al, 2007; Phillips et al, 1988; Challis, 2002)
and skills training are sometimes offered			
Continue with clinical treatment by visiting the service user regularly at home under the supervision of the consultant, controlling for disease symptoms, non-compliance, managing the complexity of co-morbidities			√
Undertake Assessment	√	√	
Conducting or facilitate a comprehensive, consistent and in-depth assessment of problems, resources and service needs across agencies	√		√
Monitoring and reassessing the service user in order to readjust the care/service plan	√	√	√
Organising, arranging, co-ordinating support and care across agencies	√		√
Directing the MDT involved in the case	√		√
Qualified to work across agencies			√
Social work qualified and based in social services		√	
Risk assessment		√	
Undertaking decisions on case closure		√	
Caseload		25-30	

Table 4: Role of care coordinator, care manager, intensive case manager

Intensive case management as opposed to regular case management reduces the need for emergency services within mental health services. It be more effective when used with older people who do not have an informal carer, improving mobility and standardising and integrating services (Meeks & Depp, 2003; Mohamed, 2003; Hammar et al, 2007). The PACE program has prevented hospitalisation through utilising this form of case management within an adult day health centre (ADHC) with transport, participation from an inter-disciplinary team (physician, nurse, OT, physiotherapy, dietetics, recreational therapist, transportation coordinator, social worker, pharmacist, psychiatrist, transport coordinator, health aides), frequent contact with service users and integrated care delivery (Gross et al, 2004). A caseload comprises of 120-150 service users and the interdisciplinary team meet each morning to discuss service user programs which comprise of continuous assessment treatment and proactive preventative approach (Trice, 2006).

SIPA (Canada) practices comprehensive geriatric assessment and consolidated case management and interdisciplinary protocols. The consolidated case management is a proactive approach whereby the case manager follows the service user through the care journey, whilst maintaining clinical responsibility, intervening with carers working with the MDT and linking with the service user physician and other specialist assessors. SIPA has two MDT per site and a caseload of 160 service users per team. It utilises 4 case managers (nurses or social workers), part-time physician, 2 community nurses, 0.5 social work/OT/physiotherapy and consultant pharmacist, 15 homemakers. Service users utilise their own GPs as the community physician is used as an urgent backup for the team and on call service provided by the team (Beland et al, 2005).

The 'Castlefields' integrated case management approach (socio-medical model), comprised of a whole time social worker and part-time district nurse (0.5) working within a health centre with was project managed by the health centre GP. The roles again participated in discharge planning and facilitated

84

early discharge which was found to be the most important element as the case management role itself was relatively small. Forty-eight service users were deemed at 'high risk' and only 4.2% compared with 18.1% of the practice population experienced an acute admission. Time shortened to 97% same day for social work assessment in comparison to a possible 6 week wait. GP consultation fell by 3% for the same group. There was also a favourable impact on the social care budgets. Other studies have also had favourable results reducing care home placements for older people by 85% (Clarkson et al, 2006). Whilst the 'Unique Care' pilot (which followed in Southbury) showed a reduction of 50% in admissions and 49% in time spent in hospital for those over 65 years who were at high risk of admission (Keating et al, 2008).

Summary

In Leutz (1999; 2005) first and largest law the question of how to make integration easier is answered through defining the mechanisms in accordance with the level of individual need and integration required. There are three levels of integration. Linkages are adequate for those people with mild needs. This is where effective communication is adequate across professional groups or agencies. Coordination occurs where needs are mild-moderate and communication/ relationships are formal. Mechanisms utilised include standardised assessment frameworks, networks, pathways, care coordination and care management. Finally full integration is used for those with moderate to severe needs and the mechanisms used are intensive case management and co-location. All of these mechanisms has been discussed in their various combinations within some of the key models e.g. SIPA, PRISMA and PACE.

2.4.2   Law 2

'Integration costs before it pays' (Leutz, 1999, p89). In 2005, Leutz updated this to *'support integration financially'*. There are three types of costs to integration, staff and support systems costs, service costs and start-up costs.

All of which require financial support if integration is to be successful (Leutz, 1999, 2005). Nevertheless, the issues in respect of funding are different depending upon which country the services are based, for example SIPA (Canada) is publicly funded (Beland et al, 2005) whilst PACE, On Lok, S/HMO require sponsorship either from private, non profit making, state or federal bodies (Bodenheimer, 1999; Trice, 2006; Johri et al, 2003. Gross et al, 2004).

Leutz (1999) found that when integration projects have been successful they have had significant amounts of start up monies, for example PACE has received start up costs on two occasions from the US government. The first occasion when it commenced as a pilot programme between 1987 and 1997 with prime funding worth millions of dollars for both capital and revenue costs from both federal and US governments and the second time in 2006 it received $500,000 to develop its 15 rural PACE programs (Kodner, 2006; National PACE Association, 2002). This is in addition to its monthly reimbursement funding per capitation through the Medicare and Medicaid programs which was established permanently by the Balanced Budget Act 1997 (Gross et al, 2004; Trice, 2006). The PACE programs developed in recent years has also received start-up costs through long term care systems and hospital sponsors. This is essential in the US because it takes 100 enrolled service users (at 10 enrolments per month) for the program to become financially viable (Gross et al, 2004). The SIPA III project intended to utilise capitation method of finance but did not do so (Johri et al, 2003; Beland et al, 2005). Johri et al (2003) also found start-up money to be an incentive for some to help with integrating financial and clinical integration, with exception to the Italian projects in Trento and Venetto. However it can also bind services to certain conditions, limiting their ability to make decisions, recruit, purchase resources and in the control and use of profits (Gross et al, 2004).

Summary

This law considers the importance of funding especially in respect of start-up costs. The mechanisms utilised include the law and partnerships.

Partnerships have developed with both government and private agencies around the world in order to achieve the initial essential support required and in some programmes ensure its sustainability.

2.4.3 Law 3

'Your integration is my fragmentation' (Leutz, 1999p91). This was supplemented with *'help not hassle for physicians'*, as integration was being pursued by managers, physicians at full stretch and experiencing role fragmentation (Leutz, 2005; Stewart et al, 2003). Fragmentation and lack of coherence, unwillingness of professionals to cooperate are some of the problems experienced by European health care systems (Delnoij et al, 2002). This is thought to be due to financial barriers, the educational backgrounds (uni-profesional education) and lack of trust (Delnoij et al, 2002).

Practitioners are grown and are members of occupational subcultures. Where occupational subcultures and other groups clash (e.g. when 'new turf is carved out' they must work out a way of adaptation that is, working together (Trice, 1993; Cornes & Clough, 2004). Adaptation between occupational groups can lead to chronic clash (continued conflict with no change between the groups and individual members), accommodation (negotiation) and assimilation (the weaker occupational culture is absorbed by the dominant) (Trice, 1993). They sometimes accommodate one another by working closely together and become interrelated. Unfortunately, this has been a most challenging aspect of integrated care (Van Raak et al, 2003). Disadvantages of integrated working are in relation to boundary working. The medical-social care boundaries include geographical, professional, status, communication (including IT and language) and the organisational boundaries which identified lack of real collaboration, lack of time to spend on collaborative relationships, unrealistic expectations and finite resources which lead to unmet needs (Coxon, 2005; Sullivan & Skelcher, 2002).

However, benefits of integrated working have been job satisfaction and shared culture. Job satisfaction as staff are more responsive to individual

needs, good experiences of teamwork, communication, cross-agency organisation (good collaborative practices), multi-professional working increased professional esteem, increased assessment capacity, professionals working to common goals, co-location. In addition a shared culture results in 'blurring the boundaries', increasing 'mutual respect', a shared belief in the model and an understanding of each other's roles (Coxon, 2005).

Mechanisms for integrated care

The three mechanisms considered here are the standardised frameworks for sharing assessment information, computerised charts and interprofessional learning. The Single Assessment Process (SAP) is one of the UK standardised assessments for sharing information and was viewed as an attempt in England to provide a seamless approach to assessment and support care management for older people (DoH, 2002). However, the SAP implementation approach has been found to be fragmented with local implementation (different assessment tools, different technologies) creating what has been called 'organisational aquariums' that is exposing challenging organisational behaviour when trying to improve the communication and coordination of assessment information across and within agencies and professionals (Wilson & Baines, 2009; Wilson et al, 2007; Glasby, 2004). The subsequent publication of the Common Assessment Framework has included all adults (DoH, 2009c). Certainly the introduction of these standardised assessment frameworks has found inconsistencies in professional practice in respect of process and principles, in addition to professional disengagement and professionalization (Ridout & Mayers, 2006).

The Single Assessment Instrument used by case managers within PRISMA was the SMAF (Functional Autonomy Measurement System) which is a reliable and valid 29-item scale developed from the World Health Organisation classification of disabilities (WHO, 1980, 2001; Hebert et al, 2008a; Dubuc et al, 2006; Desrosier et al, 1995). It measures individual functional ability, the resources available to offset the disability and the

nursing-care time and long term care costs. Clustering techniques used with an expert panel have led to the 14 homogenous disability profiles (Iso-SMAF) identified from cross sectional data on the SMAF, which explain variance in all nursing care time, costs of nursing care and total both informal and formal care costs (Dubuc et al, 2006).

The PRISMA Computerised Clinical Chart (CCC) helps to assist communication across agencies and professionals (Hebert et al, 2008a). It uses the Quebec Ministry of Health and Social Services Internet network and was first developed in the PRISMA pilot at Bois Francs in 1997 (Morin et al, 2005). This shared interdisciplinary electronic health record is favourably accepted by frail service users because it gave a sense of professionalism, security, confidentiality and they felt that they were better informed (Morin et al, 2005). However, care must be taken when using tools across countries and agencies as in the study undertaken by Lambert et al (2007). In England one of the tools accredited by the Department of Health for use with their SAP nine domains was the EASY-Care (Sheffield University, 2002). In a mixed methods study undertaken to assess tools in nursing homes, residential care and hospitals in Wales 119 assessments were undertaken with people aged 66-94 years (Lambert et al, 2007). Although the validated tool was generally well received by both professionals and service users, the tool itself was not compliant with the 12 domains of Unified Assessment Process in Wales and not accredited by the Welsh Assembly Government (WAG, 2002b).

Interprofessional education (IPE) is defined as occurring *'when two or more professions learn with, from and about each other to improve collaboration and the quality of care'* (CAIPE, 2002). Its purpose is to promote collaboration in practice to meet both service user needs and those of an evolving workforce which has to be increasingly flexible, responsive and have the ability to plan across health, local authority, voluntary and independent sectors. It engenders mutual trust and support, limits demands on any one profession, reduces stress and improves service user care. It is a recognized

problem solving strategy which enables a working together values and culture through enhancing knowledge and communication between professionals and agencies within the whole system (Freeth et al, 2002). The components of IPE are identified by Barr (2000, p23) as:

> *'The application of principles of adult learning to interactive group-based learning, which relates collaborative learning to collaborative practice within a coherent rationale which is informed by understanding of interpersonal, group, organizational and inter-organizational relations and processes of professionalisation'.*

This is in contrast to 'shared learning' and 'multiprofessional education' where 'two or more professions learn side by side in parallel' without facilitated interaction with one another. This has limited formal contact between students and most often used for the purpose of economies of scale (Carpenter & Dickinson, 2008).

Summary

This third law discussed helping 'physicians' (in the widest context) overcome the 'hassle' of professional fragmentation. Its symptoms are lack of cooperation and mistrust. Mechanisms for overcoming this include standardised frameworks for sharing assessment information and interprofessional education. Both aim to enhance knowledge and communication between professions and across agencies.

2.4.4   Law 4

You can't integrate a square peg and a round hole (Leutz, 1999 p93). In 2005 Leutz clarified this law by asking '*why is integration so difficult*? The difficulties arise from financial, administration, provider, clinical, access and benefit differences across both health and social care, when integration should be multi-dimensional (Leutz, 2005). Although these difficulties have also been shared by health managed partnerships who are attempting to integrate (Rabner, 1999).

The organisations or systems which align themselves to integration have originated from different value bases or models of care. There is also the assessment of need, whether that's health or functional, based on medical or social models. Social Services and social workers have different professional origins and models of practice as opposed to medicine and nursing. The former practice is based on abstract social models of assessment, the latter on biomedical or humanistic models of assessment (Wallace & Davies, 2009).

The sixteen barriers identified for developing PACE programs (using the DataPACE administration database) included competition, program characteristics such as service user unwilling to change physician or fund extra expenses, referral enrolment process such as poor 'gate keeping' and lack of sponsor investment in marketing, staffing including recruitment, saturation of a program capacity, damage to a sponsors reputation effected enrolment, caution practiced by potential providers, the sponsors refusal to fund growth. The prime barriers identified were state funding caps, federal and state governments which give the impression of a reactive approach to the pressures of a growing older population with a demand for care (Gross et al, 2004). Plochg et al (2006) has since found in their single case study that proactive policies that emphasised system design, incentives and population based performance measures were required to build seamless care within a competitive environment.

The S/HMO I evaluation 1985-1989 found that service users were less satisfied with their care than 'fee-for-service' participants and that costs for hospital services were lower and nursing home costs higher for S/HMO participants. These were thought to be the consequences of service design i.e. they did not design care based upon geriatric medicine, they did not engage sufficiently with the physicians, unlike other programs like PACE and On Lok they used a coordinating case management approach rather than an intensive care management approach (Johri et al, 2003; Wooldridge et al,

2001). These factors were reviewed for the development of S/HMO II especially in Nevada and Kaiser (Oregon), the latter caring for service users who appear frailer than the other programmes (Wooldridge, 2001).

Summary

This law discusses why integration is so difficult. There are various reasons including lack of funding and not using a systems approach. However, sometimes it's due to model design including inappropriate processes or not matching the mechanisms to the needs of the people requiring services.

2.4.5   Law 5

'The one who integrates calls the tune' (Leutz, 1999 p97). Leutz (2005) clarifies this by stating that it is essential to have the right person leading and managing integration. Two key areas within this law are leadership and outcomes. Key to both these concepts is the service user. Leutz (1999) argues that the more services are integrated the more users and carers become dependent on professionals to ensure that they maintain and use the integrated systems and their services. Moulin (2002, p98) argues that central to ensuring quality is the 'customer focus', that is service user and carer focus placed before staff because services should be designed around the needs of people who use them. Therefore, quality and outcome measures are linked to service user perception.

Mechanisms for integration

This sub section will discuss leadership and outcomes as two mechanisms for integration. Leadership, its dedication and management commitment over time are key component to the process of quality management (European Foundation for Quality Management) and integration (Moulin, 2002). Leadership drives how results are realized through people, policy, strategy, partnerships and resources. The results are those which people, service users and society perceive as important. The leader and his or her relationships and the influence that funders have on the leader are both factors which will influence the level and type of integration (McKimm &

Phillips, 2009). Joint commissioning has in the past experienced some success because it relied on professional cooperation rather than professional leadership.   This was due to a lack of policy direction within the commissioning process (Leutz, 1999). Leadership preserved the culture of the occupation, through its traditional vertical management roles, responsibilities, making the occupation exciting through its follower manipulation, dramatization, performing its myths, symbols (Trice, 1993; Nies, 2006). Integrated care requires a more 'organic style' of leadership which creates 'exchange conditions' between followers, emphasising the role of their collaborative relationships and negotiation (McKimm & Phillips, 2009). Cultivating competence within them they develop into accountable and responsible independent followers. They achieve this through 'stories' from practice, their flexibility, pragmatism, political awareness, risk management skills (Trice, 1993; Nies, 2006).

Moulin (2002, p24) defines quality as the *'requirements and expectations of service users'.* He argues that quality is a perception held by the service user which comes from their expectations, the process and the experience of service delivery. This is linked to equity which is about meeting individual needs within the circumstances that people find themselves. Unfortunately, a quality misfit can arise when management perceptions do not meet service user expectations, either through not understanding their needs, translating need into service specification, service delivery is not as prescribed or specified, engineering expectations which cannot be met or just not listening to frail people (Mouline, 2002; Hudson et al, 2004). Therefore, an outcome based approach is advocated, which is defined by Hudson et al (2004 p4) as 'the effects or impacts on the welfare of service users and should be distinguished from outputs, which are strictly speaking service products.' These outcomes should be based on the understanding of service user perception of expectations and measure quality of life, satisfaction. Outputs measure organisational structure (e.g. quality of management) and process (e.g. quality of partnership, collaborative relationship, quality of support) (Moulin, 2002; Donabedian, 1980).

However, the outcomes measures identified within the literature review have been primarily related to outputs rather than using a service user outcome focus to determine quality (Fillenbaum et al, 2007; Bernabei et al, 1998; Landi et al, 1999; Johri et al, 2003;Beland, 2005). The Italian randomised control trials (RCT) in Trento (Bernabei et al, 1998) and Veneto (Landi et al, 1999) resulted in a significant delay in admission to care home, improved physical function, a reduced cognitive deterioration, less home visits than the control group (Johri et al, 2003; Bernabei et al, 1998). The 6 month quasi-experimental study in Veneto demonstrated that there was a reduction in hospital admission and in number of hospital days i.e process (Landi et al, 1999; Johri et al, 2003).

Whilst the SIPA (Canada) RCT concluded that the service resulted in a lower number of delayed transfers of care, there was a 'small and cumulative' reduction in the use and cost of institutional services, there was an increase in the availability of nursing and therapy services, the burden of care was not increased for the service users and their carers and the most disabled benefited from the changes that occurred (Beland et al, 2005).

Summary

In this fifth law putting the right person in charge of integration is considered essential. Leadership and an outcomes approach are the mechanisms used and are interlinked through service user perception. The service user is the focus of getting integrated care right. Leadership within integrated care requires the development of collaborative relationships. Outcomes identified within the studies above have been primarily been related to process as opposed to service user outcome.

2.4.6   Law 6

'All integration is local' (Leutz, 2005). This final law introduced in 2005 considers the local use of mechanisms (e.g. the law) and local fit to integration (e.g. access through single point of access and decentralisation of services).

Mechanisms for integration

These mechanisms include 'local' planning and 'local' management structures. The perceptions of older people and their needs in respect of local planning for health and social care are important (King & Farmer, 2009). This study in rural Scotland verified previous findings and found that participants linked their needs to a local social dimension of care which brought with it a fear of fragmentation of care, a perceived lack of appreciation that services were not just about physical survival or technological efficiency but also made possible some social interaction, community support and a sense of belonging. Maintaining independence was thwarted by ageism and the notion of being perceived as old or vulnerable which stopped them from accessing services; a 'co-constructed paternalistic' culture of service provision between themselves and the professionals; fragmentation of complex 'silo' services with different methods of payment which participants found confusing and personal care provided by social services carers as inappropriate due to their lack of qualifications. In order to maintain their independence they saw transport as vital, moving into a care home as preferable to having close family members undertake their personal care, good quality care was having local care provided by local professionals with local knowledge (King & Farmer, 2009).

Local integration of services in Europe is variable. The decentralisation of health and care services in Sweden which was intended to allow local municipals to adapt services to local need has led to the development of local council inter-organizational home care structures which are difficult to change (Hedman, 2007). Ireland has one of the most integrated health and social care systems in Europe and Quebec the most integrated in the world (Reilly

et al, 2003; Fleury, 2005). Although both have health and social care provision under the same minister their success has been determined in different ways. Reilly et al (2003) found that the success of local integration in Ireland was more as a result of integrated management systems than integrated clinical practices. One didn't necessarily lead to the other. Although, they found that the less assessments undertaken at home the more integration the service user experienced in practice. A cross sectional survey design to examine whether there was an impact on operational care management in Northern Ireland in comparison with England, found that there was more evidence of integrated practice through greater use of shared documents with a greater involvement with health care staff (Challis et al, 2006). However, further work is required on the impact on professional roles and how they work together because working together does not happen without planning, education and training or only through structural changes such as co-location, organisational merger or the law such as the National Health Service Act 2006 section 75 in England, pooled budgets, delegated commissioning arrangements and through vertical integrated provision (Seikkula & Arnkil, 2006; Barbara et al, 2005; Barr, 2000; Barr 2007a,b). The National Health Service Wales Act 2006 section 33, The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 and The Community Care and Health Act (Scotland) 2002 provide this arrangement for Wales and Scotland respectively.

The Minimum Specifications for Systems for Elderly People includes 'easy access' which means a fast quick responding, single point of access, which provides effective needs based assessment with the ability to share information (The Great Missenden Group 1998 cited in Plsek & Wilson, 2001; Loader et al, 2009). Single point of entry is not practiced in the USA models such as PACE, On Lok and S/HMO but it is in the Canadian and European models such as SIPA, Italian models (Bernabei et al, 1998; Landi et al, 1999; Bodenheimer, 1999; Johri et al, 2003; Beland et al, 2005). The advantages to a single point of access are the ability to target resources effectively, a continuous source of referrals is assured (Johri et al, 2003). The single point

of entry is described in PRISMA as 'a unique portal' for service users, carers and professionals. Access is via telephone or referral letter and available 24/7. The portal links to a general public service called 'Health Info Line' where the case finding screening assessment tool PRISMA-7 is used to identify disabled older people who require comprehensive assessment (Raiche et al, 2008).

Summary

This law has considered the local impact of delivering service integration. It is influenced by decentralisation, and individuality. It varies in its interpretation and in the mechanisms it uses such as the law, single point of entry, and advocates the voice of the service user in local planning mechanisms.

2.4.7   Section summary

This section has considered the models and mechanisms of integrated care identified within this literature review. The common themes are improving health, quality of life and maintaining people in their own homes. Leutz' six laws (1999, 2005) were used to analyse these findings. He advocates a whole systems approach with three levels of integration based on need, linkages, coordination and full integration. The mechanisms identified within this section are care pathways, predictive modelling, care coordination, care management, intensive/case management, co-location, start-up funding, standardised frameworks for sharing information, inter-professional education, leadership, a service user outcome focus, the law and single point of entry. These mechanisms as used in accordance with their local individual approach, level of need and the barriers they experience. The common focus is that of the service user perception in their need for seamless good quality and effective care.

2.5   Chapter Conclusion

In attempting to answer the question what is integrated care, this literature review has identified that integrated care is indeed a social arrangement to

address the problem of maximising individual wellbeing and quality of care for frail or older people.   It demonstrated this through identifying three key sections within the body of literature.

Section one found that integrated care is a 'messy', 'wicked problem' (Hedman et al, 2007; Nies, 2006). Delnoij et al (2002) classification was used to analyse the thirty four definitions found within the literature. Integrated care is hindered by the lack of clear definitions as to its concept and processes. The role of the service user and carer is not currently actively present within the majority of definitions published, as integrated care as a concept is perceived by those working within systems and organisations.   However, Stein & Rieder (2009) comment that as the system of health and social care becomes more fragmented   it will 'evolve and adapt' and so defining integrated care is transient and has only meaning for the here and now (Lewin, 1993). However, this may not be helpful and practical for practitioners and project managers who are attempting to modernise and change the delivery and experience of services for frail people.

In section two a three level classification of theory was utilised (Timms & Timms,1977) to consider theories which gave meaning to integrated care i.e. systems and complexity theories; theories that show us how to integrate i.e. contingency theory, collaborative theory, configuration theory and network theory. Finally theories that give meaning to the service user work are many but those which are integral to this study are autonomy, successful ageing and human need.

Section three analysed the models and mechanisms utilised by integrated care services using Leutz's laws (1999, 2005). Although there are many mechanisms to be utilised in the care of older people, the most successful for frail people with moderate to severe needs are a combination of intensive case management (drawing on care protocols) utilising a comprehensive geriatric assessment, whilst being integrated in a multidisciplinary health and

social care team. However, integrated care has many levels to consider from the service user (micro) to organisational (meso) to societal (macro). If we are to consider integration then we need to ensure that we focus on the needs of the service user to ensure that we understand the whole system.

This chapter has:

- Demonstrated an understanding of the existing knowledge through using frameworks such as Delnoiij et al (2002), Timms & Timms (1977) and Leutz (1999; 2005) to analyse the literature.

- Demonstrated how the knowledge of integrated care links together by its definitions, theories, models and mechanisms

- The gaps identified are in engaging a service user focus to a whole integrated care system through its definition, theories and mechanisms. This currently emphasises an organisational approach to integration.

Integrated care in the UK is known as intermediate care. The next chapter will define intermediate care. Followed by how and why hermeneutic interpretative analysis with case study approach was used.

Chapter 3- The context of Intermediate care for day services: why use hermeneutic interpretative analysis and a case study?

3.1   Introduction

The aim of this chapter is to set the context of intermediate care for day services and to address why hermeneutic interpretative analysis with case study evolved.

This chapter is divided into two sections:

- Section one will set the context of intermediate care for day services by critically analysing the definitions identified within this literature review.

- Section two will address how hermeneutic interpretative analysis using Gadamer's hermeneutics with single intrinsic case study design evolved and why it was used.

This chapter will conclude by discussing the principle research aim which was 'To explore whether there is a difference between integrated health and social care day services and non- integrated health and social care day services'.

Search strategy

The literature review for this chapter was developed through searching the following databases: CINAHL, ASSIA, Social Care Online, MANTIS, journals @ Ovid full text and IBBS (International Bibliography of the Social Sciences) originally in 2008 and again in 2009. The keywords or phrases used were qualitative, quantitative, case study or research and day hospital or day centre, community reablement or community rehabilitation or intermediate care or integrated care. After duplications were removed those papers pertaining to people over the age of 65 years only were retained. Those with keywords psychiatric, learning disability, child and children were removed; in addition to those studies which were disease specific, or profession specific as opposed to generic or multidisciplinary. Three requested articles were unavailable. Searches of the secondary references highlighted other key

studies which are also included in this chapter. As a result, a total of thirty-six major findings were uncovered, although four of these articles refer to two case study (Regen et al, 2008; Kaambwa et al, 2008; Manthorpe et al, 2006; Cornes et al, 2006). These major findings of this literature review are illustrated in Appendix 8.

3.2   Section One: Setting the context for day services: Defining intermediate care

3.2.1   Introduction

Intermediate care and long term care are two names from the UK which are associated with the umbrella term of integrated care and are frequently related with the care of frail people with complex needs but not always related to age (van der Linden et al, 2001; Delnoij et al, 2002; Paulus et al, 2002; Van Raak et al, 2003; Leichsenring & Alaszewski, 2004; Ouwens et al, 2005; Barton et al, 2006; Rygh & Hjortdahl, 2007; Hebert et al, 2008; Minkman et al, 2009; Stein & Rieder, 2009). Intermediate care is seen as an essential component in the modernisation and expansion of services for the future and especially in avoiding delayed transfers of care and referral into long term care (Audit Commission, 2002; Longley, 2004; Waddilove, 2004; DoH, 2005; HM Government, 2007; Baumann et al, 2007; Wales Audit Office, 2009; Jones , 2009). It is acknowledged in Wales as being a part of integration

> *"Integration is increasingly the way services are delivered in the real world, just look at the expansion of intermediate care and it's inevitably going to increase in the future"(NLIAH, 2008, p6.12)*

Intermediate care has a diversity of services and includes admission avoidance and assisted discharge for example Community Reablement, Rapid Response, community assessment and treatment teams, intensive care at home, extra housing developments, telecare services, alternative care home provision, innovative community hospital facilities, extended primary care teams, NHS day hospital, local authority day centres and domiciliary care (DoH, 2001a; Peet et al, 2002; Enderby, 2002; Lightfoot, 2004; Brown et al, 2005; Barton et al, 2006; DoH, 2005; JIT, Scotland, 2006-2009). However, the research in respect of admission avoidance is not as strong as assisted

discharge (Regen et al, 2008; Kaambwa et al, 2008). The services utilise mechanisms and techniques for integration such as Single Assessment Process and care management (Mackenzie et al, 2005). The day services within this case study (day hospital, day centre, joint day care and community reablement) are frequently defined within both contexts of intermediate care and the modernisation of services. They are used by services users who live at home and require neither hospitalisation or care home support. The elderly care outpatient service is also a day service which older people use along their care continuum within the borough. Whilst there has been some research undertaken in day hospital and community reablement over the years (Brocklehurst, 1978; Cummings et al, 1985; Black, 1997;Bowman et al, 2005; Enderby, 2002) , there has been limited research undertaken in social care day centres for older or frail people in the past (Clark, 2001). However, this does appear to be changing with researchers considering the wider context of care and the impact of this type of service on the individual and the system (Ritchie, 2003; Minardi & Blanchard, 2004;Damiani et al, 2009).

The staff working within intermediate care are both registered and non registered professional groups such as nursing, physiotherapy, occupational therapy, social work, dietetics, speech & language therapy, interprofessional practitioner and generic support workers (Holme & Hart, 2007; Shield et al, 2006; Nancarrow et al, 2005; DoH, 2005; Waddilove, 2004; Kneafsey et al, 2003). They are employed by statutory and independent sectors (McClimont & Grove, 2004). The outcomes expected are in relation to a whole systems approach, person focused, promoting independence, health and wellbeing, quality of care (timeliness, joined up services, targeted approach) and enhanced satisfaction (Audit Commission, 2002; DoH, 2006c; DoH, 2005; DoH, 2004b,).

3.2.2 The definitions

The eleven definitions of intermediate care identified within this literature review have been analysed by using the adapted and developed classification of integrated care from appendix 4 (Delnoij et al 2002; Billings and Malin, 2005). In order to undertake this analysis a number of questions have been

developed to identify the key aspects of each definition in respect of the classification (see Appendix 7).

A general criticism of these definitions is that intermediate care is often described within a continuum of services for example acute, primary care and intermediate care services; as opposed to an approach (NLIAH, 2008; NLIAH, 2009a). Barton et al (2006) in their review of intermediate care criticised the level of integration in intermediate care and described it as poor and having a bearing on the services inability to deliver person-centred care. Furthermore, that this had an effect on the wider health and social care system because its approach provided '*additional service rather than a substitute service'* (Barton et al, 2006, pviii). Of the eleven definitions found in this review of the literature, the main focus was on the meso/macro level (eight definitions show features of 'organisational integration') rather than on meso/micro level (clinical and professional) or the macro/meso/micro level of whole systems (see Appendix 7). None of the identified definitions had features of 'functional' integration i.e. ICT, finance and human resources. Only two definitions referred to 'integrated care' (Oxford and Anglia Intermediate Care Project, 1997 cited in JIT Scotland, 2006-2009; Medway PCT & Matrix MHA , 2003). Only four definitions identified mechanisms for integration such as coordination, unified assessment, care management, shared protocols and partnership (DoH, 2001b,; NAfW , 2002; Medway PCT & Matrix MHA, 2003).

The lack of clarity in the framework of available intermediate care services has been recently commented on by the Wales Audit Office (2009a) as having a direct effect on the independence of older people. They suggest that the Welsh Assembly Government produces a model of the 'common levels of intermediate care' to enhance understanding and the development of appropriate services. This confusion is not unique to Wales. Brent Council view their intermediate care services in the same context as long term care and institutional care (residential and nursing care) and not part of care in the community (Mayhew & Harper, 2008). Unsurprisingly, Regen et al (2008) found that many of the service users admitted to intermediate care services

did not meet the Department of Health definition. They suggest that a more vigorous criterion is developed.

These eleven definitions were generally developed during a time when practitioners perceived a service gap or 'black hole' in the patient transition between acute hospital, primary and social care (Vaughan & Lathlean, 1999; Audit Commission, 2000; Stevenson & Spencer, 2002). The services within the definitions were required to be preventative, in that they provided active treatment (usually rehabilitation) which prevented hospital admission as opposed to convalescence or long term beds where patients would not receive active treatment to aid recovery (Vaughan & Lathlean, 1999; Oxford and Anglia Intermediate Care Project, 1997 cited in JIT Scotland, 2006-2009). They were multidimensional, with the intension of using a whole systems approach whilst utilising the skills and resources from many professional groups, statutory, voluntary and independent services (Audit Commission, 2000; Stevenson & Spencer, 2002). The flexibility of the provision was intended to meet the needs of their patients' journey whether through rapid access for early assessment, the provision of day care, rehabilitation at home or in a community facility or advice through a helpline. However, these intentions are not included within the definitions (Vaughan & Lathlean, 1999; JIT Scotland, 2006-2009; Making Connections, 2006 cited in JIT, Scotland, 2006-2009; World Health Organization , 2004b).

The Department of Health (2001b) (supported by the British Geriatric Society, 2008) later published a definition of Intermediate Care for both health service and local authority immediate use following the publication of the DoH (2000) NHS plan. A more detailed definition than Vaughan & Lathlean (1999) and clearly differentiating it from long term care provision. It was seen as a proactive short term service provision based on multidisciplinary assessment and mechanisms for practice for both clinical, professional and organisational integration i.e protocols, SAP, and shared records.

The definition from the National Assembly for Wales (2002) is almost the same as that of the Department of Health (2001b). The target population and purpose is the same i.e. admission avoidance to acute and continuing care services, prevention of disability and promoting independence. The difference is in the prescribed partnership (e.g. development of joint, multi-agency single service access criteria), the degree of collaboration in practice during assessment (Unified Assessment & Care Management system) and service delivery with agencies working in partnership and utilising pooled budgets. In both definitions there is also an acceptance that although the service maximum time is six weeks, certain patients (e.g. those who have had a cerebro-vascular accident) may require further time for rehabilitation or enablement.

The examples of the intermediate care service modules within these circulars (DoH, 2001b; NAfW, 2002) gave the perception of a continuum of seamless services of prescribed services with the main purpose of either preventing hospital/care admission or speed up appropriate hospital discharge as opposed to service user preventative outcomes. In practice this has been observed as a concept of unrelated services (Griffiths, 2002); which could be argued are continually focussed on the acute hospital system. In the past these intermediate care services have been evaluated with mixed results which have led to a continued debate amongst the medical profession as to their value (MacMahon, 2001; Ebrahim, 2001; Frank, 2004). Although most recently there are identified benefits for service users and staff in the form of working together in multidisciplinary teams, role flexibility and the person-centredness approach (Regen et al, 2008).

A systems approach to defining integrated care would require an explicit inclusion of 'value demand' in order to enable organisations and their services to establish an understanding of the patterns of behaviour which demand specific services i.e. understanding why and what happens, which lead to the demand. This means configuring the intermediate care service to define itself in the context of a person focussed theme i.e. a theme which is accepted across health and social care (Dufour & Lamothe, 2009). Utilising a

contingency approach (which is based on systems theory) to re-developing a definition for intermediate care would also suggest that health and social care systems consider the local environment within which they serve in order to engage an intermediate care strategy which fits with the predicted demands of its local population, and drivers for services (Lewis, 2007).   This is opposed to the 'command and control' approach of prescribing the services and outcomes that the macro or meso levels prescribe (Seddon, 2008).

Summary

Intermediate care is a UK term which is associated with the wider concept of integrated care. Eleven definitions of intermediate care have been identified over the last ten years. The majority of which refer to the organisational level of integration. It is a concept which is required to meet service user demand of frail or older people with complex needs utilising a whole systems approach. It has a diversity of multi agency and multidisciplinary resources. However, the definitions lack clarity in their purpose, their acknowledgement of the levels of integration that are required, their engagement of systems principles and in the mechanisms and techniques that are available to operationalise intermediate care for the service user. As a result Intermediate care managers may have differing perspectives on what intermediate care has to offer its service users.

3.3   SectionTwo - How Gadamer's hermeneutic interpretative analysis with a case study design evolved

3.3.1   Introduction

This section will explore how and why Gadamer's hermeneutic interpretative methodology with single intrinsic case study design evolved and was used. The rationale for this approach is that these services are complex and we need to consider the multiple levels within them in order to have an understanding of the whole.

A methodology is a 'philosophical framework' that relates to the whole process of the research and influences the methods used within it. The methods are specific procedures that are used within the research process whilst the research design links the methodology and the methods (Creswell & Plano Clark, 2007).

In order to identify the reasons why Gadamer's hermeneutics with a case study design was used to explore the difference between integrated and non integrated services, we need to consider the evidence in the literature in relation to the objectives i.e.

- How were integrated services different?
- What were the differences in integrated and non integrated health and social care services as perceived by the participants?
- Why integrated services were perceived as different to non integrated services?
- What could be learned from this study of integrated and non integrated services?
- How can health and social care services integrate in practice?

Both qualitative and quantitative designs have been undertaken in day services (i.e. day hospital, day centre and community reablement) in the past. They have debated the value of their respective services through researching outcomes and process (Forster et al, 1999; Brown et al, 2003 Regen et al,

2008; Kaambwa et al, 2008). The settings identified in this literature review were statutory and non statutory institutional day services and at home services which include day hospital, day centre, adult day care; community health centre and community reablement, intermediate care teams (Browne et al, 1994; Burch & Borland, 2001; Forster et al, 1999; Harwood & Ebrahim, 2000; Regen et al, 2008; Ritchie, 2003; Kaambwa et al, 2008). In order to analyse the literature found, a matrix identifying the methodology/method issues, results and recommendations has been used (Hart, 1998)(Appendix 8).

3.3.2   The methodology

The purpose of this sub-section is to consider qualitative research traditions and design in respect of the study aim, which is to explore the difference between integrated and non integrated services. Three methodologies were identified within this literature review i.e. ethnography, grounded theory and action research (Cornes et al, 2006; Manthorpe et al, 2006; Townsend et al, 2006; Reid et al, 2007). They originate from anthropology, sociology and social psychology respectively (Polit & Beck, 2004). They were used to evaluate services within the literature reviewed i.e. focussing on the aims of the services and to what degree they have been met (Hall & Hall, 2004).

 Cornes et al (2006) and Manthorpe et al (2006) undertook an ethnographic evaluation of intermediate care services by immersing themselves within the operational lives of the services, undertaking in-depth interviews and gathering documentary evidence in two phases. Their purpose was to explore older people's experiences of the seven new pilot projects and how they were embedded into the wider system. Ethnography is the 'holistic view of a culture' which requires a great deal of time to gain a deep understanding and description of the cultural group studied (Polit & Beck, 2004, p249). This is opposed to the individual meaning for people who share experiences (Smith et al, 2009). The findings of this study were then re-invested into the services in order to support the programmes development. However, this brought with it potential bias as the researcher in stage 1 became the implementer in stage 2. They recommended that any future research must consider that the

individuals using intermediate care services are generally frail and ill people; the terminology used in intermediate care is professionally dominant; and researchers should understand the new service background in order to assess its impact.

The case study by Townsend et al (2006) utilised grounded theory (appendix 8). The purpose of using this approach '*is that generating grounded theory is a way of arriving at theory suited to its supposed uses*' (Glaser & Straus, 1999, p3). It is built from experience of a reciprocal research relationship in the field (Marshall, 1996). This enables the researcher to understand, predict and explain behaviour in relation to social structural processes and to use the theory in practical ways (Smith et al, 2009; Polit & Beck, 2004). However, as we've already discussed in chapter 2 not all behaviour and processes in health and social care systems are predictable (Holt, 2002). Whilst hermeneutics define the interpretation of human experience through language which provides its understanding of the experience; it also helps us to answer the questions as to how were integrated services different and how can health and social care services integrate in practice? (Dowling, 2004; Smith et al, 2009).

Grounded theory uses a constant comparative analysis which is a systematic collection of data in a current process after which items are compared and categories are developed. An important aspect is the development of live field notes (Marshall, 1996; Strauss & Corbin, 1997; Glaser & Straus, 1999). Townsend et al (2006) used a case study with mixed methods to evaluate intermediate care at three levels i.e. service user, service and system. It was part of a national evaluation funded by the Department of Health and Medical Research Council and its purpose was to 'explore issues of carer relationships and support in the context of intermediate care' (Townsend et al, 2006). Grounded theory was utilised to transcribe and analyse the interviews. Their findings included five types of 'caregiving relationships' i.e. 'the temporary carer', 'shared disrupted lives', 'reciprocal supported through gentle decline', 'long term carer' and 'caregiver as care receiver'. Other findings included 'getting the service user going again', 'Reassurance and confidence

building', 'personal communication', 'carer education', 'Baton-passing to mainstream services'. Study limitations were the nature of the carer relationships researched, which were easily accessible rather than those such as neighbours, carers living away; all carer interviews were jointly taken with service users; the handing over of care to mainstream services and the differing experiences of carers and service users where informal care is long-lasting.

The third tradition identified was action research (Reid et al, 2007). Action research is used for problem solving and improvement. It involves a cyclical research event which combines 'enquiry, intervention and evaluation' (Hart & Bond, 1995,p5). It originated within social psychology and the work of Kurt Lewin who saw it as a form of 'change experiment' (Gomm, 2008; Polit & Beck, 2004). Reid et al (2007) used action research to facilitate organisational learning and change, whilst giving a deep understanding of the complexity of the new rehabilitation link teams. The purpose of this study was to evaluate the application of the new model, to assess the extent it enabled independent living and its cost effectiveness (Reid et al, 2007). In order to achieve these aims observation, interviews, focus groups, surveys and patient functional outcomes were used. Using the mixed methods approach provided a holistic approach to understanding many aspects of the new service. Key to using action research was the role of the researcher and in this study the researcher proactively developed the teams. It required formal pre-planned feedback sessions throughout the research period to present the emerging data and manage change (Hart & Bond, 1995; Gomm, 2008).

These three research traditions have offered an insight into the approaches which could be taken by the research study proposed. However, their limitations are in respect of the purpose of the study and the role of the researcher. The purpose of this study is not to facilitate learning and change in the here and now but to explore the difference between integrated and non integrated services which have already developed and serve a given population. It is not to explore the experience of a cultural group but to explore the experience and meaning given by individuals at different levels of

the whole system. Interpretative hermeneutic analysis provides the opportunity to explore, interpret and understand the meaning of the lived experience (Smith et al, 2009). This approach developed through hermeneutical phenomenology, is the theory of interpretation through language (Smith et al, 2009; Dowing, 2004). Its origins were through the work of Heidegger's 'Being and Time' (1962) within which he discussed the nature and meaning of 'Being' or 'Dasein' and its relationship with reality (Smith et al, 2009). 'Dasein' is an individual who happens with other individuals, who through the nature of being (with those other individuals) and interpretation understands its own existence i.e. reflects upon existence. 'Being in the world' is a whole which is constructed of parts which cannot be divided i.e. the individual or 'Dasein' knows of the world within which s/he exists and cannot be divided from it (Heidegger, 1962; Smith et al, 2009). 'Temporality' is Dasein's non-linear connectedness with the world within which s/he makes sense of experience and existence (Annells, 1996).

Hermeneutics as a theoretical framework for analysis was used in this research study as opposed to grounded theory, action research, ethnography and Husserlian or descriptive phenomenology because a person and their experience is interpreted as the individual living product of society (in this study the people living in the welsh borough) and so influences the system's development through individual choices, decisions and relationships (Sampson, 1989). Furthermore, the cultural effect through tradition or an individual, professional or organisational history can have an effect on the way in which research is interpreted (Smith et al, 2009). This approach ensures that the study views the services as experienced by the service user, carer and professional involved within them. This will ensure that the study considers need or demand and flow as experienced by the individual and is able to consider further research, practice and policy implications for the future (Lo-biondo-Wood & Haber, 2002).

This approach is in contrast with Husserlian or descriptive phenomenology which is the 'philosophical approach to the study of experience' which has 'shared meanings' (Smith et al, 2009, p12; Dowling, 2004). Influenced by the

early work of Hegel and his discussion of the rationality and logic of consciousness and how individuality is set within universality (Hegel, 1977; Stern 2002). Schutz (1965, p57) argues that we must understand the experience of the 'forgotten man…whose doing and feeling lies at the bottom of the whole system'. We should understand the meaning of individual consciousness and the 'intentionality' between consciousness and the entity in question (Smith et al, 2009). Schutz' (1967) Husserlian (or descriptive) phenomenology has its origins in the theories of Max Weber (Dowling, 2004). Schutz (1967) asks questions as to the relationship between the individual and society and states that in order to understand the action of a collective group we need to understand the action of the individual. Therefore, this assumes that you cannot set apart the individual from the whole entity that they are interrelated and the individual within the system is all important. Its objectivity is therefore maintained through a process of 'bracketing' i.e. the prior 'suspension of all biases and beliefs regarding the phenomenon being researched' but allows the emergence of consciousness (Dowling, 2004, p32). The whole entity in the context of this study is the day services, whilst the individuals are the service users, carers and professionals which deliver, manage and use the care available within the organisational whole. However, 'bracketing' prior knowledge may hinder the process of understanding and interpretation. Whereby the reflexive nature of considering prior knowledge supports the 'cyclical process' of understanding and interpretation, whilst also giving an understanding of what is different (Smith et al, 2009; Annells, 1996; Gadamer, 1989).

The rationale in this study is that the context of day activities across health and social care and the interpretation of the individual's meaning of the experience in relation to it are of particular relevance and interest to the phenomenon of service integration. The reason is that the development of the Reablement team and Joint Day Care service originated and were jointly commissioned from the Local Health Group commissioning objectives in 1999 and exist in parallel with other day services for frail or older people within the welsh borough. Including both integrated and non integrated services also incorporates those services which are considered 'mainstream'. It also

suggests that we must consider the historical perspective of how these services developed (Fleming et al, 2003). This leads us to consider not only hermeneutic phenomenology but also Gadamer who thought that historical appreciation was necessary for its focus on understanding (Fleming et al, 2003; Annels, 1996; Gadamer, 1989). Furthermore that understanding and interpretation were tied together (Gadamer, 1989; Annells, 1996).

Therefore using Gadamer's approach (which he considered not to be a method) will ensure that the unique voice of individual lived experience is heard and interpreted within the whole system of the study examined (Gadamer, 1989; Debesay et al, 2008). This is interpreted through language which Gadamer considered was the most central form of communication of an individual's 'being –in-the –world' and so understanding language or text leads to interpretation (Annells, 1996)

Adamiak & Karlberg (2003) argue that as service users and carers interpret information differently then the evaluation of integrated care should focus on their perspectives rather than organisational and professional evaluation. The divisions between health and social care or nursing, social work, physiotherapy and occupational therapy are man made divisions and not forced upon service users by any natural law. It's hard for professionals and their services to see the bonds or processes which bind them underneath the obvious divisions (Checkland, 1993). Therefore, considering the three levels of integration i.e. service user, professional and organisation will contribute to the depth of the study, which is its greatest strength (Polit & Beck, 2004).

In this research study using Gadamer's hermeneutics to analyse and interpret the integrated services background which has developed over time will support the exploration as to whether and how there was a difference between the integrated and non integrated services (Smith et al, 2009). The role of the researcher in this context will be to reflect on the knowledge upon which understanding has emerged and to understand her 'preunderstandings' and i.e. 'how it happened that it is so' (Fleming et al, 2003; Gadamer, 1989, p4). Gadamer further tells us that understanding doesn't give us control but

an insight into existing or being which develops our consciousness (Grondin, 2003).

Summary

What has emerged within this sub-section is that the three research traditions already used will not enable this study to explore the difference between integrated and non integrated services through interpreting individual experience and meaning. Gadamer's hermeneutics considers the historical context, the written and spoken language of the individual at service user, professional and organisational levels within the whole system. Having now identified the methodology to be used we now move towards considering the design.

3.3.3   The Design

This sub-section will discuss why the case study design was used as opposed to a quantitative design. Jackson (2000) argues that quantitative research is considered useful because systems and complexity theories obey mathematical laws. Quantitative research designs originate from a positivist paradigm within which the researcher believes in the rules of a predictable world, objectivity, a reductionist approach and that truth is gained through dividing the whole into its individual parts (Plano Clark & Creswell, 2008; Hood & Leddy, 2006;Dootson, 1995; Haase & Myers, 1988). However, a system's thinking approach argues that in order to solve a problem you should consider a person focus (Seddon, 2008). Therefore, in order to explore these non-integrated and integrated services it is important to understand person defined demand, person defined purpose and how it is achieved; in addition to person defined 'flow of work' in respect of the value and its waste (Seddon, 2008). This shares some affinity with the naturalistic approach, which believes that in reality individuals interpret their experiences and make their consequent choices because they have different perceptions of their situation. These have evolved because of their individual historical and environmental contexts (Haase & Myers, 1988; Dootson, 1995;Hood & Leddy,

2006). Therefore *'the whole is more than the sum of parts'* (Bertalanffy, 1968, p55).

However, more than five randomised control trials have been identified within the major studies found in appendix 8 (Beland et al, 2006; Bernabei et al, 1998;Burch et al, 1999; Foster et al, 1999; Gill et al, 2004). Forster et al (1999; 2008) undertook a systematic review of randomised control trials; comparing medical day hospital care in comparison with alternative forms. Their purpose was to assess the effects of medical day hospitals for older people as they were gradually being considered as an expensive form of care. There were 12 random control trials included within the review which ranged across thirty years until 1997 and included 22 day hospitals and 2867 patients (Forster et al, 1999). In 2008 only one additional study was included (Forster 2008). The day hospitals were compared with domiciliary care or comprehensive elderly care (inpatient, outpatient and domiciliary geriatric medical services) or no comprehensive elderly care.

A randomised control trial (RCT) is a quantitative experimental design where the researchers do not know the outcome and have control over the participants in order to demonstrate efficacy (Cormack, 2000). RCT is defined as *'a full experimental test of a new treatment, involving random assignment to treatment groups and, typically, a large and diverse sample'* (Polit & Beck, 2004 p730). However, RCTs can also be used in other settings such as social care and primary care (Lewith & Little, 2007; Burch et al, 1999; Burch & Borland, 2001; Gill et al, 2004). The rationale is to test the hypothesis of cause and effect, for example, that day hospital was more effective than an alternative form of care (Forster et al, 1999). Although most recently Bird et al (2007) argued that RCTs are not conducive to the real world of health and social care due to problems with participant recruitment from services.

An RCT has three main features i.e. randomisation, intervention and control (Getliffe, 1998). Reliable outcome measures are used over a period of time to evaluate the effect (Lewith & Little, 2007). Randomisation is used to ensure that the participants are equally and similarly distributed between groups

(Cormack, 2000). The study undertaken by Bernabei et al (1998) had all three features. Randomisation was undertaken with the use of computer generated list. In the Cochrane Review (Forster et al, 1999, 2008) there were three types of randomisation within the 12 chosen trials. Five trials used concealed allocation either using envelops or computer generated randomised blocks, six trials mentioned randomisation but weren't clear on their procedures and one trial allocated in accordance with patient date of birth. Clear and standardised approaches to randomisation are important in order to remove confounding i.e. a third unknown influence or variable (Lewith & Little, 2007). However, in a complex and unpredictable world such a health and social care the organisations and environment are not always open to reductive controlled and linear methods of research which have been criticised for being inflexible (McCourt, 2005; McEwan, 1989; Harvey, 2009). Furthermore, the choice of tools used may not be derived from engaging with service users to develop the study purpose and design (Seddon, 2008).

Unfortunately, the Cochrane Review disclosed that because of the multi-national locations and the spread of the studies across thirty years of practice, policy effects were likely to be different and have changed over time (Forster et al, 1999). In addition the differences due to environment and time were confounded by the varied participants and treatments available. In addition the RCTs also used 'active' controls as opposed to a control group which received neither comprehensive nor home rehabilitation. Therefore, control was limited and so led to a lack of statistical power in what were small trials (Forster et al, 1999; Polit & Beck, 2004). This also occurred in Gill et al (2004) in their RCT to determine whether physiotherapy at home prevented decline in frail older people. They used a control group who received no therapy intervention but a six-monthly home visit from a health advisor who gave health education, advice and motivational support. However, Browne et al (1994) suggests that comparability in RCTs is not ensured because of uncontrollable and unpredictable factors effecting services.

An alternative to the RCT is the quasi-experimental design (Siriwardena, 2007; Young et al, 2005a; Malone et al, 2002). This is an experimental

design which omits the randomised control element but provides an alternative (Campbell & Alwin, 1996). They include 'non-randomised control group before and after studies', measurements of the groups are taken before and after the intervention (e.g. Brown et al, 2003). Also, 'studies using an interrupted time series design' includes repeatedly measuring the outcomes before and several times after the intervention. An example can be seen in the study of the introduction of Intermediate Care services in Leeds and in three month follow up of day hospital patients (Young et al, 2005a; Malone et al, 2002).

Malone et al (2002), who studied patients 3 months following discharge from a geriatric day hospital concluded that there were no sustained improvements in mobility and functional status and that more studies were required to explore methods to delay progressive deterioration in multiple domains. Ahgren (2007) argues that using repeated measures is only valuable if the audience has knowledge of the measure. In addition, these studies suggested that other ways of delivering comprehensive outpatient care for older people should be explored. Furthermore, that future studies should focus on comparing services which aim to provide an equivalent service in comparison with groups who received neither comprehensive care nor domiciliary care (Forster et al, 1999, 2008).

The problems with quantitative studies with older people or people who are frail and have complex needs (whether longitudinal or not) are focussed on the issues around time. People who live a long time are a product of their unique historical context and so the consideration of the passing of time is crucial to any research, especially in respect of the use of controls. The control is where all groups are treated or are exactly the same with exception to the intervention or independent variable (Getliffe, 1998; Cormack, 2000). If you consider the effects of aging on any group they are unlikely to be the same and so a valuable control is unlikely unless statistically controlled (Campbell & Alwin, 1996).

Therefore internal validity is likely to be problematic. This is defined as *'the degree to which it can be inferred that the experimental treatment (independent variable), rather than uncontrolled, extraneous factors, is responsible for observed effects'* (Polit & Beck, 2004 p721). There is some unease with internal validity in most of the studies within this Cochrane Review (Forster et al, 1999, 2008). The exception is with the three studies that had a 'comparison group' of neither comprehensive geriatric care nor domiciliary care. These three studies could assure that the independent variable (that of the day hospital) was responsible for the observed effects. To overcome these problems the Cochrane Review recommended that future studies were large, multi-centred and gave considerable detail in capturing details about the participants their disease effects and treatment processes (Forster, 1999). Moore et al (2007) is an example of a larger study (mixed methods). However, the time and cost of data collection restricted the research design and divulged diverse groups with similar underlying service patterns.

Two factors which are considered important in regard to external validity are sampling and sample size in order to avoid type one and type two errors and the misinterpretation of the results (Getliffe, 1998; Devane et al, 2004). Attrition is problematic in studies with older people or people with multiple co-morbidities as they are more likely to drop out with access to follow-up being difficult (Campbell & Alwin, 1996). Browne et al (1994) assessed carer and service user outcomes attending a community health centre where they found that only 152/255 (59.6%) participants completed the questionnaire due to death, relocation, lack of consent and cognitive impairment. Accuracy in providing information becomes increasingly problematic because their responses to standard measurement tools may be affected by cognition and the physical changes of aging and may be different when interviewed (Campbell & Alwin, 1996; Carlsson et al, 1991).

Case study is an alternative design which has been used on eight occasions (23%) within this collection of studies (Moore, 2007; Newbronner et al, 2007; Townsend et al, 2006; Godfrey et al, 2005; Manthorpe & Cornes, 2004;

Nancarrow, 2004; Holroyd, Twinn & Shiu, 2001). Smith et al (2009) argue that a case study can be used within a hermeneutic interpretative analysis.

The case study is a noun and rarely a verb (Stake, 2006). This simple way of defining a case study argues that it is a method and not a methodology. The case study is a single or collection of single visible entities. They are 'things' that although visibly simple in form may be complex in nature. The case study is a single 'integrated systems' (Stake, 2006; Jaeger, 1988). However, Scolz & Tietje (2002) perceive it as a design.

An early definition of a case study states that it is:

> *'a way of organizing social data so as to preserve the unitary character of the social object being studied'* (Goode & Hatt, 1952, p331).

This 'unitary character' has been developed over time and in certain circumstances. To elaborate on this simple definition the authors further state that the unit may range from an individual to an entire culture which have relationships or processes within it. Therefore the case study has the ability to view the complexity, the unpredictability and instability which impacts on the social objects being studied and in this case the individuals who work and attend the day services (Stern, 2004). The idea of a process or a series of actions was developed by Mitchell (2000, p170) when he discussed situation analysis and substituted the word 'case' for 'social situation'. This acknowledges the case as a publicly active entity which reflects a commonly held system of beliefs. Therefore the many different types of data gained from this active entity can be used and analysed to answer the questions that academic observers have in relation to its being. Furthermore, the role of the researcher is an active one which interprets and outwardly displays the evidence of the working system's relationships to an interested audience.

We consider the case as a working entity or 'bounded system' which is bound by a phenomenon such as time or space, depending to some degree on what the researcher wants to investigate (Jaeger, 1988). Stake (1995, p2) states

that 'the case is a specific, complex, functioning thing'.... *'the case is an integrated system. The parts do not have to be working well, the purposes may be irrational, but it is a system'. T*hat each case is prospective when considering that they are comprised of people and programs.

Yin further defines this as:

> *'an empirical study that investigates a contemporary phenomenon within a real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (Yin, 2003a p13).*

It alludes to the case study as having developed out of naturally occurring social situations as opposed to, constructed by the researcher (Hammersley & Gomm, 2000). Therefore, one could argue that the day services within this study are socially constructed for the care of frail older people. The circumstances or position in which the social situation is found is contemporary (the 'here and now') as opposed to historical or artificial. Harvey (2009) argues that the 'case object' is 'ontologically real' meaning that it was not created for the research act itself.

The margins or boundaries are an important part of how we understand the case and its definition. Whilst Creswell (2007, p73) defines the case study as *'the study of an issue explored through one or more cases within a bounded system (i.e. a setting, a context)'* , Yin (2003a) suggests that the clear borders within which some see the issue as constrained, may even be ambiguous. This 'bounded system' means that it views only the issues within the case itself as opposed to being compared with other issues (Stake, 1995).

Case Study research is not associated with any particular discipline (Polit & Beck, 2004; Smith et al, 2009). The disciplinary origins influence the way in which the research questions are asked, how the data is collected, analysed and interpreted. However, the case study is compatible with system's thinking and complexity theory as it is a design which looks at social reality and it

views the social object being observed as a whole (Goode & Hatt, 1952). Indeed the focus of attention is the uniqueness and complexity of the case and not the whole population of the case (Jaeger, 1988). The changing social environment within and around the case will influence the participant experience within the case study and may even lead to new contexts (Pawson & Tilley, 1997; Stern, 2004).

Therefore, the case study gives the researcher an opportunity to explore the breadth and depth of a case at different levels and through its development in time. It is also very useful when it comes to exploring innovation or areas of research which haven't been well explored in the past. The purpose of the case study design or method is to lead to an understanding of an idea, principle, model, theory or view and develop ways in which the researcher is able to capture these concepts under investigation (Polit & Beck, 2004). Holroyd, Twinn &Shiu (2001) used it to explore the role of nursing within a community rehabilitation network.

In this research study a case study design will be used to capture the principles of applying whole systems thinking to day services for frail older people, whilst also using the methodology of Gadamer's hermeneutics to capture the understanding and meaning of the day services and their integration from the participants' experience. Hermeneutics sees the individual as dynamically constructing self and society. The self is developed from a constant process of reflection of the 'self-as-object' i.e. that 'I' constantly reflect on 'me' to developed and understand myself as an individual and as part of society (Chappell & Orbach, 1986; Marshall, 1996). Using a case study design will support the idea of the 'hermeneutic circle' by exposing the underlying tension between the complexity of the whole of the case and the linear and simple expectations and experiences of the organisation, professionals and the individuals who use these services i.e. the different levels of integration (Stern, 2004; Harvey, 2009).

Summary

Although systems theory has its origins in positivism, the complex world of health and social care has multiple unpredictable and uncontrollable influences from the environment, time and its complex participants which could bias RCT results e.g. mortality, cultures and the process of aging including cognition. The studies included in this sub-section have considered carer, service user, professional and organisational participation, across the various quantitative studies, services and settings. However, due to the nature of the quantitative research design the service user's point of view cannot be ascertained (Seddon, 2008). Alternatively, the case study approach has been associated with the principles of systems and complexity theory. It considers unpredictability and gives an opportunity to study the breadth and depth of a case at different levels of the system. Using a case study design will support the hermeneutic cycle between the individual and the whole system.

3.3.4   Using mixed methods within the case study design

This review of the literature identified seven case studies relevant to this thesis (see appendix 8). In which five case studies used mixed quantitative and qualitative methods (Newbronner et al, 2007; Townsend et al, 2006; Godfrey et al, 2005; Manthorpe & Cornes, 2004; Regen et al, 2008 and Kaambwa et al, 2008). Appendix 8 illustrates that in the context of day services for older people the majority of studies undertaken have been mixed methods (40%) whilst the remainder have been quantitative (37%) or qualitative (23%). However, what should be noted from appendix 8 is that 39% of the quantitative studies were undertaken between 1994 and 2001 whereas all mixed methods and qualitative studies have been undertaken since 2001.

Embedded case studies use both qualitative and quantitative methods of data collection and analysis. The other case studies identified used single methods and may have been holistic in their design (Scholz & Tietje, 2002). Integrated care theories generally support the use of multi methods. The

complexity of the problems advocates a contingency approach which acknowledges that quantitative, qualitative and mixed methods are all of equal value and each have their place in a research study (Johnson & Onwuegbuzie, 2004).

A case study design with multiple methods research is guided by certain philosophical assumptions and principles that guide data collection, mixture of methods and analysis throughout the study (Tashakkori & Teddlie, 2003; Creswell & Plano Clark, 2007). In this study both quantitative and qualitative methods were used in order to explore the case study of integrated and non integrated services in a whole systems fashion (Bertalanffy, 1968; Leutz, 1999; Leutz 2005). The case study data collection principle of using 'multiple sources of evidence' has been used in order to develop 'converging lines of enquiry' i.e. data triangulation (Yin, 2003a). Therefore, the primary qualitative methods had a secondary quantitative element embedded within it (Creswell & Plano Clark, 2007). Using mixed methods in this way drew on the philosophical assumptions of hermeneutics to guide the way in which data was collected and analyzed; and the mixture of methods adopted by the researcher (Scholz & Tietje, 2002; Creswell & Plano Clark, 2007). This was undertaken in order to achieve an improved understanding of the phenomenon of integrated care within day `services as perceived by those people who used and worked within them. Therefore, the study drew on the strengths of both research paradigms whilst minimising their weaknesses (Johnson & Onwuegbuzie, 2004). In addition to reducing the risk of 'monomethod' bias, the act of triangulation which occurred with using mixed methods increased the study's validity (Tashakkori & Teddlie, 2003).

Multidimensional data collection acknowledges the complex multiple aspects of transitions which occur in people's lives as they grow older (Hendricks, 1996). However, the triangulation of both quantitative and qualitative data is essential to gain rigor to a study and to gain acceptability across research paradigms (Creswell et al, 2004; Tobin & Begley, 2004; Dootson, 1995). There are four types of triangulation, data triangulation (space, time and person), person analysis (aggregate, interactive and collectivity), investigator

triangulation (using more than one researcher), theory triangulation (using more than one perspective about the same object), methodological triangulation (Denzin, 1989). This can comprise of 'between or across methods' (two different methods to examine the same aspect of a research problem; 'within-method', more than one technique within the same method (Denzin, 1989; Denzin, 1978 cited in Plano Clark & Creswell, 2008). It is the integration, comparison and combination of many sources of data, its collection and analytical process (Tashakkori & Teddle, 2003; Bryman, 2006). Sometimes achieved through the use of a meta matrix (Wendler, 2001). The purpose of these approaches is to confirm reliability and convergent validity and to gain richer understanding of the research problem and the weakness within either method used will be counterbalanced by the other (Plano Clark & Creswell, 2008).

The methods used within an interpretative hermeneutic approach have in the past included in-depth interviews, observation and historical documents. These would support the aim and some of the objectives (Smith et al, 2009). System's thinking itself focuses on the principle of problem solving complex wholes (Checkland, 1993). Previous case study research (which collated data from interviews, hospital records, observations of meetings, recorded meetings and general observations) in integrated mental health day hospital settings found that the views of relatives and professionals were different in respect of how care was coordinated from the day hospital. Whereas professionals saw team working as successful, relatives did not experience a coherency of service provision which did not always meet their needs (Smith & Cantley, 1985). However, within the studies identified within Appendix 8, other methods included service user and team/service outcomes, focus groups, survey of self completed questionnaires and semi-structured interviews (Godfrey et al, 2005; Freeman & Peck, 2006; Brown et al, 2003). Some of these methods were used whilst utilising systems theory and the multiple levels of the case study (Godfrey et al, 2005; Freeman & Peck, 2006).

Certainly using mixed methods is appealing for those professionals from various backgrounds who work together and want to understand an issue

from multiple perspectives (Plano Clark & Creswell, 2008). However, it's crucial to establish at the outset the importance and value of collecting both qualitative and quantitative data in respect of the study aim (Creswell et al, 2004). Burch & Borland (2001) undertook what originally commenced as a single blind randomised controlled trial that compared rehabilitation outcomes in a day hospital and social services day centres which was supplemented by visiting therapists. The service user outcomes were measured at four points over a period of a year and included activities of daily living and morale in addition to a caregiver outcome measurement. Staff interviews were later also included. The themes were derived from frequent meetings undertaken throughout the study period. This aspect was not included in the original study design but became necessary as the study progressed. Patient and caregiver interviews would also have been included but with the task of completing a large number of outcome measurement tools was considered to be demanding, it was felt that the additional interviews would have triggered some service users and their families to refuse to participate (Burch & Borland, 2001). Burch & Borland (2001) found that including staff interviews (which secured working relationships) added additional richness of data and complemented the quantitative data collated from service users and carers.

Outcomes measures have repeatedly been included within the studies identified within Appendix 8. The outcome measures within the Forster et al (1999, 2008) review included death, place of residence, activities of daily living, subjective health status, patient satisfaction and resource use. Although there were no significant differences between day hospital attendance and comparison treatments for the outcomes of 'death', 'death or requiring institutional care', 'death or deterioration in ADLs', there was a significant difference for day hospital when 'death or poor outcome' was examined. Moore et al (2007) have since used 'location of service user six months after discharge'. Those service users 'not at home' were considered to have a negative outcome compared to those 'at home'.

Generally studies have found that they could not consider some important outcomes such as instrumental ADLs and disability because the groups did

not normally collect the outcomes and the general uncertainty about the sensitivity of well known measures such as the Barthel Index (Mahoney & Barthel, 1965; Appendix 10 No. 29) (Forster et al, 1999, 2008; Fowler et al, 2000; Zank & Shacke, 2002; Malone et al, 2002; Kaambwa et al, 2008). Browne et al (1994) found that the emotional part of the OARS questionnaire was incomplete and service users required interviewing (Fillenbaum, 1978; Appendix 10, No. 61).   Other studies have used measurement tools such as the Sickness Impact Profile (SIP) and Occupational Self-assessment (OSA), caregiver Strain (Sviden et al, 2004; Burch & Borland, 2001). Beland et al (2006) suggest that studies should not power the test to look for large differences. However, the measurements used in Sviden et al (2004) were particularly useful as they indicated that participants in social care centres also experienced a great deal of problems with physical function. Therefore, indicating that service users not only received social care but also functional physical care in the day centre. In addition the number of secondary outcome measurement tools used within each study often exceed six in total and may contribute to problems of missing data and have prompted discussions about the need for the inclusion of more qualitative research (Fowler et al, 2000; Zank& Schacke, 2002).

The studies outlined above (and in appendix 8) have gradually looked towards delivering a holistic/comprehensive model of day care service that addresses both health and social care needs of older people living within the community. They advocate that this should comprise of social, physical, functional and emotional domains which should be assessed regularly through the use of assessment tools and which more recently focus on the client perceptions of need and satisfaction (Ritchie, 2003). It's essential that tools which measure individual client treatment are sensitive to minor change in outcomes when evaluating any service (Demers et al, 2004; Kaambwa et al, 2008). However, there are a number of criticisms. Some study designs have considered differences between groups and individuals but only from the perspective of the researcher and not the service user or carer i.e. not using a person focus perspective.

As a result Demers et al (2004) have developed a tool which can be used in facilitating choice when considering the various available outcome assessments in geriatric rehabilitation. FARGO (Framework for the Assessment of Geriatric Rehabilitation Outcomes). It is composed of four 'primary outcome domains' of mobility activities, basic activities of daily living, activities of independent living and leisure activities. There are also four further 'brief evaluations of underlying functioning' which include physical functioning, psychological functioning, social functioning, care giver status and available resources. Demers et al (2004) argues that the variation in tools used and the lack of sensitivity demonstrated by often well validated tools such as Barthel Index (Mahoney & Barthel, 1965), is often due to a lack of conceptual basis when choosing outcome measures. In addition tools are frequently designed for a specific study and are not easily transferable and cannot provide worthwhile comparison.

Summary

This section has explored how and why Gadamer's hermeneutic interpretative methodology with single intrinsic case study design evolved and was used. The rationale for this approach is that these services are complex and we need to consider the multiple levels within them in order to have an understanding of the whole. The methodology, the design and multiple methods available to be used were considered individually.

3.4   Chapter conclusion

The underpinning knowledge for exploring the integrated services are the theories of systems and complexity. These emphasise the importance of viewing the day services for older or frail people in the welsh borough as a whole by attempting to understand person focussed demand, purpose and work flow at the different levels within the system. Gadamer's hermeneutics with a case study design has been adopted to understand and interpret the meaning of the experience, perceived and lived by the participants. These are the meanings which drive the work value of the system which suffers generally from a lack of clarity in its definition of intermediate care. This

chapter has established that Gadamer's hermeneutics with a case study design is required in order to understand the complexity of the whole system. It has been used so that health and social care can gain knowledge about this much neglected area of research (i.e. day services in the community). As a result the principle research aim is 'To explore whether there is a difference between integrated health and social care day services and non- integrated health and social care day services'. The following chapter will now discuss the case study design and its methods used in more detail.

This chapter has:

- Critically analysed the definitions of intermediate care identifying that it lacks clarity, is service driven and not underpinned by systems theory. Therefore is not helpful for practitioners and managers when attempting to deliver a shared vision of the concept which is person focused.
- It addressed how Gadamer's hermeneutics will explore and capture the participants understanding and meaning of their day services experience at each level of the system, whilst whole systems principles support the case study design by ensuring that the system is viewed as a whole.

Chapter 4   The Case Study Design and Method

4.1   Introduction

The aim of this chapter is to convey the design and methods used within this research study, its case study design, use of Gadamer's Hermeneutics to guide and analyse the qualitative data; with its embedded quantitative element. This is necessary to gain a systems understanding or 'learned explanation of the participants' meaning of day services in the context of integrated care (Gadamer, 2006).

This research study was a single intrinsic exploratory case study using multiple methods. It was intrinsic as the focus of the case study was to learn more about the context, processes and interactions as perceived by the participants of the integrated and non-integrated services (Hancock & Algozzing, 2006). Also, the case study itself was of prime importance to the researcher as opposed to instrumental (where the issue of integration is of prime importance) because the case study was pre-selected i.e. the case evolved firstly and was not chosen after the issue of integration has been identified (Slate, 1995; Scholz & Tietje, 2002).

This single case study was embedded in two ways. Firstly, the single case study was defined as being the day services for frail or older people in the borough of the 'welsh borough', whilst the sub units within it were the individual integrated and non-integrated day units. Secondly, it had a qualitative hermeneutic framework with an embedded quantitative element within it (Scholz & Tietje, 2002; Yin, 2003a; Creswell & Plano Clark, 2007).

This research design or plan of action (linking philosophy with the methods) used Yin's (2003a) five components of a case study research design to illustrate this element of the multi method approach adopted (Creswell & Plano Clark, 2007). It also served to apply the whole systems thinking used to achieve the study aim.

Yin's (2003a) five components of a case study are:

- **The study aim**

The aim in an exploratory case study is to define the study questions. These are initially 'etic' in nature i.e. the researcher's views of what the questions should be (Stake, 1995). As the case evolves then the 'emic' questions of the participants become apparent. In case study research the research strategy used is a reflection of the type of questions asked.

- **Its propositions**

The study 'proposition' evolves from the research questions. It directs the researcher to the what, where and how to look for the evidence required to answer the questions in the case study. In an exploratory case study these are initial assumptions.

- **Unit of Analysis**

The 'unit of analysis' defines the case in its context e.g. geography and time. It also requires those who are the primary topic of the case study to be distinguished from those who are putting them in their context. In this study this can be distinguished by the people who are referred and attend the day services and those who are informal and formal carers.

- **The logic linking the data to the propositions.**

This defines how the researcher logically links the aim, the proposition, the objectives and the methods of gathering the data together. In this case study the researcher used the objectives to systematically rationalise why the multiple methods were used. This also includes ethics, risk, ethical approval, the pilot study and the study procedure.

- **The criteria for interpreting the findings.**

This included the mixed methods strategy and the steps of analysis. In this study the latter was based on the Gadamer's philosophy which enabled the researcher to consider both qualitative and quantitative elements of the study individually and as a whole within the context of the case (Gadamer, 2004). This ensured that the researcher kept the aim of the study and the

research questions in the forefront throughout the analysis (Fleming et al, 2003; Debesay et al, 2008).

The five components have been used as subheadings within this chapter.

4.2 The study aim

The research aim of this intrinsic exploratory case study was to explore whether there was a difference between integrated health and social care day services and non- integrated health and social care day services in the welsh borough. The aim derived from a literature review which considered methodology, design and methods used within studies of day hospital, other studies of day centres and integrated services (Appendix 8). They suggested that further studies should consider the difference between integrated health and social care day services and non- integrated health and social care day services from both service user and service perspectives.

4.3 The study propositions

The propositions or intentions of the case study were guided by the how and the why of the questions within the research aim (Yin, 2003a). In addition to previous studies which recommended a mixed methods approach there is also a need to consider participant experiences and their physical function (Imrie, 2004; Ritchie, 2003; Burch & Borland, 2001). Many of these studies were influenced by a whole systems approach (Bertalanffy, 1968; Senge (2006). Therefore the proposition or assumption for this study is that people who attend the integrated services benefit from an integrated approach to assessment and care which links clinical, professional and organisational levels. The proposition for this study was achieved through the following objectives:

a) To describe the process and primary outcomes of service delivery in integrated and non- integrated day services.

b) To identify, collate and describe secondary measurement tools which may be included within the FAGRO (Framework for the Assessment of

Geriatric Rehabilitation Outcomes) model (Demers, 2004) developing a reference tool grid for practitioner use.

c) To explore and compare the service experiences of service users, carers and staff within the integrated and non integrated services.

d) To explore and compare the relationship between the service user, the FAGRO domains (Demers et al, 2004) and integrated and non-integrated day services.

e) To gather descriptive information during the period of integration of the Joint day care on the experiences of the multi agency staff in the form of a diary, i.e. a chronology of the research process and a form of field notes to generate data, a means of assessing performance, prejudices and a means of evaluating the process.

f) To define and investigate theories of aging, rehabilitation, disability, health, personhood and whole systems theory. In addition to the concepts of person centred care, empowerment, agency, autonomy, independence and the influence and practices of service user experience.

g) To determine (explore) whether health and social care can integrate day services in practice.

4.4 Unit of analysis

This case study was an in-depth analysis of the group of geographically bound day services operating within a 'welsh borough'. The day services comprised of integrated and non-integrated types. This study investigated the meaning of the phenomenon of integrated as opposed to non-integrated day services (Lo-biondo-Wood & Haber, 2002) i.e. the primary topic was that of the integrated services as opposed to the non-integrated. As a result, it was intrinsic in design as the case was 'given' through its geographical and service boundaries (Polit & Beck, 2004).

The embedded unit which formed the 'unit of analysis' were the health and social care day services for adults within the 'welsh borough' (Yin, 2003a, see diagram 1). These services form part of the intermediate care health and social care services which serve the people of the 'welsh borough'. The

embedded services include a joint day care facility, a reablement team, a day centre, a day hospital and an outpatient clinic. The joint day care and the reablement team identified as the integrated services and the day centre, day hospital and outpatient clinic (welsh borough patients only) identified as the non integrated services.
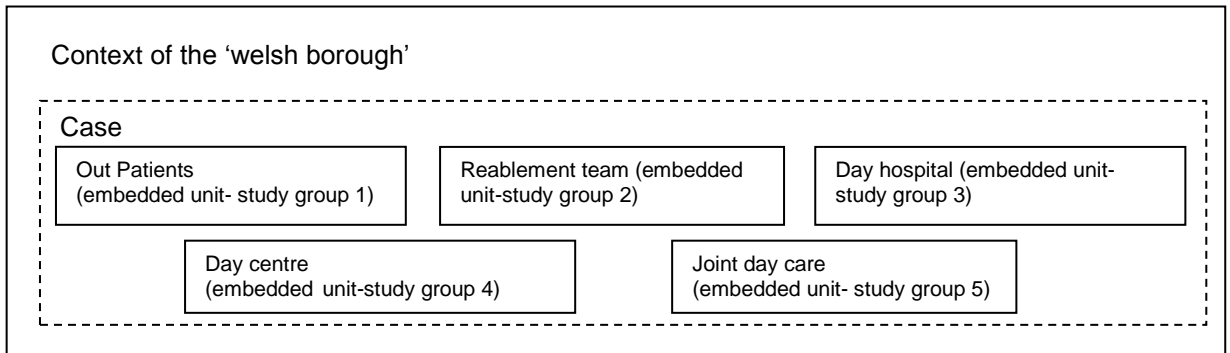
Diagram 1: Single Case embedded design adapted from Yin (2003a, p40, fig 2.4)

4.4.1 The study groups

The study population within the integrated services included service users from the joint day care facility and reablement team. These were seen as different to medical and social models of day care (day centre and day hospital) and a group not receiving any form of comprehensive day care or day hospital or comprehensive elderly assessment or domiciliary care (elderly care outpatient group). These were known as the non integrated services. With exception to the day hospital all other groups comprised of service users who were resident within the 'welsh borough'. The borough no longer had a day hospital service as it had previously merged with a day centre to provide the integrated joint day care facility; therefore the nearest demographically comparable health day unit (in service and population) was used (NPHS for Wales, 2006).

The integrated joint day care comprised of social care staff educated at NVQ level 2,3 or 4, nursing ('F' and 'E' grade) and medical staff (Senior Registrar); whilst the reablement team, comprised of medical (Senior Registrar), nursing ('F' and 'E' grade), occupational therapy, physiotherapy, dietetic, social work and speech and language therapist (all senior

therapists) and generic support workers (NVQ level three 'promoting independence')(Table 5). Both teams were initially located within a leisure centre and worked closely together. The non-integrated sites were a social services day care unit, which comprised of social care only and the day hospital which comprised of nursing ('G', 'F' and 'E' grades), medicine (consultants), senior occupational therapy and physiotherapy with access (as appropriate) to further members of the multidisciplinary team within the hospital service. The outpatient group neither attended day hospital or day centre nor did they receive a comprehensive, multi-agency assessment during the period of evaluation.

Study Group	Staff	WTE	Approx. No. people attending daily/ people on register
1- Outpatients	Information unavailable	Information unavailable	Information unavailable
2- Reablement team	Manager SNR 1 Physio SNR 1 OT F Nurse SLT Dietetics Medical Staff Grade Social Worker Reablement Officers Reablement Assistants (secondment from SSD)	1.0 1.0 1.0 0.8 0.2 0.3 0.5 0.27 6.0 2.0	97 on register
3- Day hospital	G Nurse D Nurse A Healthcare support worker SNR1 OT OT Tech 3 SNR 1 Physiotherapist Physiotherapy Assistant A&C3	1.0 2.0 1.67 (NVQL3 in care) 0.33 0.17 1.0 0.5 0.7	16 people daily
4- Day centre	Clerical Officer Care Assistant Care Assistants	1P/T 1.0 7 P/T	36 on register
5- Joint day care facility	Care Assistants Care Assistants Cook Domestic assistants Kitchen Assistant Clerk Day Service Officer Caretaker Manager	10.0 2.4 1.0 0.8 2.60 1.9 2.0 1.0 1.0	45 people daily maximum

Table 5: Staff working within the study groups during the research study (quantitative service data, BGCBC, 2001/2002/2003; Wallace and Lane, 2002; Wallace, 2002)

4.4.2 Case Study Inclusion/ exclusion criteria

The inclusion criterion for this study included patients or service users, carers or employees if they gave their consent and were:

- Over the age of 18 years of age
- Lived in the welsh borough or other borough(day hospital only)
- Attended either the day hospital, the day centre, the outpatient clinic (the 'welsh borough' patients only), joint day care and reablement team at the leisure centre or
- Recognised themselves as a carer to a service user attending one of the services above or
- Employed within the specified services above.

The exclusion criterion included patients or service users or carers if they:

- Did not or were unable to give their consent
- Experienced dysphasia
- Did not attend / was not employed within / did not recognise themselves as a carer for a service user within any of the specified services.

The researcher was informed of any referrals fitting the criteria during the research period with exception of the outpatient group. As a result, the researcher quickly developed a pattern of contacting the team leaders and visiting the sites if referrals had not been received within two weeks of the last referral.

4.4.3 Sampling

Three types of non-probability sampling were used within the study; they were volunteer, purposive and snowballing sampling respectively (Polit & Beck, 2004). As this form of sampling was used, the number of participants in advance was unknown within the sample framework. Nevertheless it ensured that the researcher had the opportunity to gain complete understanding of the phenomena of integrated and non-integrated day services through the experiences of the service users, carers and staff within the 'welsh borough'.

Volunteer sampling enabled the researcher to gain broad information and themes from the quantitative secondary outcome measures i.e. the questionnaire. Within these individual study groups, the service users were perceived as part of a 'captive population' (Parahoo, 1997). After considering the inclusion/exclusion criteria, the researcher then relied on the group manager to give advice as to whether the individual participants would require a postal questionnaire or help to complete it by structured interview. Although this is often seen as a weak form of sampling, it was considered appropriate in this study at this stage due to the age and frailty of the study population.

The questionnaires were either posted to the participants with a supporting letter inviting the participant to complete the questionnaire or the researcher contacted the participant in person to arrange a convenient date and time to complete the questionnaire. The questionnaire also included study information and leaflets (see appendix 9) and assured confidentiality in order to dispel any fear of retaliation, feelings of moral obligation and fear of being labelled as unhelpful or difficult (Parahoo, 1997).

Likewise purposive sampling was used to generate theory and in-depth knowledge through the qualitative in-depth interviews. This involved the researcher with the help of the study group manager/ team leader intentionally choosing the participants. The staff chosen had either professional or trained backgrounds to ensure an opportunity to gain a rich perspective of the services. The service users were chosen from the questionnaire volunteer samples who had indicated that they would like to be interviewed following completion of their questionnaires. The service users and staff interviewed were asked to convey their feelings, process and perceptions of the service they attended.

The sampling framework for the carer interviews was unknown; therefore the snowballing method was adopted. The service user was asked to give the researcher permission to approach his/her carer. Often this included not just the carer but a significant other person (such as a niece) who felt

more able to talk on behalf of the main carer. If insufficient numbers of carers had volunteered then further carers (having had relatives use the service in the past) known to both service users and carers would have been approached until theory saturation had occurred (Parahoo, 1997; Bowling 1997; Hall & Hall, 2004). However, this approach was not required as carers were very willing to participate.

4.5 The logic linking the data to the propositions

In order to link the data to the 'proposition', study aim, questions and objectives, the researcher used multiple methods of data collection (guided by a hermeneutic framework) as steered by previous studies of various day services (Ritchie, 2003), the principles of whole systems theory (Bertalanffy, 1968; Senge, 2006) and service integration (Leutz, 1999). Therefore it relied on many sources of data in order to explore the meaning of the phenomenon (Holloway & Wheeler, 2002) and provide the holistic understanding of this complex service provision (Yin, 2003a). This supported the understanding of the 'contemporary phenomenon' of service integration over time from professional, user and carer perspectives who are often older adults (Lo-biondo-Wood & Haber, 2002; Inui, 2003). By using multiple methods, the depth required by this complex case study was achievable, and so it overcame the individual weaknesses of using any single method (Polit & Beck, 2004). This enhanced the validity of the results found as multiple triangulations occurred through theory, design, data and analysis (Denzin, 1989; Parahoo, 1997; Lukkarinen, 2005).

Qualitative methods addressed the primary aim as to whether there was a difference between integrated health and social care day services and non integrated day services. In addition to answering the 'etic' questions:

- What were the differences in integrated and non integrated health and social care services as perceived by the participants?
- What could be learned from this study of integrated and non integrated services?
- How can health and social care services integrate in practice?

As a result hermeneutics formed the basis of the study design, through data collection, population framework and study analysis.

Quantitative methods addressed a secondary requirement within the remaining case study questions (how were integrated services different?) and proposition or objectives i.e. 'To explore and compare the relationship between the service user, the FAGRO domains (Demers et al, 2004) and integrated and non-integrated day services', and to describe the service outcomes. They supported the primary purpose of exploring the participants' interpretation of the participants' experience of the phenomena of day services (Moran, 2000). This was recognised as a supplementary role as it was acknowledged that this data set would have little value outside of this case study.

4.5.1   The proposition and objectives

A whole systems approach to understanding this case study proposition requires a researcher to have an intimate understanding of the service processes or interactions regardless of organizational boundaries in accordance to the key 'principle of the system boundary' (Senge, 2006). Therefore objectives (in italics) were used to gain that intimate or depth of understanding. The objectives and how they were achieved are identified below:

- '*To describe the process and primary outcomes of service delivery in integrated and non- integrated day services'* (objective 4.3a) the researcher utilised the information gained in objective 4.3c) and 4.3e) through the in-depth interviews, diary and field notes (observations and meeting notes) which were further embedded with a grid of identified service outcome measures and service user outcome measures. Therefore, the data methods captured both perception of experience and process by service users, carers and staff.

The service outcome measures were identified from the literature as referral source, admissions to hospital, admissions to residential or nursing home

care, proportion of people who are living independently and death and were collated monthly during the study period (Brown et al, 2003). Many of these outcome measures served as feedback information and informed various parts of the study groups (embedded units) and so potentially enable managerial staff to make any corrective changes to the service that are required. Therefore, these outcome measures had the potential to give the study groups opportunities, to see if they were meeting their service aims (Katz and Kahn, 1966). Four study groups (with exception of the outpatient group) initially agreed to collate this information on a monthly basis throughout the period of the research study. However, due to changes in staff and increasing numbers of service users attending the services, all groups were unable to collect all the data as described. The most consistent service outcome collected within all groups was the Total Number of Referrals and Referral Sources. Therefore only giving the study groups an understanding of an aspect of the 'inputs' made to their services (Katz and Kahn, 1966).

Another quantitative aspect to the study considered service user outcome measures. The FARGO model (Demers, 2004) is a conceptual framework and could be considered a specialist assessment within the principles of the standardised Unified Assessment Process (Welsh Assembly Government, 2002) in Wales). Each of the standardised UK frameworks comprises of domains (9-12) and sub-domains which in Wales populates a minimum dataset of information (Wallace & Davies, 2009; Welsh Assembly Government, 2006d).

However, these standardised frameworks do not purport to be frameworks for evaluating outcomes in older people. The FAGRO model (Demers, 2004) was developed through a systematic research process which included literature review, service user interview and professional expert focus group. The model comprises of four primary activity domains (Mobility, Basic activities of daily living, Activities of independent living, Leisure activities) which were considered important to older people living in the community. These are then sub-divided into the underlying functioning

element of the activity domain i.e. physical functioning, psychological functioning, social functioning and caregiver status & available resources.

- To achieve the objective '*To identify, collate and describe secondary measurement tools which may be included within the FAGRO model (Demers, 2004) developing a reference tool grid for practitioner use (*4.3b); a reference tool grid for practitioners was developed (see appendix 10) using the FAGRO model (Demers, 2004). This facilitated the identification of secondary outcome measures to be used within this research study.

In order to achieve this an initial literature search was undertaken using Cinahl and Medline databases (1982-2004) with a combination of the keywords, measurement tools, function, satisfaction, health and wellbeing, quality of life, social support, rehabilitation, geriatric and elderly. The terms mental health, paediatrics, learning disability and palliative care were excluded from the literature search. A total of 136 tools were retrieved initially. These were then sifted in two stages by grasping onto Gadamer's philosophy (Gadamer, 2004; Fleming et al, 2003) and Baltes and Baltes (1990) model of successful ageing. All of which resulted in the study requiring a tool (or tools) which:

1. Gained an understanding of the FAGRO activities and functions as understood by the service users
2. Could be self-administered as opposed to professionally administered
3. Could be used by older service users living in the community as opposed to a hospital environment
4. Was for general use with people who have a disability or frailty and not for administration to service users with a specific disease or for those who attend specific services.

Stage one resulted with thirty (30) tools and scales which had some understanding of the FAGRO (Demers, 2004) activities and functions (see Table 6). However, following this stage it became apparent that a stand alone single tool within those identified would not fulfil the requirements of the framework. Following the stage two sifting for self administration,

community use and general usage (points 2-4 above) the number of tools was reduced to a total of nine (9).

Outcome measure	Reference
Impact on Participation and Autonomy Questionnaire (IPAQ)	Cardol et al, 2001
AIMS 1 & 2 (The Arthritis Impact Measurement Scales 1 & 2) (AIMS 2 is the shorter version)	Hagen et al, 1999
Barthel Index (BI)	Mahoney & Barthel, 1965; Wellwood et al, 1995; Wilkinson et al,1997
Craig handicap assessment and reporting technique (CHART) revised	Whiteneck et al, 1992 Zhang et al, 2002
Camberwell Assessment for the Needs of the Elderly (CANE)	Secker et al, 2001.
Canadian Occupational Performance Measure (COPM)	Law et al, 1991; Trombly et al, 2002;
Fullerton Functional Fitness Test (FFT) battery	Miotto et al, 1999
Functional Independence Measure (FIM)	Keith et al, 1987
Functional Assessment Measure (FAM)	Gurka et al, 1999
Katz ADL	Katz et al, 1963; Katz & Akpom, 1976
London Handicap Scale (LHS)	Harwood et al, 1994; Harwood & Ebrahim, 1995
Reintegration to Normal Living Index (RNL)	Wood-Dauphinee et al, 1988
Therapy Outcome Measures (TOM)	Enderby, 1997
Comorbidity Symptom scale (CmSS)	Crabtree et al, 2000;
Reintegration to Normal Living Index	Harker et al, 2002
Euroqual 5D (EQ5D)	The EuroQol Group, 1990; Dawson et al,2001
SF-12	Ware et al, 2002; Hurst et al, 1998
Quality of Well-being Scale (QWBS)	Kaplan et al, 1976
General Sickness Impact Profile (SIP)	Bergner et al, 1981
Nottingham Health Profile	Hunt et al , 1981
Rivermead Rehabilitation Centre Life Goals Questionnaire	Davis et al, 1992
Quality of Life Index (QL-INDEX)	Spitzer et al, 1981
Life Satisfaction Questionnaire	Fugel-Meyer et al, 1991
Dartmouth COOP Charts	Nelson et al, 1987; Mc Horney et al,1992
Schedule for the Evaluation of Individual Quality of Life (SEIQOL)	O'Boyle et al, 1992
Lancashire Quality of Life Profile	Secker et al, 2001; van Nieuwenhuizen et al, 2001
General Health Questionnaire (GHQ-30)	Ohta et al, 1995
Geriatric Quality of Life Questionnaire	Forster et al, 1999; Guyatt et al, 1993
General Sickness Impact Profile (SIP)	Forster et al, 1999; Bergner et al, 1981.
Health Related Quality of Life (HRQoL)	Broyles et al, 1999

Table 6: Outcome measurement tools- stage 1 sifting of tools

In order to adequately cover the requirements of the FAGRO (Demers, 2004), these tools were then examined for compatibility, ease of use (i.e. easy to read/ understand and short in length) reliability and validity. The Impact and Participation Questionnaire (IPAQ), AIMS 1&2 and General Sickness Impact profile (SIP) were considered too long although all were considered reliable and valid (see table 7). The Geriatric Quality of Life Questionnaire, Life Satisfaction Questionnaire and Nottingham Health Profile demonstrated various difficulties with reliability (see table 7). Whilst further examination of the Dartmouth Coop Charts demonstrated that the more charts used the less sensitive it was to change and it was less reliable than the shortened SF-12.

Outcome measure	Appropriateness	Comments	Reference
Impact on Participation and Autonomy Questionnaire (IPAQ)	The IPAQ addresses autonomy and participation in 5 domains, autonomy indoors, family role, autonomy outdoors, social relations and work and educational opportunities. For use with people who have chronic disorders.	Responsiveness requires further study. Good test-retest reliability, intra-class correlation coefficients ranged between 0.83 and 0.91 32 items within the 5 domains.	Cardol et al, 2001
AIMS 1 & 2 (The Arthritis Impact Measurement Scales 1 & 2) (AIMS 2 is the shorter version)	Partly adapted from Katz's Index of Activities of Daily Living, the RAND and BUSH Scales. To assess patient outcomes in arthritis and other chronic diseases. AIMS1 has 45 multiple choice questions with nine subscales. It assesses 9 dimensions of health and functional ability (mobility, physical activity, ADLs, dexterity, household activities, pain, social activity, depression and anxiety. Another 19 items cover	Both very large scale which does not cover all FAGRO domains. Both reliable and valid. Sensitive to change.	Hagen et al, 1999

Outcome measure	Appropriateness	Comments	Reference
	general health, health perceptions and demographic details. AIMS2 has 78 items, additional sections include arm function, work and social support, in addition to satisfaction with function, problems of arthritis and self designation of priority areas for improvement.		
London Handicap Scale (LHS)	To enable an individual's health state to be described in terms of disadvantage in six main areas: Adults with physical or neurological impairment. Six items Mobility, physical independence, work and leisure, social integration, orientation, economic self sufficiency.	Six point scale for each item. Easily understood. Reliability and validity good. Coefficient reliability for the general population 0.84. Also good cross cultural validity.	Harwood et al, 1994.
SF-12	A multi-purpose short-form questionnaire with 12 questions. A generic measure non specific age, treatment group or disease. Includes physical functioning, physical role, bodily pin, general health, vitality, social functioning, role emotional and mental health	4-week recall period. Easy to use. Group level reliability coefficients obtained (0.73-0.87)	Ware et al, 2002
General Sickness Impact Profile (SIP)	To document the effect of sickness on everyday activities and behaviour; all population; All population 15 point scale which is added up and given an overall score 136 items which describe a	Time to complete: 20-30 minutes to complete. Time consuming and tiring to complete. Valuable for use with assessing impact of illness on patients with	Bergner et al, 1981

Outcome measure	Appropriateness	Comments	Reference
	specific dysfunctional behaviour:12 categories and two dimensions physical and psychosocial which include sleep & rest, eating, working, home management, recreation and pastimes, ambulation, mobility, bodily care and movement and social interaction, alertness behaviour, emotional behaviour and communication	chronic illness. Test re-test reliability 0.88-0.92; internal consistency 0.81-0.97; Correlation between scales (Katz and NHISI) scored 0.64 and 0.55. Correlation with clinical status score 0.40-0.60. Less sensitive to clinical change than SF-36 and Barthel Index.	
Nottingham Health Profile	To document a patient's perception of their health status and the effects of it on their behaviour; All Population; acceptable to older age group. Empirically weighted scores for 'yes' responses. Scores are presented in terms of a profile rather than an overall score. The higher the score the greater the perceived number of problems 45 items divided over 6 sub scales (physical mobility, pain, sleep, emotional reactions, social isolation and energy	Time to complete: short Dichotomous scale (yes/no).) Provide only a shallow profile needs to be used in combination with other tools e.g a functional disability scale Test-retest reliability 0.45 (home life)-0.88; Face, content and criterion validity satisfactory; sensitive to change; correlates well with clinical measures; predicts LOS in hospital patients and progress at 3months and one year;	Hunt et al, 1981
Life Satisfaction Questionnaire	To measure client satisfaction with life as a whole (happiness); General Adult population. Nine items examining client satisfaction with family, life and friendship, financial situation,	Six point score ranging from 1 (very dissatisfied) to 6 (very satisfied). Provides a client profile which can be monitored over time.	Fugel-Meyer et al, 1991

Outcome measure	Appropriateness	Comments	Reference
	vocational situation, leisure and self care.		
Dartmouth COOP Charts	A general health measure. They cover physical functioning/fitness, feelings/emotional condition, daily activities, social activities, pain, overall health, social support and quality of life. A further question aske the patient to look at change in health Consists of nine questions. Five response categories for each question with each response category being linked to a drawing intended to represent the health state.	retest intraclass correlations for elderly patients ranged from .78 to .98. Less precise than SF 12.	Nelson et al, 1987; Mc Horney et al, 1992
Geriatric Quality of Life Questionnaire	A health-related qualify of life (HRQL) questionnaire designed for the frail elderly. The GQLQ includes 25 questions focusing on activities of daily living (ADL), symptoms, and emotional function.	Lengthy questionnaire. No advantage over simpler measures. Responsiveness coefficients ranged between 0.26-0.50	Guyatt et al, 1993

Table 7 Outcome measurement tools and scales following stage 2.

Consequently, the London Handicap Scale (Harwood et al, 1994) and the SF-12 (Ware et al, 2002) were chosen as the appropriate tools to use for this research study.

These tools were then mapped across to the FAGRO (Framework for the Assessment of Geriatric Rehabilitation Outcomes) (Demers, 2004) (see Figure 5). The domains within this framework have two layers, the Activity Domains and the Functioning Domains. The Activity domains consist of 'mobility activities', 'Basic activities of daily living', 'Activities of independent

living' and 'Leisure activities'. The Functioning Domains comprise of 'Physical functioning', 'Psychological functioning', 'Social functioning', 'Caregiver status & available resources'.

In order to ensure that the two scales were compatible with the FAGRO (Demers, 2004) framework the questions within the two questionnaires (London handicap Scale and SF-12v2) were mapped across the Domain definitions as demonstrated below. Following which both questionnaires were amalgamated putting the SF- 12 (a shortened version of the SF-36, Ware & Sherbourne, 1992) in front of the London Handicap Scale (LHS) (Harwood & Ebrahim, 1995) as instructed (see Appendix 9 for final questionnaire). The questionnaire at this stage consisted of thirteen questions (with ordinal sub- scales) in total.

Activity Domains:

These are the four 'Primary Outcome Domains' within the Framework.

1. Mobility activities i.e. inside or outside the home.
   Relevant research questionnaire No: 8 (Mobility- LHS)
2. Basic activities of daily living i.e. self care activities related to bodily functions
   Relevant research questionnaire No: 9 (i) (Physical Independence-LHS)
3. Activities of independent living i.e. routine activities which maintain the home e.g. shopping, cleaning and managing money.
   Relevant research questionnaire No: 2 A (SF-12v2)
   [Relevant SF12v2 Scale: Physical Functioning (PF) 2A & 2B. NB. The physical functioning domain within FAGRO is a secondary domain which informs the primary activity domain of Independent living].
4. Leisure activities i.e. the participation and enjoyment of leisure activities within a person's free time.
   Relevant research questionnaire No: 10 (Occupation- LHS)

Functioning Domains
These are the underlying functions within the four 'Primary Outcome Domains'.

1. Physical functioning
   Relevant research questionnaire No: 2B (SF-12v2); 3A (SF-12v2); 3B (SF-12v2); 5 (SF-12v2); 6B (SF-12v2)
   [Relevant SF12v2 Scale: Vitality (VT) = 6B; Bodily Pain (BP) = 5; Role Physical (RP) = 3A & 3B]
2. Psychological functioning
   Relevant research questionnaire No: 4A(SF-12v2); 4B (SF-12v2); 6A(SF-12v2); 6C(SF-12v2); 12 (Orientation-LHS)
   [Relevant SF12v2 Scale: Role Emotional (RE)= 4A & 4B; Mental Health (MH)= 6A & 6C]
3. social functioning
   Relevant research questionnaire No: 7 (SF-12v2); 11 (Social Integration- LHS)
   [Relevant SF12v2 Scale: Social Functioning (SF) = 7]
4. caregiver status and available resources
   Relevant research questionnaire No: 9(ii) (additional question); 13 (economic self sufficiency-LHS)

Figure 5: SF-12v2 and LHS tools mapped to FAGRO (Framework for the Assessment of Geriatric Rehabilitation Outcomes)

Mapping these questionnaires demonstrates that they meet the requirements within the FAGRO (Framework for the Assessment of Geriatric Rehabilitation Outcomes) (Demers, 2004) domains whilst also

showing the difference in content of each of the original questionnaires. The London Handicap Scale covers a broad-spectrum of the FAGRO framework (Framework for the Assessment of Geriatric Rehabilitation Outcomes) (Demers, 2004), although it dominates the Primary Outcome Domains. It covers the 'Mobility activities', 'Basic activities of daily living' and 'Leisure activities' (three Primary Outcome Domains) and the 'Psychological functioning', 'Social functioning' and 'Caregiver status and available resources' within the secondary functional domains. The SF-12v2 is more specific in its questions and is limited to only one Primary Outcome Domain (i.e. Activities of independent living). Whilst the majority of its questions are focussed on the Secondary Outcome Domains that of 'Physical functioning' and 'Psychological functioning', with a single question directed to 'Social functioning'.

All domains were adequately covered by the two original questionnaires with the exception of 'Caregiver Status and available resources'. The definition of which refers to the wellbeing and resources (including the provision of home care). Question 14 (LHS) asks about financial resources available in relation to expenses and affordability only. Therefore, an additional question/statement (9b) in relation to the use of carer and home care services was developed i.e. 'I have home care (or a carer) to help me look after myself'. The service user was asked to indicate frequency per day (once per day- five times per day and more) of care received. It was anticipated that this would give an indication of carer burden (see appendix 9).

- In order to achieve the objective '*To explore and compare the service experiences of service users, carer and staff within the integrated and non integrated services'* (4.3c), in-depth interviews were undertaken with service users, carers and staff in all study groups.   This allowed the researcher to gain a deeper understanding of their experiences of both study group process and service and what meaning it had in their lives. This also led the participants to talk about their understanding of health and social care services. An interview commenced with a

general statement for example 'tell me about your experiences of [study group] and what it means to you'. Topics guiding the interview centred on asking the participant about mode of referral, daily experience, review, care co-ordination and impact on quality of life. The 'Etic' questions then transferred or reflected into 'Emic' questions such as:

- When I have a problem which threatens the way I live at home (health, care, housing etc), how do I easily and quickly solve my problems?
- If I need help, who helps me or who solves them for me?
- What about the roles of the professionals/ services when I need problems solved?

The aim was to conduct approximately two in-depth interviews with service users, carers and staff in all five study groups. All in-depth interviews were audio taped and transcribed verbatim.

The remaining objectives of defining and investigating theories would be achieved through the literature search and the discussion throughout this thesis.

4.5.2   Ethical approval
Ethical approval was processed through COREC and gained from [name] Local Research Ethics Committee (REC No: 04/WSE05/6), [name] Healthcare NHS Trust ethics committees (Including risk and scrutiny committees) (reference No: RD/316/04) and Social Services in November and December 2004 (Appendix 11).

4.5.3   Ethics
The case study was bound by time and so the data collection commenced with the pilot study in January 2005 and study completed in December 2006. All study participants within the study were approached informally and given an explanation as to the study being undertaken with an opportunity to question the researcher before consent was sought. Reassurances were given both verbally and in written form with regard to

confidentiality. All data was deemed anonymous, recognised only by the researcher through a research identifier in order to avoid duplication. The research identifier including initials and six numbers identifying date of birth e.g. CW 030862

Consent was obtained through receipt of a signed and witnessed consent form before starting the study. The Principles of the Declaration of Helsinki were adhered to (WMA, 1964). The consent form, letter of invitation to participate within the study and information leaflet were given to the participant on the first day of attendance or at appropriate points within the study as indicted within the process below. However, in recognising that the participant has the right to refuse to participate or withdraw at any time, under such circumstances the participant was assured that his or her decision was respected and that it did not effect their treatment or care.

In some circumstances the researcher encountered participants (after the individual preliminary discussion with the researcher) who are unable to complete the questionnaires due to problems with confusion or speech. Under such state of affairs it was considered unethical to continue with the questions, as this may have caused the participant undue distress, anxiety or undermine confidence (Cormack, 2000). The questionnaire was marked with a research identifier and the reason for non-completion stated on the questionnaire and in the research notes.

During the data collection period the Nursing & Midwifery Council (2004) through its 'Code of Professional Conduct' required that all practitioners 'promote and protect the interests and dignity of patients and clients.' Whether a practitioner (in this case the researcher) acts or not upon an issue, situation or information within its knowledge, it is interpreted by the governing body as a wilful decision i.e. the practitioner's reflection, interpretation and action of the given situation. Not to 'do' anything is not an option. Therefore, the position of undertaking research within the clinical or home environment can incur responsibility upon the researcher. This is to ensure that the research undertaken has a sound evidence base, that the practitioners who have responsibility for care within the field are aware that

service user has consented to participate and that the research does not have a harmful effect on the participant. The code has since been updated to include 'Make the care of people your first concern, treating them as individuals and respecting their dignity' (NMC, 2008).

In order to conform to the requirements of the principles set within the Data Protection Act 1998, once data was collected it was stored within the researcher's computer at the University of Glamorgan. Access to the data was only available by the researcher as it was password protected. Once the thesis has been completed and the study deemed as finished (after publication) then all data will be destroyed.

4.5.4   Risks

Considering the sample and setting the researcher identified and quantified the risks to the study and developed an action plan in the event of those risks occurring (see table 8).

Risk	Risk ratio 1 (low risk)- 5 (high risk)	Action
Low number of participants within any one group of study 1	3	Identify reason for low numbers and act appropriately.
Inability of some service users to complete the service user outcome measurement tools.	1	The pilot will identify the proportion of service users unlikely to be able to complete the tools. Should this occur then the tools could be used by the researcher as a structured interview, should the participant wish to continue to participate within the study.
Action within one of the agencies renders a group unstable e.g. raising the cost of day care.	3	Evaluate current position and continue or arrest study as appropriate either within the affected group only or the whole study.
Service users may feel there's a risk to the service delivery.	1	Risk is reduced through the provision of information and letter of consent. Ensure that researcher has the opportunity to alleviate any concerns throughout the study, through providing contact telephone numbers and frequency of visits to sites.

Table 8: Risk action plan

4.5.5 The pilot study

The pilot study in January 2005 gave the researcher an opportunity to uncover any weaknesses and strengths of the primary and secondary measurement tools only. The primary outcome measures (as described in proposition ii a) were collated for 1 month by all study group staff, in order to ensure that the framework to collect the data was in situ.

The piloting of the secondary outcome tool included 12 respondents in total from the study population (Bowling, 1997) using the identified secondary outcome measure. This required explaining to the participants that the

questionnaire was being tested and would be accompanied by a one-to-one interview to gather any information they had about their experiences of completing the form. As anticipated this found that the font and its size needed some adjustment to a larger size (size 14) and that the whole question with its optional answers needed to be on the same page. Other comments gathered included a typographical error and the need to include a space for the date completed and the unit name on the front page. This pilot also gave an indication as to how many participants may have needed assistance due to physical disability. This was anticipated to be in the region of approximately 10% due to blindness and the physical effects of stroke.

In addition to the formatting of the secondary tool, the process of collecting the data then questioned the researcher as to how this information was to be clearly stored and labelled. As a result the questionnaires from each of the study groups were stored in Lever Arch files and clearly identified as 1st and 2nd questionnaires. The identification numbers were then entered into the case study database. This Case Study Database at this stage was an Excel workbook with a sub sheet for each study group. Each study group sub sheet included the primary information by month and the individual participant identifier with date of 1st and 2nd questionnaire. It was acknowledged that the researcher needed to undertake training in both SPSS and Nvivo packages in order to enter the information collected and analyse it in the future. A brief report of the pilot study can be seen in appendix 12.

4.5.6   Procedure

The qualitative and quantitative data sets were collated both concurrently and sequentially (see diagram 2). The following steps to data collection were adopted after the study protocol had been written, approved and pilot completed and analysed:

1. The systematic search and collation of five sources of evidence which ensured that the researcher was able to investigate a range of documents that reflected the historical context, the attitudes and

behavioural issues which supported the development of the integrated services and their sustainability (Yin, 2003a; Gadamer, 2004). In addition to basing any single finding on multiple sources of evidence. The five sources of evidence were:

a. The systematic search for the integrated services documentation was undertaken at the beginning of the study. The documentation included newspaper cuttings, original business case, meetings agendas, notes of meetings and project manager written reports, previous service evaluation. A reference of all documentation was entered into a library file into Endnote X [Bld 2114], labelled (i.e. numbered) and stored for ease of access.

b. The systematic search for archival records of the integrated services such as original organizational charts, current information mapping and budgets, the original project manager diaries of the integration; was also undertaken at the beginning of the study, whilst the service data was collated throughout the study period. The service data was captured and analysed using SPSS version 13.0.

c. A search for any physical artefacts (at the beginning of the study) which reflected the role of the reablement team divulged a poem about reablement which was created by one of the reablement officers. This reference was entered into Endnote X [Bld 2114].

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┌─────────────────────────────────────────────────────────────────┐
│  • **Gather descriptive field notes in the form of a diary, observations,** │
│    **documentation e.g. meeting notes of integrated services throughout** │
│    **study period**                                              │
│  • **Service data collected throughout study period**           │
│                                                                  │
│        Non integrated              Integrated                    │
│          services                   services                     │
│  ┌───────────────────────────┬───────────────────────────┐      │
│  │ **Questionnaire completion** │ **Questionnaire completion** │   │
│  └───────────────────────────┴───────────────────────────┘      │
│                                                                  │
│  ┌───────────────────────────┬───────────────────────────┐      │
│  │ **Service 12 wks**         │ **Service 12 wks**         │      │
│  └───────────────────────────┴───────────────────────────┘      │
│                                                                  │
│  ┌───────────────────────────┬───────────────────────────┐      │
│  │ **Questionnaire repeat**   │ **Questionnaire repeat**   │      │
│  └───────────────────────────┴───────────────────────────┘      │
│                                                                  │
│  ┌───────────────────────────┬───────────────────────────┐      │
│  │ **In-depth interviews**    │ **In-depth interviews**    │      │
│  │     Service user           │     Service user           │      │
│  │       Carer                │       Carer                │      │
│  │       Staff                │       Staff                │      │
│  ├───────────────────────────┴───────────────────────────┤      │
│  │                    **Data Analysis**                   │      │
│  └─────────────────────────────────────────────────────────┘    │
└─────────────────────────────────────────────────────────────────┘
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Diagram 2: Study procedure

    d.   Interviews were in two forms, the formal survey and the open-ended in-depth interviews (Yin, 2003a, b).

        i.   The formal survey comprised of service user questionnaires which were collated in two stages. The first either by post or interview, dependant upon service user abilities and preference. The second questionnaire by the same procedure some 12 weeks later. This served as an introduction and follow up to the service user. The questionnaire data was captured and analysed using SPSS version 13.0.

ii. In-depth interviews were gathered following the collation of the study questionnaires. These were conducted at home or in the day service as requested by the participant. They were recorded by tape and transcribed verbatim. All information captured was entered into Nvivo 7.0 software package. Data analysis followed.

e. Direct observations were achieved through the many visits to the study sites. These were casual rather than formal observations, notes of the observations were made and entered into the researcher's journal of the research process in the Nvivo 7.0 software package.

2. The development of the case study databases. The purpose for these databases was, to ensure that evidence was organised effectively, categorised and accessible. That data could be cited as appropriate, to secure the date and time when the evidence had been collected and to demonstrate that the study protocol had been followed. A system of cross referencing ensured that interview notes cross referenced the sources of supporting evidence. Due to the researcher's inexperience the databases occurred in four forms:

a. The Excel spreadsheet of interviews and questionnaires listed individually by date interviewed/ questionnaire received and their unique research identifier (participant initials and date of birth e.g. CW 030862).

b. Itemised responses to the service data and questionnaire captured and analysed using SPSS version 13.0.

c. Endnote X [Bld 2114] to form the bibliography of written records found.

d. The case study data from all other sources other than the questionnaires were captured using Nvivo 7 software.

4.6 Criteria for interpreting the findings

The aim of the analysis for this intrinsic case study is to understand the whole case (Stake, 1995; Gadamer, 2004) through combining the analysed data into categories or themes. In order to do this the strategy used for interpreting the findings was to follow the study questions, proposition and the 'Emic' questions which led to the case study. This ensured that the researcher maintained a clear focus whilst undertaking the analysis; reflecting the requirements of the research aim (Yin, 2003a), which was 'to explore whether there was a difference between integrated health and social care day services and non integrated day services'. It also supported the principle of ensuring a chain of evidence between the aim, the study questions, the proposition, and the data collected at this stage. Therefore, ensuring that the researcher was able to achieve the hermeneutic rule of moving from the whole of the case to the part of the case and back to the whole (Gadamer, 2004; Fleming et al, 2003).

Having identified the strategy, the criteria for analysing the findings for this single embedded case study was then considered. The strategy for analysing the quantitative and qualitative data was initially undertaken separately. The quantitative analysis was undertaken first.

4.6.1 Quantitative analysis
4.6.1.1 Primary outcomes

The primary outcome measures collected were analysed using descriptive statistics within SPSS version 13.0. The quantitative data was collected for 12 months (January 2005- January 2006), although the data between April 2005 and January 2006 were analysed as this was the most constant. Descriptive statistics only were used to analyse this data following data checking for collection and entry errors. No outliers were detected. Missing data was not replaced as it was not true missing data but unknown data for whole variables (Field, 2005).

Study Groups 2-5 agreed initially to collate this information on a monthly basis throughout the period of the research study. However, due to changes

in staff and increasing numbers of service users attending the services, all groups were unable to collect all the data as described. The most consistent primary outcome collected within all groups was the Total Number of Referrals and Referral Sources. Therefore only giving the study groups an understanding of an aspect of the 'inputs' made to their services (Katz & Kahn, 1966).

4.6.1.2   Secondary outcomes

The analysis stage for the secondary quantitative data commenced with deconstructing the questionnaire into its three parts i.e. the SF-12v2, the LHS and the additional question. The next stages included cleaning, coding, identifying statistical tests to be used; whilst using the statistical software package SPSS 13.0.   Descriptive and inferential statistics were used to analyse the SF-12v2 (Ware & Sherbourne, 1992) and London Handicap Scale (Harwood & Ebrahim, 1995) service user questionnaire. The inferential tests used were the Kruskal- Wallis, Mann- Whitney (post hoc test) and Bonferoni Correction (Field, 2005).   In order to ensure that a full understanding of the 'hermeneutic circle' had occurred the survey data was analysed first, allowing the researcher to give some feedback to the interview participants with an opportunity presenting for further discussion about the experience. This was essential so that very elderly participants were given the opportunity to recall events and re-establish the relationship between themselves and the service user.

SF-12v2

One hundred and thirty three (n=133) service users responded (29%) to Phase 1 (SF-12v2) of the questionnaire (thirty eight requesting interview) and sixty (n=60) respondents returned a Phase 2 questionnaire. Following alterations to the data structure within the file (to reflect the repeated measures design), data inspection for errors and omissions, and three respondents were deleted. One respondent appeared at two centres, whilst two respondents had few answered questions within one of the questionnaires and not returned either the 1st or 2nd phase questionnaire.

This resulted in a total of one hundred and thirty (n=130) 1st phase (SF-12v2) questionnaires. Missing data was replaced with group means (Field, 2005).

The sixty (n=60) 2nd phase questionnaires when returned appeared complete and so the number of completed 2nd phase questionnaires was 60. When divided into the five study centres the total number of 2nd questionnaires were considered to be too small to analyse Study Groups 1, 3 and 4 with inferential statistics as repeated measures although comments can be made on their descriptive statistics. This was due to the nature of the anticipated subtle effect of the conversion process or treatment on the service user, as a result from using the services in question. Larger individual groups of respondents would be required to ensure that scores would be discernable (Clegg, 1990). The small number within the 2nd phase of returned questionnaires was due to death, increased frailty and mental confusion, moving to a care home or to live with family, partner or family refusing on behalf of the respondent, respondent only consenting to be included in 1st phase questionnaire.

Therefore, the computed SF12v2 transformed scale scores were compared by Study Groups 1-5 for 1st phase questionnaire only (stage 1). The repeated measures (1st and 2nd phase questionnaires) were then compared within the Study Groups, integrated and non-integrated services (stage 2). Results of the descriptive statistics in addition to inferential statistics for Study Groups 2 (RT) and 5 (JDC), integrated and non integrated types are reported in the next chapter. The integrated services type comprised of reablement team (Study Group 2) and joint day care (Study Group 5); whilst the non-integrated type comprised of out-patients (Study Group 1), day hospital (Study Group 3) and day centre (Study Group 4).

Descriptive statistics were undertaken at each of the three stages of coding for both 1st and 2nd phase questionnaires (i.e. recoded raw scores, computed raw scores into same scale and the transformed scale scores) for the SF12v2. These transformed scale scores were calculated by summing

the computed raw scores across their identified scales (see above). Norm Based Scoring was not undertaken as these are calculated using 1998 samples of the General U.S population (Ware, 2002).

The scales were scored from 0-100. A higher score represents a better health status within a domain scale, 0 representing worst health status within the domain and 100 representing best health status within the domain (Ware et al, 2002). This standard questionnaire asked its respondents about experiences of health which had occurred within the previous four weeks.

The results of these descriptive statistics suggested that we cannot assume that the sample data within the five Study Groups had a normal distribution, the SF-12 is an ordinal scale, the Study Groups violate homogeneity of variance and non-probability sampling had been used within this study design (Polit & Beck, 2004). Therefore, as the assumptions for parametric testing have been violated, a non parametric test such as the Kruskal-Wallis test is required to see whether these eight independent groups (the scale domains) significantly differ on referral.

In order to demonstrate where the difference lies, ten Mann- Whitney tests were used. They looked for differences between the independent domain scales and whether or not they had the same origins (Field, 2005). Bonferroni Correction was used to interpret the analysis to avoid an accumulation of Type 1 error of more than 0.05. This was achieved by dividing the critical value of .05 with the number of tests performed to give us 0.005 as our critical level of significance.

London Handicap Scale (Questions 8-13 with the exception of 9ii)

This generic health status questionnaire quantifies the disadvantage experienced by an individual due to ill-health into one handicap score between 0-100., with 100 representing no disadvantage and 0 representing the maximum possible disadvantage (Harwood & Ebrahim, 1995). It utilises the six dimensions of handicap to do so.

Descriptive statistics were undertaken. Missing data was replaced using the group mean imputation. No outliers were observed. Means, variability and distribution of the six handicap dimensions of Mobility, Physical Independence, Orientation, Occupation, social integration and economic self sufficiency all indicate that the data deviates from normal. Standard deviation points indicated that the Study Groups were generally heterogeneous. Whilst certain Study Groups within each of the dimensions demonstrated that the distribution was generally leptokurtic with either a negative or positive skew. There were few similarities between integrated services on referral (Field, 2005).

Again the results of these descriptive statistics suggest that we cannot assume that the sample data within the five Study Groups has a normal distribution, the London Handicap Scale is an ordinal scale, the Study Groups violate homogeneity of variance and non-probability sampling has been used within this study design (Polit & Beck, 2004). Therefore, as the assumptions for parametric testing have been violated, a non parametric Kruskal- Wallis Test followed by Mann Whitney Test is required to see whether these six independent groups (the scale dimensions) significantly differ on referral (Field, 2005).

Stage 2-Comparing between questionnaire phases 1 & 2

The data within the descriptive statistics suggested that there was a difference within the integrated and non integrated services. Stage 2 of the statistical analysis commenced with descriptive statistics and as the assumptions of parametric testing had been violated a non-parametric Wilcoxon Signed Rank Test was utilised. This allowed a comparison of two sets of scores (phase 1 & 2 which came from the same respondents) to be compared (Polit & Beck, 2004; Field, 2005).

Integrated and non integrated services

Integrated Services (phase 1 n=62; phase 2 n=38) comprised of Study Group 2 (reablement team) and Study Group 5 (joint day care), whilst Non-

integrated Services (phase 1 n=73; phase 2 n=22) comprised of Study group 1 (outpatients), Study Group 3 (day hospital) and Study Group 4 (day care).

The quantitative analysis was then written up by the researcher in order to capture all steps, analysed data and thoughts with regard to discussion. This ensured that in the future analysis of the whole case study none of the essential details were lost and decisions could be made as to what data should be included in the final written thesis.

4.6.2   Qualitative analysis

The primary qualitative strategy was founded on Gadamer's five stages developed by Fleming, et al (2003). This interpretive approach was considered essential to understand the meaning of the data collected through the multiple methods. Humans interpret their experiences through a background of prejudices and judgments. The study documents, interviews, research diary and observations collated have all captured 'authentic and inauthentic' ways of being which are essential to the experience of everyday living. This five stage approach was adapted to aide the researcher in capturing the 'authentic' which were deeply owned by those who participated within this study. The five stages were:

1. *Deciding on the research question*

The research questions already identified in the first of Yin's (2003a) five components were used to focus the researcher and the participants on the exploration of the integrated and non integrated services. These then translated into the 'Emic' questions reflected by the service users.

2. *Identification of pre-understanding*

Gadamer requires the researcher to identify any pre-understanding of the context, culture and history that has influenced the development of the individual's experience and interpretation of the phenomenon (Parakoo, 1997, Gadamer, 2004). Pre-understandings or prejudices were provoked through discussion with health and social care colleagues and later with the researcher's conference presentation of early findings (Wallace, 2006). The researcher had worked with older people as a junior and senior nurse for 20

years and had previously undertaken the roles of joint day care development officer, project manager and intermediate care development manager (1999 – 2004). Therefore she had an intimate understanding of the services and their evaluation, winning the Queen's Nursing Institute Award for Innovative and Creative Practice in 2001 and Highly Commended by the Community Hospital Association in 2003. The researcher's prejudices of a clinical and nursing background and a commitment to integrated services are acknowledged and undoubtedly were evident although changing throughout the research process. The prejudices changed through reading texts such as Baltes & Baltes (1990), Agich (2003), Billings & Leichsenring (2005), developing a research journal with the purpose of gathering reflective field notes on the process and having conversations with staff who worked in the study groups and colleagues at the university (Fleming et al, 2003). This enabled the researcher to maintain her focus on the phenomenon of exploring the meaning of the integrated and non integrated services as perceived by the participants.

3. *Gaining understanding through dialogue with participants*

Gaining understanding through dialogue as described by Gadamer (1989; 2004, 2006) occurred within this case study through the means of in-depth interviews. In the in-depth interviews the main question was:

'tell me about [name of study group] and what it means to you'.

It started the dialogue which led to other questions which directed the researcher into a deeper and further understanding of the integrated or non integrated service attended. Questions asked depended upon the interaction and understanding between researcher and the participant. At all times the researcher was trying to identify what she could learn from the participant about the service attended. The aim of the interview was to come to a 'shared understanding' (Gadamer, 1989; 2004; 2006). This developed through meeting the participants originally and undertaking the survey questionnaire, further informal discussion whilst making the appointment to visit and then through the formal interviews. Supplementary questions were

asked when needed and depended upon the relationship developing with the interviewee, who was being interviewed (service user, carer or staff member) and the need to explore thoughts that were being expressed at that moment in time. Examples of supplementary questions asked were:

Did someone approach you about coming to [name of study group]?
Did you have any expectations about coming here?
What do you understand about [name of study group]?
Are you aiming to get something out of coming here?
How does that make you feel?

Supplementary questions asked of the staff participants were:

Tell me about the [name of the study group] how does it work?
What happens here, its routine?
How does a service user get to come here?
What about the processes between the RT and secondary care etc?
What about service user outcomes?
What about your relationships with social workers?

Supplementary questions for carers:

How did [service user] access the [name of study group]?
Did you have any expectations about the service?

4. Gaining understanding through dialogue with text

Gaining understanding of the power of speech through dialogue (tone etc) in comparison with text is described by Fleming et al (2003) as not only the act of listening to the tapes whilst reading the interview text, but also considering the participants body language. In addition to this the context of the integrated services was considered in the form of historical and service documents and observations of participants within the research venues. For the interview data this included transcribing and coding. The study documents and observations this involved numbering the documents and preparing summaries. An outline of the Summary Document can be seen in figure 6:

> **Name of document:**
>
> **Event or contact if any, with which the document/ observation is associated:**
>
> **Significance or importance of document/ observation:**
>
> **Brief summary of content/ observation:**
>
> - *If document is central or crucial to the following:*
> - What were the differences in integrated and non integrated health and social care services as perceived by the participants?
> - Why integrated services were perceived as different to non integrated services?
> - What could be learned from this study of integrated and non integrated services?
> - How can health and social care services integrate in practice?

Figure 6: Outline of Summary document contents

This was all undertaken whilst using the computer software package Nvivo 7.0 (QSR International, 2006).

The process used in order to progress the analysis was to:

a. *Gain an understanding of the whole through*:

   i. Reading all the written documentation whilst considering the questions set in Figure 6 and so focussing on the whole. Writing summaries of documents and highlighting key text. Printing off all the summaries and considering the content in respect of the whole and then selecting key documents for further analysis. These documents were then numbered using the Nvivo 7.0 package. This information was verified through cross referencing the document summaries, researcher pre-understanding and some discussion with staff when collating the evidence.

ii.   The process descriptions were obtained by interview with the staff in
       each of the study groups, (e.g. day hospital sister and auxiliary) at
       the beginning of the research period. Synopses of the conversations
       were created as documents within the NVivo7.0 software (QSR
       International, 2006). These were then translated into process
       flowcharts using the ISO9000 most common symbols and Visio
       2003 (Microsoft Office, 2009). Following which they were verified
       (with those interviewed) as correct representations of the
       conversations.   The five process flow charts (Appendix 13) have
       been analysed using the characteristics of 'system's thinking'
       (Bertolanffy, 1968; Katz & Kahn, 1966; Checkland & Paulter, 2006).
       This data was then coded into new and existing 'free nodes'. These
       process flow charts represent sub-systems which are an integral
       part of a health system, a social care system or even an emerging
       'health and social care' system. All of which are 'open systems'
       which continually interact with their environments and as a result
       experience continual change as laws, policy and research evolve.
       The process flow charts have been structured to identify 3 distinct
       process interactions:

       - the service user's referral journey following referral to the
         relevant team/department
       - those interactions which are internal to the employing agency
       - those interactions which are external to the employing agency

iii.   Reading all transcribed text whilst listening to taped interviews. As
       there was a vast amount of information to consider and assimilate,
       the researcher did this in two stages. *First* the raw data was first
       listened to/read through/ visually inspected after each interview was
       collected. This was also whilst considering the questions set in
       Figure 6 and so focussing on the whole.   This ensured that an
       overall understanding was gained at an early stage by the
       researcher. *Second,* when the researcher had collated all data and
       was ready to commence analysing the whole, she chose to make
       verbal notes through a voice recorder in order to capture her

response and acknowledge the influence of any pre-understanding of the case.

iv. Reading all observations/diary and listening to any comments on observations made on tape during the study.

v. Listening to all taped comments made to gain an understanding of the whole.

b   *Every sentence and section was examined to identify the themes*. These themes challenged the researcher's 'pre-understanding' of the case, which was that the services were integrated. In their turn the data within Nvivo 0.7 software was coded to support theme or 'free node' development. These 'free nodes' are 'the collection of references about specific themes' which are 'stand alone' and not at this stage identified as related to any other node (Nvivo.07), see table 9 for examples of 'free nodes'. These contained descriptive coding at first which gave description to each of the free nodes.

Name	Sources	References	Created	Modified
care plan	1	1	07/02/2009 16:30:11	07/02/2009 16:30:50
checklist for integrated services	4	5	26/11/2006 14:58:56	27/11/2006 00:12:42
Reablement team	2	2	07/02/2009 16:12:06	10/02/2009 10:25:55
Day care [name]	2	8	27/11/2006 00:07:56	27/11/2006 00:47:52
day hospital	4	25	26/11/2006 23:40:30	07/02/2009 16:07:43
detached care planning	1	1	07/02/2009 15:57:18	07/02/2009 15:57:18
Grey space	4	5	26/11/2006 18:04:54	10/02/2009 10:11:08
health and social care interface	3	3	26/11/2006 12:14:20	07/02/2009 16:21:38
information sharing	3	8	07/02/2009 16:07:05	07/02/2009 16:32:33
Joint day care	1	1	07/02/2009 16:09:59	07/02/2009 16:21:39
Levels of integration	8	12	07/02/2009 16:55:47	10/02/2009 11:06:25
Loneliness	3	5	26/11/2006 18:26:45	29/08/2008 16:05:40
Mood changing	1	1	29/08/2008 17:15:22	29/08/2008 17:15:22
No formal relationship	2	3	04/02/2009 12:31:15	10/02/2009 10:11:08
Outpatients	1	6	07/02/2009 16:23:11	07/02/2009 16:32:33
Proactive caring	3	6	26/11/2006 11:30:16	07/02/2009 15:48:47
proactive client	1	3	27/11/2006 00:10:20	27/11/2006 00:12:42
relationship- coordination	2	7	07/02/2009 16:03:57	07/02/2009 16:32:33
Relationship- Linkages	8	12	04/02/2009 12:29:31	10/02/2009 10:25:55
uneasy allies unwanted guests	1	1	07/02/2009 16:16:18	07/02/2009 16:17:26
Uneasy allies unwanted guests (2)	6	9	07/02/2009 16:56:18	10/02/2009 15:33:12

Table 9: Examples of 'free nodes' created within the study

The relationships were then demonstrated through 'tree nodes' within the package and so developing the depth of the themes. The 'tree nodes' demonstrate relationships that are organised into a hierarchical structure (Nvivo7.0). As these Tree Nodes developed their hierarchies were adjusted in accordance with the evidence from all sources identified (see Appendix 14)

b. *The sense of the text as a whole was then drawn-out.* This was achieved through relating the themes to the 'etic' questions and whole systems theory, so achieving the aim and the propositions of the case study in a logical manner. As soon as the data was all transcribed into the software, a 'Text Run Query' was undertaken for the words 'day centre [name]' and 'day centre'; Joint day care [name], 'Joint day care [type]' and '[building name]', 'day hospital [type]' and 'day hospital [name]'; 'outpatients' and 'OP'; 'Reablement [type]' and Reablement team [name]'. The text captured was spread to the paragraph surrounding the words. These were then merged into the existing free nodes.

The next stage was to read the free nodes (whilst also listening to the taped interviews) and look for the deep meaning of the participants lived experience otherwise known as 'lebenswelt' which is embedded in the participants perceptions of the study groups practices and procedures (Miles & Huberman, 1994; Grondin, 2003). That is gaining a deeper understanding of what differentiated the integrated from the non integrated services and to consider whether services could truly integrate in the future.

As the study analysis developed, some nodes (themes) were then merged or moved. For example the node called 'Role of the Informal Carer' was thought to be part of the 'Environment' but through reading the sources the role changed as a direct result of the services and so was moved to the Day Services (Service User/ Carer Journey) Parent Node. This resulted in the Parent Node being renamed from Service User Journey to Day Services (Service User/Carer Journey).

c. *Diagrams, data and passages that were representative of the shared understanding of the researcher and participants were then chosen.* These can be seen in the next chapter, in addition to a vignette which is introduced in chapter one (Mary Williams) and two quotes, one which begins and another which ends this thesis. Models were developed at the beginning of the analysis to give an outline sketch of what was first seen by the researcher e.g. figure 7, the carer/service user coordination model.

Fully independent Service user as coordinator

Independent physically frail service user care coordinator with some carer support

Service user dependence imposed – carer as coordinator presumed

Dependence self imposed or Resigned Helplessness – carer as co-ordinator demanded
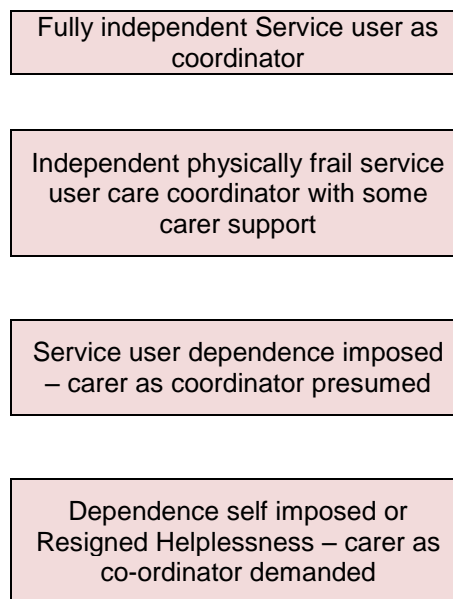
Figure 7: Carer / service user coordination model

Later after further considerable analysis, discussion with study participants, colleagues and service experts such as Chief Executive, Age Concern [name of area] and coding; a dynamic model was developed. This was then translated into the 'service user/ care relationship model' and can be seen in the next chapter. Its presentation to the [name] new Frailty Project provided further discussion as to its value and relevance to practice for the future (Appendix 2).

5. Trustworthiness of data .
This was established through:

- This step by step guide to the analysis and the identifying and giving evidence to the decisions made throughout the process (Creswell & Plano Clark, 2007). Figure 8 'Understanding the whole' is a diagram of the overall process of analysis undertaken.

- Establishing credibility, this was achieved through the use of participant and text quotations within the thesis to verify themes and facilitate the reader's considered opinion about the evidence presented.

- Confirmability was achieved through returning to the participants on four separate occasions i.e. following the pilot study, following process flow mapping, following interim survey results and at the end when the results of the whole were achieved. This ensured that truthfulness of culture, language and understanding of the case and the study groups were accurately gained.

Quantitative Analysis	Qualitative Analysis
Primary data	Documents
	Process descriptions
	In-depth interviews
	Observations

What sense can I make of the whole?

Develop themes (interpretation)

Embed quantitative results into the qualitative

Which Vignettes demonstrate the whole?

Develop Meta Matrix
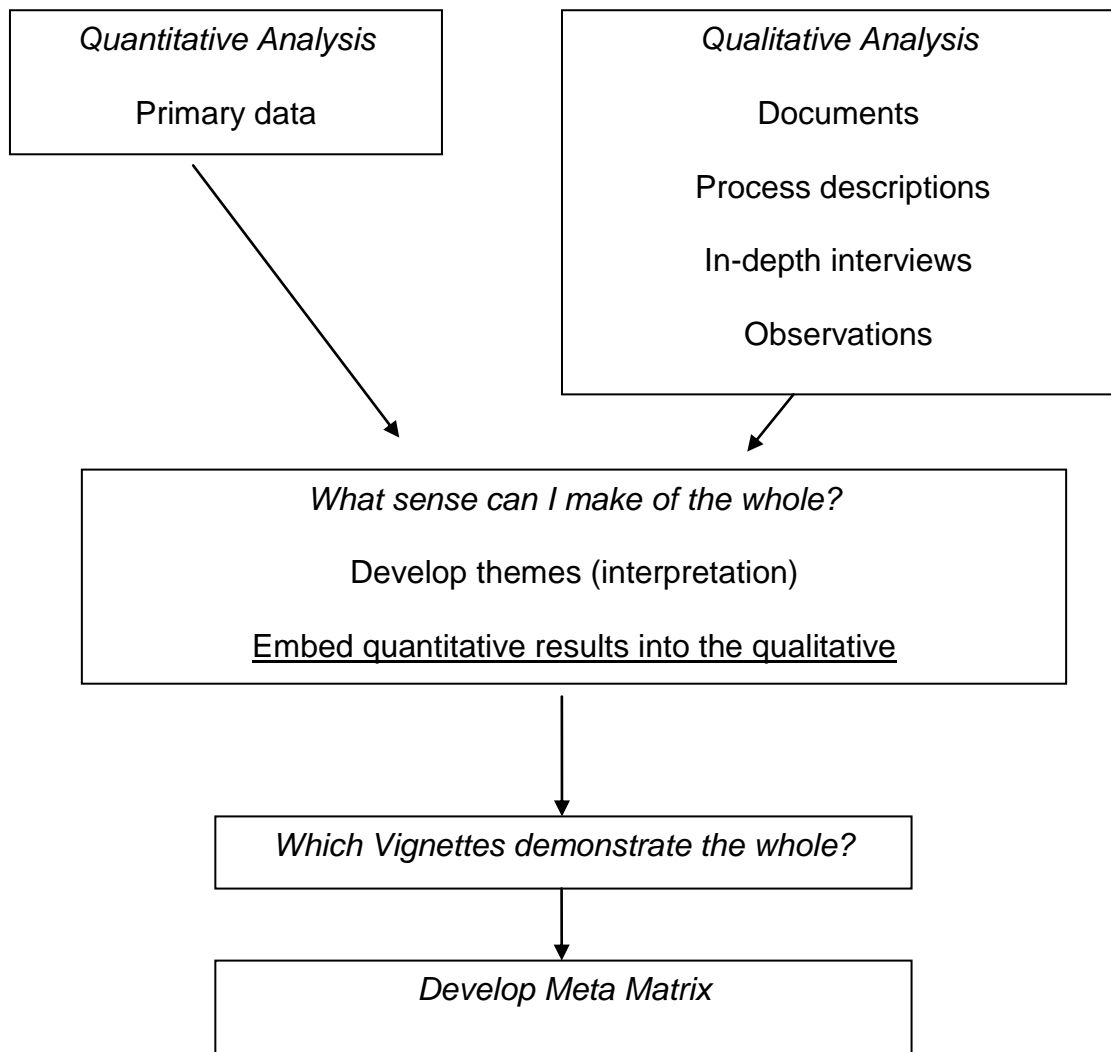
Figure 8: 'Understanding the Whole'.

4.7　　　Merging quantitative and qualitative as a whole

Triangulation is an approach used to 'define accurately the topic of study by using more than one method' (Lukkarinen, 2005) and its purpose is to avoid any error which may be present when using a singular approach to research (Lukkarinen, 2005; Binstock, 1996; Denzin, 1989;). An embedded design requires both qualitative and quantitative data to be merged at some stage, so that the value of the secondary quantitative data can be seen in relation to the primary qualitative data (Creswell & Plano Clark, 2007; Binstock, 1996).

In this research study to affect the understanding of the whole the researcher at first read the written up draft qualitative process and results followed by the quantitative process and results, then merged this information into the themes which had already emerged from the qualitative data.

However, in order to gain further understanding of the results obtained and to ensure that the 'etic' questions were answered, this study utilised a discussion/ meta matrix (Miles & Huberman, 1994; Wendler, 2001; Lukkarinen, 2005; Creswell & Plano Clark, 2007;Carr, 2008). This was used as all data originated from the participants perspective (Holloway & Wheeler, 2002) with the ultimate aim of exploring whether they perceived a difference between integrated health and social care day services and non- integrated health and social care day services and what could be learned from this study?

This approach further facilitated the hermeneutic rule of moving between parts (quantitative and qualitative) of the data to the whole, so that the researcher was given an opportunity to reflect and so grasp again the meaning of the written and unwritten text as perceived by the participants (Fleming et al, 2003). The fourth 'etic' question provided the forum for the discussion chapter.

4.8 Chapter Conclusion

This chapter has defined and discussed the case study method. It has introduced the research study, how it was defined as a single intrinsic case study, and its use of Gadamer's hermeneutics to guide and analyse the qualitative data; with its embedded quantitative element. This was necessary to gain an understanding of the meaning of integrated care. Yin's (2003a) five components of a case study research design were used to illustrate the multi-methods approach adopted. This included the study aim, its propositions, unit of analysis (details of study group, sampling and ethics, the process and procedure, pilot study), analysis (criteria for interpretation i.e. Fleming et al, 2003, development of the results) and how the qualitative and quantitative data merged. The case study method served to apply the whole systems approach which was required to understand the clinical, professional and organisational levels of integration of services, the voice of the service user within it; and ultimately whether there was a difference between integrated and non-integrated services.

The next chapter presents the results in themes to further define the case and answer the questions how and why were integrated and non integrated care services different. The four themes are the study participants, commissioning and decommissioning integrated services, the journey within day services, navigating services and orchestrating care

This chapter has:

- Introduced and defined the intrinsic embedded case study design, Gadamer's hermeneutics which was used to guide and analyse the qualitative data with embedded quantitative element.
- Used Yin's (2003a) five component of a case study to analyse the methods and process used within this case study in order to capture the whole essence of the phenomenon.

Chapter 5 Case Study Results

5.1 Introduction

The aim of this chapter is to understand the intrinsic case and to present the descriptive detail, the data sources and quotations whilst attempting to triangulate the data (Stake, 1995). This chapter presents the results in themes to further define the case and answer the questions how and why were integrated and non integrated care services different. The four themes are the 'Study Participants', 'Commissioning and Decommissioning Integrated Services', the 'Journey within Day Services', 'Navigating Services and Orchestrating Care'. The chapter concludes with the meta matrix whilst answering, what could be learned from this study?

5.2 The Case – further background demography

The case was bound by geography and time and so the demographic information given is that provided by the documentation identified within the study. The 'welsh borough' has a declining population which is also ageing as the working age adults move out of the area. In 2000 the 'welsh borough' had a population of 71,200 people living within the five main towns (BGCBC et al, no date). These towns are linked to some major welsh cities by road and rail systems. In 2001 the resident population was 70,100 (ONS, 2005; BGLHB & BGCBC, 2004). Those people over 80 years of age had increased by 16% over the previous 10 years whilst there had been a reduction of 3% in the total population (ONS, 2005; BGLHB & BGCBC, 2004). Unfortunately the borough did not recover economically from the end of the steel and coal industry in the 1980s and 1990s.

General health within the borough is poor in comparison with the rest of Wales. Approximately, 12.5% of the population are carers (Welsh average 11.7%), with 30% of them providing over 50 hours of unpaid care per week (BGLHB & BGCBC, 2003). All but three wards within the borough fell within the 20% most deprived wards in Wales (BGLHB & BGCBC, 2003).

Twelve thousand people in the borough are aged 65 years and over (17%) and 3000 people are over eighty years of age (5%). The number of people over 80 years of age has increased by 23% whilst the whole population of the borough has decreased by 3%. Whilst nine thousand five hundred and fifty seven (9557) people over the age of sixty years described themselves as having a limiting long term illness in 2001, one hundred and fifty nine per thousand older people over sixty five years of age are assessed by social services per year (1908 people) (132/1000 in Wales) and one hundred and twenty seven people per thousand older people received social services in their own home (1524) (99/1000 in Wales). This is opposed to thirty four people over sixty five years of age per thousand people who were living in residential or nursing home care. Forty five residents of the borough were delayed transfers of care in hospital settings in August 2003(BGLHB & BGCBC, 2003).

5.3   Data Collection

Data collection was undertaken between January 2005 and December 2006. The length of time taken for data collection was due to two reasons:

1. The twenty-five participants who requested to be interviewed as opposed to completing the questionnaire by post. Reasons for the requests included difficulty in holding a pen (Obs.9/RT/dayhospital), problems with eye sight (Obs.8/RT/daycare), not being used to completing forms or bills 'I don't do forms'(Obs.2/Jdc).

2. The introduction of Fair Access to Care (WAG, 2002b) triggered an alteration to the cost of day care from £1 to £20 approximately for some service users which were implemented late 2004. This resulted in a change of client group attending the day care services which were accessed through social services. Some service users chose not to attend due to cost. In order to ensure that the researcher wasn't missing a potential participants group, the non attendees were contacted to confirm reason for non attendance.

The data analysed within this study included:

- Fifty-five historical and service documents including archived records and artefacts
- One hundred and thirty five survey questionnaires with three letters of explanation.
- Twenty five in-depth interviews
- Nine observations
- Twenty –two reflective diary insertions [included post pilot study]

See appendix 15 for a list of data sources analysed.

The results of the case have been presented in such a way as to describe the detail of the services and to demonstrate the differences between the study groups. Therefore the following themes have been presented:

5.4   The Study participants

5.5   Commissioning and Decommissioning Integrated Services

5.5.1 Commissioning Integrated Services- why these services?

      5.5.1.1   Linking strategic systems

      5.5.1.2   Authenticating Judgements

      5.5.1.3   The integrated and non integrated services-operational purpose

5.5.2 Operational service characteristics and levels of integration

      5.5.2.1   Linkages between services

      5.5.2.2   Co-ordinating services

      5.5.2.3   Integrating teams

5.5.3 Decommissioning of Integrated Services

      5.5.3.1   Uneasy allies/ unwanted guests

      5.5.3.2   Informal decommissioning

The journey within day services

5.5.4 Autonomous referral system

5.5.5 Assessment and Review

5.5.6   The experience of care

5.5.7   'The Grey Space'

Navigating services and orchestrating care

5.5.8   Utilising community services

5.5.9   The service user and carer relationship

5.8   What could be learned from this study of integrated and non integrated services? - the meta- matrix.

5.4   The study participants

The mean average age of the participants within this research study was 71 years old. Study group 1 (OP) had the youngest service user (27 years). Study groups 1 and 5 had the oldest service users (101 years). See Table 10 for average age per group. The older age demonstrated in study group 4.

Study Group/ Participants	Mean (SD)	Range in years	Number of participants		
			Phase 1 Questionnaire (SF12v2/LHS)	Phase 2 Questionnaire (SF12v2/LHS)	In-depth Interviews
Study Group 1 (OP)	71.0 (19.98)	27-101	23	23	5	4	4
Study Group 2 (RT)	72.59 (11.51)	46-88	33	35	24	23	6
Study Group 3 (DH)	73.72 (9.86)	54-94	25	25	8	9	4
Study Group 4 (DC)	84.65 (6.47)	69-93	23	25	9	9	5
Study Group 5 (Jdc)	75.22 (14.04)	39-101	26	27	14	15	6
Total			130	135	60	60	25

Table 10: Average age of participants per group in years and number of participants per group

Life expectancy in the 'welsh borough' for males (73 years) and females (79 years) is below the Welsh average (75 years for males and 81 years for females) (HIAT, 2004; 2005). Therefore the participants within study groups

1,2,3 and 5 are below the average life expectancy of the population of the welsh borough and Wales; whilst those in study group 4 are (on average) above the average life expectancy of the population of the 'welsh borough' and Wales. The study questionnaire did not ask participants to identify their sex and so the differentiation between male and female within that aspect of the study cannot be made. However, of thirteen service users interviewed, eleven were female and two were male. Of the eight carers interviewed five were female (one mother, two daughters, one wife and an unrelated family member) and three were male (two sons and one husband). Staff interviewed included six female and one male.

Four hundred and sixty one (n=461) questionnaires were posted to study participants during phase 1 with one hundred and thirty five (n=135) completed questionnaires acquired by post and following survey interviews (34.1% returned). Reasons for non completion included death, fear of losing a place in the outpatient queue whilst engaging in conversation and choosing not to do so (Obs.3/OP, OP). A letter of explanation received by the researcher and written on behalf of a service user demonstrates an inability to complete the form and a potential group of service users who attend these services that are hard to reach and so their voices are unheard.

> *'Thank you for your interest and questionnaire addressed to my husband [name]. He does not have the patience to deal with the ticking, being eighty-three years of age. I therefore return the correspondence so that it may be used elsewhere.'(Participant No. GB310822).*

The numbers of in-depth interviews were larger than expected because some service users found it difficult to sustain a lengthy conversation, memory was at times poor, confusion (Obs.3/OP) or they were at times reluctant to discuss the reality of the experience as they saw it and needed frequent reassurance about my role and confidentiality (Obs.8/RT/dc; Int. 1/service user/RT; Int.2/service user/RT). All ages accessing the study groups had a range of needs which required the assessment or care only available within these services.

5.5 Commissioning and Decommissioning Integrated services

This theme has been subdivided into its two sub-themes that of 'commissioning integrated services- why these services' and 'decommissioning integrated services'. It offers a snapshot of the strategic and operational context within which the integrated services were developed. It offers an understanding of the levels of integration across the study groups during the time of the research study; and how the relationship between the two integrated services was subsequently unofficially decommissioned. It gives some answers for the two 'etic' questions

- How were integrated services different?
- Why integrated services were perceived as different to non integrated services?

5.5.1 Commissioning Integrated Services- why these services?

The chronology of events and key local documents which led to the development and commissioning of the integrated services are outlined in Appendix 16. In this sub theme both contingency and configuration theories are used to understand the rationale for mechanisms used and decisions made to enable vertical knowledge management across meso and micro levels. Contingency theory argues that success is driven by the fit between organisational strategy, its environmental drivers and pressures such as service user needs and other organisational needs. Successful adaptation to fit avoids a 'misfit' which may result in service user dependency (Lawrence & Lorsch, 1967;Donaldson, 2001; Jansen, 2007). In this study the assessment and identification of need at both meso and micro levels are key to enabling that fit, in addition to the role of 'boundary spanning' which only occurred operationally within and across the integrated services. In this context the prevailing theme required to support the development of 'networks of interrelationships' (configuration theory), was 'working together' (Mintzberg, 1989, p96). Tools for integration were needs assessment, unified assessment and 'new flexibilities'.

5.5.1.1   Linking systems- working together (horizontal)

The health and social care systems within this study were bound to work together by Welsh Assembly Government, were linked together by the Needs Assessment and the role of the LHB as health commissioner at the meso level (BGLHB & BGCBC,2003; NAfW, 2001; Lewin, 1993). However, the translation of their strategic direction of working together into an operational context lacked clarity as their commissioning strategies were developed separately. Consequently, as time progressed the Local Authority proposed to develop a separate reablement service in addition to the already operational service included within this study.

In linking both health and social care systems the role of commissioner for these new services fell to the Local Health Board (LHB) as it travelled through its own development from the borough Health Team in 1996 to Local Health Group in 1998 and to the LHB in 2001. They were the key commissioners for health services whilst the Local Authority Social Services Department had responsibility for social care commissioning during the period of this research study. Due to its relatively small population size the Local Health Board was a member of the [name] Secondary Care Commissioning Group for the purpose of commissioning secondary care services.

The Health Social Care and Well Being Strategy was the initial binding document and its implementation structure during the period of the study was coordinated by the Local Health Board and included partners from other statutory and non statutory health and social care organisations (BGLHB & BGCBC, 2004). Managers from study groups 2 (RT) and 5 (Jdc) were members of its Elderly Care group.   The head of provider services in social

services (representing study group 4 - day care) and medical directorate

manager and community general manager (representing study groups 1

(OP) & 3-day hospital)   were also members of this group (GHA & BGCBC,

no date, BGCBC et al (no date) ;BGLHG (2002-2003) (see diagram 3 for

vertical linkages in yellow).
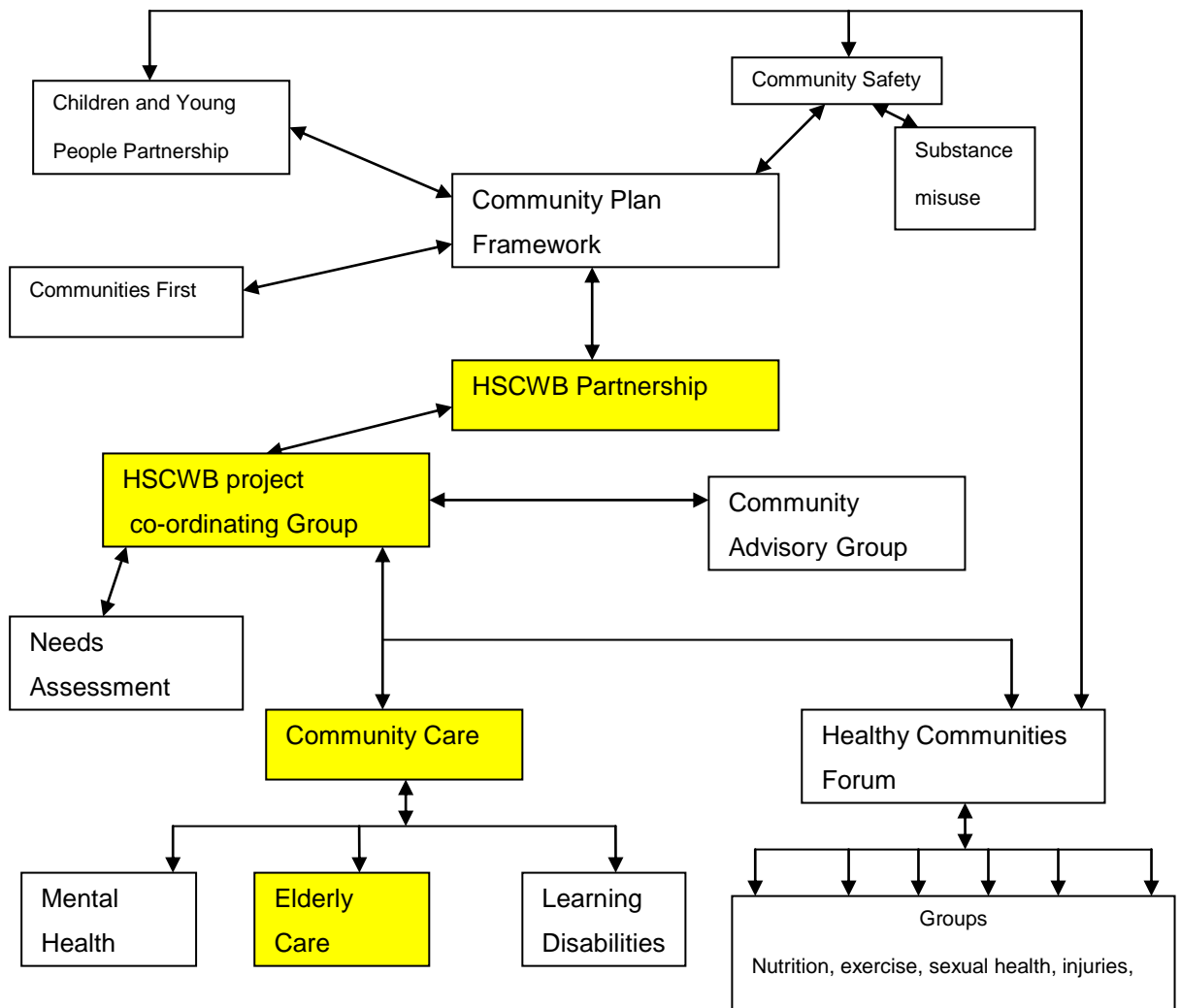
Diagram 3: Health, Social Care and Well Being Strategy Joint Planning Framework (2004)

Key documents developed for the purposes of guiding commissioning were:

- Draft HSCWB plan (BGCBC et al, no date)

- Needs Assessment (BGLHB & BGCBC , 2003) which screened the population and informed the
  - HSCWB Strategy (BGLHB & BGCBC, 2005-2008b) and HSCWB Action Plan (BGLHB & BGCBC, 2005-2008a)
  - Community Plan 2005-2009 (BGCBC, 2005-2009).
  - Commissioning Strategy for older people (BGCBC, 2006))

The Local Authority worked in partnership with the LHB to develop the first four documents but had a separate Commissioning Strategy for older People which was published in 2006. The HSCWB plan achieved its priorities within the NHS through the Service and Financial Framework (SaFF) process which involved the LHB reviewing the provider organisations proposed Annual Service and Commissioning Plan (ASCP) service developments. The Intermediate Care Strategy for the 'welsh borough' had not been written during the period of this research study but was being written by the LHB during the writing up phase of the study in 2009.

The Needs Assessment (BGLHB & BGCBC et al, 2003) was written after the Draft HSCWB plan (BGCBC et al, no date) and both informed the development of the integrated services. It acknowledged the need for *'permanent 'intermediate care' services for people who do not, or no longer need, to be in a District General hospital' …… 'intensive rehabilitation services to improve independence, confidence and strength in older people who have been ill'* (BGLHB & BGCBC, 2005-2008b, p7). The two service aspects of need identified in this document for intermediate care services are in relation to aiding hospital discharge following an acute crisis and improving individual independence, confidence and strength after a period of ill-health, through rehabilitation.

The Draft HSCWB plan (BGCBC et al, no date) definition of service for older people in the locality was *'The service area for older people exists to serve and provide services to vulnerable people who have attained the age of 65 years.'* (BGCBC et al, 2002/2007). This service focussed definition is not included in the draft Action Plan (BGLHB & BGCBC et al, 2005-2008a)

where the emphasis has moved from vulnerable people to encouraging a healthy lifestyle (swimming) (p14), accessible advocacy services (p16), raising awareness of the NSF for Older People and the Older People's Strategy (p68).

The strategic themes and priority aims relevant to older people their carers and intermediate care services can be seen in table 11. Although this is a joint health and social care Action Plan four out of six of the themes and aims relevant to this case study in the context of 'intermediate care' and the role of the carer, have a disease, a 'condition' or acute service perspective rather than an individual need or problem focus.

Strategic Theme and Priority Aim
Strategic theme: Listening to the voices of people and their carers   **Priority Aim:** Involve service users and carers in decision-making processes, including the management of **their conditions**
Strategic Theme: Targeting and modernising services to raise standards and meet local needs   **Priority Aim:** Develop **intermediate care** services to reduce reliance on **hospital admission** and provide joined-up services for people.
Strategic theme: Individuals living as independently as possible and placed at the centre of services   **Priority aim:** Achieve a person centred approach, through the development of a Unified Assessment and Care Management framework
Strategic Theme: Individuals living as independently as possible and placed at the centre of services   **Priority aim:** Promote independence and choice by providing and developing services that enable people with **specific conditions** to be cared for at home, or in other appropriate settings.
Strategic Theme: Individuals living as independently as possible and placed at the centre of services   **Priority Aim**: Reduce the numbers **of patients experiencing delays** in transferring between care settings
Strategic Theme: Equality, with everyone having the same right to services and opportunities   **Priority Aim:** Review the impact of this Strategy on all from an equalities and health impact perspective.

Table 11: HSCWB Action Plan Strategic themes and Priority aims relevant to this study

Key actions and milestones to achieve these themes and aims were through developing services and joint training e.g. intermediate care beds within residential care settings, integrated community services and facilities, home care toileting service, specialist assessment teams, rapid access clinics, supportive equipment and technologies, integrated injury prevention and falls management programme, flexible patterns of homecare including 'roaming homecare' and reablement (BGLHB & BGCBC, 2005-2008a, p 30, 32, 33, 53, 57, 59). The provision of adult day care is not considered within this Action Plan. The vehicle for joint or integrated services was seen as the standardised framework for sharing information in Wales i.e. the unified assessment process (WAG, 2002b).

The welsh borough Community Plan (BGCBC, 2005-2009) 'health, social care and wellbeing' section has the theme of *'working together to improve the health and wellbeing of all people living and working in the welsh borough'*. Its monitoring body is the HSCWB strategy board. Its key projects are unified assessment processes, reduce delayed transfers of care, support independent living and recruit and retain health and social care staff (BGCBC, 2005-2009).

The Commissioning Strategy for older people (BGCBC, 2006) has a vision of *'caring with people instead of caring for people'* through *'maximising independence, minimising dependence and intervene where appropriate'* (p4). It was *'fully integrated with the Community Plan and the HSCWB strategy and evolving joint commissioning strategies with health partners'* (BGCBC, 2006, p2), which included 'day opportunities and intermediate care priorities. The seven service priorities are:

1. Long term Care (residential care)
2. Domiciliary Care (promote independence through reablement programmes)

One of the commissioning intentions for this priority is to *'Develop a reablement service, estimated costs of £65k' (p8).*

3. Day opportunities (Generic and specialist day opportunities)

The day opportunities are sub divided into generic and specialist services, the former to be developed in partnership with lifelong learning and leisure whilst the latter to be developed in partnership with health, with the aim of working with individuals to restore their independent living.

'The directorate wishes, with health, to undertake a comprehensive re-design of the current day care provided by both agencies, focussed on rehabilitative support and day respite.'(p9)

4. Assistive technology (alarms etc)
5. Direct Payments (budget allocation)
6. Housing (retirement village)
7. Intermediate Care (special care centres for people with complex needs to avoid hospital admission and institutional care)

Reablement, day centres (opportunities) and intermediate care, are all considered as separate services within this strategy. The Unified Assessment Process is not considered within this document.

5.5.1.2 'Authenticating judgements- integrated services'

The judgements made by the project manager and team throughout the commissioning process of the 'integrated services' were authenticated through service user expressed need, expert acknowledgement of the service response, peer and management agreement and participation of the service development and public recognition of a job well done. [See Appendix 15, 16; see chapter 4 table 5 for staff working within the reablement team]. A key tool in this knowledge management both vertically and horizontally across services and agencies were the Manager Monthly Report (CRP, 2001-2003; Anon, no date). These gave evidence of active operational 'boundary spanning' across professions and agencies practiced by the manager and members of the team on a daily basis in response to the expressed need. The judgements made included:

- Project management structure and membership (CRP, 2001-2003a; BGLHB, 1999-2003).
  - Agreeing a suitable method of obtaining information on service user satisfaction and its step by step approach including guidelines for interview, pilot and information included in final report (BGLHG et al, 1999a; BGLHB, 1999-2003).
  - The choice of models, operational policies to fit and business case including method of weighting (BGLHB, 1999-2003; BGLHG et al, 1999b)
  - Implementation plan and exit strategy (CRP, 2001-2003a; BGLHB, 1999-2003)
  - Development of project evaluation and choice of tools used (Upton, 2003; CRP, 2001-2003a;CRP, 1999-2004)
  - Referrer and customer satisfaction surveys (Upton, 2003; BGLHB, 1999-2003; CRP, 2001-2003a)
  - Marketing RT and JDC (CRP, 2001-2003a;BGCBC, 2001-2003; BGLHB, 1999-2003).
  - Integrating day hospital and day centre to create the joint day care facility (CRP, 2001-2003a; BGLHB, 1999-2003; BGSS, 2003-2004)

- Operational Team
  - Operational team membership, job descriptions, methods of interviewing and appointing team members, base for pilot project and post pilot team, 12 hour shift and rota systems for re-ablement officers, management rotas and professional/medical cover (out of hours) (CRP, 2001; CRP, 2001-2003a)
  - Operational processes and decision trees e.g. discharge planning from hospital to RT, communication processes, referral processes across agencies and professional groups outside of the team, client diseased on arrival at house (CRP, 2001-2003a; GHCT, 2001)

187

- o Development and implementation of joint documentation (CRP, 2001-2003a)
- o Choice of units and additional learning for Reablement Officers NVQ level 3 training (CRP, 2001-2003a; CRP, 2001-2003ab; CRP, 2001b)
- o Development of recreational therapy assistant role in joint day care facility 2003-4 (Anon, 2003-2004; CRP, 2001-2003ab)

The RT and Joint day care were products of a perspective that traditional concepts such as day hospital and day centre were not meeting the needs of the older people (BGLHG et al, 1999). These perspectives were based on noteworthy pieces of work undertaken either separately or jointly by health and social care between the period of 1996 and 2002 which considered individual service user need, evidence of good practice and current policy (Wallace & Lane, 2002; BGLHG et al, 1999; BGCBC, 1997-2000;O'Leary, 1999;GHCT, 1999-2001). The history and significance of the reviews underpin the operational and business planning documentation throughout that period and that which followed in 2002-2004 (appendix 16).

Service user need was initially expressed in the 1996 review [undertaken by a social worker and a nurse] which assessed patients attending the original day hospital within the 'welsh borough' and service users attending 'another day centre' using a Barthel Index (Mahoney & Barthel, 1965) (Appendix 10 Tool Grid, No29) and description of individual social networks. The review identified two issues:
1. An overlap of provision for this client/service user group
2. Several groups of clients/service users had health and /or social care needs which were unmet.

This was an early attempt to undertake configuration learning and so create service user intelligent services (Srai & Gregory, 2008; Engestrom, 2004).

A catalyst for the development of further work undertaken came in the form of the Director of Public Health Report in 1998 (GHA, 1998) which highlighted that the major health problems experienced were due to an

ageing population, socio-economic deprivation, the legacy of industrialisation and smoking. Subsequently, in 1999 the 'Report on Service User Satisfaction Survey for Day Care Facilities' (BGLHG et al, 1999, p12) considered admission and referral, communication, transport, staff and environment and services available. Participants included those people who attended day hospital and the two day centres that provided adult day care within the borough.

The service users in 1999 wanted to have a clear idea as to why they had been referred to the services, accessing day hospital using hospital transport *'being last on the list means you have to wait a long time'*, that was up to 1.5 hours (p12); continuity of care *'you never see the same person twice'*(p13); service users in 'another day centre' would have liked access to a GP, a registered nurse, chiropodist, patients at the day hospital would have liked more keep fit and activities, service users at 'another day centre' would have liked *'some way to use hands'* and exercise (p13). The service user attendance in the project team meetings (see figure 9) also ensured that service user need was expressed.

During this experience the role and needs of the carer were expressed as an essential component which needed to be included within the new developing operational policy and was subsequently included in the business case. After which, Age Concern became an integral partner of the 'core implementation group' delivering carer support during the pilot project (Anon, no date; CRP, 2001-2003a). After public consultation (in the form of 'road shows' e.g. outside the local supermarket) agreement on the 1999 model and confirmation of need to be developed was obtained. In 2000 a service user opinion poll asking whether they had any objections to a joint day care facility being introduced to the day centre demonstrated that 66% expressed an opinion that it would be very useful, that it would be a good idea and would have no objections.

Peer agreement and participation of the developing new services came in the form of practitioner attendance, discussion (noted in minutes) and action

plan agreement to the project meetings throughout the four years of planning and operational development. The structure was inclusive of statutory, non statutory organisations and a service user. The sub groups had specific roles to play i.e. the multi-professional group's role was to develop the operational policy and business case with optional models, whilst the multi-agency group's role was to develop and undertake a user friendly satisfaction tool, to share and disseminate examples of good practice and 'to act as a forum for the voice of the service user and carer' (BGLHG et al, 1999).

Steering Group

Local Health Group/board general manager (chair), NHS Trust (senior manager medical directorate, Consultant Geriatrician), Social Services Dept. (Director and Heads of Service), GP representative. RT /Jdc operational team membership from 2001 onwards. Served by Development Officer

[Each member represented an organisation and fed progress and decisions made to their respective management teams]

Multi- Professional Sub –Group

 Speech and Language therapy, Occupational therapy SSD, Occupational Therapy Trust, Team Manager Social Work SSD, Manager another day centre SSD, Chief Dietician, Senior Staff Nurse Day Hospital, Principal Officer Home Care & Day Services SSD, Senior Practitioner Social Work SSD, Senior practitioner OT SSD, Senior Practitioner SSD, Development Officer (Chair)

Multi-Agency Sub –Group

Principal Officer Home Care & Day Services SSD, Manager another day centre SSD, Day Service Client, Senior Staff Nurse Day Hospital, Representative Age Concern, Chairman Community Health Council, Representative Crossroads, Senior Nurse (Quality) Health Authority, Development Officer (Chair)

Figure 9: 1999- 2001 membership (GHCT, 1999-2001)

Funding for the agreed joint day care pilot (i.e. RT with Joint day care) was secured for 18 months in early 2001 by the Local Health Group and the pilot commenced in August 2001. A pooled budget of £520k for the 18 month pilot was managed by them (Health Act 1999, s31; NHS Wales Act 2006 s33; NHS Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2004).

The joint project manager was appointed by all three services but accountable to the LHB general manager. However, the project manager each month had to sign confirmation that the financial movements for the project between SSD, the Trust and the LHB were the same (Wallace, 2001, Wallace, 2002-2004). This demonstrated that even though a tool for integration was used to secure financial commitment this did not necessarily lead to operational trust. See Fig 10 for the revised project structure utilised from April 2001 onwards.

Steering Group
General Manager LHG
General Manager BGB (Trust)
Director Social Services
Consultant Geriatrician

Project Assurance
UWIC evaluation, Queens Nursing Institute (Award for Innovative & Creative Practice)

Project Manager

Project Support
4 Sub Group
1. Multi-Professional
2. Education & training
3. Personnel
4. Information/evaluation
5. Core Implementation Group

Project Team

Figure 10: Project structure 2001 onwards

A referrer satisfaction survey later in 2002 was extended to all medical, surgical/ orthopaedic wards in the local DGH and all health and social care

professionals working within the locality. The majority of referrers were satisfied with the RT with comments such as *'the success I have noticed is largely contributed to the intensity with which your team can work and the flexibility that you can offer'* (CRP, 2001-2003a). An area of improvement identified was feedback information on clients' progress and decisions made following referral to the team.

Expert acknowledgement was received through the Queens Nursing Institute Award for Innovative and Creative Practice (QNI) in 2001, the formal evaluation reported by UWIC in 2003, and the Community Hospital Association Highly Commended award (CHA) in 2003. The former paid for the project evaluation and pilot of hand held personal computers to undertake assessment at home. The latter commended the partnership and collaborative arrangements which had led to the development of the Joint day care facility (BGLHB,1999-2003; BGSS, 2003-2004; Upton, 2003)

Public consultation and recognition of a job well done is evident in the interest taken by visits and letters of communication received from members of the public, the public consultation at the local supermarkets to the development of the RT and Jdc (BGLHB, 1999-2003). Key local and national politicians visited the RT and Joint day care for example the HM Lord-Lieutenant, Nationally Assembly Member, chairman of the NHS Trust and health authority, county borough councillors. Many of these visits were recorded in local and national newspapers such as Western Mail, local [name] Gazette and nearby town Chronicle. Letters of enquiry and congratulations on the work undertaken were also received from the Director of NHS Wales and Director of Nursing (NHS Trust). Members of the public having experienced both the RT and the JDC sent letter of thanks. The following excerpt from a letter demonstrated the value that service users placed on the acts of humanity that they experienced when interacting with the people who ran and attended the services.

> *'I'm writing to express my gratitude to all staff concerned, for the wonderful attention, courtesy and kindness I received. I looked forward very much to the daily visits I had. I really enjoyed my visits to [name of Jdc], and looked forward so*

much to the day out, as meeting different people and chatting to them was so uplifting, I must add how much I enjoyed the meals also'(Letter 30/04/2002 in RT, 2000-2004).

5.5.1.3   The integrated and non integrated services- operational *purpose*

'*permanent 'intermediate care' services for people who do not, or no longer need, to be in a District General hospital' …… 'intensive rehabilitation services to improve independence, confidence and strength in older people who have been ill'* (BGLHB & BGCBC , 2005-2008b, p87).

This theme has been subdivided into the study groups to demonstrate some distinct differences and similarities of the services operational purpose as perceived by the operational policy and the three participant groups i.e. the staff, the service users and carers. Although not all study groups had written operational policies, the service users and their carers were clear as to why they were using them. The vertical link between strategic purpose and operational purpose cannot be made in all study groups (see table 12).

Study group	Operational policy	Staff, Service user and carer perception of purpose	Venue for service delivery	Staff employing agency	Reference
Study Group 1 Outpatients	None	Medical assessment Diagnosis Treatment Monitoring condition and participant skills	Outpatient department DGH/Community Hospital	NHS	Int.25/OP/Staff;
Study group 2 Reablement team	Yes Functional training MDT assessment Working with carers	'Promoting and maintaining independence' Assessment /joint assessment Functional training & adaptation Supporting carers through building rapport Whole system discharge	Service User's own home	NHS plus 2 seconded reablement officers from SSD	Wallace & Lane, 2002; BGLHG et al, 1999
Study group 3 Day Hospital	None	'Promoting independence' through dignity and control 'Whole picture' Assessments Diagnosis/confirmation Problem solving	Day hospital within Community hospital	NHS	Int.23/dayhospital/staff
Study Group 4 Day Care	None	Reduce Social Isolation Respite for carers Avoid depression Personal hygiene Relieve loneliness and anxiety	Unit within local authority residential care setting	SSD	(BGCBC, (2001/--2003
Study Group 5 Joint day care (jdc)	None	Promote independence Prevent hospital admission Improve quality of life through activities and community integration Reduce Social isolation Provide information /communication centre Regular and reliable respite and care	Unit within CBC Community Leisure facility	SSD	Int.12/Jdc/staff, Int.17/Jdc/staff

Table 12: Operational differences and similarities between study groups 1-5

Study Group 1-Outpatients

No operational policy was available for use at the point of data collection or during the writing up phase of the study. Staff, service user and carers shared similar understandings as to the purpose of the outpatient appointment but the number of uncoordinated appointments had an associated personal cost for the service user. Staff perceived the purpose of the outpatient appointment as a service user opportunity to see the consultant's team for assessment, diagnosis and treatment (Int.25/OP/Staff). A service user purpose was to monitor her disease and to ensure that she

was able to administer the medication safely and competently (Int.19/OP/service user). The Carers purpose was 'seeing a specialist' or a nurse to ensure that the relative was as well as could be expected and to solve any problems, to monitor skills and medication.

> *'I go for a check up, to see how I'm getting on. It's my breathing it is and I can't walk very far. They check on my breathing. I go every six weeks'* (Int.19/OP/service user).

Both service users lived independently and attended a number of outpatient appointments (not necessarily with the same consultant or at the same hospital) and GP clinics to maintain their health (Int.18/OP/service user; Int.19/OP/service user). During one interview the service user explained that she had three appointments during that week, one with the GP about a new problem, a consultant appointment in the local DGH and a day surgery appointment in a tertiary centre (Int.19/OP/service user).

Study group 2-Reablement team

This study group had an operational policy and statement of purpose with objectives which was linked to the needs assessment (BGLHB & BGCBC, 2003), HSCWB Strategy (BGLHB & BGCBC , 2005-2008a) and Action Plan (BGLHB & BGCBC, 2005-2008b). The policy and statement of purpose advocated a multiagency and multi-disciplinary approach to service assessment and provision which identified the needs of the service user whilst recognising the role of the carer. This was developed in 2001 with the intention of promoting service user independence at home. Assessment, communication and governance were key words in its four objectives.

> *'service strives to promote, maintain and improve client function and independence through assessment, investigation, time-limited treatment and rehabilitation of people over the age of 65 years as appropriate. It will support the client in his/her aim to remain at home for as long as both client and carer wish whilst maintaining dignity, confidentiality and individuality. This will be achieved within a time limited multidisciplinary and cross professional*

approach in the client's own home and through the use of health and social care facilities as appropriate' (BGLHG et al, 1999; Wallace & Lane, 2002. p3).

When asked about the purpose or role of the RT, the staff perceived this as 'to promote and maintain independence' (Int.4/RT/Staff; Int.3/RT/Staff). They saw this as different to other services within the borough. RT involved assessment including joint assessment, the achievement of service user goals and choice. Although predominantly focussed around hospital discharge the staff worked with service users referred from home by social services and the adaptation of circumstances after a life event. They felt that they had difficulty in expressing their purpose to hospital and General Practice staff. The concept of understanding that the team managed the whole of the discharge was a particular problem with hospital staff. The whole discharge would include e.g. ensuring that the service user had a meal, cup of tea and were able to cope at home in that first 24 hours, take a letter to the doctor and sort out any problems with e.g. equipment, medication.

The service users saw the purpose of the service as giving training on how to live independently at home and at times taking over from relatives after a hospital discharge. Tasks included emptying the commode, getting ready for bed, showering, cooking, providing meals, building confidence and changing wounds dressings. The intense nature of the support, the MDT involvement, its flexibility and the speed of attention and service delivery was positively acknowledged.

> *'They started off calling to do the commode and they'd make me a coffee and then they'd come at half past three; and help me get ready for bed. I don't know when the physio started. The nurse was coming regularly to dress the wound and from what they told me they came for three months and then handed over to the district nurses team..'*(Int.2/RT/Service user)

The carer (warden in sheltered accommodation) had frequently seen service users returning from hospital with or without RT support. RT liaised with the

warden, ensuring that they could cope with activities of daily living within the flat and getting their medication.

> *'the reablement team are excellent at looking at their circumstances and if there's any help that they need… Are they able to make themselves a cup of tea? Are they able to get around their flat? Do they need any aids? If they can access all that...so it enables a resident to live back in their own flat which is an excellent idea because people, unless they're unable to say that they're unable to live here..this is their home'*(Int.6/RT/carer*).*

Often the carer had witnessed that the RT were waiting for the service user to arrive from hospital. The carer felt included as she 'built a rapport' with the members of the team who visited. The carer compared this with other experiences she'd had when service users were discharged home; when she wasn't expecting them, the service user didn't have a key, milk or bread. On one occasion she had to ask the ambulance crew to return the service user to hospital as she felt that *'she wasn't well enough to be discharged'* (Int.6/RT/carer*).*

Study Group 3- Day Hospital

There wasn't an operational policy available for use at the point of data collection or during the writing up phase of the study. The staff saw their purpose as promoting independence through trying to return some lost dignity to the service user.

> *'We're about enabling the patient to be as independent as possible you see. There isn't a written philosophy but we try to give the patient back control over their own lives'* (Int.23/dayhospital/staff*).*

In order to '*see the whole picture'* it was necessary to refer the service user to other members of the multidisciplinary team such as the occupational therapist, the physiotherapist (who were based at the day hospital), the social worker or 'care and repair'. They did not refer service users to the local reablement team (Int.23/dayhospital/staff).

The service users used the day hospital to attain assessments, diagnosis and information (Obs.1/dayhospital; Int.22/dayhospital/service user/carer; Int.21/dayhospital/service user; Wallace, 2002). They already 'knew' what was wrong either through a previous discussion with a GP or consultant which highlighted possibilities or through self diagnosis via the internet. However, they needed professional confirmation of the diagnosis and like the carers wanted some solutions or guidance in order to understand and live with the disease.

> *'That's all we ask is to understand why things are happening and what we can do to help live with the Parkinson's'* (Int.22/dayhospital/service user/carer).

Study group 4- Day Care

The Day Care unit did not have a statement of purpose or operational policy of its own (BGCBC, (2001-2003). Staff perceived that all the service users attended the day centre for socialization and some for a bath. (Int.10/ daycare/staff). The service users saw the day centre as a way of avoiding depression and social isolation. Respite from '*been in the house continual'* (Int.9/daycare/service user) or '*just facing the walls'* (Int.8/daycare/service user). They were aware that it also provided respite for their families. Carers valued the opportunity for '*a break from being a carer'*, being able to have breakfast and get dressed at a leisurely pace, watch breakfast T.V or spend time with a loved one such as a partner.

> *'That's time when I don't have to think about my mother'* (Int.7/daycare/carer).

It was equally important that the visits to the day centre met the service user's need in respect of loneliness and associated anxiety when alone.

> *'My mother's just one of those people that wants to be with somebody all the time'* (Int.7/daycare/carer).

198

Study group 5-Joint day care (jdc)

The joint day care statement of purpose referred to its previous existence as a social services day care unit. It states that it:

> '*provides quality day care, for high dependency service users in a safe environment. ……. is committed to supporting service users, families and carers towards greater independence to provide a service that is responsive to their needs and choice'* (Wallace & Lane, 2002, p3).

Staff interpreted the unit aim as *'To promote independence and improve quality of life'* (Int.12/Jdc/staff) and to *'prevent admission to hospital'* (Int.17/Jdc/staff). This is achieved through being 'welcoming' and 'being friendly', providing activities such as art and exercise, 'informal assessment', introducing adult education and providing opportunities to go out into the community and outside the home and centre whenever possible, building confidence (Int.12/Jdc/staff).

The service users perceived the jdc as an opportunity to feel valued as a person by their fellow service users. It was a rare opportunity to have close relationships with people their own age. It satisfied a need to express feelings about their lives with those they could trust, who could understand their situation. They sat with one another talking about the events that had happened throughout the previous week such as their relationships with their children, grandchildren and sometimes neighbours, comparing experiences and illnesses, they acquired information from visiting individuals such as the police, benefits agency, undertook activities such as exercise to music and craftwork (Obs.4/Jdc/Daycare; Int.13/Jdc/serviceuser/carer; Int.14/Jdc/ service user; Int.16/Jdc/service user/carer). Sitting and sharing a meal with someone was important because they often ate by themselves. One participant described the unit as

> '*A communication centre! Everybody have got a different view on things and disability. There's people out there that are quite embarrassed cos they've got, shall we're say*

they're incontinent, and things like that, you know?'
(Int.13/Jdc/service user/carer).

Other service users used the opportunity to promote the sharing of information about their disability with fellow service users and the officers in the unit. They felt useful by doing so. They'd learnt to use a computer and surf the net at the unit, skills that they were also able to use at home with the family (Int.14/JDC/service user; Int.16/JDC/service user/carer).

They trusted the day service staff with intimate and private needs such as toileting. They felt that the staff knew them individually well enough to help them with prompting for toileting, getting them on and off the toilet, cleaning and changing clothes if they became incontinent. Something they were only comfortable to share with people they trusted to do the tasks promptly with the least embarrassment. and would not consider going to another facility because of that need(Int.13/JDC/carer/service user; Int.14/JDC/service user; Int.16/JDC/service user/carer; Int.15/JDC/service user).

It was also an opportunity to escape the home avoiding isolation '*those four walls'*, where they get the opportunity to participate in individual and community activities. Activities that they once took for granted such as shopping, eating in a restaurant and swimming. Its importance to the service user is seen with the phrase '*we get freedom'* the freedom from being at home and the people with whom they lived (Int.13/JDC/carer/service user; Int.14/JDC/service user; Int.16/JDC/service user/carer).

The JDC offered a constant and reliable opportunity for a carer who was working. She could rely on the bus arriving on time in the morning at the same time. This meant that she could go to work without relying on someone else to come into the home (Int.13/JDC/carer/service user). Another carer found this essential for completing domestic tasks like shopping in the week without having to ask or rely on other extended family members (on the weekend) who were working in the week.

It also provided a desperately expressed opportunity for a carer to rest after nights of disturbed sleep when caring for a relative who had profound physical disabilities. One carer often had to get up in the night to help his mum move a leg, with limited movement due to a 'stroke'. Even though they'd purchased a reclining chair to sleep in, so that mum could move positions herself, she often needed her son to help her move or stand at night.

> *'It must be very difficult for her to get comfortable. We take that for granted and its easy if you're mobile you can move and get comfortable any time… but if you can't stand up!'(carer shaking his head)*(Int.16/JDC/service user/carer).

Summary

This sub-theme has included 'authenticating judgments', 'linking systems-working together' and 'operational purposes'. The difference between services can be seen in their operational purpose and in the theme of 'working together'. The systems were linked together through the development of a strategic network and documents. Tools for integration included needs assessment, and new flexibilities. In this study the identification of need at both meso and micro levels played a key role in enabling the fit between the integrated and non integrated services and the people who use the services. However, services were commissioned separately and with exception to the integrated services did not demonstrate an operational purpose of working together across agencies. Not all services were vertically linked to the strategic aim as defined by the needs assessment, the missing tool here may be interpreted as the operational policy which was only evident within integrated services.

5.5.2 Operational Service Characteristics and Levels of integration

The study groups within this study provide non urgent, routine and planned care for their service users. RT (Study Group 2) also provided a more urgent and appropriate form of care for service users who had functional problems

and would otherwise require admission to hospital or a care home. This could be as a result of falling, 'going off their feet', unable to cope at home.

The period of time the study groups provide this care can vary from a single outpatient appointment to several years of care provided within study group 4 and 5 (Day care and JDC). Study group 2 and 3 (RT and Day hospital) varied from a few days to approximately 15 weeks. The characteristics of all services can be seen in table 13. These characteristics have been grouped into the following levels of integration as defined by Leutz (1999; 2005).

5.5.2.1   Linkages

Linkages are characterised by the stable, mild to moderate nature of the service user need and the response of the service to meet those needs (Leutz, 1999; 2005). This will include separate assessors, documentation and assessors sharing information informally. Study Groups 1 (OP) and 4 (day care) are service examples of linkages.

Study Group 1 (OP) provided specialist comprehensive geriatric assessment, diagnosis, review and feedback to the referrer (PF1/OP; Int.25/OP/Staff). The referrals were filtered by a process within the consultant office and medical records. This uni-professional consultant team provided geriatric assessment, treatment and diagnosis utilising xray, haematology etc in different locations. Further treatment is reliant on his clinical knowledge, clinical network and knowledge of the health and social care systems within which he works. This is provided by a formal written referral process (to another professional such as physiotherapist or another consultant) based upon the service users presenting need within the consultation (Obs.3/OP);Int.25/OP/Staff).

The consultant had extensive clinical networks across the health organisation and strategic networks across statutory and non statutory organisations within the area (Int.25/OP/Staff). The formal sharing of information within the consultant team was via the medical record, referrals

and GP letters (PF1/OP; Obs.3/OP). Although this didn't mean that the service user experience was continuous care.

> *'I went on Monday and they'll send for me again in a few weeks to go again. I go every six weeks or so. I don't see the same ones every time I go mind'(Int.25/OP/Staff).*

Study Group 4 (day care) staff were working towards NVQ level 2 whilst the manager of the day centre had a Diploma in Management NVQ L5 (Int.10/daycare/staff; BGCBC, 2001-2003). The centre referrals and reviews were formally provided by the social worker who was not co-located (PF4/daycare; Int.10/daycare/staff). If the service user needed medical attention whilst at the centre then staff called the local district nurse team or suggested that the service user visited the GP. If the staff were at all concerned about the service user then they contacted the social worker (Int.10/daycare/staff). These were the only staff contacts apart from occasional contact with a family member (Int.10/daycare/staff). They relied on the social worker to discuss transport arrangements with the service user and family. Following which the social worker would inform them as to whether they were required to pick up the service user with day centre transport (Int.10/daycare/staff). The service did not utilise community resources outside of the centre.

> *'The social workers are more involved with the care plans than we are, we're at the end of it really. If they see someone needs somewhere to go on a daily basis then they'll get in touch with us, but we don't actually deal with them direct. We get a copy of the care plan. So we get an idea of who's coming in' (Int.10/daycare/staff).*

5.5.2.2   Co-ordinating services

Coordination is the sequencing of care from different systems or sub-systems in an organised and formal manner. Study group 3 (day hospital) and 5 (JDC) show some aspects of coordinating services. The day hospital has a multidisciplinary team which works together within it, although

members of the team are managed separately and have separate support workers with different roles and titles. The multidisciplinary team use the medical notes as a focal point of communication and sharing information about the service user. The day hospital sister manages and coordinates the operation of the day hospital i.e. getting people to and from the venue, gathering information, assessments and treatment plans undertaken by the individual professionals (Wallace, 2002; PF3/dayhospital). The nursing sister reinforces instruction and explanation of treatment and care to the service user.

Study Group 5 (JDC) uses a key worker system to ensure that service users have aims and objectives are met. They coordinate two different services within the building i.e. service users who utilise social day care and those who access Community Reablement and day care. All service users have access to the registrar or consultant through the RT nurse and can be reviewed by them. The JDC manager can ask for an individual to be reviewed by the nursing and medical team. The JDC organise transport for all the service users either their own through social services or utilise ambulance control to bring in service users who are unable to use the social services transport due to a physical dependency e.g. use of oxygen (Int.3/RT/Staff; PF5/JDC). Although the staff still describe themselves as being on 'sides' and the difference between health and social care as 'totally different'.

> *'We (obviously from reablement) we're actually from the nursing part of it, the medical side, so if the doctor wants to see anybody actually we can bring them into the day unit to be seen, its to be reviewed for medication, so they need some nursing intervention and of course there's a bit of respite if they have a carer and things at home. And from a social service point of view we have an OT and physio down there to look at whether the clients from a social service unit should be still going there, whether they would be beneficial for luncheon clubs, if they don't meet the high dependency criteria, because their criteria is from a social services perspective. Its totally different from a health perspective their criteria is, if they need anything done for them they have a dependency whereas from a health perspective the*

*dependency has to be a lot more higher than what they
would be to access a day hospital than they would be to
access a day service because the two are combined within
the day care unit also the clients go to the day care unit
from the social care perspective, they can access the doctor
as well'(Int.3/RT/Staff).*

5.5.2.3   Integrating teams

Full integration occurs where there are 'pooled' resources. Study Group 2
(RT) were identified by both service users and staff as having some
characteristics of an integrated team. The integration occurs with the co-
located multidisciplinary team members of the team i.e. the occupational
therapist, physiotherapists, nurses, reablement officers. Certain members of
the team practice a 'generic' or 'transdisciplinary' assessment i.e. either OT
or physiotherapist could undertake the assessment where the individual roles
are not always clear as they share expertise and maximise the use of their
expert resources (Robnett & Chop, 2010). Joint decision making resulted in
the treatment/careplan. Service user own goals and outcomes were used
which staff believed promoted independence, individual choice, satisfaction
and enhanced staff morale (Int.3/RT/Staff; Int.4/ RT/Staff; Int.5/RT/Staff;
PF2/RT).

*'a strong integrated team of professionals and non-
professionals. Crossing boundaries of working… well and
we're developing the way of working where I (physio) can
do what a traditional OT role or vice versa we're integrating
that way so not the separate role of that's the OT's job and
that's the physios job but that's the teams role… we do the
same multidisciplinary assessments and agree for the best
way forward for that client and so if an expertise for that
client is needed then we'll step in' (Int.5/RT/Staff)*

The development of generic working originated with the reablement officers.
These are support workers (NVQ level 3 minimum) and support the roles of
the   registered   professionals   within   the   team   by   delivering   the
treatment/careplans that they develop. Their purpose to provide continuity for
the service user and minimize the number of people going in and out of the

service users house. This way of working saved time, developed good relationships with the service user, gave the service user a person to whom they could direct their questions.

> *'If one person can take responsibility for the client and do most things then that's got to be better for continuity, rather than lots of people going out to do lots of little bits. And I think the driving force behind the reason why we started working like this is because it's the basic philosophy from where we started working from. Right at the start it was, we are going to work this way we are going to break down the borders between professionals. It was never said but it was a feeling right from the start that we were going to work differently and that was driving us to employing and educating generic workers and I suppose it overlapped into the professionals and as professionals we felt we should be generic as well and develop a more generic way of working.'(Int.5/RT/Staff)*

Communication was formally structured within the team with a team diary used for daily communication, a white board with daily update on service users decisions awaited e.g. estimated discharge date from hospital, weekly team meetings with the whole team to discuss service user problems (Obs.9/RT/dayhospital). The study group has extensive networks which include Age Concern carers project, CAPIC, Care and Repair, Community Health Council, Crime prevention, Crossroads, Disability alliance, departments within statutory health and local authority services, James Ottley, road safety, St Johns Ambulance (CRP, 2003; CRP, no date; BGHCF, 2002; BGLHG et al, 1999;BGLHG, 2002;GHCT, 2001;BGSSD, 2001-2002) and utilised community resources such as luncheon clubs, church groups, supermarkets.

Characteristics of levels of services and levels of integration	Study Group 1 (Linkages)	Study Group 2 (Team integration)	Study Group 3 (Co-ordinated)	Study Group 4 (Linkages)	Study Group 5 (Co-ordinated)
Settings	Outpatient department in District General Hospital (Obs.3/OP)	Service User's own home (Int.1-6/RT/Service user/staff/carer)	Day hospital in Community Hospital (Obs.9/RT/dayhospital)	Day care unit in statutory care home (Obs.6/Daycare)	Purpose built day care unit in community leisure centre (Int.12-17/JDC/staff/service user/carer)
Models or philosophy of assessment & care	Medical-Comprehensive Geriatric Assessment (CGA) (Int.25/OP/Staff)	Medical (CGA) nursing, social work, occupational therapy, physiotherapy, transdisciplinary practice (Int. 3-5/RT/staff)	Bio medical, (Wallace, 2002; Int.22-23/dayhospital/service user/carer/staff)	Social work (PF.4/daycare; Int.10/daycare/staff)	Social work, Nursing, CGA, exercise, (Int.3/RT/Staff; Int.12/JDC/staff; Int17/.JDC/staff)
Support workers	OP nurses (Obs.3/OP)	Generic reablement officers working to consensus of joint documentation (Wallace & Lane, 2002; Int. 1-6/RT/service user/staff/carer)	Separate professional identified support workers (Physiotherapy assistant, healthcare support worker and tech 3) (Wallace, 2002; Obs.9/RT/Day hospital)	Care assistants delivering social work care plan (BGCBC, 2001-2003; Int.10/daycare/staff)	Care assistants delivering care/treatment/exercise plans for RT, SW, leisure. (Wallace & Lane, 2002; Int.12,17/JDC/staff)
Type of care	Non-urgent/routine Planned (Int.25/OP/Staff, Obs.3/OP; PF1/ OP)	Urgent/non-urgent/routine/ Planned (PF2/RT;Wallace & Lane, 2002; Int. 1-6/RT/service user/staff/carer)	Non-urgent/routine/ Planned (PF.3/dayhospital;Wallace, 2002)	Non-urgent/routine/ Planned (PF4daycare, Int. 7-11/carer/service user/staff)	Non urgent/ routine/ planned (PF.5/JDC;Wallace & Lane, 2002; Int.12,/17JDC/staff,)
Service user self direction	Various levels of self direction to no self direction (Int.25/OP/Staff, Obs.3/OP)	Various levels of self direction (Int.1,2,6/RT/Service user/carer)	Various levels of self direction (Int.21-24/dayhospital/service user/carer/staff)	Various levels of self direction to no self direction (Int.7-11/daycare/service user/carer/staff)	Various levels of self direction (Int.12-17/JDC/staff/service user/carer)
Professional Communication/ information sharing	Share information formally (PF1/ OP; Int.25/OP/staff, Obs.3/OP)	Weekly team meeting Joint team documentation, team diary, Unified Assessment document (In.4/RT/staff; Obs.9/RT/dayhospital)	Share information informally and formally through medical notes. (Obs.9/RT/dayhospital, In.22/dayhsopital/service user/carer)	Share information with social worker and Home care informally (Int.10/daycare/staff; Obs.6/Daycare)	Share information formally and informally with social worker and with RT. JDC staff meetings, Service user meetings. (Wallace & Lane, 2002; Int. 3, 17/JDC/service user/carer/staff)

Characteristics of levels of services and levels of integration	Study Group 1 (Linkages)	Study Group 2 (Team integration)	Study Group 3 (Co-ordinated)	Study Group 4 (Linkages)	Study Group 5 (Co-ordinated)
Networks	Extensive clinical networks in health organisations (Int.25/OP/Staff, Obs.3/OP)	Extensive clinical, professional and managerial networks across statutory and non-statutory organisations (CRP, 2003; CRP, no date; BGHCF, 2002; BGLHG et al, 1999, BGLHG, 2002;,GHCT, 2001;BGSSD, 2001-2002)	Clinical and Health organisation and limited others. Which include social work and care and repair. (PF.3/dayhospital; Int.22-23/dayhospital/staff/service user/carer)	Limited, formal network to Social work and informal district nursing only (Int.10/daycare/staff)	Formal to social work and RT, Informal to Leisure (swimming, gym), fire, education, (computer skills, arts/ crafts) police, Age Concern, schools (primary and secondary) (Wallace & Lane, 2002; Int.14,16,17/JDC/staff/serviceu ser/carer)
Management arrangements	Medical director NHS Trust (Int.25/OP/Staff)	Originally Joint Health and Social Care appointment until 2004. Now Team manager, Borough Manager NHS Trust (GHCT, 1999-2001).	Borough Manager, Day hospital manager manages nurses only within unit, NHS Trust. Allied health professionals managed by their own departments (Wallace, 2002)	Hierarchy of care assistants, 3rd officer, 2nd officer and Officer in charge, Head of provider Services, Social Services L. A. (BGCBC, 2001-2003)	Hierarchy of Care assistant, Day Services Officer, Day Services Manager, Head of Provider Services, Social Services, L.A. (Wallace & Lane, 2002; Int.12/JDC/staff)
Co location of assessment and provider staff	Separate (Obs.3/OP)	Within the core team only (PF 2/RT; Int. 3,4,5/RT/staff)	Within the core team only (PF.3/day hospital, Obs.9/RT/dayhospital)	Separate (PF.4/daycare; Int.10, 11/daycare/staff,/service user)	Separate Formal Informal in-house (Int.12,17/JDC/staff)
Referral	Referral from GP. Formal referral used to others (PF1/OP)	Referral not required within the RT only to social services and other services outside of the RT (PF2/RT)	Formal referral between team members and to others with use of appointment cards for service users to see allied health professionals (Wallace, 2002, Obs.1/day hospital)	Formal process of referral from Social work only (PF.4/daycare; Int.10-11/daycare/staff/service user)	Formal process of referral from social work and RT. Informal with leisure (PF.5/JDC; Int.17/JDC/staff)
Goal/ treatment/care planning	Treatment planning (PF1/ OP, Obs.3/OP)	Service user goal planning (PF2/RT; Int. 5/RT/staff)	Treatment Planning (PF.3/day hospital)	Care plan received from social worker (Int.10/daycare/staff)	Care plan from social work referred service users; Service user aims and objectives. RT service user goal planning. (Int. 3/RT/staff, Int12, 17/JDC/staff)
Assessment	Consultant assessment (PF1/ OP; Int. 25/OP/staff, Obs.3/OP)	Generic assessment for core team- specialist assessments when needed (PF 2/RT; Int. 3,4,5/RT/staff)	Separate MDT assessments (PF3/dayhospital, Int.23/dayhospital/staff)	No assessment in study group- social work assessment prior to referral (Int.10/daycare/staff)	Formal (outside of unit) and informal assessment (Int.12,17/JDC/staff)

208

Characteristics of levels of services and levels of integration	Study Group 1 (Linkages)	Study Group 2 (Team integration)	Study Group 3 (Co-ordinated)	Study Group 4 (Linkages)	Study Group 5 (Co-ordinated)
Lead assessor	Consultant autonomy (PF1/ OP, Int. 25/OP/staff; Obs.3/OP)	None- duty manager designates according to service user need (PF2/RT; Int. 4/RT/staff)	Consultants (including Parkinson's, PEG, Rheumatology, Medical, Dermatology) (Wallace, 2002, Obs.1, 9/dayhospitalRT; Int.22/dayhospital/service user/carer)	None in centre -social worker autonomy (Int.10/daycare/staff)	RT inside the unit and social work outside of the unit dependant upon service user need (Upton, 2003)
Joint visits	-	By RT members and with Social workers (PF.2/RT; Int.4,5/RT/Staff)	Nurse and occupational therapist at home very occasionally (Int.23/dayhospital/staff)	None (Int.10/daycare/staff)	-
Follow up post discharge	Follow up appointments following initial 1st appointment (PF1/OP; Obs.3/OP,.Int.19/OP/service user)	3 month follow up phone call or visit. Also following transition to domiciliary care (PF.2/RT; Int. 4,2/RT/service user/staff)	No follow up following discharge (PF3/JDC)	Review by social worker. No follow up post 'discharge' (PF.4/daycare; Int.10/daycare/staff)	Review of care plan by social worker. RT review and follow up 'post discharge' (PF5/JDC; Int.3/RT/Staff)
Utilising community/ voluntary resources	-	Lunch clubs, supermarket customer services, Age Concern (Int.4/RT/Staff)	Parkinson's Disease Society, stroke association (PF.3/dayhospital, Obs.1/dayhospital)	None (Int.10/daycare/staff)	Schools, Age Concern, police, fire (Int.12, 14/JDC/staff/serviceuser)
Joint documentation	Medical records (Obs.3/OP, Int. 25/OP/staff)	Joint documentation developed by the whole team. Medical notes used for information only (CRP, 2001-2003a; GHCT, 2001)	Medical records (Obs.9/RT/dayhospital)	No-Day care notes for day care use only (Obs.4/JDC/Daycare)	Care plan and care notes, RT plan, exercise plan (Int.12,17/JDC/staff)
Appointed Care coordinator	-	Single care co-ordination role within the core team to build team consensus (Int.5/RT/Staff)	Information gathering by sister (Obs.1/dayhospital; Wallace, 2002)	None (Int.10/daycare/staff)	Care assistant as Key worker, JDC manager as information gatherer. (Int.12,16,17/JDC/staff/service user carer)
Transport	Self arranged (Int. 25/OP/staff, Int.19/OP/service user, Obs.3/OP)	No transport required service delivered at home (Wallace & Lane, 2002, BGLHG et al ,1999)	Either self drive or hospital transport arranged by staff (Wallace, 2002; Obs.1/dayhospital)	Arranged by social worker (Int.10/daycare/staff)	Arranged by staff LA transport or ambulance control- depends on service user need. (Wallace & Lane, 2002; Int.14,17/JDC/service user/staff; Obs.7/JDC)

Table 13: levels of service and integration

Applying these characteristics to an adapted Boon et al (2004) 'models of team health care practice' (see model 1), it is possible to position the services within the study groups along a continuum of team practice models.

Study Group 4 (SG4) (day centre) (Leutz, 2005, linkages) is recognised as parallel practice as its characterised by a care team working in a common care home setting. This is a single agency model. Its emphasis is on the single social model of care in relation to loneliness and social isolation. Its roles within the care setting are social care specifically defined. It has a dominant single profession that of the social worker as autonomous lead assessor.

Study Group 1(Outpatients) (Leutz, 2005, linkages) is recognised as a consultative team as its characteristics are of expert practitioners who give advice to medical colleagues through formal methods of referral and letters. This is a single agency model which has a reliance on one model of care that's based on a medical model with its assessment in the form of the Comprehensive Geriatric Assessment (Int.25/OP/Staff) and medical notes.

Study Group 3 (SG3)(day hospital) (Leutz, 2005, coordination) is recognised as a coordinated team. Its characteristics are of a 'formalized administrative structure'(Boon et al, 2004,p3) of professionals from a single agency brought together (not line managed as a single team) for the purpose of providing assessment and treatment for a particular service user group.

Study Group 5 (SG5) (Leutz, 2005, coordination) is characterised by its multi-agency/multidisciplinary approach with health, social care and leisure professionals providing assessment and plans to further independence and wellbeing as identified by the service users objectives. They do not all meet together, make their own decisions and recommendations about the service user. The JDC is managed by an officer in charge who collates this information and delivers the activity or care required by and in discussion with them as individuals. Care, treatment and exercise plans are not jointly

written. Care assistants within the JDC work to a key worker model which identifies and supports delivery of service user own objectives which include working with the multiagency professionals.

Study Group 2 (SG2) (Leutz, 2005, full integration)is characterised by its integrative combination of health and social care professionals which includes occupational therapy, physiotherapy, nursing, social work, consultant in geriatric medicine, dietetics, speech and language therapy. It also refers carers to Age Concern carers project. Its team leader is an occupational therapist who manages the co-located core team of nursing, occupational therapy, physiotherapists and generic workers. It utilises service user own goals and has developed its own joint documentation and uses consensus decision making.

SG4	

Parallel Practice

Collaborative

Multidisciplinary /multi agency

Integrative

Consultative

Coordinated

Interdisciplinary/Interagency

SG1

SG5

SG2

SG3

Philosophy

- emphasis on the whole person (health and social care) increases
- Reliance or dominance of one model of care decreases (neither medical or social model)
- Jointly developed operational policy and practice

Structure

- Generic roles increase
- Team networks increase as they consider the whole person and promote independent living in the community
- Increase in complexity from single agency to multi agency model

Process

- Number of formal processes and practice of information sharing increases
- As model complexity increases single professional autonomy decreases
- As model complexity increases lead assessor is based on individual's greatest presenting need

Outcomes

- The greater the emphasis on the whole health and social care person the greater the use of service users own goal planning

Model 1: Continuum of Health and Social Care day activity models. Adapted and enhanced from Boon et al (2004) Continuum of team health care practice models.

Summary

The differences between the services are now apparent from parallel practice to integrative. Their characteristics have been analysed by using Leutz (1999, 2005) levels of integration and applied to an adapted Boon et al (2004) 'models of team health care practice' (see model 1) where they have been positioned along a continuum of team practice models.

5.5.3   Decommissioning of Integrated Services
5.5.3.1   Uneasy allies/unwanted guests

The partnership and collaborative relationships between health and social care services were at times uneasy. The state of the working relationships between managers, practitioners and their peers working at the health and social care interface were observed and commented on by inspectors, staff, carers and service users.

In 2003 the Joint Review commented about the state of SSD partnership relationships as *'can best be described as cordial rather than being effective partnerships delivering outcomes for people'(Audit Commission, 2003, p59).* It noted that the only use of 'health flexibilities' had been with the development of the RT pilot project which it acknowledged as promising.

The historical evidence during the development of the integrated services suggests that unease was due to commitment slippage leading to 'collaborative inertia' (Huxham & Vangen, 2005, p3) between health and social care partners and services. Commitment slippage was predominantly in respect of social work, reablement officer and clerical provision originally agreed by social services within the team. The state of the collaboration demonstrated through the unilateral decision making, trying to ascertain effective modes of communication between systems and a service user incident (BGCBC et al, no date; CRP, 2001; CRP, 2001-2003a; RT, 2000-2004; Wallace, 2002-2004; BGLHB, 1999-2003; Int.4,5/RT/Staff; Int12,13,17/JDCservice user/carer/staff).

In May and September 2000 the project steering group confirmed the financial funding between partners. Social Services confirmed Reablement Officer (6.0 wte), admin (0.5 wte) social work (0.27), £175k capital funding for 2001/2002; whilst the remaining costs were confirmed by the LHB as health commissioners. However, it wasn't until Jan 27th 2003 that the RT gained a full allocation of staff *'for the first time we are a full team'* (Wallace, 2002-2004).

In October 2000, the commitment of Reablement officers had reduced to 4.0wte and capital funding to £125k (BGLHB,1999-2003). E-mails during this time highlighted the informal discussions that were occurring about financing the project

> *'that the £125k committed from social services for 2001/2002 are capital monies and cannot be used for staffing costs due to current local politics. [Name of Trust senior manager] has established that there aren't any monies forthcoming from the Trust'* (CRT, 2000-2004, 4th Oct. 2000).

The Trust subsequently agreed to second a nurse to the project in April 2001 (CRP, 2001-2003a; BGLHB, 1999-2003).

In January 2001, discussions on the capital costs of adapting the SSD 'another day centre' building suggested they would be greater than anticipated. In a response the LHB *'highlighted that any increase in capital costs would result in a reduction of revenue funding available & would shorten the period of the pilot'(BGLHB,1999-2003).* As a result the LHB undertook a feasibility report for the provision of day care within the borough and an interim model was developed in April 2001. In April 2001 SSD were *'experiencing some difficulties with realising the 37 hours but would have further information following a meeting with the Director'.* In June 2001, SSD confirmed that they would be funding 1.0wte Reablement Officer and £75k capital funding, the original social work and clerical arrangements (CRP, 2001; CRT, 2000-2004; BGLHB,1999-2003).

In 2002, the SSD Joint Review Position Statement provided by social services states that

> *'despite attempts to flag up Reablement as a service outcome there will be undoubtedly be some hard thoughts and possibly words to the continuation of the Reablement Project…. This comment is made on the basis of an e-mail which at first glance hints that Health might not be willing/able to identify their component of the scheme'* (BGCBC,May 2002, p23).

The role of the social worker (0.27 wte) within the RT was not provided for the first 7 months of the project, (August 2001 until March 2002) and clerical support not until 2003. This was due to *'changes within the social work department'*. During that time RT had to fax its social work requirements to the local SSD. This effected the way and the speed in which RT were able to initiate social care packages when required (CRP, 2001-2003a, Project Manager Report 30/7/01). This practice also occurred during the lifetime of the research study and let to feelings of disappointment and frustration.

> *'very often she'd ring me up [social work assistant] and say 'I'm going down to so and so are you doing anything? if I was in the office or even on my day off I'd go. I worked along side [name of social work assistant] with the clients that I worked with. Since [name of social work assistant] have left there's been nothing like that at all. The process is lengthier. [Social work name] took over from [name of social work assistant] then she was ill then we had a different referral form which had to be filled in and that takes time.. you're talking about a turnover of service which can now take six to seven weeks'. '[Name of social work team manager] have been up and made a promise that from his end in social services in [name of town], like he will do the turn over in 2 or 3 days. Yes things have altered since [name of social work assistant] have gone. The closeness is not there from an RO [reablement officer] point of view. I've gone and done joint visits with [another social worker] once or twice'* (Int. 4/RT/staff)

The role of social work provision fluctuated between a registered social work and a social work assistant without consultation with the RT or JDC manager during the pilot project and subsequently during this research study (CRT, 2000-2004; Wallace, 2002-2004; BGLHB,1999-2003;

214

Int4,5/RT/staff). Operationally, staff relied on individual personalities who understood and demonstrated commitment to the RT; the willingness and ability to engage with staff about possible service users. When the relationship worked well it supported the integration of the case management of individuals with complex needs and it shortened processes

> *'Like she would ask me..'How do you think she'll fit with reablement?' I've got a cracking person for reablement and she's living in residential but she wants to live independently again. She hasn't lived in the community for 6 years and now she wants to live out on her own . ..And from the time that woman came out of residential I went to [name of social work assistant] and helped her pack and unpack her boxes I went through everything from getting her dressed in the morning to going shopping, getting her pension. ..... I'm not saying that the others don't understand reablement though, I'm not saying that at all, they do understand but I haven't had any phone calls like that unless they come on my day off, but then others would say……..[name of social worker] would come and look at the board and say 'how did so and so get on with the shopping at [supermarket] after? She would look at that board and pick up six people who she would know the programme and know what was going on with that person. These social workers are not involved in that depth.'(*Int4/RT/staff *)*

At some stage during the research study the named provision was withdrawn. This wasn't a formal decision but occurred gradually and so the team manager's approximate conclusion is that this may have occurred sometime during 2005 (Heslop, 2009).

During the pilot period the RT was based in 'another Day Centre' in order to develop the relationship. The provision of a MDT room as base for the RT had been agreed with SSD providing telephones, e-mail and internet facilities. Further operational difficulties arose in the evenings, weekends and bank holidays. Social services day centres were closed at weekends, at 5pm and over bank holidays when community health services were available. During 2001-2002 the RT had to make alternative provision in the evenings, at weekends and over the 11 day period over Christmas, at

weekends and 5-8pm during the week. The staff were unable to access the building e.g. for equipment, medical notes any other operational needs. Staff had to ensure on a Friday afternoon that they planned for potential service user needs over the weekend until they could acquire access again on a Monday morning (CRP, 2001-2003a). This was resolved when RT staff were given permission to have a key and alarm code with training for the building in 2002. Alternative provision was sought during the Christmas of 2001 at a local community hospital. This provision was not required again following a number of e-mails from the Director of SSD (CRP, 2001-2003a; CRT, 2000-2004).

Telephone points for RT use were installed in November 2001 and Health Trust e-mail access during February 2002. RT did not acquire SSD e-mail use during the pilot phase at the 'another day centre' building. Only the occupational therapist (a previous employee) had access to the SSID (Social Services Information Database at SSD social work buildings) to gain information on current service users. Only the nurse at the RT was able to access the health Clinical Workstation in the community hospitals within the borough. Permanent access to SSD e-mail and Clinical Workstation became available in 2004 with the development of the JDC and the relocation of both integrated services to the Abertillery leisure centre. (BGLHB,1999-2003;CRT, 2000-2004).

Unilateral decisions were made by SSD in the JDC with regard to the nature and provision of day care in 2004 and later in 2006 (Int.12,17/JDC/staff). SSD reduced the number of days allocated for day care within the unit by 1 day without consultation and agreement with the LHB and Trust (CRT, 2000-2004 e-mail 24/02/2004). The provision of day care in 2006 had been divided into 1 day for young disabled people (Monday) and Tuesday-Friday for older adults. Service users commented

> *'Wheelchair users , walking, people with zimmer frames*
> *and things like that... they've all got their days. To me that's*
> *itemized. At the end of the day they're all disabled people.*
> *There's not a specific disabled person. This joint day care*

have itemized people they separated them. Now somebody walking with a zimmer frame or a stick can help someone in a wheelchair with their limited sense. But they've got all wheelchair users in one day and all walking people in another. … and there's youngsters and there's elderly. Now sometimes the elderly likes the youngsters to speak to. It don't make sense to me why they've done it'(Int.13/JDC/carer/service user).

Operationally staff became indifferent to one another during the early integration phase of the day hospital and the day centre in 2003. Health staff from the day hospital refused initially to meet with SSD staff to have daily meetings about the service users expected. This culminated in an incident in 2004 whereby a service user left the JDC without notifying any of the staff and neither health or social care staff saw it as their responsibility to find the service user. The operational staff (who were employed by SSD) saw it as a health responsibility as the service was based on hospital premises, whereas the health staff saw it as SSD responsibility because the service user was accessing day care (Wallace & Lane, 2002;CRT, 2000-2004; Wallace (2002-2004).

'certain members got on really well with the reablement team but a lot didn't. They just got told a lot. That's what I think, personalities. I think it could have been a good working relationship, cos they knew their job and we do ours and combined we could always come up with a solution' (Int.12/JDC/staff).

5.5.3.2 Informal decommissioning of integrated services

A series of events led to the informal decommissioning of the integrated services in 2005. The informal decommissioning included two aspects of the working relationships, those between RT and JDC and also between RT and social work. Significant actions were the implementation of the Unified Assessment Process documentation, the relocation of RT to a 'community hospital' and the differing agenda between strategic and operational staff. The impact of this decommissioning is suggested in a possible increase in numbers of referrals to GP and district nursing services. At the same time

as the relocation, the JDC experienced an increase in the number of service users admitted to hospital (Table 14).

In 2006-2007 Health Inspectorate Wales undertook a 'Review of the Progress against Healthcare Standards for Wales' (BGLHB, 2007). In the welsh borough it agreed with the LHB self assessment of *practising* at corporate and operational/clinical outcomes levels for Standard 24. This was:

> *'Healthcare organisations work together with social care and other partners to meet the health needs of their population by:*
>
> *a. having an appropriately constituted workforce with appropriate skill mix across the community; and*
> *b. ensuring the continuous improvement of services through better ways of working'(BGLHB, 2007,p37).*

Examples of joint initiatives submitted as evidence were 'multi-agency Reablement' (Study group 2) and 'Joint Day Care for the Elderly' (study group 5). Therefore officially the study groups were perceived as an integral part of the partnership working arrangements.

In practice the co-location of the RT and the JDC came to an end in August 2005 when the RT (now managed by the NHS Trust) moved from its new location at 'a community hospital'. The staff at the JDC saw this move as a reason for the dismantling of the partnership arrangement. The JDC appear to have swapped one relationship for another i.e. move away from a health partner to a leisure partner.

> *'the reason why the relationships with health and leisure have changed is that we've moved onto the site with leisure and reablement have moved to [name] hospital and we have all the facilities here within the same building. It's just a matter of walking up the corridor and there they are. I think that move from here to [name of community hospital] destroyed the partnership' (*Int.17/JDC/staff)*.

The convenience of co-location with the leisure facilities and team promoted an informal partnership between them with service users accessing the gym and swimming pool. (Int.17/JDC/staff).This type of arrangement is described within the CBC Commissioning Strategy for older People as a generic day opportunity as opposed to the specialist day opportunity, working in partnership with health (BGCBC , 2006).

Staff at the JDC (study group 5) described the event of the RT move with some sadness. The on-site health advice, physiotherapist, nursing and visiting staff grade doctor was then replaced by advising the service user to visit the GP.

> *'We used to have a good working relationship with reablement but now very little. I know [physio] came down last week and came and spoke to one of our service users and spoke to her about exercise. Well 2 actually and she showed them exercises to do, but other than that its a shame really 'cos we had such a good working relationship, but that's gone. When they were on site, especially with [nurse], if we had problems down here people got I don't mean cuts and bruises but Mrs So and so had got a rash or a swelling we'd leave a message and she would come back down here and she would advise. I mean they ask us for advice but we're not nurses. All we can say is make an appointment to see your GP' (Int.12/JDC/staff).*

The communication and accessibility of the relationship also ended at this stage with staff calling for advice but the RT unable to respond due to what was perceived by the JDC manager, staff and RT staff as a change in the RT agenda.

> *'we ring but they don't come 'cos they're tied up with other things (Int.12/JDC/staff)*

> *'what I'm finding is that reablement have moved towards the health side than the social in the past year….. a different kind of re-abling and the Parkinson's, more medical side than social side' (Int.4/RT/Staff)*

An impact of this change in partnership arrangements was a perceived gap in knowledge and skills, with a care assistant delivering an exercise class to a group of people with physical disabilities, without access to advice from a registered physiotherapist. Service users also observed this change in practice which resulted in the district nurse making home visits to the service users home to measure blood pressure and check on health needs which were originally being met at the JDC.

> *'She [nurse] used to call in the unit but all that stopped now and we have to have the nurse call at home once a fortnight. …..You can't get the nurse to call there anymore'(Int.16/JDC/service user/carer).*

At the same time JDC experienced an increase in service users being admitted to hospital. Table 14 demonstrates numbers of service users at study group 4 and 5 admitted to hospital, to a care home and deaths from April 2005-January 2006.

Study Group	Admissions/ Death	Apr 05	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 06
4	Hospital	3	3	2	2	1	0	1	4	3	1
	Care home	0	1	1	0	0	1	0	1	0	0
	Deaths	0	2	2	2	0	0	1	0	3	0
5	Hospital	2	0	1	2	1	4	4	2	5	9
	Care home	0	0	2	0	0	0	0	0	0	0
	Deaths	0	0	1	0	0	1	0	0	0	0

Table 14: Admission to hospital, care home and deaths April 2005-January 2006

Study Group 5 (JDC) admitted 30.00 service users within the 10 month period. Upon further investigation the rate of admission increased from Sept 05 (n=4) to Jan 06 (n=9). The co-location ended in September 2005. In contrast Study Group 4 (DC) (with the oldest study group population) during the 10 months study period experienced 10.00 service user deaths, 20.00 service users were admitted to hospital and 4.0 service users admitted to a care home.

Operationally the impact of implementing the Unified Assessment Process documentation between health and social care led to the RT having to fax it to the social services department before services would be implemented. The information flow arrangements described by the RT (study group2) process flow chart saw the social work assessment as part of the multi-agency team and not as a separate referral (appendix 13). In practice in 2006 the relationship had changed with both the lack of continuity of social worker and the inclusion of a referral form. Although the UAP referral process and form delayed service provision and distanced the relationship between team members, it also improved the amount and quality of information received by the team.

> *'we had a different referral form which had to be filled in and that takes time.. you're talking about a turnover of service which can now take six to seven weeks'(*Int.4/RT/staff*).*

> *'with UAP [unified assessment process] through now and we're using the same standardised documentation through to refer to one another so that should be better I think we're getting the crossover of information, more information from the social side automatically and hopefully they're getting that from us as well with the UAP' (*Int.5/RT/staff*).*

The process itself had changed from a discussion with the social worker either by phone within the MDT team meeting on a Tuesday to a lengthened process whereby the social worker sits outside the MDT team.

> *'We fax them straight away, then they go back out, then you as a social worker got to go and do a visit. Then they go back to the office' (*Int.4/RT/staff*).*

Summary

This sub-theme has two parts, 'uneasy allies/unwanted guests' and 'informal decommissioning'. 'A cordial relationship' viewed by the Audit Commission (2003) in reality experienced 'collaborative inertia' through commitment slippage, unilateral decision making and loss of co-location. As a result

there is a suggestion that this may have led to an increase in hospital admissions and the use of GP and community nursing services.

5.6 The journey within day services

The service user's journey through the integrated and non- integrated services varies from the point at which an enquiry is made, a referral is initiated through to assessment, service delivery and review. This theme gives an understanding as to how the service user journey is perceived by all participants. Its sub themes include 'autonomous referral routes', 'assessment and review', 'care experiences' and 'wellbeing'.

5.6.1 Autonomous referral routes

All study groups accept referrals for service users aged 18 years and over. The services have their formal routes by which service users are accepted into the services and through which service user information travels. The referrals appear to be autonomous in their sources and in their processes with inbuilt controls. However, on occasion participants utilised informal methods to access the services they needed.

Referral data was not available for study group 1 during the period of data collection or during the writing up phase. However, outpatient activity for new adult medicine outpatients in the borough hospitals was 70 patients during 2002/2003. The majority (1643) of new outpatient patients accessed the service outside of the borough (BGLHB & BGCBC, 2004). See table 15 for referrals to study groups 2-5.

Statistics/ Study Group	Study Group 2 RT	Study Group 3 DH	Study Group 4 DC	Study Group 5 JDC
Sum No. Referrals Received	400.00	198.00	13.00	22.00
Mean (SD)	40.00 (7.36)	19.80 (6.23)	1.30 (1.06)	2.20 (1.75)
Range (min/max)	20.00 (30.00-50.00)	22.00 (9.00-31.00)	3.00 (.00-3.00)	6.00 (.00-6.00)

Table 15: Referrals received Study Groups 2-5; April 2005 - January 2006

Upon examination of the referral routes, each Study Group was distinct and on the whole sourced from their respective employing agencies (table 16).

Referral routes (% of total referrals) / Study Group	Study Group 2 RT	Study Group 3 DH	Study Group 4 DC	Study Group 5 JDC
Employing agency	*NHS Trust*	*NHS Trust*	*CBC*	*CBC*
SSD via social worker	0.00	0.00	13.00 (100%)	20.00 (91%)
Hospital (DGH)	252.00 (63%)	44.00 (22%)	0.00	0.00
Community setting inc. community hospital, district nurse and GP	148.00 (37%)	154.00 (78%)	0.00	0.00
RT	0.00	0.00	0.00	2.00 (9%)

Table 16: Study Group 2 - 5 Referral Routes utilised April 2005 – January 2006

Slight differences were visualised within the referral data received. JDC (Study group 5) experienced a reduced number of referrals in April (n=1), Aug (n=1) Sept 2005 (n=0) and Jan 2006 (n=1). Whereas, Study Group 4 (day care) experienced this depression in June (n=0) and Dec (n=0) 2005 and Study Group 3 (DH) in Oct (n=9) and Dec (n=14) 2005. The depression in numbers coincided with seasonal/school holidays. In contrast Study Group 2 experienced a steady increase in referrals from 30- 50 per month throughout the 10 months period of data collection. The referral pattern changing within this time as an increased number of GPs started to refer to the service.

The referrals which trigger the processes within each of the five study groups; are each guided by five different referral criteria with their own filtering systems and variable routes available which include a series of individual steps (table 17; appendix 13). None of the Study Groups accepted referrals directly from the service user.

Study Group/ referral routes available	Study Group 1 OP	Study Group 2 RT	Study Group 3 DH	Study Group 4 DC	Study Group 5 JDC
Medical/surgical practitioners (Consultants	√	√	√	√	√
Social workers		√	√	√	√
Any other health or social care professional		√		√	√

Table 17: Referral routes available (Wallace, 2002; appendix 13)

The referrals also had varied modes of acceptance, filtering and sorting systems which exercised control on service user access to the services. Written referrals only were accepted by study groups 1, 2 and 3; whereas, verbal referrals are also accepted by groups 4 and 5, to the social services department. These routes were not always utilised, as they used friends or relatives to acquire the services (appendix 13).

> *'One of the carers that do work down here…...she said you know you can go down to [day centre name] and you don't have to pay any extra and so I thought that's something for nothing… so I got in touch with the [name] social services'* (Int.8/daycare/service user).

> *'A friend of ours is a councillor and she knew a stroke nurse. He had a word with the nurse and before I knew it a letter came from the day hospital'* (Int.21/dayhospital/service user).

> *'Well over 12 months ago [neighbour's name], he said why don't you come over here with me and I might have come over here in a taxi with him'* (Int.11/daycare/service user).

5.6.2   Assessment and reviews

Assessment and reviews (either by registered or non registered workers) form the basis of identifying problems, need and risk which inform the service users individual plan of care, treatment or objectives whilst attending the services within this study.

Assessment occurred within the service user's journey (appendix 13). This included a process of collecting information/data in accordance with model of assessment used. In study group 1(OP) this occurred in the clinic, in study group 2(RT) this occurred twice, firstly as a pre-assessment either in hospital or at home, secondly in the service users home. In study group 3 assessments occurred in the day hospital and occasionally in the physiotherapy department, whilst in study group 4 & 5 assessment occurred in the service users own home.

> *'The social worker does the assessment. I do find that we look at the last bit, their identified needs identified by the social worker. We provide the social interaction identified by the social worker as their needs for example any respite care for her husband the main carer'* (Int.17/JDC/staff).

There were three models of assessment and care/treatment service provision visible within this study. In one model of service provision assessment was undertaken, plans and treatment or care provided by the registered Study Group workers only with minimal support from support workers. This occurred within groups 1 (OP), and 3 (day hospital) and immediately led to a plan of treatment of care delivered by the registered worker(s). These would be considered as specialist or in-depth assessments within the Unified Assessment Process (WAG, 2002). In study group 1(OP) the assessment was usually always undertaken by a medical consultant (geriatrician). Assessment in Study Group 3 (day hospital) was allocated according to a request within the GP referral and in accordance with the team leader's professional judgment.

The second model in Study Groups 2 (RT), assessment was undertaken by the most appropriate professional or professionals according to need (i.e. nurse, occupational therapist, physiotherapist, medical consultant). A single treatment/ care plan was then developed by the team with support worker involvement in assessment and care delivery.

> *'[OT name] and I would go in and do the assessment and as soon as they would come home from hospital, usually they ask for us to get there as they're getting home. …everything they do in their daily routine we ask them to do while we are there'(Int.4/RT/Staff, reablement officer-non registered professional)*

The third was an example of separate assessment and provider model of service provision and was delivered with study group 4 (day care) & 5 (JDC) (BGCBC, 2002). In study group 4 (day care) the assessment was undertaken by a social worker who was not part of the day care team but part of a social work team detached from the provider service. The care plan developed by the social worker and the care provided by the day centre. In study group 5 (JDC), the referrals received from SSD, the assessment and care plan was undertaken by the social worker; the referrals received from study group 2 the assessments and care/treatment plan were undertaken by the team prior to admission to the unit, day care provided by the unit staff and reablement by the RT staff.

> *'Assessment is separate from the provider services, which is what was planned years ago but in order to measure what we do, we need them to be interlinked, to see if there's an outcome from the assessment. …This would help me with my partners to go to them and say well this person needs this and that, yes if there were more identified needs instead of a blanket social interaction, yes. It would make life a lot easier and we'd know what we're trying to achieve' (Int.17/JDC/staff).*

Assessment and reviews were also undertaken by non registered workers (NVQ level 2 and 3) in study group 2, 4 and 5 only. In study group 2 the pre-assessment was undertaken by the Reablement officers who had undertaken NVQ level 3 following training and achievement of competencies by the MDT.

In study groups 5 (NVQ level 2), the staff perceived and experienced gaps in assessment and care plan provision in respect of risk, goal planning and service delivery. They needed this information to deliver individual service

user care and plan for future services. Trying to plan for unknown needs without training caused frustration, which was audible in staff voices. Key worker staff undertook risk assessments, identified individual medical and social history when they interviewed the service user on induction to the unit or day centre.

> *…the risk assessments. On transport, in the centre, in home, if we need to take their coats on and off. We the key workers actually do all of that but for new people coming in we should have a risk assessment in place for transport before we pick them up but we don't and I'm quite concerned about that I got to be honest….But the social worker's been out there but they don't identify a risk and there has been many a time, when there've been quite some concerns, high thresholds that the Service User can't get over. It might be a simple, you know a bit of a broken path, it might not be a full assessment that they need to do but key points.*
> *' (Int.12/JDC/staff)*

> *'Because the assessment isn't done here we look at that individual's needs more than the social worker. So we're an unofficial assessor. There isn't anyone in the centre who is qualified to assess but we've done it because we've had to. We assess the person and what their needs are and we're trying to make that more formal, we're looking at the goal planning , we look at what they would want to do and what would help them' (Int.17/JDC/staff).*

There was an opportunity for review of assessment and treatment/ care provision within all the processes. Not all study groups used goals or outcomes to plan care. Study Group 1 (OP), the consultant would request the service user to attend a repeat outpatient appointment for review. Study Group 2 (RT) had two types of review that of reviewing the service user own short and long term goals within the action plan; and they undertook a 3-month review post discharge from the service with all service users usually over the phone but occasionally in person.

> *'Well they did say then that they'd be finishing and it would have been six weeks at least and they would be getting in touch with me in 3 months and I'm expecting them to phone' (Int1/RT/service user).*

Study Group 3 (day hospital) undertook care plan reviews but did not plan goals with the service user, although when interviewed the nurse considered its importance.

> *'I think we should be looking at goals. We don't do formal goals with the patient. But I try to see what they want to achieve. I think that the patient's perspective is very important you really need to know if they're satisfied and if we've been caring enough. ……..We can't just do what they want, we have to look at what they need and sometimes we don't agree' (Int.23/dayhospital/staff).*

Social workers undertook the official reviews for the social work assessment for study group 4 (day care) and 5 (JDC). The unofficial review was undertaken by the non registered workers within the unit and with the service user.

> *'we work in the key worker system. when we do reviews, once a month reviews we try, but usually 6 weekly, we also write in a folder every fortnight to see how they get on but people might deteriorate people might improve and I in particular always ask if there's anything that they want to do or they would like to do and we aim for that' (Int.12/JDC/staff).*

> *'….They don't look further into it to see what we could provide. They don't see to come back and see if they've improved. I think the review mechanism is being looked at, at the moment. But in my experience until now, its only the reablement team that have put that in place. And they are looking a bit more in depth to what they want from us.'*

The frustration expressed by this member of staff both in words and tone of voice in 2006 appears to be a continuation of a problem seen by the Joint Review team and reported by them in 2003.

> *' a clearer focus on care management on helping people move forward is needed, as some service users are not aware of what it is they are expected to achieve and how and when they could complete their involvement with social services'(Audit Commission, 2003, p6).*

The members of staff at the JDC were looking for 'expert' direction to guide them in delivering what the service user required. Staff within the unit were not educated to undertake a social care assessment and did not feel equipped to do so. In 2003, the Joint Review of social services in the welsh borough concluded the department was 'not serving people well' by not implementing assessment and care management in adult services in a structured and consistent way and that service users were frustrated by not easily being able to get information and advocacy. In 2001 the District Audit Commission criticised the provision of rehabilitation services in the area. A GP interviewed within the report stated that older people suffered from 'Hot potato syndrome'. He clarified that older people were passed from service to service without acquiring the services that they needed to solve their problems.

5.6.3   The experience of care

All participants who were interviewed and their carers were in appreciation of the services they had received from the study groups within this research study. There are two aspects to this 'experience of care', a positive care experience and a negative care experience. The theme of 'care' is defined as *'those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway'* (Leininger, 1988,p9). In this study positive care experiences include the act of nurturing independence, wellbeing, dignity, confidence building, respect, trust, continuity of individual care provision, and relieving loneliness. Time was a key requirement for a positive service user and carer experience. Prejudiced behaviour and language characterised the negative care experience.

Nurturing independence and dignity
Study Group 2 (RT) supported and nurtured the promotion of functional independence in the service users they cared for at home. They achieved this through supporting the service users' daily routine. Then gradually enabling the service user to gain confidence (and self belief) to undertake the tasks themselves; trusting that the service user would gradually know

when they were able and ready to regain control of the daily routine; and respecting the decisions that the service user made throughout the process of promoting independence. The reablement officers were able to achieve this by working (a number of times per day) with the same service users and their own goals within their treatment plan (developed by the registered team members) throughout the daily 12 hour shift.

> *'I think there were about 8 of them. In the beginning for a good many weeks they started off coming four times a day. That was to see to my breakfast and my dinner, this was when I came out of hospital, dinner and their last call would be at 7 'o' clock in the night, well they did that for probably a fortnight. In this time I was sort of managing a little bit…... And I said to them I don't think it's necessary for you to come for the evening one….. and then it got after a few weeks I was doing my breakfast myself and they would come in and help me with my dinner and sort of get my dinner and do any washing up or anything like that.(Int.1/RT/Service user)'*

On other occasions it appeared to be a battle to convince or prove to the service user that they were able to regain independent living, without assuming a role of dependency or helplessness post hospitalization. In one example, after the experience the service user appreciated what she had regained and although it was hard work, she enjoyably reminisced about the service and what she had achieved with pride. The member of staff was confident in the service's aim and purpose of promoting independence. This translated itself in her being focused and confident that the approach taken was in the service users best interest i.e she had the ability to lead the service user towards and reach her potential independence and autonomy.

> *'With reablement we stand back and prove that they are independent…I've been to people and they didn't expect reablement to be as we were. I've got a lady down in [name of town] and she keeps saying to me now don't forget to come and visit me and the first three weeks I was the wicked witch of the west. I really was the most awful person on this earth because I was going in there and she would say 'do this, do that' and I'd say no. And she would say well you do nothing nothing for me at all. I'd say to her well why do you need me to do it and she's say well I've*

> *just come out of hospital. And this lady had no restrictions at all…..and she says you remember those first weeks we had together and I didn't understand about that reablement service and look what I can do now. I would have led back she says and we used to have a laugh. It wasn't a laugh I can assure you..'(Int.4/RT/Staff).*

The service user felt that she had created a relationship which she wanted to pursue with the member of staff. This approach also perpetuated into the way the staff spoke and treated the service users. The respect of ordinary pleasantries of 'this lady', please and thank you, treating the service users as equals with the right and ability to make decisions in their own best interest.

This experience of being respected and valued as an equal was also experienced by the participants in study group 5.

> *'They're all as one they're not quarrelling or rowing and they treat us the same. Each one the same. They talk to you with respect, very respectful (Int.15/JDC/service user).*

Being in control

In study group 3 (day hospital) the service users emphasized the need to be cared for but 'in control' of the experience. They gained control through the staff talking to them with respect for their 'intelligence' and 'knowledge' that they brought to the relationship and spending time with the service users and building a relationship based on trust. The service users felt as if they were the centre of the care being provided.

> *'He spoke to me I felt I was in control. No fobbing off. He told me everything. If you asked anything…even though [carer name] was there, he spoke to me'* (Int.21/dayhospital/service user).

Staff appeared approachable and gave them the freedom to ask questions whilst in the day hospital and to ring from home should they want advice, being taken seriously. *'she didn't mind me asking and I didn't feel a burden'*

(Int.22/dayhospital/service user/carer). This approach adopted resulted in avoiding possible crisis.

> *'one day I was a bit worried about [service user name] he wasn't well and I know they said give them a ring, so I did. She told me what to do and that she'd ring back. She spoke to the doctor and gave me some instructions, they brought the appointment forward and although it wasn't urgent, we got over that hurdle. So I know that they mean what they say.'(Int.22/dayhospital/service user/carer)*

This extended into the honesty which they felt they had in the relationship between the professionals and the service users. An example of which was demonstrated when staff admitted to not having the answer to a problem but pursued to find out and use it as a learning experience for both staff, service user and carer.

Time

Time was considered a valuable experience of care by those delivering and receiving the services in study group 2 (RT), 3 (day hospital) and 5 (JDC). In study group 2 it was the amount of time that the service user spent on the programme and the number of sessions per day that the individual required. These were related to the service user needs and their problems.

> *'Well we've had some people who've had reablement and they've been in and out within a fortnight, others will take 18-20 weeks and even longer we had one gentleman who was with us nearly 9 months we had him up and down the stairs and making a cup of tea after his stroke. We never mention a time limit..'(Int.4/RT/Staff).*

In study group 3 (day hospital) this was perceived as the amount of time that they were given to express themselves in order to understand the problems they encountered, taking time to listen to the service user and the need to feel free to ask questions and not feel they were a burden. The service user felt valued as a person which was emphasized in the repetitive *'he spoke to me'* (Int.21/dayhospital/service user). The service users and carers compared this with other services they had recently received within the NHS whilst trying to solve the same problem which had given the

service user the feeling that she was there to serve the health care professional's purpose and not her own.

> *'they [previous acute care experience] don't have time to sit with you, they don't spend anytime finding out what's wrong with you, and you can see they're busy, we understand that, but they're washing their hands wanting to go to get on with the next person, once they've got all they've wanted.'(Int.22/dayhospital/service user/carer)*

As opposed to

> *'They take notice of what you say, they take time to listen to you. Nothings too much bother they don't mind finding things out for you. They take time to find things out about you, what the problem is….They're not waiting to rush you to sit down so that they can see the next person. They listen to you.' (Int.22/dayhospital/service user/carer)*

This was often related to kindness

> *'even the person serving the tea…no trouble.. for both me and my husband'(Int.21/dayhospital/service user)*

Participants who attended study group 5 (JDC) also felt valued by the day service staff not only spending time listening to them but also being given the opportunity to listen to the day service staff talk about their lives.

> *'They stop and talk to you and listen to you and sometimes they like to be listened to. They spend time with us, its nice to know, its valuable.'(Int.15/JDC/service user)*

Relieving Loneliness and isolation

During the study period loneliness was acknowledged as a key problem in the borough (GHA & BGCBC, 2002-2007). Being lonely was something that participants experienced in study group 2 (RT), 4 (day care) and 5 (JDC). In study Group 4 the most important feature of the experience of care was the relief of being lonely, which was perpetual for them. They talked about days of monotonous routine in their own home which took a lot of effort, with

perhaps only seeing a relative once a week, domiciliary carer once or twice a day. The visits to the centre helped but didn't always provide someone to talk to. They compared this with their own past lives when they were able to engage in social interaction in the street, neighbours dropping in and out of the house; meeting friends and neighbours shopping; being a useful member of the family looking after grandchildren.

> *'It helps, It takes me out of myself. I'm talking to you now, but there's nothing to talk to, only the telly. I do have a book to read which they do bring me from the library….*
> *'Otherwise I have to get my own tea, my own dinner, my own supper, so that takes time cos it takes me longer to do, or to get about.' (Int.11/daycare/service user).*

> *'well I suppose you can have a talk, you don't know what to say the biggest part, instead of just facing the wall…. its just sociable'(Int.8/daycare/service user).*

> *'the thing is if I don't go out of the house I'm staying in the house aren't I... and it makes me mind that I'm doing something. I'm in the chair at the moment but later on I'm doing something. I might be looking at the television but i'm speaking to different people. I think it all helps. You're mixing. I'm pleased to come out..[laughter] and if I can't come out, there's nothing I can do about it!' (Int.14/JDC/service user)*

In study group 4 (day care) and 5 (JDC), the distressing feature of their experience was not just expressed by the words that they spoke but is was accompanied by the expression of sadness and helplessness in the low slow gravelly tone of voice with which they spoke, occasionally relieved by a buoyant tone when they talked about the food that was prepared for them at the centre or when talking about a special member of the family. During the interviews service users were sometimes in tears as they described their loneliness and their grateful relief of having a day out once or twice a week. They were continually expressing how grateful they were to the staff and how kind the staff were to them.

The participants in study group 2 (RT), 4 (day care) & 5 (JDC) were lonely because partners and family members the same age had died or were only accessible over the phone because of mutual immobility. Close family members such as sons and daughters were busy working throughout the day. The participants who attended study group 4 (day care) were relieved to be with people but found it difficult to converse with one another generally because they didn't know one another. They lived in different valleys, hadn't been to the same schools or had moved into the area. So at mealtimes they made small talk about food and experiences they had with grandchildren.

'Well everyone is so friendly. A lot of friendliness here I find, the staff and the people. I know none of these people' (Int.9/daycare/service user).

'Oh I'm not from here I'm from [name of village 5 miles away] so I don't know any of them from here. I'm not from around here. I've never seen them before' (Int.8/daycare/service user).

Participants experienced similar problems regardless of whether they lived in their own homes or had moved to supported housing i.e. a warden controlled flat. Old friends or people they had known for a long time were important. Meeting new or old friends was a problem. They experienced a loss of confidence in their own independent physical mobility and the ability to converse with new people. They missed not having a close confidant.

'I've never been a good mixer. I used to go downstairs for bingo. I don't see anyone from here. I should go and meet them but I don't I've lost my confidence. I've never liked that path I couldn't walk it. Its confidence!' (Int. 1/RT/service user)

'those who are able to get out and about on the bus will do their own thing, but the more frail they become, they do become very lonely. …you've got those who literally won't see anybody from day to day except for me knocking the door.'(Int.6/RT/carer warden).

'It's that closeness of relationship that you're missing, to be able to express your feelings. I just wish i could get somebody to just sit and talk to me. Even if it's for quarter of an hour you know. If I moan and say rub my back, she'll [daughter] say stop moaning and sometimes you just want a moan. No I don't want much. But at least I'm not in pain. Sometimes you just want to let off steam, but I'm pretty placid mind.'(Int.15/JDC/service user).

Negative Care Experiences

The negative care experiences were experienced by those older people and some staff who attended study groups 3 (day hospital),4 (day care) and 5 (JDC). These were in relation to the language spoken, the ability to influence the care environment, the stigma felt by the service users which prevented them from attending the study group environments.

Not all service users wanted to be seen as part of the group of people attending day hospital, the day centre or the JDC. They expressed this through refusing to attend the JDC study group 5 *'I'm not going there'* (Int4/RT/staff) and the study group 4 (day care) *'No, I don't want to go down there'*(Int6/RT/service user). Whilst some service users were observed sitting outside the day hospital in the adjacent corridor or refusing to enter the day hospital. Members of nursing staff demonstrated respect and acknowledged their individual requirements by taking observations such as blood pressure in the corridor and undertaking assessments and blood tests in a room adjacent to the day hospital (Obs1/dayhospital; Int4/RT/staff).

Day service staff within study group 5 spoke of older service users not having the same opportunities as younger day service users. Younger disabled service users were perceived as having more opportunities to use the gym and the swimming pool facilities within the adjoining leisure centre. Whereas for a person over 65 years, the swimming assessment seemed to take longer to access and staff couldn't rationalise why that would be so. The service users were also divided into young disabled attending the JDC

on a Monday and service users over 65 years on a Tuesday- Friday. There were different opportunities available for the young disabled on a Monday than there were on a Tuesday- Friday. Service users, carers and day service staff felt that this was segregation.

> *'Just because they're over 65 doesn't mean, well they may not want exact same things but they want more of the same opportunities. I don't know, going back over Christmas, on a Monday physically disabled, we done a month in Big Pit a month looking around Caerleon, ruins and different things, where else did we go, quite a few places, St Fagan, bowling. But yet we don't seem to be able to follow that through with the Tuesday- Friday clients and its not for a lack of not wanting to go, its justifying it. ..We do push for it but all we get back is that, that it can be justified for the Monday group but not on the others.'*
> *(Int.1/RT/Service user)*

Not all members of staff working at the day hospital (study group 3) used an empowering approach. On occasion, although service user and carer had both expressed a wish to be include in the consultation, the carer was excluded and so they had to strongly voice their intentions on how they wished the consultation to proceed.

> *'she [therapist] came up to him and wasn't including me in the conversation. We soon put that right. And the way she was talking to us we have a bit between these ears you know [pointing to the top of her head] and we want to be treated as if we do.'(int.22/day hospital/service user/carer)*

On another occasion a member of staff was observed walking behind a service user and at the same time talking about the service user to the relative without including the service user in the conversation. The member of staff occasionally gave the service user words of encouragement such as '*good girl'*. On another occasion during the same observation said to a service user. *'you need to bring your daughter with you. Never mind for today we'll see what we can do.'* (Obs.1/dayhospital). The acts appeared patronizing. This was also observed in Study Group 4. The stark contrast of

the modern, comfortable, bright and cheerful accommodation with language such as 'good girl' and 'there's a good girl'.(Obs5/daycare). This was further substantiated by an incident whereby the researcher was asked (following an interview with a participant) to speak over the phone to the home care organizer. He opened the conversation in an aggressive and hostile tone with *'I've got something to say to you, she's hit one of my carers'* and was convinced that the participant was *'off her head'* (Obs.6/Daycare). During the interview the participant had appeared tearful, frightened and angry (but not aggressive) that someone was going to suggest that she should leave the home she had shared with her son and husband.

5.6.4 'The Grey Space'

Participants who verbalise a 'grey space' recognised gaps in service which were constraining elements to the individual experiencing subjective wellbeing. The opportunity to experience social integration was not readily available to them because of the fear and confidence in relation to walking, environmental control of individual risk and the experience of pain. All of which impacted on a person's wellbeing i.e. subjective quality of life (Daatland, 2005). Therefore this 'grey space' was an area where health or social care was perceived as impacting upon one another.

> *There's this grey area when it comes to health and social*
> *care I don't think I could completely separate one from the*
> *other. As I said before, one merges into the other and can,*
> *I think cause the other. (Int.23/dayhospital/staff)*

Afraid of walking outside

Service users interviewed had experienced trips and falls either at home or in the community which had resulted in hospitalisation. As a result they experienced a loss of confidence in walking outside unassisted which impacted on their ability to have social contact and often resulted in isolation. Whereas before hospitalisation they had walked to the local town for pension, appointments and minor shopping now they talked of the fear of falling again, ending up in hospital and not being able to return home. So in

order to avoid that happening again they didn't go outside of the home environment.

> *I've lost all confidence and I can't go out …..*
> *(Int.1/RT/Service user)*

> *There was another man…. his wife had died Now he's had a stroke and he can't drive no more. That's the end of his life. The only little bit back to normality was that just up the road was a farm with two sisters who used to live up the road in a farm that had been cut in half, one sister was 90 the other was 80 odd. So he used to go up to them. By the time reablement pull out it was the dark nights and the path was getting unevenly up to the farm house from here up to the bus stop up there(points) all he really wanted he said was to visit the two sisters once or twice a week because they used to talk to him about his wife. He was too scared to walk up that path he used like to go up about half past seven and come back about half past nine, that's all he wanted out of life. ….To me by the summer he might have managed to go over. I think he would have been better in himself if he could have done that all through the winter. And by the following winter he might have been up to doing it by himself. I mean I couldn't carry on doing that going there at half past seven and then again at half past nine, it doesn't alter the fact that it's somebody's wellbeing. (Int. 4/RT/staff)*

Imposing Social isolation

Social isolation was imposed in two ways, self imposed or imposed by another. Controlling the environment was perceived as reducing an individual risk. Some participants actively chose not to engage in activities such as day care but to stay at home. This was due to physical changes to the body which posed a risk to personal independence or as a way of coping with the physical change, such as continence or paralysis.

> *'the grey space for me is,…. that lady .... she has slight mental health problems and don't get me wrong she was isolated she had one daughter who went there once or twice a week and another daughter who lived away and sent her letters. She couldn't communicate, she couldn't speak....she's lost her speech… She could only point and say U, ugh and she liked to see these letters and she liked conversation. You could have a joke and a laugh, once you got to know her. Now she wouldn't have liked to have gone*

*to the day unit, she would have been horrified to have been
sat amongst all those people because …. she was a bit of
a messy eater and she would have been horrified at that.
She was incontinent to say the least …, so that would have
been another issue for her. Now she needed support …. in
her own home...... All she needed was someone to visit her
three times a week read her letters have a laugh and a joke
with her, she would do her own thing in her kitchen and
then she was ready to watch the football in her home.
That's all she needed….'*(Int.4/RT/Staff).

Other participants had social isolation imposed upon them by a professional, a member of the family or the local community. Here the participants were feeling imprisoned within their own homes. This was usually due to the perceived risk of falling. Controlling the environment to the parameters of home or a day care unit was perceived as reducing the risk to individual physical safety.

'well I can't go out on my own shopping I'm not allowed to'
(Int.9/daycare/service user)

*'Another lady, her son had stopped her going outside
because the doctor had told her a few months ago that she
shouldn't walk outside alone'* (Obs.8/RT/daycare)

The participants accepted the instruction that health professional or son gave them and conformed to living a restricted lifestyle.

*'Another woman told me of her experience being a
'prisoner' in her own flat because a new woman had moved
above her after being in prison for assaulting her own
husband. The woman had left the tap running and the
client had experienced running water in her flat with the
outcome that wall paper was peeling off the walls. She
threw tampons and cans, cigarette stubs out of the window
so that the client couldn't walk outside in the garden;
drinking alcohol and partying late at night, leaving rubbish
bags outside the client's flat. She was frightened to go out
of her front door'* (Obs.8/RT/daycare)

This was an imposed situation where the participant felt unable to safely challenge the other tenant. She had contacted housing and social services but the situation had not been resolved and she felt powerless and fearful.

Being in Pain

The nature of the pain experienced was continuous with little respite. It impacted on movement and mobility which inhibited participant activity. Service users experienced the pain in different ways; as separate to their wellbeing, as a challenge which was to be overcome, as something which required expert assistance.

> *'I'm not really bad in myself. I can lift my head when I'm sat down it's where the bones have gone all out of shape in my neck [demonstrating]. And the pain … it stops you know and then its alright and then it comes back in my arm you know. …' (Int. 8/daycare/service user)*
>
> *'One gentleman [name of service user] A lot of pain.. very much so... his legs are very bad and he does suffer with pain and he wants to be as mobile as possible, which he does. He pushes himself … he do tire and get so out of breath and he's in pain. As soon as he's finished he's in terrible pain, constantly in terrible pain and he tries to go beyond the pain barrier' (Int.12/JDC/staff).*
>
> *'I have pain in the back of my heels and I'm waiting for the hospital appointment..'.(Int.18/OP/service user)*

Measuring subjective health, quality of life and disadvantage
Health and quality of life has been measured subjectively by the service user at two stages using the SF12v2. Disadvantage through ill-health has been measured subjectively by the service user at the two same stages using the London Handicap Scale.

Stage 1(upon referral): SF12v2
The subjective health and quality of life measure using SF-12v2 suggested that upon referral the only significant difference between integrated and non-integrated day services were within the Social Functioning scale domain between OP (study group1) and RT (study group 2); and the Role Emotional scale domain between the two integrated services (study group 2-RT and study group 5-JDC) and day care, a non –integrated service. See Table 18 for transformed scale scores on referral.

Study Group/ SF12v2 Mean (SD)	Physical Functioning (PF)	Role Physical (RP)	Bodily Pain (BP)	General Health (GH)	Vitality (VT)	Social Functioning (SF)	Role Emotional (RE)	Mental Health (MH)
Study Group 1 (OP)	38.04 (40.50)	30.43 (33.88)	47.79 (34.47)	28.26 (28.11)	18.48 (22.88)	52.62 (37.34)	50.54 (36.05)	46.20 (28.56)
Study Group 2 (RT)	22.18 (32.15)	25.91 (31.87)	43.73 (30.61)	32.36 (22.77)	25.00 (28.64)	19.85 (29.91)	47.35 (31.52)	51.14 (21.96)
Study Group 3 (DH)	11.83 (15.93)	18.26 (16.27)	47.00 (30.89)	30.17 (32.79)	18.00 (26.54)	37.00 (33.17)	38.14 (35.50)	52.50 (28.18)
Study Group 4 (DC)	20.65 (38.18)	43.69 (39.05)	56.52 (39.32)	33.26 (32.39)	26.02 (30.60)	39.58 (43.74)	76.63 (35.42)	54.34 (24.89)
Study Group 5 (JDC)	14.84 (24.95)	32.46 (28.96)	51.89 (26.39)	31.92 (27.06)	26.86 (32.35)	31.73 (34.32)	44.80 (24.81)	54.89 (21.56)
Total Respondents (n=130)	21.26 (32.07)	29.69 (31.39)	48.97 (32.11)	31.28 (28.06)	23.053 (28.29)	34.81 (36.60)	50.81 (34.58)	51.84 (24.72)

Table 18: Transformed scale scores on referral to the study groups Stage 1 SF12v2

The scales score 0-100 within each domain; 0 representing worst health status within the domain and 100 representing best health status within the domain (Ware et al, 2002). Kruskal- Wallis test (non parametric) was used to see whether these eight independent groups (the scale domains in table 19) significantly differed on referral. There was a significant difference between groups within the Social Functioning (R<0.014) Role Emotional (R<0.002) scale domains only i.e. their values were less than 0.05.

	PF	RP	BP	GH	VT	SF	RE	MH
Asymp. Sig.	.193	.193	.626	.893	.779	.014	.002	.624

Table 19: Significance values for SF-12v2 Scale Domains (Kruskal Wallis Test)

In order to demonstrate where the difference was, ten Mann- Whitney tests were used. They looked for differences between the independent domain scales and whether or not they had the same origins (Field, 2005). Bonferroni Correction was used to interpret the analysis to avoid an accumulation of Type 1 error of more than 0.05. This was achieved by

242

dividing the critical value of 0.05 with the number of tests performed to give us p<0.005 as our critical level of significance.

Four significant values could be seen:
- A significant value could be seen when comparing Study Group 1 (OP) and Study Group 2 (RT) in the Social Functioning domain scale (U=185, z=-3.40, r=0.001).
- A significant value could be seen when comparing Study Group 2 (RT) and Study Group 4 (day care) in the Role Emotional domain scale (U=202.5, z= -3.03, r=0.002).
- A significant value could be seen when comparing Study Group 3 (day hospital) and Study Group 4 (day care) in the Role Emotional domain scale (U=136, z= -3.21,r= 0.001).
- A significant value could be seen when comparing study group 4 (day care) and study group 5 (JDC) in the role emotional domain scale (U=117.5, z= -3.70,r= 0.00).

Therefore, upon referral:
- Participants from Study Group 2 (RT) perceived a worse health status in social functioning when compared with Study Group 1 (OP). That is physical or emotional problems interfered with the participants social activities (Ware et al, 2002).
- Participants from Study Groups 2 (RT) perceived a worse health status in role emotional when compared with Study Group 4(DC). That is they accomplished less or did activities less carefully than usual (Ware et al, 2002).
- Participants from Study Groups 3 (day hospital) perceived a worse health status in role emotional when compared with Study Group 4 (day care). That is they accomplished less or did activities less carefully than usual (Ware et al, 2002).
- Participants from Study Group 5 (JDC) experienced worse health status in role emotional when compared with Study group 4(DC).

> That is they accomplished less or did activities less carefully than usual (Ware et al, 2002)

London Handicap Scale

This scale quantifies the disadvantage experienced by an individual due to ill-health into one handicap score between 0-100., with 100 representing no disadvantage and 0 representing the maximum possible disadvantage (Harwood & Ebrahim, 1995) (see table 20).

Study Group/ LHS Mean (SD)	Mobility (um)	Physical Independence (upi)	Occupation (uoc)	Social Integration (usi)	Orientation (uor)	Economic Self Sufficiency (uses)	Handicap score
Study Group 1 (OP)	.5348 (3.36)	-1.965 (5.47)	1.88 (3.48)	5.53 (2.89)	5.31(5.13)	5.11(4.91)	66.91 (16.92)
Study Group 2 (RT)	-2.26 (3.37)	-2.689 (4.58)	.574 (2.76)	4.19 (3.30)	5.05 (5.75)	5.23 (3.79)	60.60 (16.76)
Study Group 3 (DH)	-.616 (3.37)	-3.580 (2.83)	-.152 (3.64)	4.68 (2.06)	5.43 (4.83)	3.90 (4.84)	60.16 (13.37)
Study Group 4 (DC)	-1.188 (2.99)	-2.328 (3.38)	.492 (1.37)	4.75 (2.82)	6.55 (5.41)	7.21(3.55)	65.99 (10.10)
Study Group 5 (JDC)	-2.730 (3.94)	-3.256 (2.91)	-.515 (1.88)	4.78 (2.92)	5.73 (4.76)	4.91(4.65)	59.41 (11.22)

Table 20: LHS dimension scores on referral to study groups

Handicap Score

The Kruskal- Wallis (non-parametric test) showed that there was a significant difference between groups within the Mobility (R< 0.002), the occupation (R<0.020) and the economic self sufficiency dimensions (R< 0.034) i.e. their values were less than p< 0.05.

	Mobility (um)	Physical Independence (upi)	Occupation (uoc)	Social Integration (usi)	Orientation (uor)	Economic Self Sufficiency (uses)
Asymp. Sig.	0.002	0.808	0.020	0.285	0.794	0.034

Table 21: significance values for the LHS scale dimensions (Kruskall Wallis test)

Again the post hoc test (Mann- Whitney tests) was used to look for the difference between scale dimensions and whether or not they had the same origins. Again Bonferroni Correction was used to interpret the analysis to

avoid an accumulation of Type 1 error of more than 0.05. This was achieved by diving the critical value of 0.05 with the number of tests performed to give us p<0.005 as our critical level of significance.

Four significant values could be seen:

- A significant value could be seen when comparing Study Group 1 (OP) and Study Group 2 (RT) in the mobility dimension (U= 206, z= -3.25, r= 0.001).

- A significant value could be seen when comparing Study Group 1 (OP) and Study Group 5 (JDC) in the mobility dimension (U=152.5, z= -3.18, r= 0.001).

- A significant value could be seen when comparing Study Group 1 (OP) and Study Group 5 (JDC) in occupation dimension (U=160.5, z= -3.04, r=0.002).

- A significant value could be seen when comparing Study Group 3 (DH) and Study Group 4 (DC) in the economic self sufficiency dimension (U= 171.5, z= -2.89, r=0.004).

Therefore, upon referral:

- Study Group 2(RT) perceives greater disadvantage in their mobility than Study Group 1(OP) i.e. disadvantaged in their 'ability *to get from one place to another, using whatever help, aids or means of transport that are normally available'* (Harwood & Ebrahim, 1995, p7).

- Study Group 5 (JDC) perceives greater disadvantage in their mobility than Study Group 1 (OP).

- Study Group 5(JDC) perceives greater disadvantage in occupation than Study Group 1 (OP) i.e. disadvantaged in their *'ability to do what one wants to do with their own time.'* (Harwood & Ebrahim, 1995, p7).

- Study Group 3 (DH) perceive greater disadvantage in economic self sufficiency than Study Group 4(DC) i.e. disadvantaged through *'the effect of ill-health on the ability to earn a living and the use of resources overcome disadvantages associated with ill-health'* (Harwood & Ebrahim, 1995, p7).

Stage 2-Comparing between questionnaire phases 1 & 2

Integrated and non integrated services

The data within the descriptive statistics suggested that there was a difference within the integrated and non integrated services. Stage 2 of the statistical analysis commenced with descriptive statistics and as the assumptions of parametric testing had been violated a non-parametric Wilcoxon Signed Rank Test was utilised. This allowed a comparison of two sets of scores (phase 1 & 2) which came from the same respondents to be compared e.g. non-integrated services (study group 1-OP, study group 3-DH and study group 4- DC) (Polit & Beck, 2004; Field, 2005).

London Handicap Scale

There was no significant difference between scores for the scale dimensions and the overall Handicap Score when comparing phase 1 and phase 2 questionnaire scores for integrated and non-integrated services.

SF12v2

The score for Bodily Pain (BP) was significantly higher for non integrated respondents in phase 1(Mdn=43.75) than in phase 2(Mdn=25.00). The 'z' score (z= -2.33) is significant at p=0.020. Therefore because this value is based on the negative ranks we should conclude that there is a significant difference in bodily pain from the 1st phase to the 2nd phase questionnaire. This sub scale is scored so that a high score indicates lack of bodily pain (Ware et al, 2002). Therefore respondents had significantly more pain interfering in their normal day in phase 2 than they experienced during phase 1 i.e. on referral to the service.

Additional Question Home care [FAGRO Functional Domain 4]

Although increased independence (through less home care/ carer) could be seen in study Group 2 (RT) and 3 (day hospital) only when comparing the means of 1st and 2nd phase questionnaires. When using the Wilcoxon Signed Rank Test no significant difference was seen within each study

group in relation to increased independence i.e. reduced amount of home care/ carer support used between 1st and 2nd phase questionnaires. Also, no significant difference was seen within integrated and non integrated services in relation to increased independence i.e. reduced amount of home care/ carer support used between 1st and 2nd phase questionnaires.

5.7 Navigating services and orchestrating care

The service user and carer experience of navigating and orchestrating care is discussed in the two sub themes of utilising community services and the service user and carer relationship.

5.7.1 Utilising community services

It is important to remember that the participants experience day services as variable amounts of time in their everyday lives. The proportion of time spent in the experience of being in a day service depends upon the service user's perception of its purpose, whether it meets his or her needs and the individual's level of dependency on others whilst trying to maintain a life living at home (Int.18/OP/service user; Int21,22/day hospital/ service user/carer;Int16,15/JDC/service user/carer). The frequency of occurrence of attendance depended upon the type of service in proportion to need. The effort in receiving the day service varied as to whether they found transport to get there, OP or day hospital, they had transport provided for them day care or JDC) or they did not require transport because they received the service at home.

Not all study participants (Int.7/daycare/carer) had experienced in-patient care during their lives but utilised a number of community services to remain at home (table 22). The participants attending Study Group 1 (OP) utilised fewer community services. Participants in Study Group 2 did not directly refer themselves to the GP but utilised the medical care available within the service itself. All participants within the study groups experienced some form of unpaid 'care' (table 22).

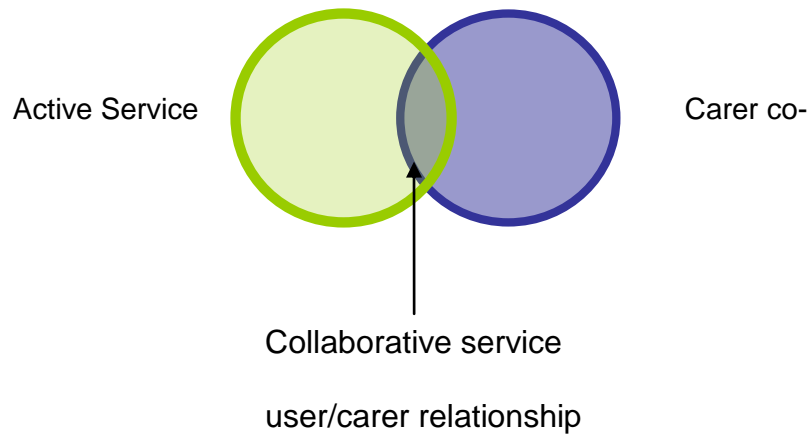| Participants/ services utilised	SSD/OT	SSD Benefits	unpaid carer	Paid care	GP	Leisure	District nurse	CP	Optometry	OPD	CPN
Study Group 1			√	√	√					√	
Study group 2		√	√						√	√	√
Study group 3	√	√	√	√	√		√				
Study Group 4			√	√	√		√	√	√	√	√
Study Group 5			√	√	√	√	√		√	√	

Table 22: Services utilised by study group participants

5.8   The Service User and Carer Relationship

Bland (1999) defines the core values of independence as 'privacy, dignity, choice, autonomy and fulfillment'. Autonomy is a positive concept with qualities of self-assertion, critical reflection, absence of external causation and knowledge of one's own interests which include action, belief, reasons for action (Dworkin, 1988).

The study participants verbalised certain characteristics regarding the service user and carer relationship in respect of autonomy and independence. This is demonstrated through the following non-linear model in relation to the service users' own care coordination and the movement towards collaborative care co-ordination and carer control. The participants perceived an ability to move back to active service user co-ordination once a period of crisis was over. This could happen within a day or over a period of time such as weeks or months. Significantly participants did not perceive the carer co-ordination role as a professional role but the carer as a confidante. See Model 2 for a visual perspective.

Model 2:Service User/Carer Relationship

Active Service   Carer co-

Collaborative service

user/carer relationship

Minimal carer input	←——————→	Maximum carer input
Autonomous service user (SU)		Dependent service user (SU)
Confidante relationship	←——————→	Carer relationship
Self -reliant SU		Not self- reliant SU
SU Privacy self-contained	←——————→	SU Privacy not self-contained
SU Dignity self-assured		SU Dignity not self assured
SU choice dominant	←——————→	Carer choice dominant
SU self-esteem maintained		SU self- indifference
SU fulfilment self determined	←——————→	SU Fulfilment facilitated

5.8.1   Active service user co-ordination

Active service user co-ordination is defined as when the service user
actively organizes his or her timetable of complex service arrangements
with a number of providers (health, social, private care services) on a
regular basis and as required. The active service user co-ordination role
was seen in Study Group 1(OP) and 2(RT) and was divided into '*active
service user coordination- independent living'* and '*active service user-*

supported living' (see table 23). The only difference between the two was that the participants in the latter group had a social services care plan.

This role on the whole demonstrated some positive values of privacy, dignity, choice, autonomy and fulfillment. Although participants lived in differing environments (own house and supported housing) and made certain compromises in privacy, choice and dignity, they saw themselves as actively coordinating their own care and as living independently. The participant negotiating with registered practitioners, agencies and private care arrangements when timetabling individuals coming into the home required altering.

> *'I don't see anyone having an over view picture of my needs, only me…The carer comes on a Tuesday morning. So….I have my shower, I get my nurse …on a Wednesday and then I get Lisa on a Thursday. If the nurse then, she should have come yesterday but she didn't so she's been this morning. The carer now this week they come on a Monday morning to help me with a shower. ... So I'm organizing all this, oh yes!'* (Int.1/RT/Service user)

They had a desire to be independent in their own homes although they saw this as being outside of the whole system and being in a lonely battle. An inner battle because they didn't like to complain and an outer battle trying to get someone to communicate and listen to them.

> *'a lot of people don't realise that you have to cope with it, you've sort of got to fight yourself in a way'*
> (Int.2/RT/Service user).

> *'he [social worker] phoned me and said that he'd come and see me and he never came and I phoned him back and he said he'd come but he never came, he never phoned and I never heard anything. The warden phoned and they said he wasn't there and then she phoned another week and they told her he'd been on holiday and she phoned him at least 5 times and of course I'd only seen him that once and I said don't bother any more (Int.2/RT/Service user).*

Service user levels of privacy were dependent on physical ability to maintain personal activities of daily living i.e. ability to wash and dress without help.

In study group 1 the participant was able to complete all personal care. In study group 2 the participant was able to complete daily personal care (i.e. washing and toileting) but not showering. Loyalty and trust was an important factor in the relationship between participant and the paid carer. All participants were able to manage their own daily finances and pay bills (Int.1, 2/RT/service user;Int19/OP/service user).

Dignity was demonstrated through self respect, pride and self esteem. These were lived through an ability to control and live their own lives, for example an ability to choose their own confidante who was a person outside of the family.

> *'I've got my old friends... I know there's next door if I needed her'* (Int.1/RT/Service user).

Although participant 19 (study group 1-OP) chose to have guidance about health and financial matters from various members of the family, her confidante was a female friend living in nearby supported housing. Her respect and self esteem came from her ability to participate as part of the family, maintaining the family home, giving advice to grandchildren, hosting family parties, her ability to walk to town and do her shopping. Whereas, self respect and pride in participants 1 and 2 (RT) came from their ability to demonstrate control and coordinate their daily care.

Therefore participants' ability to engage with the outer community was different. Participant 19 (study group 1-OP) continued to do so herself, participants 1 and 2 (study group 2-RT) by proxy through a confidante or private domestic arrangement. The impact on an informal carer/ relative/confidante was minimal. They didn't see themselves as carers but as a friend, son or daughter-in-law.

> *'I'm not my mother's carer. She's my mam. I'm there if she needs me'* (Int.20/OP/carer).

Participants took pride in their ability to recall the detail about care experiences, local history and current local affairs and gossip. Participant 1 (RT/service user) maintained a diary as an aide memoir and referred to it throughout the interview. Participants 1, 2 (RT/service users) and 19 (OP/service user) had an ability to recall and relay decisions they had made and why they had made them which boosted their self-esteem. How people treated the participants and talked to them affected their pride and at times disappointed them (Int. 1,2/RT/service users). Nevertheless, they were assertive.

> *'she's only been here five minutes when she was going and I pointed it out to her when she was going and she stopped for the full quarter of an hour' (Int.2/RT/Service user)*

> *Because she's so assertive and able to speak for herself she can then …. move onto the next stage herself. She's able to say that 'I'm a little unsure of using the shower.'(Int.6/RT/carer)*

Choice was limited by their physical ability to choose what they want to achieve generally in their own lives and how they wanted to live it, due to, for example breathing difficulties and restricted mobility. Choice also appeared limited by fixed outpatient appointments or reablement appointments made for them as prescribed by the registered professionals. However, it was demonstrated through the ability to choose whether or not the participant still needed certain equipment, when the participant wanted the RT (Study Group 2) service to withdraw at certain stages, choosing and arranging appointments to see the optician. The participant in study group 1 demonstrated choice through choosing who she would take with her to attend the appointments and how she would get to her appointments either by taxi, hospital transport, walk or relative (Int.19/OP/service user). Choice of informal paid help was made through people they knew.

Some participants actively challenged 'expert' opinion and critically reflected on their own experiences of care to maintain their independence. They considered the advice they were given and planned their future choices of

when to move into sheltered accommodation or a care home or if a similar situation happened again.

> *'He said I would like you to go into somewhere... I'm not ready for a nursing home. I'm putting it off'* ….. *'I don't like you being there on your own'. (Int.1/RT/Service user)*

> 'Last year I had a terrible accident …. I was in about 9 weeks between [name of district hospital, community hospital and care home]. I was in [care home] for 20 days. If the same situation happened again I would have asked for reablement. If I'd had that rest at [community hospital] I'd have said no let me go home and I wouldn't have gone to [care home]. Mind you they did my food and I couldn't have done that myself. They did nothing else for me and for 20 days that cost me £1260 but nobody mentioned the payment to me, nobody mentioned the payment to me, ..It wasn't until October November when the bill come.'
> (Int.2/RT/Service user)

Table 23: Characteristics of service user/carer relationship

Characteristics	Active Service User Coordination		Collaborative relationship	Carer co-ordination control
	independent living	**supported living**		
Study participants (source)	**Study Group 1 (OP) Int. 19/Service user**	**Study Group 2 (RT) Int. 1, 2/service user**	**Study Group 3 (DH) Int. 22/service user carer; Study Groups 1(OP) & 2 (RT) (during crisis) Int19/OP/Service user; Int1, 2/RT/service user.**	**Study Group 3 (DH), 4 (DC) Study Group 5 (JDC) Int. 16, 15, 13/service user/carer**
Accommodation	Own house	Supported housing/ own home	Own house/supported housing	Supported housing/ own home
Community engagement	• Minimal restriction through restricted physical condition. Attends church, weekly shopping in local market	• Engagement by 'proxy' i.e. through a confidante, online shopping, relying on relative with transport to go shopping or do the shopping for them	• Engagement by proxy through a confidante. E.g. due to gradual loss of driving skills, voice production and acute illness (Int.22/dayhospital/service user/carer,Int19/OP/Service user;)	• Facilitated by carer through social services and family (Int.7/daycare/carer; Int.13/JDC/service user carer).
Social Services engagement	• None	• Through and following RT (Study Group 2) for arrangement of care at home services excluding private arrangements • Contact with social services required only when formal alteration to care plan required (Int.6/RT/carer)	• Through DH for equipment, adaptations and benefits (Int.22/dayhospital/service user/carer). • Engagement with either service user or carer or both (Int. 6/RT/carer; Int22/day hospital/service user/carer) • None (Int.19/OP/service user)	• Established routine of paid carers (Int.15, 16/JDC/service user; Int7.Daycare/carer) • Established routine of day services only. Family undertake personal care (Int.13/JDC/carer/service user; Int7.Daycare/carer)
Carer/confidante	• Son not a carer, friend as confidante (Int.20/OP/carer)	• Warden as confidante (Int.1/RT/Service user). Daughter as confidante (Int.2/RT/Service user)	• Wife or Husband as confidante (Int.22/dayhospital/service user/carer).	• Confidante linked to day service • Family member (next of kin) as carers (Int.15,13 /JDC/service user/carer; Int7.Daycare/carer)
Privacy	• The ability to undertake own personal activities of daily living without assistance. • Manages own daily finances (Int.19/OP/service user).	• Able to manage personal daily activities of daily living such as washing and toileting but help required for getting in and out of the shower (Int.1/RT/Service user; Int.2/RT/Service user) • Privacy linked to relationship with paid care. (Int.1/RT/Service user; (Int.14/JDC/service user).	• In crisis e.g. prior to hospital admission privacy compromised (Int.1/RT/Service user; Int.2/RT/Service user) • Compromised and relies on the skills of the paid and unpaid carers and confidante (Int.22/dayhospital/service user/carer, Int. 6/RT/carer)	• Participant makes compromises with embarrassment and discretion or disregards privacy in order to achieve social fulfilment (Int.13,14/JDC/service user/carer; Int.23/dayhospital staff).
Dignity	• Self worth, self-esteem maintained through her community, social and family status (Int19.). Linked to choice	• Self respect and pride demonstrated through her control and arrangement with her private help (Int. 1, 2). • Dignity linked to choice of confidante	• Linked to relationship with confidante and their ability to be assertive when required (Int.22/dayhospital/service user/carer; Int. 6/RT/carer 6)	• Linked to relationship unpaid carer and contract with paid carer (Int.13.15.16/JDC/service user/carer) • Loss of self-worth as

	of confidante.	(Int.1/RT/Service user).		participants conform with carer and paid care routines and decisions (Int.13,15,14/JDC/service user/carer ; Int.23/day hospital/staff)
Choice	• Able to consider and choose who to ask to accompany her to outpatient appointments (Int.18/OP/service user).	• Able to assert own choice between services and equipment (Int.1/RT/Service user). • Able to plan and choose direction of future lifestyle (Int.1/RT/Service user)	• Choices made known to confidante prior to crisis. Confidante chooses on participant behalf (Int.22/dayhospital/service user/carer; Int. 19, 20/OP/service user/carer; Int.6/RT/carer)	• Dependant on carer relationship / contract with paid carer (Int.13, 15/JDC/service user) • Access to confidante restricted to choice of company at study group 4 & 5 (Int.16, 13,15/JDC/service user,) • Does not engage in life or daily choices. Carer makes all choice decisions (Int.7/daycare/carer; Int.23day hospital/staff; Obs.2/JDC)
autonomy	• Able to reflect on previous hospital experiences. • Able to recall detail of previous outpatient visits. • Problem solving how to get to appointments without family support.	• Able to critically reflect on hospital admissions in the last year (Int.1,2/RT/Service user,). • Using a diary as an aide memoire to help her co-ordinate her health and social care arrangements.(Int.1/RT/Service user) • Problem solving without assistance or seeks advice from close friend. (Int.1,2/RT/Service user) • Actively challenges 'expert'/official opinion about her situation and assert opinion (Int.1,2/RT/Service user,). • Plan for the future (Int.1/RT/Service user).	• Confidante problem solving and engaging with health or social care professionals on behalf of participant when not able to do so (Int.6/RT/carer, Int.22/dayhospital/service user/carer; Int. 19, 20/OP/service user/carer;)	• Carer problem solving with but mainly on behalf of participant when not able or refusing to do so (Int.1615/JDC/service user/carer/ Int.7/daycare/carer)
Fulfilment	• Able to fulfil social competence through walking to nearby friends, church, family; and maintain a weekly shopping routine independently (Int.18/OP/service user)	• Social competence is restricted due to restricted mobility to the home (Int.1,2/RT/Service user). • Uses diary to satisfy her need for accurate information about appointments, hospital stays etc. (Int.1/RT/Service user)	• Fulfilment related to confidante ability to manage crisis satisfactorily on behalf of the participant and return autonomy, choice, privacy and level of dignity as before. Int.6/RT/carer, Int.22/dayhospital/service user/carer; Int. 19, 20/OP/service user/carer;)	• Social competence is only fulfilled through facilitated attendance to day centre or JDC and family (Int.15, 16/JDC/service user/carer; Int.7/daycare/carer) and use of internet (Int.13/JDC/carer/service user)

5.8.2 Collaborative relationship

In this context the 'collaborative relationship' is defined as when two individuals (who normally live independent lives), experiences one of those individuals leading activities with knowledge of the other, during a period of time when that person is unable to sustain autonomous living. The aim of which is to gain a positive outcome in order to return the individual to an autonomous lifestyle. This relationship can be a time of transition during the day or over a period of weeks or months. It occurs on an ad-hoc basis. It is a subtle relationship with carer empowering but co-ordinating and advocating only when the service user is unable to make rationale decisions in a crisis or physically unable to do something.

During a time of crisis or physical frailty due to an illness or pre and post hospital admission, privacy was compromised due to the physical needs of the individuals (washing) (Int.1,2/RT/service user). This relationship was required for a short time. During this time decisions were made or facilitated on behalf of the participant but having had previous consent to do so or in consultation with the participants at that time. This relationship is based on trust and a common understanding (between participant and confidante/ carer) of the participant's needs at that time and their general desires with regard to their life and lifestyle.

> *'More often or not whoever it is at the end of the call centre .. they'll call an ambulance. That person's afraid of the ambulance coming cos they're afraid of going into hospital, cos they ain't going to come back out and they've said.. 'don't let them call an ambulance [carer's name], see if I'm alright first. It was about 8 o clock in the morning, he's pulled the cord and he's got problems with his breathing, he's on oxygen.. I went in and I could see him and I said look let me phone the ambulance, you need it. 'Alright' he said, It's the decision,… when you're very ill. That you need somebody that you trust to help you make that decision'* (Int.6/RT/carer).

5.8.3 Carer co-ordination control

Carer control of co-ordination occurs as a result of dependence being imposed through illness, through the actions of another person or through the service user choosing not to engage in daily living activities.

The carer as co-ordinator makes decisions on behalf of the service user. This may be due to the service user giving up the role of paying bills or not having had the role of paying bills as traditionally done by a husband. Consent to participate within the study although came from the service user, was sought by the service user from a son or daughter. It appeared that service user autonomy was fragile here as the service user relied on that person to be maintained in their own home (Obs.2/JDC). In interview 15 (JDC/service user) this made her feel that she was the '*underdog*'. Where carers had refused paid care and undertook the personal care themselves, service user choice, dignity and autonomy were further restricted.

> *'I know I can't wash and dress myself'[son]…..*
> *'and ...so I have to do it [mother]. I don't want strangers coming in and out of my house everyday. They can't tell you when they're coming . Say we had a regular carer and she got taken ill, and social services, they don't write you a letter to tell you that you got Mrs so and so this week..and so you just have to wait for someone to turn up and they tell you that I'm your home care this week [name of carer].I know that we can get him ready for the day centre and we don't have to worry that he's going to be ready in time. If he's had an accident then we don't worry we can change straight away and we don't worry do we love? (Int.13/JDC/carer/, carer)*

Having a physical impairment and disengaging from activities resulted in loss of dignity, privacy and choice as to when and how to undertake the activities.

> *'So many of the patients just want to have everything done for them. They just want you to sort everything out for them, let me give you an example. I asked a lady the other day…can you wash your face? No she said the carer does that. I asked her can you feed your self and she said yes. So I said if you can feed your self then why can't you wash*

*yourself? She said that she had a carer to do
that'(Int.23/dayhospital/staff).*

Where dependency was self imposed, the service user has made a clear decision that she didn't wish to undertake daily activities of living and social activities without some support. The service user was detached from organising daily activities and wanted others to care for her.

> *'Now my mother now she's 88.and when she was 80
> she decided she was doing no more. Well she's
> always been a very busy lady and well she felt she..
> well things well became hard…'* (Int.7/daycare/carer.)

The daughter has witnessed that her mother's physical health has been deteriorating, she had problems with her eyesight, mobility and balance. This had resulted in her being unable to go out unless accompanied.

> *'It's not like she can walk anywhere she's doddery. She's
> got cataracts, …and she's got a stick with her. But to me
> she's not looking good, not looking at the floor but she's
> always looking down. She's been giddy on and off for
> donkeys years. Trying various medication but they do
> nothing…… but now she doesn't go anywhere unless
> anybody takes her'(Int.7/daycare/carer)*

The service user has a highly organised routine organised for her to maximise the company she had throughout the week. The following quote from a carer from study group 4 (day care) suggests that mother had somehow manipulated the situation to her advantage.

> *'Well my mother's just well I can't quite explain it. well why
> my mother's got someone to go in every morning and she
> goes down on a Monday, Wednesday Friday to have a cup
> of coffee, Tuesday and Thursday bingo, Sunday she comes
> to me.'(Int.7/day care/carer)*

The complexity of the arrangement is demonstrated in the following text. There is a combination of paid care through social services domiciliary care, day care and Crossroads. The unpaid care is provided by the two sisters who visit or have mother in their own homes six days a week.

> *'Monday afternoon she goes up to my sister's shop, Friday afternoon she goes up to my sister's shop, Tuesday I go down and shower her, Thursday i go down and sort her money out and I do whatever, Saturday I go down and do all her tablets for the week apart from keeping her company. ……………At one time I was doing it all every day, morning, night everything. She's got these ladies coming now and she pays them the going rate. And they, they're called [name of independent contractor], Monday, Wednesday and Friday they go downstairs and pay for the tea and toast. Go down on a Tuesday and Thursday and pay for bingo. Everything my mother has she pays for with exception of Crossroads and up 'til now she did get a week in[care home] back last year when my sister was going away and we did eventually have to pay for the week. Now she goes on a Saturday morning from about 10.30 until about 3.30, my mother's just one of these people that wants to be with somebody all the time.'(Int.7/daycare/carer).*

The daughter interprets the dominant reason to be the need for company; her mother doesn't want to be alone. Before the care package was implemented her mother used to phone her every day and describes her as '*never off the phone'*. The daughter perceives her role as that of her mother's main carer which she has acquired but not chosen because her one sister lives 30 miles away and the other lives nearby, leads a busy life. The role as carer she observes as a role reversal which has crept up on her because her mother has chosen not to make decisions about everyday occurrences. The carer understands this as normal behaviour and has accepted that this is her mother's choice. Although there appears to be an element of frustration in the tone of the daughter's voice.

> *'when I think in the beginning how did she become like that…….Its not that there's anything wrong with her mind, she just depends on us for everything. I'm always her mother.'(Int.7/daycare/carer)*

In this case the act of caring is reinforced through acts of love such as *'When I'm down there then, before I come from there, she loves current buns, toasted, in bed.'* Although this role has resulted in some resentment with her comparing herself with her mother, both retired, she's extremely tired as she's busy caring for her mother, whilst her mother is tired and *'she*

259

doesn't do anything'. The shrill tone of her voice re-enforced the desperation of the situation.

The resentment of coping with a job and the caring role was also evident where another mother and daughter had a turbulent relationship.

> *'She says 'I come down every night to see you at half past six' and by about the time they have a meal you know, she'll call in [name of superstore] on the way to bring me something you know she'll say [abruptly] 'I've got to go I've got to go.' put my food down on the table and she'll have to go……….Well I supposed she's so tied up in work she's got a hard job like, well you know she do take it out on me. [Granddaughter] said Nan because she loves you so much you're a sitting duck. Well they say you take it out on the ones you love' (Int.15/JDC/service user).*

Summary

This theme has considered 'utilising community services' and 'the service user and carer relationship'. The spread of services utilised demonstrated that those utilising OP used fewer community services. A non-linear model of the service user relationship has been offered for consideration utilising core values of independence and autonomy to define its characteristics.

5.9   What could be learned from this study of integrated and non integrated services?

The meta matrix in appendix 17 captures significant aspects of the whole of the case study in respect of the first two 'etic' questions posed:

- How were integrated services different?
- Why integrated services were perceived as different to non integrated services?

In answer to the first 'etic' question, generally, all study groups were different in their purpose, their level of integration, their team orientation of practice and the dominant perception of service user/carer relationship that
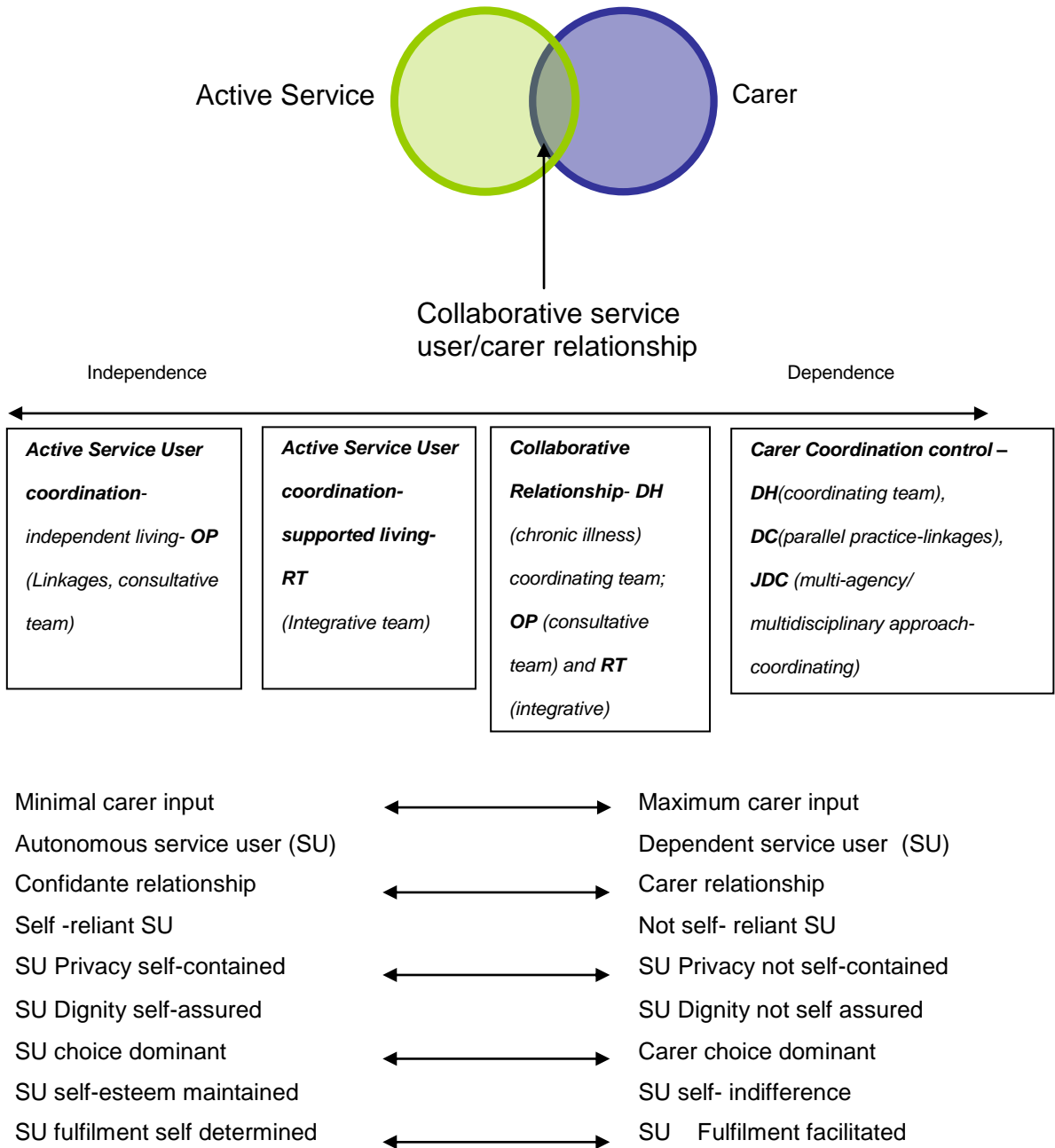
was expressed by participants. However, what can be seen is that the level of team orientation and integration does not appear to be proportionate to the nature of the service user/ carer relationship and the level of independence/ dependency demonstrated (Model 3).

The service user/carer relationship model and study group provision in Model 3 gives a visual explanation. It demonstrates that where there was 'active service user coordination' and the service user lives independently, the study group (1-OP) is a consultative team with linkages (level of integration). Where there was 'active service user coordination' and the service user experienced supported living, the study group (2-RT) were integrated both at a level of integration and team level.

Where there was a 'collaborative service user/carer relationship' the participants may have experienced a change in relationship but their service experience was dependant upon which service they were referred. If they were referred to day hospital (study group 3) then they experienced a coordinating team and coordinating level of integration. If referred to out-patients then they experienced a consultative team; whilst, if they were referred to RT (study group 2) they experienced an integrative team and integrative level of integration.

'Carer Coordination control' where there is maximum carer input and service user dependency, service users and carers service experiences were also variable. Where service users were referred to day hospital (study group 3) they experienced a coordinating team. Whilst if participants were referred to day centre (study group 4) they experienced parallel practice with linkages or multi-agency/multidisciplinary team approach with coordinating level of integration for those referred to JDC (study group 5).

Model 3: Service User/Carer relationship model with team orientated health and social care practice and level of integration

Active Service

Carer

Collaborative service user/carer relationship

Independence

Dependence

Active Service User coordination- independent living- OP (Linkages, consultative team)	*Active Service User coordination- supported living- RT (Integrative team)*	*Collaborative Relationship- DH (chronic illness) coordinating team; OP (consultative team) and RT (integrative)*	*Carer Coordination control – DH(coordinating team), DC(parallel practice-linkages), JDC (multi-agency/ multidisciplinary approach- coordinating)*

Minimal carer input	Maximum carer input
Autonomous service user (SU)	Dependent service user (SU)
Confidante relationship	Carer relationship
Self -reliant SU	Not self- reliant SU
SU Privacy self-contained	SU Privacy not self-contained
SU Dignity self-assured	SU Dignity not self assured
SU choice dominant	Carer choice dominant
SU self-esteem maintained	SU self- indifference
SU fulfilment self determined	SU Fulfilment facilitated

262

In answering the second 'etic' question 'why integrated services were perceived as different to non integrated services?' the matrix demonstrates that the integrated services were developed from the review of day centre and day hospital only some ten years ago. Operationally they either had an operational policy or statement of purpose whereas the non-integrated services had neither. The integrated services had extensive and large networks across agencies whereas the non integrated networks were limited to their own agencies. Service user goal planning and service user aims and objectives were used within the integrated services as opposed to treatment planning and care planning. The integrated services utilised care coordination (study group 2) or key worker roles (study group 5).

5.10   Chapter Conclusion

This chapter presented the results of the intrinsic case whilst pursuing the case study aim, proposition and the first three 'Etic' questions (or propositions) in an attempt to answer the question: What were the differences in integrated and non integrated health and social care services as perceived by the participants?

- How were integrated services different?
- Why integrated services were perceived as different to non integrated services?
- What could be learned from this study of integrated and non integrated services?

The next chapter will discuss the final question '**How can health and social care services integrate in practice?'**

This chapter has:

- Introduced the intrinsic exploratory case study;
- Presented the results in themes which are the study participants, commissioning and decommissioning integrated services, the journey within day services, navigating services and orchestrating care;
- Learned that these services are different in their purpose, level of integration, team orientation and practice and in their service user/carer relationship.

Chapter 6   Discussion – How can these services integrate in practice?

6.1   Introduction

The aim of this chapter is to discuss how these services can integrate in practice and to reflect on the research process. As a consequence it will also make reference to the knowledge of the case to date in respect of the New [name] Frailty Project.   In order to achieve this aim this chapter has been divided into two sections:

- Section one attempts to answer the last 'etic' question of the case study i.e. how can health and social care services integrate in practice? It will do this by addressing the key issues that have arisen from this research study and providing further knowledge of the case to date in respect of the New [name] Frailty Project.

- Section two will be a reflexive act within which I make assertions about the results and what I understand about my research in the context of day services. It will discuss theoretical implications, limitations and innovation.

6.2   Section one- How can health and social care services integrate in practice?

6.2.1   Introduction

Change is a constant factor in society today (Jaafari, 2003; McMillan, 2004). The move towards joint working has in the past questioned respective agencies real ability to distinguish between health and social care when working with frail or older people and their families to meet their complex needs (Glasby & Littlechild, 2009; Ahgren & Axelsson, 2005). Integrated working challenges traditional concepts of service delivery, through retaining a clear sense of the service user, lessened dependence, providing services of high quality for people with complex needs (Ovretveit, 1993; Malin et al, 2002). However, the ability to work together effectively (at whatever level) is dependent upon organisational and managerial support; leadership, the quality of relationships between staff and service user, challenging the real

fear of integration and how we manage knowledge throughout the system (Brown et al, 2003; Attwood et al, 2003; Ahgren & Axelsson 2005).

Knowledge comes in two forms, tacit (or personal contextual) and explicit (or stripped and generalised) knowledge. Understanding, controlling and utilising this knowledge is essential if health and social care services are to integrate in practice. The vertical linking of the micro and macro, the global and the local or strategic policy and clinical, is at the centre of understanding how we implement integration in practice. This interconnectedness of knowledge is necessary because change occurring in one part of the system impacts on another. Therefore we need to learn together how this knowledge crosses boundaries to know what is happening, why and to whom in order to attempt to integrate in practice (Attwood et al, 2003).

The main issues identified within this study have highlighted challenges in respect of integrated working. These were:

- Conceptual confusion in respect of defining integrated care and intermediate care.
- Cultural approaches to care which result in a negative experience for frail or older people.
- A vertical gap of mutual knowledge transfer between strategic organisations, operational services and service users/carers, macro-micro-macro.
- The level of team orientation and integration does not appear to be proportionate to the nature of the service user/carer relationship and level of independence/dependency demonstrated.

These issues are perceived as occurring at four levels of the system i.e. client, professional and organisational management and policy level. Therefore answering the question as to how can health and social services integrate in practice is not a single problem with a single answer but a composite problem with interdependent parts (Allport, 1965; Sankaran et al,

2009). Indeed it may not even be the right question because we are assuming that we will meet the needs of those people who have the greatest and most complex needs if we integrate these services in the future (Ovretveit, 1990).

In order to define the selection of available documents which are pertinent to this discussion the literature within this chapter focussed on the key words "complexity and change management", knowledge management, "systems and "change management". An initial search was undertaken on COPAC, ASSIA, EMBASE and SCIE. A total of 44 texts resulted.

6.2.2   How can we integrate health and social care services in practice?

In order to answer the question and address these issues we will consider the process of managing adaptive change and how we effectively manage knowledge through using systems and complexity theory (McGreevy, 2008; Boyatzis, 2006). Systems' thinking helps us to understand how to manage complex social problems and the uncertainty and difficulties of how to integrate care in practice. It is a '*conceptual framework, a body of knowledge and tools'* the purpose of which is to uncover 'patterns' and to identify ways in which we can manage change (Senge, 2006, p7). Practicing whole systems in integrated care means understanding individual behaviour (especially anxiety), its change, differing perspectives and managing outcomes at different levels; which are all important in the development of working together with all stakeholders including informal carers (Hudson, 2006). In effect this means putting people first in an attempt to solve wicked problems (Seddon, 2008); understanding at a structural level '*what causes the patterns of behaviour?'* (Senge, 2006, p53); and giving an insight into the various levels of a problem through utilising the individual's tacit knowledge.

Complexity theory is known to give adequate explanation but provides us with little practical application of the theory. It argues that organisations reflect collective identities and so change is about using forms of

communication to alter interacting relationships at the micro level (Karp & Helgo, 2009). Basic ideas for change are 'inviting the whole system into the room', 'thinking globally before acting locally', 'focus on the common ground first before concentrating on problems and conflict and 'self management and responsibility for action' (Shaw, 2002, p147). The purpose is to make sense of what is happening now through a process of learning.

Alternatively, there are a number of whole system frameworks we can use to discuss the issues or problems which we have identified from this case study. As we have encountered in chapter 1 Moulin (2002) advocates the "Excellence Model" as a person centred approach to achieving quality and uses the framework of structure, process and outcome. However, it's a comprehensive performance management system rather than a change model. Sankaran (2008) uses Checkland (1993) seven-step version of soft systems methodology. This takes the problem from the real world into the systems world and back by exploring the expressed problem and then considering conceptual models and feasible, desirable change. This is similar to a consultancy model and requires a remote observer/intervener response. Whilst Attwood et al (2003) prescribes a framework for whole systems development which has the three components of the inner and outer 'context', 'process' and 'outcome'. It works with the real dilemmas or issues that present themselves in order to attain the right outcomes for the service user within the whole system. As whole systems is advocated by Welsh health and social care policy and the new 'Frailty Programme' has identified that it is using it to manage its change; then this framework will be used in this chapter to consider how health and social care services can integrate in practice (Jones, 2009).

6.2.2.1   Outer Context

The outer context is defined by the dilemmas of policy making (Attwood et al, 2003). Within this outer context integrated care remains on the policy agenda in Wales for the care of frail people (Jones, 2009). This is an attempt to fit the needs of frail older people at a local level, with the services

available and planned at a global level of the system. The development of community services within the principality continues to be driven by the number of older people who will require services in what is increasingly a challenging economic climate.

However, the conceptual confusion in respect of defining integrated care and intermediate care is apparent when you consider the Welsh Assembly Government Policy during the last ten years. Both terms are not defined as interrelated although we have seen in chapter 2 and 3, integrated care is the umbrella term for intermediate care. Intermediate care is seen as a *'range of services managed within an established and co-ordinated system'* as opposed to an approach with levels and mechanisms of integration (WAG, 2006a, p65). In some areas intermediate care is perceived as a health term 'and ends where social care begins' (Scourfield, 2007, p57). The clarity of defining these terms is required in order to build intermediate care identity and gain some 'top-down direction' so that a clear interpretation is gained for operational service delivery across health and social care (Attwood et al, 2003; Delong & Seeman, 2000). Broad definitions are difficult to implement and lead to operational conceptual confusion and conflict (DeLong & Seeman, 2000).

Historically, the NHS Plan in Wales (NaFW, 2001) discussed integration in the context of primary care and its role in dealing with complex problems and to ensure that standards of care required can be met.

> *'patients needs can be best met through the delivery of integrated care, moving care beyond the walls of the hospital, to include family doctor, community nurse, social care, the independent sector and the vital role played by informal carers and volunteers' (NAfW, 2001 p15).*

Subsequent documents have supported and strengthened this vision of a strengthened primary and community care service (Jones, 2009). The vision has been developed in the context of a partnership model across the whole system of health and social care including statutory and non-statutory

sectors (WAG, 2002d; WAG, 2006c; WAG, 2007c; WAG, 2008g). However, the 2002 document 'Wellbeing in Wales' stated that 'a multiplicity of terms can cause confusion or can create artificial barriers to partnership working' (WAG, 2002d, p12). This was in the context of 'the words are different but the goal is the same' (WAG, 2002d, p12). In the last 10 years the strategic documents in Wales have used multiple words within the continuum of working together to describe how it wants the public services in health and social care to work in partnership. They include links, integration, integrated partnership, coordinated partnership, working closely together, joint working, collaboration (WAG, 2002a,b,c; WAG, 2003 a,b,c; WAG, 2004; WAG, 2005; WAG, 2006a,b,c,d; WAG 2007c,d,e; WAG, 2008 e,f,g). These words are often used interchangeably in the UK (Dickinson, 2008). However, the lack of consistency in the language used around the levels of working together within policy documents has not aided its legitimacy and value at all levels of the health and social care system. The terms partnership, linking, co-ordination and collaboration are all used to describe the relationships without consideration given to their practical meaning which is necessary for implementation (WAG, 2005b; WAG, 2002c; NAfW, 2001). Is it not surprising then that a professional body such as the Nursing & Midwifery Council does not require a collaborative or partnership arrangements to working together within its code but a 'cooperative' approach (NMC, 2008).

The practice emphasis of integration within the Welsh Assembly policy context has been coordination through care pathways, protocols, case management, information sharing, although not consistently (NAfW, 2001; WAG, 2002a; WAG, 2003 WAG, 2006a WAG, 2008a). The issues of how to manage people's complex needs in respect of full integration (i.e. intensive case management, co-location, trans or interdisciplinary assessment) has not truly been addressed. Although the strategy for social services in Wales clearly states the intention of practicing integrated care for approximately 5% of the population who have complex needs; and the 'Designed to Improve Health and the Management of Chronic Conditions in Wales: An

integrated Model and Framework' acknowledges the need for managing complexity (WAG, 2007a; WAG, 2007d).

However when we consider knowledge management these words will be interpreted by different people at different levels of the health and social care system in different ways (Delong & Seeman, 2000). For example the partnership approach is used in association with professionals and with service users (DoH, 2008a; Gottlieb et al 2006). Unless we have some clarity on the levels of integration required this can lead to confusion within the process of service delivery (Scourfield, 2007).

As a result we continue to see that intermediate care isn't achieving its potential, it suffers from organisational conflict over resources, professional and organisational ideological conflict when we attempt to co-exist (Cornes & Clough, 2004; Scourfield, 2007; Regen et al, 2008). In addition to an emerging barrier between intermediate care and social care delivery i.e. that intermediate care is in the domain of health and finishes when social care starts (Scourfield, 2007). This study identified this practice in the theme 'Commissioning and decommissioning integrated services'. Therefore in order to ensure that professionals and services deliver integrated care the Welsh Assembly Government should recognise that there is interdependence between concept clarity and operational delivery. It should reconsider re-defining intermediate care and align it to the principles and mechanisms of integrated care in order that the systems are able to clearly deliver a shared vision of the operational concept.

6.2.2.2   Inner context

The inner context is defined by the values that steer the work within the system and five contextual policy dilemmas (Attwood et al, 2003). In this sub section if we are to consider how these services can integrate in practice then we also need to take into account the vertical mutual transfer of knowledge and values which enable that process.

There are two groups of values to consider within this section, that of the individual and organisational. Hofstede (1991) argues that at the centre of an individual's culture are values which are affected by generational, gender and class differences. This case study identified that there were approaches to care which resulted in negative experiences for frail or older people. These were in respect of staff and carer attitudes to older people and lack of inclusiveness in the service delivery. De Beauvoir states that 'societies attitude towards the old is deeply ambivalent' (1970,p2). However, this study has observed on occasion that it is not merely unsure of its attitude but at times individuals have behaved as if an older person was a burden, invisible and sometimes ignored.

Most recently, guidance in Wales such as 'Passing the Baton' has advocated returning back to basic values in a response to delivering seamless care through the discharge planning process. It argues that 'values drive behaviour, not processes' and that people working in the wider health and social care system have a responsibility to ensure that they share and apply the same core values through their mechanisms of practice (NLIAH, 2008,p18). The values they advocate are good communication, commitment to coordination, being collaborative, consideration of individual and organisational limitations, creativity and inventiveness in partnership and a duty of care to act with integrity (NLIAH, 2008). These are to be achieved through learning and reflection.

Attwood et al (2003) identified ten core values which were essential to the success of whole system development. They were optimism, empathy and humility, tenacity and courage, learning, relationships, whole system perspective, local knowledge for local solutions, building social capital, celebrating small steps and the long view. Whilst Scourfield (2007) in his study of intermediate care and home care services found that service users wanted values such as clarity of care, 'personcentredness', continuity including reliability, consistency, competence and flexibility. This study of integrated and non integrated services identified values such as 'being in

272

control', respect, trust, nurturing independence, dignity and autonomy. It identified that these values were expressed through the valuable time spent together. The diversity of values expressed in these studies is also evident within the third sector (HM Treasury, 2006).

If we consider all of these values in the context of systems thinking then through observing collective behaviour within complex systems, we can understand how all individuals and systems are changing and working with one another in order to plan (and proactively intervene) for the new developing working patterns (Plsek & Greenhalgh, 2001; Ivory & Alderman, 2005; Haynes, 2003; Sweeney & Griffiths, 2002). Albertini et al (2007) argue that when you consider intergenerational social support in families then the micro cultural patterns of values, beliefs and attitudes reflect the macro family gender, age and generation values of society and welfare regime. Therefore there is an influence from the global structures of the health and social care system on the behaviour of individuals who receive the services and perhaps also those who practice within it. As a result further research is suggested to consider the influence of the values and culture of the macro health and social care system and the micro level formal and informal carer. In addition to clearly identifying the appropriate values which we as a society wish to collectively practice at all levels within our health and social care systems

Another issue identified by this case study was a vertical gap of knowledge transfer between strategic organisations and operational services. This may be as a result of local policy dilemmas. Attwood et al (2003) consider five contextual policy dilemmas, 'top-down and bottom-up, 'consumer and citizen', 'treatment and prevention', 'consultation and involvement', 'long and short term'. Chapter one of this thesis identified that organisational integration was the most commonly identified definition of integrated care. In this study strategies such as needs assessment were used to support the development of 'networks of interrelationships' through the theme of 'working together' this attempted to avoid a misfit between organisational strategy and the environmental drivers. There were also organisational structures and mechanisms such as the 'Health, Social Care and Well Being

Strategy Joint Planning Framework', key published documents and 'boundary spanning' in place at the meso level to promote working together. This supported the horizontal integration of the system at the meso level. However, the vertical integration of the meso and micro was only supported by the project structures during the project phase from 1999 until 2004 linking the project to the HSCWB strategy joint planning framework. Attwood et al (2003) argue that an over-reliance of a top down approach can effect trust increasing suspicion and counteract working together. This may have contributed to the informal decommissioning of the integrated services. Therefore, if these services are going to successfully integrate in practice then consideration should be given to how the mutual vertical integration is managed between meso and micro levels of the system.

The services within this study had different ways of organising themselves, whether referral routes, methods and models of assessment. These operational mechanisms were individual to them and fitted into their individual organisational cultures. These cultures comprised of differing values, norms and beliefs which were effected by the study group aims, its history, the relationships of the people working and using the services (Hardy, 1993). This case study observed that the registered and non registered practitioners within the integrated services acted as facilitators, enablers and nurturers. They identified that there was a known misfit in the 'grey space' in order to enable wellbeing, especially in respect of pain, loneliness and isolation. However, although the original work of this study in 1996 had attempted to create intelligent services little collaborative work was evident with the service user groups and representatives to enable their long term engagement with the integrated services (Srai & Gregory, 2008; Engestrom, 2004). The issues arose when the integrated services were commissioned and attempted to practice in a way which didn't match the non-integrated services differing ways and times of working which reinforced non integrated service culture and possibly finally resulted in the informal decommissioning of the integrated services.

In addition, aligning the service user/carer relationship to the study group provision (demonstrated in chapter 5) highlighted that the level of team orientation and integration did not appear to be proportionate to the nature of the service user/carer relationship and level of independence/ dependency demonstrated. Structured dependency theory suggests that the past lives and experiences of older people especially in respect of social inequalities in addition to aspects of their individual character may have an effect on the degree of dependency/ independence/ interdependence that they experience (Baldwin et al, 1993). Unfortunately when this study observed maximum carer input and service user dependence they experienced parallel practice with linkages or a multiagency/multidisciplinary team approach with coordinating level of integration. This is in contrast with Leutz (1999; 2005) first law which advocates that the greater the need the greater the degree of integration required. Therefore where the duration of need is long term or terminal and where service users have minimal self direction then case managers (practising intensive case management) manage all care (Nies, 2004; Leutz, 1999).

Therefore, continuity of care can only be achieved if we consider the role of the service user and informal carer within the context of the whole system in order to solve their problems and meet their needs. Care-giving is a cultural system which also requires us to understand dependency and obligation. Perceptions around intimacy, identity structure and the role of care-giving and reciprocity, as carers sometimes see themselves as repaying a service for being looked after when they were young (Albert, 1990; Fry, 1996). Care-giving has been seen as a 'subsystem of shared knowledge' and as a result is an important part of defining 'value demand' i.e. the demand that is valued by the service user (Albert 1990; Seddon, 2008). Therefore if the health and social care systems are to consider how these services are to integrate in practice then the role of carer as care giver should be acknowledged as an integral part of how we interpret and manage the care required by the service user.

The meaning of being a service user and carer is an individual experience of disease, physical function and independence (Parker, 2001; Frank & Meyer, 2002). Therefore, complexity theory may argue that unexpected events in the care of the service user and carer are to be expected. As a result we should consider that all levels of the system vertically and horizontally are effected by the local interaction of the service user and carer because that's in effect where the business of caring is conceptualised, interpreted and constructed. Therefore, future intermediate care developments should consider the level of integration and level of team orientation across health and social care in relation to the presenting service user /carer relationship value demand. They should also consider how they are going to manage the impact of the service user/carer relationship in relation to their presenting need throughout their journey across health and social care i.e. through linkages, care coordination, case management, intensive case management or even an algorithm of health and social care in proportion to assessed need. In addition all levels of the health and social care system should identify how they utilise the knowledge gained from the clinical level to understand and plan service provision which meets the service user/carer value demand. Furthermore, research is required to understand the service user/carer/registered and unregistered professional relationship in respect of care coordination and management within the health and social care system.

Summary of outer and inner context

The interdependence of the outer and inner context of the whole system should be considered when attempting to answer the question how can these services integrate in practice. Achieving integration is possible through a context focus on the service user and the carer (Vaarama & Pieper, 2005). This means not only understanding service user diagnosis in relation to working together but also through considering how the disease, its characteristics and effect are interpreted by the patient, the carer, the professional and wider society in relation to independence and autonomy (Parker, 2001; Frank & Meyer, 2002). They are in effect interdependent of

one another and so the knowledge gained from the local micro level is essential to achieving integration, whilst the knowledge 'top-down' global level is also essential to guide the values, culture and mechanisms required, enabling integration to occur in practice at each level of the wider system.

6.2.2.3   Process

The process is work defined by the 'five keys' which are leadership, public learning, diversity, meeting differently and follow-through (Attwood et al, 2003). According to systems theory change must be managed by managers and experts through the development of practitioner leadership and management skills through their understanding of organization, relationship and patterns (Bridgeforth, 2005; McKimm & Phillips, 2009). These should be analysed in detail before any model is developed (i.e. a role analysis, a social analysis and a political analysis) in order to understand the knowledge about the situation (Sankaran et al, 2008). Bridgeforth (2005) argues that systems are three dimensional. Therefore, practitioners should understand the context of the social system within which they work, including internal culture, its values, fulfilment and ambitions; in addition to their interdependencies and the systems within their external environment such as Welsh Assembly Government and voluntary organizations. Furthermore that the way in which the system transforms is chaotic.

Attwood et al (2003, p29) argue that during the process of change an individual should 'always act as if engaged on a learning journey'. Furthermore, that we should understand the difference between 'know about' and 'know-how' knowledge' and that processes can only be changed by the participants in order to ensure that contextual relationships are not misinterpreted (Peinhaupt et al, 2004). Beeson & Davis (2000) argue that in non-linear systems 'dissipative or transformational change' considers that organizations move between order and disorder/stability and instability and as a result the consequences of an action or input can be disproportionate. These can lead to the organisations reconfiguring themselves. As a result

any change management process should consider holism and emergence in relation to the whole of the system and the emergence of unpredictable behaviour within the system.

However, if we consider complexity theory, then processes are stable maps of past patterns and by being reflexive, people constantly change them (Shaw, 2002). Furthermore, there are two sources of learning 'reflecting on the experiences of the past' and 'sensing and embodying emergent futures' (Shaw, 2002). People make change happen because they are already complex with given meanings and values (Beeson & Davis, 2000). Whilst a systems thinking leader interprets the role as enabling people to make new meanings for themselves through a process of learning (Attwood et al, 2003). Change is the 'multiple patterns of interactions' between people with a shared understanding (Beeson & Davis, 2000, p182). Conversations between people lead to a 'living present' where individuals are able to give meanings to patterns of identity and difference through understanding personal and social realities of the past (Shaw, 2002). As a result change can happen at any time and not just through a managed process because individuals don't necessarily follow the rules of the system. Therefore it cannot be managed through a hierarchical structure but through 'cycles of change' (Beeson & Davis, 2000).

The New Frailty Programme has utilised a systems approach to managing change. As a result it has built a hierarchical model of project management or 'holding framework' which has a purpose of providing a place which will enable quicker learning about 'wicked' problems whilst managing individual or group anxiety. It has embraced diversity by matching the members of its project board and work streams with representation from the wider health and social care system (GFP, 2009a). The work streams or 'action learning groups' (e.g. workforce work stream) have a particular role in inspiring collective learning (as opposed to individual learning), understanding the values required and socially constructing new roles in response to the service user and carer needs within the new collective whole systems

vision. Once knowledge about and possibly how to address these problems has been identified by the board and work streams, then the role of the leader is occupied with how to engage stakeholders (including the workforce across health and social care, partners such as the 3rd sector not represented within the project structure) in contributing to the vision, whilst ensuring that the whole picture is understood by all (GFP, 2009a; Attwood et al, 2003).

Bringing people together (across boundaries) to learn about one another values, diversity and history, also promotes the use of diverse services when trying to meet service user and carer needs (Attwood et al, 2003). The value of learning and developing together when adopting a systems approach should also be embraced during the short and longer term operational stages. Here the vision is to learn how to tap into its whole corporate knowledge and use this intelligence to the advantage of the service user and carer. This can be achieved through identifying and defining the working principles and behavioural values that are required to drive sustainable processes and the integrated system (Attwood et al, 2003). A 'middle ground framework' can link both bottom-up and top-down knowledge and allow continued learning between registered and non-registered professional and managerial knowledge. In addition to continuing to engage, learn and reciprocate knowledge with the service user and carer. This has been initially achieved in the New Frailty Programme through Locality Project Teams, their links to the global Programme board and the underpinning knowledge of understanding about outcome indicators which were valued by older people (Murray et al, 2009).

Summary of process

The process of change is engrossed in the act of cross- boundary learning in order to solve 'wicked' problems collectively. It relies on dialogue, relationships and interaction between people. To achieve this, a 'holding framework' is required to harness 'know about' and 'know-how' knowledge, promote quick learning and develop a sustainable systems vision of the

complex whole. The New Frailty Programme has engaged in this approach to achieve sustainable change.

6.2.2.4   Outcome

The outcomes from the change process are described as part of the 'change architecture' (Attwood et al, 2003). This is the 'processes and activities which support and bring about change' not only for the here and now but for the sustainable future (Attwood, et al, 2003, p187). Complex problems within the health and social care context will not be solved through predictable linear simple standardised or reductionist processes but require mechanisms which can cope with unpredictability and instability (Miles, 2009; Scott & Hoffmeyer, 2007; Ivory & Alderman, 2005; Fraser & Greenhalgh, 2001). Interdisciplinary processes are emergent and not linear (Scott & Hofmeyer, 2007). This means that people working together have to develop methods of communication whereby they share information, understand each other's professional language, understand each other's roles including models of assessment and planning. This is essential in order to gain a mutual understanding of an issue or problem, so that they can negotiate and clarify processes to come to an acceptable solution (Senge, 2006).

In answering the question how can these services integrate in practice the New [name] Frailty Project through its work streams (action learning groups) has developed an outcomes approach to planning which has a person focus. As a result it is planning an integrated governance structure, performance framework with three levels of evaluation (service user, service and locality), single point of access, 'Support and wellbeing worker' (generic health and social care non-registered worker at NVQ level 3), intensive case management and the Community Resource Teams. The purpose of these outcomes is to address the context of the current situation and support the management of knowledge through learning, throughout the process of short and long term change. They have developed from the new work streams (action learning groups) and will be supported by an

implementation network of five locality project teams. These will act as regional communities of practice (GFP, 2009a,b).

Organisations which are knowledge based such as public services need to establish certain vital relationships (connections) with each other or they will experience 'liability of unconnectedness' which leads to reduced organisational growth because of lack of innovation and learning. This is when the relationships have failed to make the attachments which engender trust not only within the organisation but across organisations. The strength of the relationship (whether weak i.e. 'infrequent and distant' or strong i.e. 'frequent and long-lasting') ties is considered in accordance with time, 'emotional intensity', 'intimacy or mutual confiding' and reciprocity (Kilduff & Tsai, 2003).

As we have already seen learning is an integral feature of change and is the tool which influences behaviour and relationships across boundaries (Wenger, 1998; Peck & Dickinson, 2008; Senge, 2006; Attwood et al, 2003; Shaw, 2002). Networks in all their forms are integral to communication, learning and delivering the outcomes required for these services to integrate in practice.   In turn this influences the management of knowledge throughout the system. Networks as a virtual organisational form can cross boundaries, are wide reaching, flat and offer flexibility (Attwood et al 2003;Alter & Hage, 1993; Goodwin et al, 2004).

The coordinating behaviour which dominates within networks has been utilised in Scotland within their Managed Care Networks (MCNs) which they define as:

> *'linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner unconstrained by existing professional and Health Board boundaries to ensure the equitable provision of high quality clinically effective services throughout Scotland' (Woods, 2001, p6).*

Their purpose is to translate the national government policies into local reality through informed professionals for example in Project Chain, a project which improved quality of life of older people as a result of creating integrated networks (Warner & Gould, 2003). Network effectiveness is measured by outcomes in a hierarchy of cause and effect in systems, organizational and client levels, which are relative to the system limitations and are network 'phase specific' (Alter & Hage, 1993). Therefore in order to translate the government policy in respect of intermediate care and link all levels of the system from micro to macro the Welsh Assembly Government should explore the possibility of developing a managed care network for 'integrated care and frailty'.

Communities of practice (COP) are also forms of networks and are where we collaborate, learn and develop practice. They are formed as a result of local interaction of people in everyday practice (Shaw, 2002). In practice we develop tightly packed networks of relationships with 'knowledge workers' across boundaries which help us to solve wicked problems. These communities of practice do not sit underneath a hierarchy of organisation but around practitioners (Wenger, 1998; Shaw, 2002). Wenger (1998) argues that meaning emerges as a result of a process of people interacting and casting an agreed understanding of objects under discussion. This is where patterns and identity are created (Stacey et al, 2000; Shaw, 2002). All of these approaches support the development of social capital within the system (Attwood et al, 2003).

Networks and communities of practice require technology and material resources in managing person focussed knowledge, communication and the development of continuity of care. The New Frailty Programme utilises it either in the form of a standardized framework for sharing assessment information, information on a web-based forum, e-mailed Monthly Briefing on Implementation Work streams (Loader et al, 2009; Wallace & Davies, 2009; GFP, 2009b). Technology can transfer knowledge vertically from service user at the micro-level to the organisation (meso) to government (macro) in order to translate individual needs into accurate service,

workforce and other resource provision required to care for people. This is in addition to linking people to individual resources in their wider public and private networks (Fry, 1996; Loader et al, 2009; Wallace & Davies, 2009).

6.2.2.5   Section Conclusion

This section considered the last question of the case study 'how these services can integrate in practice?' It identified that this was a complex problem with a composite answer which involved considering it at four different levels of the system. In order to identify some answers Attwood et al (2003) framework of context, process and outcome was adopted. Whole systems theory has been used in the past to underpin service development in intermediate care where the focus is the service user their identified needs and their journey along the care continuum (Roe & Beech, 2005; Beech, 2005; Ahgren & Axelsson, 2005; Leutz, 1999, 2005; Weich et al, 2004; Foote & Stanners, 2002). It advocates an 'inclusive approach' promoting the contribution of all stakeholders at client, professional and organisational management levels (Ovretveit, 1998; Manthorpe et al, 2006). Complexity theory has offered us a complementary approach which focuses on the interacting relationships of individual at the micro level (Shotter, 1993; Shaw, 2002; Karp & Helgo, 2009). What has emerged is that knowledge is interconnected and that people work at all levels and interact with one another. However, the micro level where the service user and carer interact is where tacit knowledge emerges and value demand is acknowledged. Only if we understand and engage with this relationship and manage the knowledge we gain vertically and horizontally throughout the whole system will we understand how to integrate these services in the future.

6.3   Section two - A phenomenological reflective act

The second section of this chapter is a reflective act and will be discussed in the first person. The purpose is to explore what I understand about my research process, whilst acknowledging that I as a researcher have grown and changed as a result of the experience and its process. Whilst doing so I will also discuss results, limitations and innovation (Cormack, 2000).

D'Cruz et al (2007, p75) describe three variations of reflexivity, 'a considered response to an immediate context', 'an individual's self critical approach' and 'the part that emotion plays' in practice. A definition of reflexivity is offered as 'a critical approach to professional practice that questions how knowledge is generated' (D'Cruz et al, 2007, p77). Whilst Archer (2003, p26 cited in Carter & Sealey, 2009) defines reflexivity as 'an activity in which the subject deliberates upon how some item, such as a belief, desire or state of affairs pertains or relates to itself.' In order to enable this act, Smith et al (2009) offer a phenomenological four layers of reflection 'pre-reflective reflexivity', the reflective 'glancing at' a pre-reflective experience', attentive reflection on the pre-reflective and 'deliberate controlled reflection'. I will explore what I understand about my research in the context of day services, its theoretical implications, limitations and innovation through the first three layers whilst the fourth is the act of writing this reflective section itself.

6.3.1   What do I understand about my research in the context of day services?- 'A deliberate controlled reflection'

The fourth layer of this reflective event is an overarching act of writing this controlled reflection. It envelops the three layers of *'pre-reflective reflexivity',* 'the reflective 'glancing at' a pre-reflective experience' and 'attentive reflection on the pre-reflective'. All four layers develop through my reading through the sequence of events of the research process and undertaking a systematic analysis of the whole episode.

6.3.2   Layer 1: 'pre-reflective reflexivity'

This layer is defined by Smith et al (2009) as 'the minimal level of awareness'. At the beginning of this academic journey my level of awareness in respect of the learning and personal development I would encounter was minimal. I registered for the Mphil/PhD in December 2002 whilst working as the 'Intermediate Care Development Manager' within the local NHS Trust. The data collection period started in January 2005 and lasted until December 2006. There are two main issues here within this

layer that of my identity as the researcher and the changing identity of the case through time (Cormack, 2000; Bevan, 2009).

My role as researcher moved from that of practitioner/ manager/ researcher to lecturer/researcher working outside of the health and social care organisations in April 2005. The change in identity gave the role some objectivity and reassurance to staff/service users and carers that this was for an academic purpose and not attached to the organisational agenda. Although it is understood that when using interpretative phenomenology a researcher is never separate from the research but 'integrated into the research findings' (de Witt & Ploeg, 2006, p216). However, it led to the unavailability of some information, data, staff and historical documents; such as social workers, outpatient data, and information of when outpatient services moved from one community hospital to another. As early as August 2005 I was aware that I was relying on informal arrangements with practitioners and managers to collate the data as I no longer had the means to search for it myself. At this point I realised that this was my research project and nobody else's interest. As the research study wasn't an integral part of the organisations and staff agenda unless documents and statistics were readily available, they were unavailable for example the operational policies and outpatient service reviews.

In respect of the identity of the case itself I have to ask whether it is the same case now as when I started this research process in 2002 (Bevan, 2009). The answer to that has to be no. Health and social care policy and law have changed (NHS Act (Wales) 2006; WAG, 2008a). As a result, health and social care services in Wales have changed over the years (WAO, 2009a,b; NHS Wales, 2009). When I commenced this study two of the services were young integrated care pilots. This study has witnessed the informal decommissioning of the integrated health and social care services to their possible inclusion and further development in the New Frailty Programme phase 1 and phase 2 (GFP, 2009a). It also experienced the movement of services from one site to another, change of staff and management structures.

I made the decision after my experience of engaging with the ethics process in 2004 to write a reflective diary (August 2005 until March 2007) to help me log and give some meaning to my experiences throughout the research process (Begley, 1996). Later I also presented early findings of my work to an international conference (Wallace, 2006). Both of these written artefacts have provided the foundational memory of this reflective research experience.

6.3.3   Layer 2: 'the reflective 'glancing at' a pre-reflective experience'

This layer 'involves intuitive, undirected reflection on the pre-reflective', what have I become aware of during the 'flow' of the experience? (Smith et al, 2009). During the 'flow' of the experience I became aware of the complexity of this study and my inexperience and naivety as a researcher and a necessity to behave in a systematic manner. Therefore the reflective diary also became a log of events (or form of time management) with weekly or monthly goals to achieve and to remind me of what had to be achieved within the timescale of the research study.

My strengths as a researcher lay in my experience as an interviewer and a manager. In the context of nursing I have over 20 years of undertaking individual assessment and so capable of detecting verbal and non-verbal communication (Begley, 1996). My management experience had taught me to write a detailed protocol, develop an 'audit trail' for my data collection and use the reflective log to help with sustaining motivation and time management. My research inexperience increasingly led to frustration and a necessary task to develop my process of learning and thinking through varying methods. I embarked on a series of study days/sessions to increase my knowledge of Nvivo 7.0, Endnote and SPSS 13.0. When I encountered a possible problem not knowing how to analyse the SF12v2 data, I approached a statistician. He advised that I should use SPSS 13.0 and checked the data analysis that I undertook following his advice. In order to ensure that I had confidence in my ability to use SPSS 13.0 I subsequently

used it to analyse the data for another piece of research (Wallace & Wiggin, 2007). I was aware of the increasing amount of reading I was undertaking in order to complete early stages of the research process e.g. the tool grid (appendix 10). However, I was also aware of the danger of reading away from the focus of enquiry.

Further strengths included the multiple methods of data collection, three types of participant (service user, carer and staff), the use of case study method with interpretative hermeneutics, although complex, allowed me to undertake an in-depth investigation of the system (King & Farmer, 2009). This resulted in what can be seen as a rich case study which enabled me to gain an insight into the system as a whole.

The main limitation to this study is its single researcher. The research Councils UK (No date) advocates multidisciplinary research or investigating the problems of the ageing population in respect of health and social type services. A multi-disciplinary approach would have enriched the quality of the study outcomes through uncovering diversity, similarity and difference which to a single researcher can only be unknown. Another limitation was the complexity of the case with its five forms of data generated over 45 hours of recorded interviews for transcribing in addition to historical document notes, questionnaires, observation notes etc. As a result the almost two years of data collection took another eighteen months to analyse.

Some delay was experienced within the study period in 2004/2005 as the 'welsh borough's' Social Services increased individual charges for their social care services, which included day care. The effect was to reduce the number of service users who wished to attend as the charge increased from a nominal £1 per day to £20 per day. Initially this altered the attendance levels within the day care and joint day care services as those service users who were most independent decided not to use the services on offer.

Although I gained some useful information from the pilot, its main criticism is that I used it as a 'pre-test' of the quantitative data collection tools rather than a pilot test of the whole case study. It would have been more useful to have used it to develop an understanding of the concept of the case study, especially the qualitative issues encountered within it as this was the primary source of information, for example, the need to develop a bibliography of all meeting notes, diaries, etc (Yin, 2003a).

6.3.4 Layer 3: 'Attentive reflection on the pre-reflective'

This third layer is the 'experience becomes an experience of importance' (Smith et al, 2009). The experience of this research study is of importance because of its value to research and practice. Interpretative phenomenological research may not divulge its full rigour until after the research study is complete (de Witt & Ploeg, 2006). However, de Witt & Ploeg (2006) demonstrate rigour through the use of a framework of 'balanced integration', openness, concreteness, resonance and actualization.

The rigour of these research findings were sought from the research itself, the study participants and also from independent actors such as the Chief Executive of Age Concern [name] and the New Frailty Programme. The results themselves were recognised by the participants and independent actors who understood the context of the case (Bamford, 2008). In accordance with interpretative hermeneutics these research findings have demonstrated rigour through its multiple meanings in the form of 'balanced integration', concreteness, openness, resonance and actualization (de Witt & Ploeg, 2006). An example of a balanced integration or 'the in-depth intertwining of philosophical concepts within the study method and findings' within the research results (de Witt & Ploeg, 2006, p224) is demonstrated in the 'active service user co-ordination' sub theme. The service user outside of the whole system expresses the loneliness of managing her independence with being in a battle to achieve it.

The study has demonstrated openness of decision making through its methods chapter and the reflective diary (de Witt & Ploeg, 2006). An example from the reflective diary demonstrates the daily decisions which had to be made during the data collection period.

> '*there are some differences between the groups especially those who attend OP and the day services. The language used when interviewing has to change for certain participants. Those with memory difficulties, I've had to ensure the language is simplistic and easily understood and that I don't cause any anxiety* (Reflective diary, 18/08/05).

The service user and carer relationship model is an example of 'concreteness' or 'lived throughness' whereby the participants' level of autonomous being is considered in the context of the relationship. This context of relationship is considered in the 'lifeworld' of the participant (de Witt & Ploeg, 2006). Whilst the resonance of language within the text demonstrates rigour, as the service user/collaborative relationship, the service user expresses the fear of death and not returning home.

Actualization occurs in the future after the research study has finished through any developing significance. The importance of this study is recognised when we consider Townsend et al (2006) grounded theory study which found 5 types of 'caregiving relationships'. Through widening the study to mainstream services such as outpatients, day hospital and day centre this study was able to conceptualise the service user and carer relationship as three distinct roles rather than five and in relation to autonomy and the level of service integration itself. This could contribute to further research in understanding care giver stress in the future.

The importance of this study and its research findings to the New Frailty Programme are evident in their acknowledgment of the researcher as the programme academic advisor and their use of the service user/ carer relationship model in the development of the Support and Wellbeing Worker (GFP, 2009a,c). It may also be of future significance to the primary care and community services in Wales following its requested presentation to the

RCN Wales conference in November 2009 (Wallace, 2009). The 'service user and carer continuum with team orientated practice and level of integration 'will contribute to reshaping the relationship between the health and social care system and service users and carers. It achieves this by giving all participants an insight into the relationship between service user and carer and the level of integration that is available to currently meet their needs. This is especially timely due to the debate 'Who pays for Care in Wales' (WAG, 2009c). Recommendations of significance are number 8, 13, 15 which discuss appropriate levels of caring within an individual's capacity, an individual's responsibility for planning their own care needs, 'an equal right to high quality care based on need' and the integration of health and social care in order to promote independence (WAG, 2009c, p17 & 20).

Therefore this study may have a small part to play in the modernisation of services for frail or older people in Wales. Finally a process of reflection has led me to consider (in health and social care) that we are now experiencing pressure from an aging population with multiple co-morbidities which results in fragmentation of care for some complex individuals in a system which is in 'phase transition' (Lewin, 1993; Latour et al, 2007). Phase transition is a sudden and rapid shock change when moving across cultural boundaries which occurs because of slight changes to the system or its environment (Lewin, 1993). In south Wales, the development of the Local Health Boards, the development and challenges of sharing information through standardised frameworks (Unified Assessment), integrated care service pilots such as those within this study could be interpreted as examples of a progression of slight changes to the system. These events occur across Wales (and possibly the UK) and are evident in the development of the all Wales Communities of Practice for Unified Assessment, Effective Discharge Planning and Intermediate Care (NLIAH, 2009b). As more characteristics are attracted to the system it reaches a point at which it experiences 'bifurcation', whereby the system changes its course because of the direction of force of these 'attractors' which create 'boundaries of instability' (Haynes, 2003).

The emergence of initiatives across Wales such as the New Frailty Programme developing 'networks of cooperation and control' across boundaries can create tension causing some boundary instability and system change (Plsek & Wilson, 2001; Davies et al, 2001; GFP, 2009a). As a result what is now emerging is a paradigm change from the care of older people to the care of frail people which does not limit care by age but recognises service users with expressed needs as the legitimate focus of care. This way of looking at the world has changed because of the progressive policy development of working together, technological advances and the shift in values and priorities which the wider health and social care system recognises as required by society (Handy, 1993; Malin, 2002). This has been supported by articulate supporters within primary and community care in Wales who have explained and legitimised the assumptions of frailty and integrated care in order to promote the paradigm change (Jones, 2008; Jones, 2009; WAG, 2009b; BGS, 2009; GFP, 2009a; Burholt et al, 2009).

This potential paradigm change requires a different approach which strives to understand the underlying causes of presenting problems i.e. a preventative approach to care.

6.4 Chapter conclusion

The aim of this chapter was to discuss the final question of the case study, how can these services integrate in practice, in addition to offering a reflective account of the study itself. It has achieved this through offering an insight into the key issues which have arisen through the development and maintenance of integrated services, in addition to providing further knowledge of the case to date in respect of the New Frailty Programme. The key issues were

- Conceptual confusion in respect of defining integrated care and intermediate care.
- Cultural approaches to care which result in a negative experience for frail or older people.
- A vertical gap of mutual knowledge transfer between strategic organisations and operational services, macro-micro-macro.

- The level of team orientation and integration does not appear to be proportionate to the nature of the service user/carer relationship and level of independence/dependency demonstrated.

Finally it gave assertions about the results and what I understood about my research in the context of day services in Wales today.

The purpose of qualitative research on ageing is to explain meaning, develop human knowledge that speaks to us, and engage in social advocacy or the creation of awareness (Rubenstein, 1992; Hendricks, 1996). This case study has explored the meaning of the day services in the lives of the participants. By doing so they have developed the knowledge that these innovative attempts to integrate were indeed pilots within a long ten year process which is now exploring, planning and managing the change across the whole of the geographical area not only of the 'welsh borough' but also a wider geographical area in south Wales. The knowledge has given us an insight into the barriers, the effects and the gaps in development and delivery of integrated care. In particular the importance of including the role of the service user and the carer in the whole system and that the underlying patterns emerge from their meaning of the effect of disease on their relationships versus the services they require to live their lives. This in itself has created awareness across the health and social care community within the geographical area of the 'new frailty programme' that integration needs to occur at all levels of the system. In addition it has enabled them to develop the right workforce with the appropriate skills, competencies and capability to deliver an intelligent system of care which focuses on the individual and their care-giver. Giving them the ability to be part of the system, to be heard and have their knowledge shared by all levels of the system.

This chapter has:

- Discussed how these services can integrate in practice through effectively managing knowledge within the system. It utilised Attwood et al's (2003) framework of context, process and outcomes to analyse the key issues that have arisen from this research study.

- Provided a reflective act within which I have discussed the strengths and limitations of my research study.

Chapter 7   Conclusion with Recommendations

7.1   Closing Quote

> 'It feels somewhat premature to offer an opinion on the extent to which services will be able to integrate. The comment is based on the fact that historically there have been obstacles to integration. Success or otherwise depended very much on the stance of individuals rather than organizations' (BGCBC, 2002, p 110).

This quote written in 2002 in the social services Joint Review Position Statement reflects the opinion of this study that health and social care services within this geographical area continue to be a long way from delivering whole systems person focused care for frail or older people. The world of health and social care generally struggles in its attempt to prepare itself for the 'graying population' that will demand to have its expectations met. The World Health Organization (2008) has 'drifting' concerns that the expectations of health promotion, people focused care, reliability, equity, solidarity and social inclusion will not be met by current organizations. Although, we could argue that this case study demonstrates that in this geographical area there has been a gradual evolution towards integrated care provision since 1996. As a result there is now an opportunity in the greater local geographical area (and perhaps Wales) to shift towards person focused socially inclusive integrated care services for frail or older people.

The literature review (chapter 2) within this thesis was divided into three sections and discussed the definitions, theories and mechanisms of integrated care. It demonstrated that integrated care is a 'fuzzy', 'wicked' concept. It is the world wide umbrella term which in the UK encompasses intermediate care. The first section identified and expanded Delnoij et al (2002) classification of clinical, professional, organizational and functional, with additional systems integration; and a total of thirty four definitions of integrated care. There has been a concentrated effort in defining

organizational integration within the literature. This large number of definitions has contributed to concept confusion and highlighted a gap in person participation and focus in defining integrated care. Therefore it is recommended that:

The integrated care fraternity should consider encompassing the voice of the individual receiving services when they define a single operational definition for integrated care which is person focussed, in the future.

The second section introduced the theories which give meaning to integrated care. These were explored by adapting Timms & Timms (1977) three level classification of theory. Those theories that explain integration were systems and complexity theories. Those theories that show us how to integrate were network, collaborative, contingency and configuration. Whilst the theories that give meaning to the service user world are biological, psychological and social theories of ageing, in particular autonomy, need and successful aging. These theories demonstrated that the three level classification of theories should be considered in order to interrelate the whole system and cope with unpredictable emergence. In addition, there is a variable theoretical underpinning of whole systems theory to service delivery, which is essential to identify and understand the demand which originates from the service user and carer. Therefore it is recommended that:

The integrated care fraternity should consider the three level classification of theory when defining the concept of integrated care. This will ensure that assessing, planning and commissioning or planning care are interrelated to achieve a whole systems and person focused perspective and facilitate unpredictable emergence.

The models and mechanisms of integrated care were identified and explored whilst using Leutz (1999; 2005) six laws of integration. The common focus for all service provision should be the service user

perception of their need for seamless good quality care. Therefore it is recommended that:

Organizations who are planning integrated services for their local populations consider the mechanisms for integrated care in proportion to individual need. Those people who are frail and require full integration will require intensive case management.

Chapter 3 defines day services in the context of intermediate care as a UK term only under the umbrella term of integrated care. It identifies eleven definitions of the concept. It is defined in the context of a service continuum rather than being underpinned by systems theory, acknowledging the levels of integration and its mechanisms available proportionate to individual need. As a result this lacks concept clarity. Using a contingency approach would utilise a theme which is acceptable to both health and social care. Therefore this study recommends that:

The Welsh Assembly Government should reconsider the definition of intermediate care and align it to the principles of system theory and classification of levels of integration, identifying mechanisms of integration available in order that systems and their organisations are able to clearly deliver a shared vision of the concept which is person focused.

Section two within this chapter explores how and why Gadamer's hermeneutic interpretative methodology with single intrinsic case study design evolved whilst considering the literature available in the context of day services and intermediate care. It considers methodology, design and methods in order to address the complexity of the case and consider the multiple levels within the system.

Chapter 4 conveys the design and methods used within this research study. It used Yin's (2003a) five components of a case study to analyze and illustrate decision processes of the design and the multi-methods adopted to

answer the aim and its propositions. The act of engaging with the hermeneutic cycle is demonstrated.

This geographically bound single intrinsic case study design has five embedded study groups within it, the outpatient clinic, the reablement team, the day hospital, the day centre and the joint day care facility. Three types of non probability sampling were used i.e. volunteer, purposive and snowballing. Ethics, risks to the project, the pilot study, the process and software used for analysis are all discussed. The qualitative methods used were in-depth interview, observation and the systematic search of artifacts, records, documentation.   The embedded quantitative elements were primary outcomes measures such as numbers and routes of referrals and the secondary measures were the SF-12v2/ London Handicap Scale. These tools were identified using the FAGRO framework developed by Demers (2004). Triangulation and the merging of the data are discussed with the purpose of understanding the whole.

During this chapter the role of the researcher is discussed in addition to her prejudices in respect of knowledge of the services and clinical nursing background.

Chapter 5 answers the question, whether there was a difference between integrated health and social care day services and non integrated day services within a bound geographical area. The differences explored were those as perceived by the participants and what could be learned from this study. The themes presented were 'the study participants', Commissioning and Decommissioning Integrated Services', 'the journey within day services' and 'navigating services and orchestrating care'. It concluded that the health and social care integrated services were different in their purpose, their culture, their level of integration, their team orientation of practice and the dominant perception of service user/carer relationship that was expressed by participants. Furthermore that the level of team orientation and integration does not appear to be proportionate to the nature of the service

user/ carer relationship and the level of independence/ dependency demonstrated.

Therefore the following recommendations are made:

When commissioning or planning services a greater understanding is required in respect of the service user and carer relationship and their experience of disease and service provision. This will enable the fit of service user 'value demand' with service provision.

Further research is required to give a greater understanding of the triadic relationship between service user, carer and formal caregiver and how this impacts on the decision making processes for formal and informal care provision in respect of clinical practice, professional practice and organisational integration and planning.

Further research is required to understand the triadic relationship between negative autonomy, moral obligation and service user behaviour which may impact on carer wellbeing and lead to carer stress.

A greater understanding of the training needs of service users and carers is required in order to support then in their role of self coordination of service provision, especially in respect of the possible development of the personalisation agenda in Wales.

Chapter six discusses the final question (or proposition) posed by the research study 'How can health and social care services integrate in practice? It discusses the issue of knowledge management and argues that knowledge is interconnected with people working at all levels interacting with one another. However, the micro level where the service user and carer interact is where tacit knowledge emerges and value demand is acknowledged. Engaging with this relationship and managing the knowledge we gain both vertically and horizontally is essential in order to

understand how to integrate these services in the future. Therefore this chapter recommends that:

All levels of the health and social care system should identify how they utilise the knowledge gained from the clinical level to understand and plan service provision which meets the service user/carer value demand.

Research is required to consider the influence of the values and culture of the macro health and social care system on the micro level formal and informal carer. In addition to clearly identifying the appropriate values which we as a society wish to collectively practice at all levels within our health and social care systems

In order to translate the government policy in respect of intermediate care and link all levels of the system from micro to macro the Welsh Assembly Government should explore the possibility of developing a managed care network for 'frailty' or 'intermediate care'.

Care-giving has been seen as a 'subsystem of shared knowledge' and as a result is an important part of defining 'value demand' i.e. the demand that is valued by the service user (Albert 1990; Seddon, 2008). Therefore if the health and social care systems are to consider how these services are to integrate in practice then the role of carer as care giver should be acknowledged as an integral part of how we interpret and manage the care required by the service user.

The aim of this intrinsic case study was to explore whether there was a difference between integrated health and social care day services and non integrated day services within a bound geographical area. The differences explored were those as perceived by the participants. The remaining questions asked what could be learned from this study and how can health and social care services integrate in practice? These questions are answered in detail in chapters 5 and 6 of this thesis. The rationale given for

this approach is that integrated care for frail or older people is a complex concept and occurs at many levels of the system but in particular the person (clinical), professional, organisational and policy levels. Its operation occurs through people, their relationships and dialogue with one another at each of these levels both vertically and horizontally. Key to this approach is the person focus at each level of the system. Therefore any approach to integration has to be multidimensional in order to ensure that integration occurs within the whole system.

The quote at the beginning of this conclusion appears downcast and despondent at the presenting ability of health and social care services to meet the growing expectations of the public to deliver integrated services. However, this final positive and uplifting artifact found in the service documents gives some hope that these health and social care services will meet the needs of the frail or older people in the future through a clinical relationship which can cascade the value demand through to professional, organizational and policy levels and so ensuring that integration across health and social care is person focused.

A Poem written by Sheila Prisk (Reablement Officer) in 2003

Referrals come in we respond with a call,
regaining independence is our ultimate goal.
Reassure and encourage to regain lost skills,
Respond with assistance, all in good wills.

Environment their home, hospitals are past,
with strength and determination, recovery steady, not fast.
Equipment we bring to help them along,
Exercise programmes to make them strong.

Arrive at their home anxious they may feel,
Assessment carried out and plan agreed.
Collaboration is the name of the game,
Motivation and achievement our main aim.

Building relationships, Aware of their difficulties,
information we gather, enhancing their possibilities.
Begin to stand back when goals they achieve,
Remembering to praise, their expectations we raise.

Long shifts we work, on a rota too,
Talking and listening is what you must do.
Confidentiality will be put to the test,
Give the client the choice, their decision is best.

Enhancing their lives, that's the work of the team,
Emptying commodes we can if need be.
Every day is different, experience we gain,
Education and employment, long may it reign.

Meetings are required to discuss progress,
Feedback is desired to ensure no digress.
Tasks of all kinds reported in daily,
To ensure we're in line with good health and safety.

Everything is going according to plan,
Encouragement given, succeed they can.
Extra services, if needed, referrals we make,
Ensuring their safety, no chances we take.

Now they are able, a look of pride on their face,
Not forgetting what they achieved at their own pace.
Numbers to contact, with them we leave,
Wishing them well, in themselves they now believe.

Team work, togetherness, an experience to reflect,
Shout from the rooftops that reablement is BEST