# ANGLIA RUSKIN UNIVERSITY

# THE IMPACT OF THE NEW INTEGRATED OLDER PEOPLE'S CARE SERVICES IN CAMBRIDGESHIRE ON SERVICE USERS

## MEI HU

## A Thesis in partial fulfilment of the requirements of Anglia Ruskin University for the degree of Doctor of Philosophy

**ANGLIA RUSKIN UNIVERSITY**
ABSTRACT


**FACULTY OF HEALTH, SOCIAL CARE & EDUCATION**


**DOCTOR OF PHILOSOPHY**


**THE IMPACT OF THE NEW INTEGRATED
OLDER PEOPLE'S CARE SERVICES IN CAMBRIDGESHIRE
ON SERVICE USERS
By MEI HU
July 2011**

Social care and health services for older people in Cambridgeshire have been integrated since April 2004. This study examines the effect of the integration programme on service users. Previous research into health and social care integrations predominantly centre on process issues and pay much less attention to outcomes. No study has evaluated the impact of fully-integrated care services for the whole user group of older people.

Theory-led programmatic approach was used in this study. Multi-method data collection and analysis were employed to uncover and examine the causal links, the contextual conditions, the implementation process, causal mechanisms, and intended and achieved outcomes of the integration programme.

This study reveals an improvement in the physical functioning of one in three occupational equipment users; a rise in the level of satisfaction of 85% of occupational health and 82% of physiotherapy users; older people with complex problems and high-level needs were able to be helped to live at home; and waiting time for both assessment and for services within two weeks and four weeks were below the national achievement and the ministerial targets. It also reveals a lack of change outcomes in social care, and service users' low level of satisfaction with social care services, which appear to be associated with the privatisation of long-term social care and the predominant aim in social work of achieving maintenance and prevention outcomes. The integration programme's goals—unifying the care system, easier and simpler access to services and a single and quick assessment—were not fully reached, mainly because of users' low awareness of the integration, incompatible ICT systems and lack of funding.

This study contributes to knowledge on how the total integration in Cambridgeshire has benefited users and how theory-led programmatic approach can be used in this area and in the study of this kind of complex social programme.

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# 1 Introduction

## 1.1 Aims and focus of the study

In April 2004, a comprehensive reform programme to integrate social care and health services for older people was introduced in Cambridgeshire. It fundamentally changed the way care services for older people were delivered and continued to change it (Cambridgeshire County Council et al., 2003). This study examines the causal links, contextual condition, causal mechanisms, content, implementation process and development of Cambridge City Primary Care Trust's (PCT) integration programme and investigates its effect on service users.

## 1.2 The social background of this research

In the UK, a wide range of services for older people has long been provided by the Social Services; the National Health Service (NHS); agencies such as housing authorities; and the voluntary and independent sectors, which worked separately and independently. The whole system for delivering care was difficult to understand and did not always work efficiently. Communication between professionals and the various agencies was not always good. As people with health and social care service needs were assessed separately by different agencies there was some duplication and overlap (Department of Health, 2000; Foote and Stanners, 2002; Cambridgeshire County Council, 2003; Glasby and Littlechild, 2004).

The Department of Health was well aware of the problems:

> If patients are to receive the best care, then the old divisions between health and social care need to be overcome. The NHS and social services do not always work effectively together as partners in care, so denying patients access to seamless services that are

tailored to meet their particular needs. The division between health and social service can often be a source of confusion for people. Fundamental reforms are needed to tackle these problems. (Department of Health, 2000:70)

After New Labour came to power in 1997, the government made one of its top priorities to bring down the 'Berlin Wall' that divides health and social services (Department of Health, 1998a:97) and proposed a number of reforms to the health and social services. It introduced new legislation and guidance and provided funding to promote co-ordinated and joined-up working and to break down the barriers between social services and primary health care (Department of Health, 1998b; Department of Health, 1998c; *Health Act, 1999*; *Health and Social Care Act, 2001*; Department of Health, 2002a; Department of Health, 2003; Department of Health, 2004; Department of Health, 2005a). The *Health Act 1999* (Section 31) pooled NHS and local authorities' budgets with a single lead commission and integrated provision. To further encourage joint working between local councils and health authorities, the NHS Plan (Department of Health, 2000) introduced Primary Care Trusts (PCTs) as organisations into which primary health and social care services could be integrated (Department of Health, 2000). Eight new national standards and service models of care for all older people were set by the National Service Framework for Older People (Department of Health, 2001a). Standard Two of National Service Framework for Older People and detailed guidance introduced a single assessment process to ensure that older people receive 'person-centred care', and that their care needs are assessed appropriately, effectively and seamlessly, regardless of the boundary between health and social care (Department of Health, 2000:23).

Although the government proposed joined-up working there was no nationwide

standardised model or form of inter-professional working. A range of health care and social service integration initiatives emerged, including the Older People Integrated Health and Social Care Service in Cambridgeshire.

## 1.3 The integration of social and health care service for older people in Cambridgeshire

In October 2003, Cambridgeshire County Council, Cambridge City PCT, East Cambridgeshire and Fenland PCT, Huntingdonshire PCT and South Cambridgeshire PCT issued a joint consultation document entitled 'Improving Care through Integration' (Cambridgeshire County Council et al., 2003), which proposed to integrate health and social care services for older people in Cambridgeshire, initiating a form of total integration unique in the UK. In this programme each Cambridgeshire PCT would act as a lead commissioner for all health and social care services for older people in its locality, manage a pooled budget provided jointly by Cambridgeshire County Council and the respective PCT and create integrated management for a defined range of community-based services (Cambridgeshire County Council et al., 2003).

An integrated management structure was designed. A Director of Older People's and Adult Services was appointed from each of the four PCTs to lead the integrated service in the PCT (for the structure of the integration programme, see Figure 1.1). The new Older People's Service would directly employ all staff working in social care for older people (including assessment, care management, social work, homecare, day care, rehabilitation, specialist workers, access and reception), in community nursing services for adults, in therapy services and in intermediate care services. It would not directly employ GPs and the primary care staff they employ,

but would have them as colleagues and share a wider team approach with them. It was proposed that the new integrated services would continue to provide healthcare services to people under 65 (Cambridgeshire County Council et al., 2003).
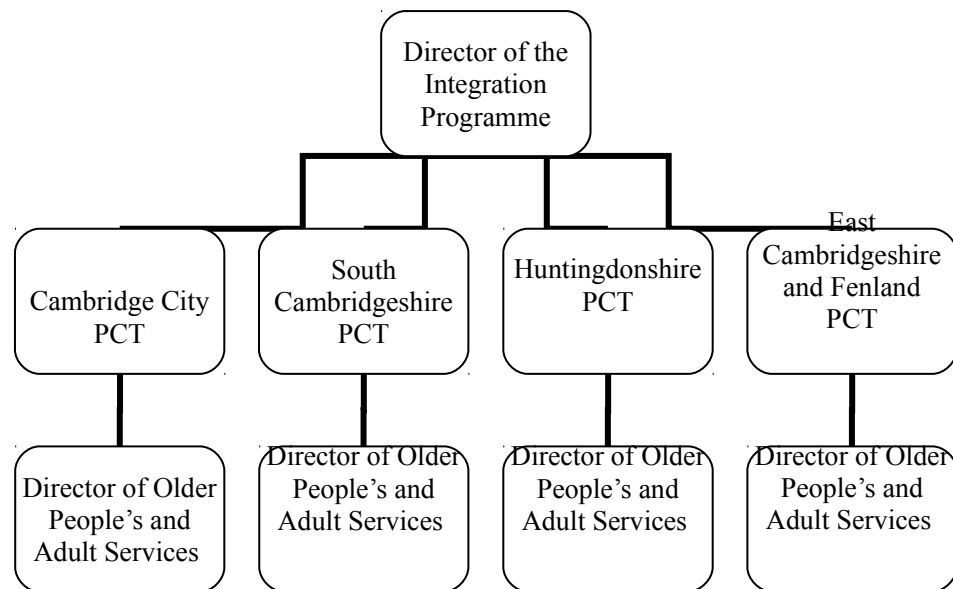


Figure 1.1 Structure of the programme of integrating health and social care service for older people in Cambridgeshire.

The locality model of the new integrated service was proposed after preliminary discussions. The locality model would develop the care service(s) as a series of localities in each PCT area. Each locality would be defined by natural population groupings of about 30,000–50,000 people and would have a manager responsible for health and social care. There would be a number of teams in each locality, each with a team manager. The locality teams would, in time, be fully integrated. The professional teams within a locality team would be initially configured as they were until it was possible to achieve co-location, which was crucial to achieve full integration, which was viewed by the staff involved as one of the most important aspects of the work to integrate services (see Figure 1.2: Example of Locality Structure).
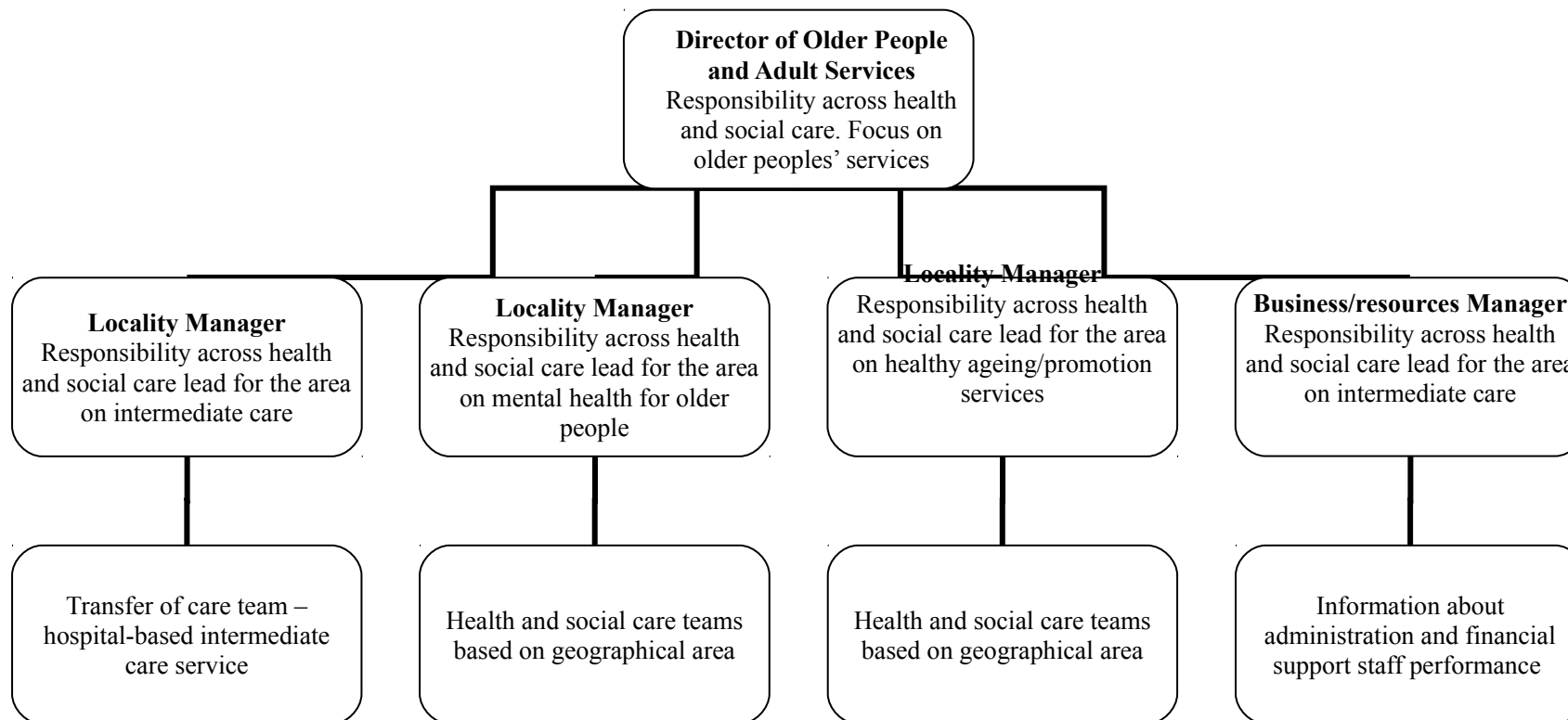
Figure 1.2 Example of Locality Structure
(Source: Cambridgeshire County Council et al., 2003:44)

Some new care pathways were developed around the key service principles. A care pathway is defined in the National Service Framework for Older People as:

> An agreed and explicit route an individual takes through health and social care services. Agreements between the various professionals involved will typically cover the type of care or treatment, which professional will be involved and their level of skills, and where treatment or care will take place. (Department of Health, 2001a)

Focus on three new care pathways – access to services, assessment, and co-ordination of care – was proposed for the first year of the integration. Access to services should be simple, clear and straightforward with a consistent approach 24 hours a day and seven days a week through two main routes: one via Cambridgeshire Direct, which was to be developed to work in a way similar to NHS Direct with older people or their carers able to refer themselves via either Cambridgeshire Direct or NHS Direct; the other by referral from professional partner agencies which would refer users to their local integrated service.

Once an older person had contacted the service, all their health and social care needs would be quickly assessed and recorded. The assessment would be integrated. Named care co-ordinators or key workers in the new service would guide older people with complex needs through the services and ensure co-ordination of interventions (Cambridgeshire County Council et al., 2003).

Changes were proposed to promote the wellbeing of older people in all aspects of their lives. A unified care system was intended which would be easy and simple for service users to understand and access and which would make better and more economical use of resources, reduce the risk of users falling between two services and allocate a single key worker to coordinate each user's care (Cambridgeshire County Council et al.,

2003; Cambridge City Primary Care Trust, 2004). This new programme was to be phased in over a period of three to five years. All these intended outcomes are discussed in the outcome section of this chapter.

As required in the guidance on using the powers of the Health Act 1999, an extensive consultation exercise on the integration proposals was held between 1 October and 31 December 2003. The outcome of the consultation exercises was that stakeholders consulted strongly supported the proposal (Cambridgeshire County Council and Cambridge City Primary Care Trust, 2006).

In March 2004, Cambridgeshire County Council signed a Section 31 Partnership Agreement with each of the above-mentioned four PCTs to establish working arrangements for the integration of health and social care services for older people. Under the agreement, the County Council would provide funding and other support to the PCTs while the PCTs, on behalf of the Council, would fulfil all of its statutory duties towards older people and act as the lead commissioner for all health and social care services for older people from the pooled budget. Key performance indicators were agreed by Cambridgeshire County Council and the four PCTs and set out in the agreements with targets to be achieved by the PCTs in 2005-2006 and 2006-2007. These Section 31 Partnership Agreements went into effect on 1 April 2004. In accordance with these agreements the County Council transferred its £70 million annual budget for Older People's Services and its nine hundred social care staff to the four PCTs (Cambridge City Primary Care Trust, 2004).

The Section 31 Partnership Agreements were revised on 1 April 2005 and 1 April 2006 and rewritten in October 2006 when the Cambridgeshire Primary Care Trust replaced East Cambridgeshire and Fenland Primary Care Trust, Huntingdonshire Primary Care

Trust and Cambridge City and South Cambridgeshire PCT (Cambridgeshire County Council and Cambridge City Primary Care Trust, 2006).

## 1.4 Previous research on the integration of social and health care

A number of research projects have explored the pros and cons of joint working (Lymbery, 1998; Johnson et al., 2003; Stewart et al., 2003; Kharicha et al., 2004). Some difficulties and barriers to joint working due to differences in occupational culture, professional identity, status and accountability have been observed (Huntington, 1981; Johnson et al., 2003; Stewart et al., 2003; Nies, 2004). Some researchers (Ross and Tissier, 1997; Evans and Killoran, 2000; Office of the Deputy Prime Minister, 2005) assessed the effectiveness and efficiency of integrated programmes and integrated care services. Others examined the impact of multi-agency organisations on professionals, users and their families (Peck et al., 2002; Manthorpe and Iliffe, 2003; Townsley et al., 2004; Abbott et al., 2005). Some assessed the implications of joint working and community care outcomes for older people (Levin et al . 2002; Brown et al., 2003; Davey et al., 2005). Brown et al. (2003) used mixed methods to examine the impact of integrated care teams on older people living in the community, and did not find any implications of the integrated care teams in terms of service users' clinical outcomes and their experience of or satisfaction with the services they received.

Manthorpe and Iliffe (2003) found that working relationships between the integrated teams were becoming closer as a result of the convergence of organisational cultures. Barnes et al. (2005) examined the development of cross-sectoral collaborative capacity. However, no study has evaluated the impact of the fully integrated care services on the whole user group of older people, the implications of which remain

unclear.

## 1.5 The originality of this study

Among previous studies, Brown et al.'s (2003) is the only one bearing some similarity to my study. Using a non-randomised comparative design and based on qualitative analysis of interviews conducted, the authors evaluated the impact of the integrated and co-located health and social care teams on older people living in the community. Members of the integrated teams included social workers, social work assistants, occupational therapists, occupational therapy assistants and district nurses, and the teams were co-located in large fund-holding general practices. A traditional non-integrated site in their study consisted of a social services team and a separate team of district nurses attached to a general practice. By measuring the clinical outcomes of the proportion of older people who remained living independently at 18 months from the date of initial referral to the social services department they compared the clinical effectiveness of services delivered by integrated primary-care-based health and social care teams with those delivered using the traditional, non-integrated method. They compared service users' experiences and satisfaction in the process of asking for and receiving help from the two teams, measuring the outcomes against the Barthel Activities of Daily Living Index, the Abbreviated Mental Text, the Geriatric Depression Scale and the Philadelphia Geriatric Center Morale Scale. The study revealed that the degree of integration did not have an impact upon service users' clinical outcomes and no major difference was found between the two groups of users in their experiences of asking for help or their satisfaction with the services they received.

My study differs from that of Brown et al. (2003) in the following respects. First, the

format and degree of the integrations under study were very different. The integration of health and social care services for older people in Cambridgeshire was on a much greater scale and involved far more major organisational structural changes than the co-location of members of teams in general practices examined by Brown et al. Second, the research populations were different. This research evaluates an integration programme for a whole group of service users – older people – rather than just two integrated teams, as in Brown et al.'s research. Third, this research is not comparative, as Brown et al.'s is. Fourth, the research focuses of the two studies are different. Brown et al. evaluate the effect of the integrated service delivery team on the service users by measuring clinical outcomes, while this research evaluates the effect of fully-integrated health and social care on the service users by exploring their experiences of and views on the new integrated services. Lastly, Brown et al. used multiple methodological methods, including non-randomised comparison with qualitative interviews, whereas this research uses the theory-led programmatic approach.

## 1.6 Significance of this study

The integration of social and health care services in Cambridgeshire was a unique form of total integration in this country, integrating all older people's social care staff from Cambridgeshire County Council's Social Services into Primary Care NHS Trusts. There has been some research into other forms of integration, including studies on co-locating social workers or care managers to general practices (Cumella et al., 1996; Lymbery, 1998); locating visiting physiotherapists in Social Services day centres (Burch et al., 1999); co-locating the district nurse care manager in social services teams (Levin et al., 2002; Davey et al., 2005); integrated rehabilitation teams (Carrier, 2002) and Partnership Health and Social Care NHS Trusts (Peck et al., 2002;

Department of Health, 2002a). However, there has been no study on whether and how the total integration of social and health care services in Cambridgeshire benefits the service users from their own perspective.

## 1.7 Research question

This research was designed to find out how service users perceive the integration of social and health care services in Cambridge. It adopts the theory-led programmatic approach and employs mixed-method data collection and analysis to evaluate this organisationally-led social programme.

## 1.8 Outline of the thesis

This thesis consists of six chapters. Following this introductory chapter, Chapter Two reviews the literature relevant to this research, including that on different models of health and social care integration, theory of efficient integration and evaluations using different approaches such as the method-led and theory-led approaches.

Chapter Three presents the methodology of this research, including the theory-led programmatic approach I adopted and quantitative and qualitative research strategies. It describes the design and methods of this research including the sampling process and methods used for data collection in each of the three phases; the research tools employed; the methods used for quantitative and qualitative data analysis; ethical considerations; and measures for reliability and validity.

Chapter Four presents my findings, including the causal links, the contextual conditions, implementation process, causal mechanisms, intended goals and achieved outcomes of the integration programme, and attempts to explain why some of the planned goals of the reform were not achieved.

Chapter Five discusses the perceived implications of different outcomes, including changing outcomes and maintenance or prevention outcomes, and the implications of the privatisation of social care for social care service users. It discusses the theory of the integration programme and its contradictory implications. At the end of this chapter, I discuss the limitations as well as the strengths of my study.

Chapter Six, the concluding chapter, presents the significance and main contributions of the study.

# 2 Previous studies on health and social care integration

## 2.1 Introduction

This chapter reviews the literature on health and social care integration relevant to my study. First, it reviews the terminology used to refer to integration in this context and the agencies involved in health and social care integration. Second, it reviews the changing emphasis in the New Labour government's policies on health and social care reform. Third, it comments on the different models of health and social care integration in the UK. Fourth, it discusses the shift of emphasis in the evaluation of health and social care integration from focusing on outcomes to focusing on process and structure. Fifth, it reviews the different theories of efficient integration. Last, it analyzes the advantages and limitations of the method-led and theory-led approaches, presenting examples from previous studies employing different approaches and focussing on the impact of health and social care integration on service users.

As a first step, this literature review was conducted using Anglia Ruskin University Library's web site. The following bibliographic sources were searched:

- ◇  Academic OneFile,

- ◇  Applied Social Sciences Index and Abstracts (CSA),

- ◇  [Care Knowledge](#),

- ◇  JSTOR,

- ◇  Social Care Online (SCIE),

- ◇  Social Policy and Practice including ChildData (Ovid),

- ◇ Social Services Abstracts (CSA),

- ◇ Sociological Abstracts (CSA),

- ◇ Web of Science via the Web of Knowledge (ISI),

- ◇ Wiley InterScience Journals, Campbell Collaboration (C2),

- ◇ Health Profiles - Association of Public Health Observatories (APHO),

- ◇ UK National Statistics Publication Hub (Office of National Statistics),

- ◇ Intute: Social Sciences, and Intute: Statistics and Data.

With the use of the internet search engines Google and Google Scholar, this search was extended to include grey-zone literature such as academic working papers and ministerial reports.

The following key words and phrases were used for the literature search:

- ◇ 'integration AND social care and health care',

- ◇ 'partnership AND social care and health care',

- ◇ 'collaborative working AND social care and health care',

- ◇ 'joint-working AND social care and health care',

- ◇ 'realistic evaluation',

- ◇ 'theories of change' and 'programme theory'.

The search using these words resulted in 2069 hits. The numbers of items retrieved initially from the list of sources were recorded in Appendix 1.

After the initial search, all titles and abstracts or keywords of the 2069 hits were reviewed. Inclusion criterion - health and social care integration were then applied.

There was no limit on dates. However, the publication dates of items retrieved covered the period from 1962 to 2010. Under Countries, only the UK was covered for the different models of health and social care integration. Examples of previous studies employing different approaches and focussing on the impact of health and social care integration on service users were mainly chosen from studies conducted in the UK. The only exception was the Bernabei et al.'s (1998) randomised study conducted in Italy. It was included because no other studies in the UK were found to employ only the randomised controlled trial approach. A UK sample study was found employing randomised controlled trial approach (Burch et al., 1999; also Burch and Borland, 2001), but it has a further investigation with another qualitative approach.

Reference lists of the selected publications were searched using a snowball method. Any relevant studies not previously discovered were included. 192 Publications in total were reviewed in greater detail using a hardcopy of the full paper.

## 2.2 Health and social care integration

### 2.2.1 A phenomenon with different terminologies

Integration of health and social care is referred to interchangeably using a variety of terms including 'partnership working', 'collaborative working', 'cooperation' and 'joint-working' (Dickinson, 2006:376). Leathard identifies 52 separate terms used to refer to the phenomenon (Leathard, 1994). Some commentators argue that there are subtle differences between these (see Miller and Ahmad, 2000; Powell and Glendinning, 2002; Glendinning et al., 2003; Dowling et al., 2004). According to Glendinning et al. (2003: 197) the terms are located at different points on a continuum of collaboration, which extends from separation through 'encounter',

'communication', 'partnership', 'collaboration' and full 'integration', with

'partnership' located around the middle and 'integration' at the far end of the

continuum. Leutz (1999) defines integration as:

> the search to connect the health care system (acute, primary medical, and
> skilled) with other human service systems (e.g. long-term care, education, and
> vocational and housing services) in order to improve outcomes (clinical
> satisfaction, and efficiency). (Leutz, 1999:77)

In this dissertation I use the term 'integration' to embrace a wide range of meanings,

from the closer coordination of care services for individuals to the formation of

managed care organisations (Leutz, 1999).

The ideology of integration is that different agencies working together across

boundaries will result in better services for service users (Dickinson, 2006). Integrated

care is defined as:

> a well planned and well organised set of services and care processes, targeted
> at the multi-dimensional needs/problems of an individual client, or a category
> of persons with similar needs/problems. (Nies, 2004:18)

Apart from health care and social care, other services like education, housing,

transport, leisure and the wider community were also integrated with health and social

care (Peck, 2002; Glasby, 2005).

### 2.2.2 Changing emphasis in government policy

According to Glasby (2005), New Labour's emphasis on health and social care reform

policies shifted. Following the party's election victory in 1997, a raft of policy and

legislation was designed to ensure that health and social care services had more

effective inter-agency coordination and provided service users and carers with a more

seamless experience (Glasby and Littlechild, 2004). However, the government initially

ruled out structural reorganisation as the solution to the problem and shied away from

the idea of an integrated, single-purpose health and social services agency (Hill, 2000;

Johnson et al., 2003). The Department of Health's *Partnership in Action: New Opportunities for Joint Working between Health and Social Services - A discussion document* stated clearly:

> Major structural change is not the answer. We do not intend to set up new statutory health and social services authorities. They would involve new bureaucracy and would be expensive and disruptive to introduce. Our proposals set out a better course which is less bureaucratic and more efficient for users, for carers and for staff working in those services who are often as frustrated as the people they are trying to help by the failures of the system. (Department of Health, 1998b:5)

At the start of the 21st century there appeared to be a shift in government policy, indicating that major structural change was now perceived as part of the answer (Glasby, 2005). In 2000, the NHS Plan (2000) advocated stronger and deeper co-operation by health and social care agencies and called for fundamental changes and the creation of single multi-purpose care trusts for England. In addition to tackling the problem of insufficiency in health and social care collaboration, these care trusts would be responsible for commissioning and delivering primary and community health care as well as social care for client groups (Glasby, 2005; Heenan and Birrell, 2006). The *Health and Social Care Act 2001* removed many of the financial and organisational barriers to integrated working, and by 2002 some two-thirds of primary care trusts had started working in collaboration with local authorities (Glendinning and Coleman, 2003). Yet there is a tone of dissatisfaction with the progress of health and social services reform in the government's policy document *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform* (Department of Health, 2002b) and a hint that further changes were coming:

> We will keep the relationship between health and social services under review. Older people and other service users have the right to expect that local services are working as one care system not two. We will monitor how far the NHS Plan and these further reforms we are proposing take us towards that goal. If more radical change is needed we will introduce it. (Department of Health, 2002b:33)

In 2005, the adult social care Green Paper *Independence, Well-being and Choice* focused attention on improving assessment of people's care needs, individual budgets, and direct payment from social services for buying people's own care and services, and on improving integrated partnerships. It set out a vision of future adult social care offering service users more control, more choice and a seamless person-centred service. The development of new and exciting models of service delivery was encouraged. Although a degree of local flexibility was allowed, the Green Paper clearly states:

> We do not want to impose solutions. Decisions about the best models to suit local circumstances should be made locally. **However, we are clear that doing nothing will not be an option**. (Department of Health, 2005a:50)

With the last sentence printed in bold in the original document, it is clear that there was a change of emphasis in health and social care integration policy from no requirement for major structural reorganisation to an emphasis:

> on integrating front-line services, on new organisational structures and on developing new ways of working to "modernise" traditional approaches to need. (Glasby, 2005:28)

Integrating health and social care became a statutory requirement rather than an option (Greig and Poxton, 2001a; Knight et al., 2001). The reason for this shift in emphasis was not to improve cost effectiveness, as major structural change would presumably create new bureaucracy and be more expensive (Department of Health, 1998b). It has been suggested that the government was dissatisfied and impatient with the lack of progress in partnership working (Hudson and Henwood, 2002).

With this encouragement from the government, a range of new and different models of health and social care integration developed, moving towards a deeper level – the organisational and structural merger – and to a broader scope involving services (Glasby, 2005).

### 2.2.3 Different models of health and social care integration

There is a range of different models of integration with various levels of agency involvement, various numbers of different partners incorporated with their associated agendas and various purposes (Mackintosh, 1992; Hastings, 1996; Peck, 2002; Glasby, 2005; Dickinson, 2006). In the medical social work model, general practice defines what specialist service social workers provide, whereas in the social services model a social worker's caseload reflects social services provision and is decided by social services' priorities rather than those of health agencies (Corney, 1983). In co-location, social workers are physically located in general practices, whereas in attachment, a named social services staff member provides personal contact with a general practice without actually being based there (Hardy et al., 1996). Three models of joint commissioning by primary health and social services were identified – based on area or locality, at the level of a practice or group of practices and at the level of individual patients (Glendinning et al., 1998). Three levels of integration that health and social care services might need to adapt to were differentiated – linkage, in which service providers are systematically linked with autonomous organisations; coordination, involving more structural development; and full integration, in which new services and approaches are created with a single approach and pooled funding (Leutz, 1999).

Glasby (2005:30) suggests that health and social care integration might be illustrated on a continuum of depth and breadth relationship (See Figure 2.1).

On the depth axis there are a number of different levels of integration, and on the breadth axis a range of combinations of partners. Adult services are at a high level of relationship but have a small number of partners, while children's services, by contrast, are at a low level of relationship but have broader relationships with a wider range of

stakeholders. Glasby (2005) suggests that both services are attempting to move

towards the same point, with adult services extending integration horizontally across

health, local authority and wider community, and children's services ascending the

ladder and moving their relationship towards more organisational and structural

integration. In practice, there is a great difference in integration between organisations

(Dickinson, 2006).

**Depth of relationship**

Formal
merger

Partnership
organisation

Joint
management

Co-ordinating
activities

Consulting
each other

Sharing
information

**Breadth of relationship**

Health and      Health and wider      Health, local
social care      local authority      authority and wider
community
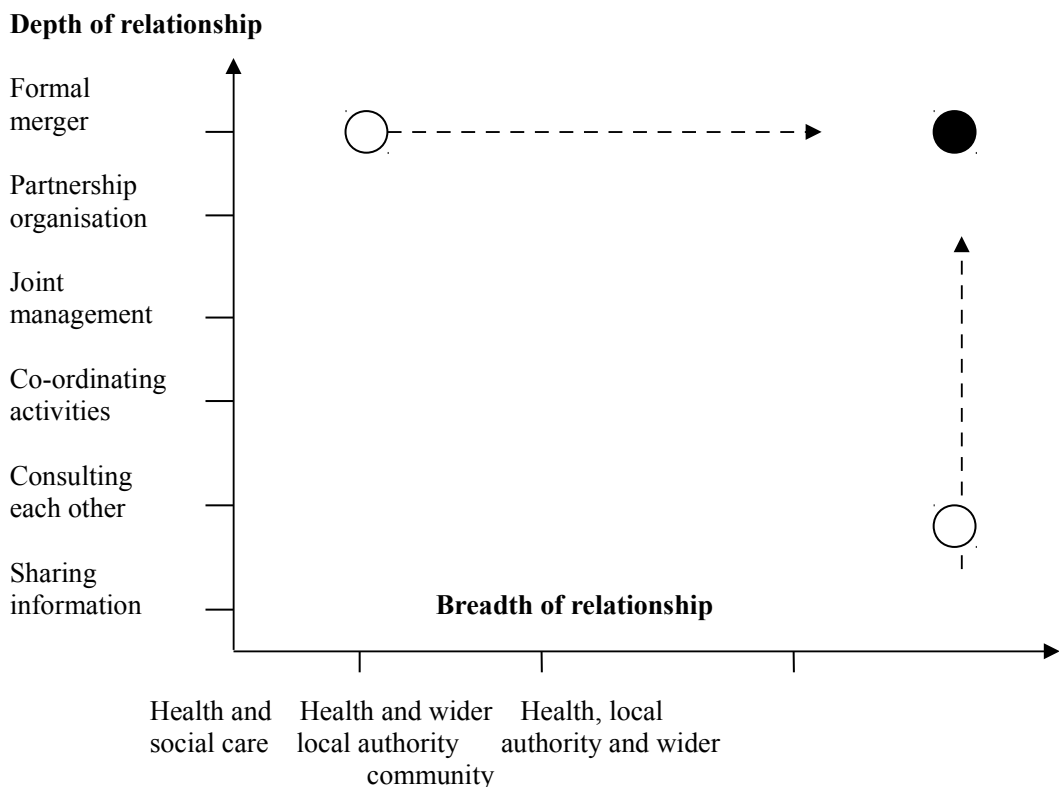
Figure 2.3 Integration in children and adult services
(Glasby, 2005:30)

A rich variety of health care and social service integration initiatives emerged in the

UK with relationships of different depths, breadths and purposes. Appendix 2, Models

of Health and Social Care Integration, lists all the health and social care integration

models I was able to identify through an exhaustive search of literature. The models

are listed from the shallowest to the deepest level of integration, from integrated

activities, an integrated team, an integrated care management system, an integrated

organisation with joint management and a partnership health and social care NHS trust

to integrated care services for a user group. Within each level of integration, the models are listed chronologically in order of their dates of publications. As the purposes of the integrations and the numbers of stakeholders involved vary greatly, a brief description of each programme is provided in the definition column and the stakeholders involved are presented in the stakeholders' column.

## 2.3 Theory of efficient integration

There are theories to explain why integration happens, what it should achieve, what form of integration is to be developed and why. Challis et al. (1988) identify optimist and pessimist perspectives in their explanation of reasons for integration. Adding 'realist' perspectives to optimist and pessimist perspectives and incorporating a range of theoretical approaches, Sullivan and Skelcher (2002) produce a framework for understanding integration that differentiates between optimist, pessimist and realist perspectives (see Table 2.1, sourced from Sullivan and Skelcher, 2002). Reviewing these perspectives, Glasby and Dickinson (2008) suggest that the form which integration takes also explains why it happens. This section reviews how theories underpinning Sullivan and Skelcher's (2002) optimist, pessimist and realist perspectives explain the drivers and the forms of integration.

Table 2.1 Theory of and approaches to integration
Source: Sullivan and Skelcher, 2002:36

| Questions | Optimist | Pessimist | Realist |
|---|---|---|---|
| Why does collaboration happen? | Achieving shared vision: *Collaborative empowerment theory* *Regime theory* Resource maximisation: *Exchange theory* | Maintaining or enhancing position: *Resource dependency theory* | Responding to new environments: *Evolutionary theory* |
| What form of collaboration is developed and why? | Multiple Relationships: *Collaborative empowerment theory* Coalitions: *Regime theory* | Interorganisa-tional network: *Resource dependency theory* | Obligational, promotional and systemic networks: *Evolutionary theory* Policy networks as meso level or governance instruments: *Policy networks theories* |

## 2.3.1 Optimist perspective of integration

### *Drivers for integration*

Optimist perspective of integration in Sullivan and Skelcher's framework (2002) features shared vision and consensus among stakeholders. It suggests that integration takes place in order to achieve a shared vision among stakeholders through prior consensus and the negotiation of disagreement. Three theories, exchange theory, collaborative empowerment and regime theory, underpin the optimist perspective and explain why integration happens (Sullivan and Skelcher, 2002). These theories suggest that integration mainly for altruistic purposes produces positive outcomes or improvements to the entire system.

Levine and White's (1962) exchange theory suggests that integration happens when organisations depend on each other for resources in order to realise their respective

goals or objectives (Levine and White, 1962). Dickinson (2008) suggests that this exchange concept of integration implies synergy or collaborative advantage.

Himmelman's (1996) collaborative empowerment theory argues that the value of integration is its capacity to transform power relationships in society in order to achieve social justice for disadvantaged and discriminated communities. Power, for Himmelman, is 'the capacity to produce intended results' (Himmelman, 1996:22). Only through collaborative betterment or collaborative empowerment may this power be shared amongst different stakeholders to achieve the vision of social justice. He argues that collaborative empowerment is 'the capacity to set priorities and control resources that are essential for increasing community self-determination' (Himmelman, 1996:30).

Regime theory (Stone, 1993; Stoker, 1995) is interested in integration between a myriad of different sectors. it suggests that organisations from different sectors come together and combine their capacity and resources in order to be effective and to achieve long-term gains for the good of the wider system (Stoker, 1995).

### *Forms of integration*

For optimists, the illustration of the forms of integration as a continuum of depth and breadth relationship is important because it suggests that deeper, wider and more effective forms of integration can be developed from a lower-level relationship. For the form of integration to be developed, collaborative empowerment theory suggests that it consists of multiple relationships and regime theory explains it as coalitions (Sullivan and Skelcher, 2002). In some cases, the achievement of the optimal form of integration is not possible. Himmelman (1996) implies that once stakeholders recognise the

benefits of other forms of interaction, they will definitely be driven to seek to achieve the optimal form of integration (Sullivan and Skelcher, 2002).

## 2.3.2 Pessimist perspective of integration

### *Drivers for integration*

Theories underpin a pessimist perspective of integration in Sullivan and Skelcher's framework (2002), which suggests that integration takes place when organisations or agencies can preserve or enhance their power and their own gains above all else. Pessimist perspective derives from resource dependency theory (Pfeffer and Salancik, 1978). An early sociological formulation of resource dependency theory was by Emerson (1962), who argues that social relationships commonly involve 'ties of mutual dependence' between the parties (Emerson, 1962:32). Party A depends on the resources controlled by party B to achieve desired goals. Each party is able to control or influence the other's activities and gratification. Resource dependency theory implies that organisations will seek to establish relationships with others in order to gain and defend an adequate supply of resources (Sullivan and Skelcher, 2002).

### *Forms of integration*

Resource dependency theory explains the form of integration to be developed as an inter-organisational network, a phenomenon that states the nature of authorities and resource relationships between these organisations. The basis of interactions between organisations within the network is the exchange of scarce resources across the network (Benson, 1975). Organisations can change their dependence relationships by decreasing their acquisition from other organisations or by increasing the dependence of others on them (Sullivan and Skelcher, 2002; Dickinson, 2008).

### 2.3.3 Realist perspective of integration

*Drivers for integration*

The realist perspective to which Sullivan and Skelcher (2002) refer is not realist ontology in research, as Dickinson (2008) argues, but a view of the reasons why integration happens, which is different from the views of the optimist and pessimist perspectives. Alter and Hage's (1993) evolutionary theory, which sets out the realist position and suggests that integration takes place in response to the wider environment, and that both altruism and individual gain can coexist. This theory suggests that integration is probably due to a number of reasons. Agencies are forced to collaborate due to the external environmental changes. These changes mean that collaboration is necessary both for increasing power of resources over other agencies and for producing better services for users (Alter and Hage, 1993; Dickinson, 2008).

*Forms of integration*

Evolutionary theory regards the form of integration to be developed as a sequential model of inter-organisational network. Alter and Hage (1993) propose a model of inter-organisational network development, from obligational, promotional to systemic networks. They suggest that each type of network is an essential forerunner of the next. The loosely linked informal obligational networks develop to quasi-formal clustered promotional networks and then lead to a formal interorganisational unit, a systemic network (Alter and Hage, 1993). The network is developed and further integration established from exchanging and negotiating interactions between stakeholders across organisational boundaries.

The final theories to explain the form of integration to be developed are policy network theories, which also fit in with the realistic perspective on integration (Sullivan and

Skelcher, 2002). Policy network theories explain the form of integration as a policy network. For March and Fhodes (1992), a policy network, is a structured set of relationships between government, agencies and other key interests engaged in bargaining and negotiation over policy (Marsh and Rhodes, 1992). Policy network is seen as meso-level to understanding the exercise of power in policy-making or a mode of governance (Sullivan and Skelcher, 2002). As Daugbjerg and March state:

> The policy network is a political structure which can constrain and facilitate the actions of agents. At the same time, policy networks are the product of patterns of structured privilege, based on access to and control over resources, and are constructed and reconstructed through the actions of agents. (Daugbjerg and Marsh, 1998:70)

## 2.4 Evaluation of health and social care integration

While health and social care integrations remained a focal point in the UK government's policy strategy over the first decade of the 21st century (Dickinson, 2006), an increasing number of evaluations of these programmes was carried out with different focuses and approaches. This section discusses the shift of emphasis in the evaluation of health and social care integration from focusing on outcomes to focusing on process and structure, and presents examples of previous studies employing method-led or theory-led approaches focussing on the impact of the integration on service users.

### 2.4.1 Processes and outcomes

The term 'outcomes' refers to 'the impacts or end results of services on a person's life' (Glendinning et al., 2006 :2). Research into outcomes identifies three groups of social care outcomes that are important to older people: change outcomes, maintenance or prevention outcomes, and service process outcomes (Qureshi et al., 1998; Glendinning

et al., 2006 ). Change outcomes relate to improvement of physical, emotional and mental functioning, such as changes in symptoms and behaviour, improvement in physical functioning and mobility, improvement in confidence and skills, and improvement in morale, achieved by service interventions. The social care outcomes valued most by the majority of older people are maintenance or prevention outcomes affecting their physical and mental functioning, wellbeing or quality of life, including meeting basic physical needs, ensuring personal safety and security, living in a clean and tidy environment, keeping alert, active access to social contact and company, and having control over one's life. Service process outcomes relate to the way services are delivered. They are the perceived impact of the process of service delivery on service users, or their experiences of using services. Among the indicators of service process outcomes are feeling valued and respected, being treated as an individual, having a voice in and control over services, value for money, a 'good fit' with different sources of care support, and a 'good fit' with cultural and religious preferences (Qureshi et al., 1998:12; Glendinning et al., 2006 ).

It is claimed that the evaluation of integrations should measure their outcomes rather than be concerned with their processes, i.e. how health and social care professionals work together (Challis et al., 1988; Hardy et al., 1992). However, research into health and social care integrations is overwhelmingly centred on process issues, with much less concern for outcome success (Dowling et al., 2004; Jacobs et al., 2009). A number of available partnership assessment tools, audits, and benchmarks developed and used to assess the effectiveness of partnership working, such as the Partnership Readiness Framework (Greig and Poxton, 2001b), Healthy and Effective Partnership Test (Local Government National Training Organisation, 2001) and the Partnership Assessment Tool (Hardy et al., 2003), appear to focus predominantly on process issues (Sullivan

and Skelcher, 2002; Dickinson, 2006).

There are four reasons for this emphasis on the process and structure of integrations. First, some government health and social care documents (see Department of Health, 1998b) tend to focus more on the means of delivering health and social care and on structural issues rather than on the outcomes (Henwood, 2006). Second, current performance management systems tend to focus more on process than on outcomes (Glasby and Dickinson, 2008). Third, integrations themselves might be seen as the end result as they may produce 'socially desirable benefits' (for example the involvement of partner organisations) even if they do not produce better outcomes such as improved health or quality of life (Dowling et al., 2004:311). Fourth, assessing the outcomes of integration can be problematic. It can be difficult to define and measure the outcomes of integration. The process of integration can be measured in the short term, while the outcomes, for example improved health or quality of life, take longer to become visible enough to be identified and measured. These outcomes are also difficult to attribute to a single cause and their evaluation of outcomes also tends to be more expensive than evaluation of process (National Audit Office, 2001; Sullivan and Skelcher, 2002; Dickinson, 2008).

As a result, most studies are concerned with processes of integration; a few measure process success, a small number study outcomes, and very few actually examine the relationship between successful outcomes and a specific integration. As there has been little research on how an integration works for the service providers and users, the presumption that integration will improve services for users remains unproven (Dowling et al., 2004; Dickinson, 2006; Glasby and Dickinson, 2008). My study aims to fill the gap and contribute to knowledge about whether the Cambridgeshire model of integration of health and social care for older people has a positive and/or negative

impact on service users.

## 2.4.2 Method-led evaluation

Evaluations of integration programmes have been carried out using a wide range of approaches. This section discusses the strengths and limitations of method-led approaches and a few other individual key approaches. Examples of studies employing each key approach have been chosen from the very few studies concerned with the impact and effectiveness of integration programmes.

Wortman (1983) suggests that:

> Evaluation research is an applied, largely (and unfortunately) atheoretic, multidisplinary activity. (Wortman, 1983:224)

Traditionally, debates about evaluation have been methodologically based between being in favour of quantitative and qualitative approaches (Cook and Reichardt, 1979; Lincoln and Guba, 1985; Campbell and Russo, 2001; Stame, 2004). The long and intensive debates between advocates of quantitative or qualitative approach increased the popularity of method-led evaluation and have created the impression that many problems in evaluation are caused by methodological shortcomings: therefore, refinement of research methods alone can lead to the solution of difficulties and problems (Chen, 1990).

Method-led evaluation focuses on the overall relationship between the input and output of a programme and provides a gross assessment of whether or not a programme produces the specific outcomes selected for examination. However, method-led evaluation does not concern the transformation processes between the input and output. It tends to maximise one type of validity at the expense of the others, and seems unable to deal with the complexity of integration and issues of attribution (Chen

and Rossi, 1987; Chen, 1990; Pawson and Tilley, 1997; Birckmayer and Weiss, 2000; Dickinson, 2008).

Among the main method-led approaches employed in the evaluation of health and social care integration are randomised controlled trials, non-randomised comparative designs, qualitative methods and the multi-method approach. Each of these approaches with sample studies is discussed below.

### *Randomised controlled trial (RCT)*

The RCT is seen as the 'gold standard' (Nichols and Crow, 2004:268) in evaluation, and even, by some, as the only valid evaluation (Farrington and Jolliffe, 2002). The RCT employs pre-treatment and post-treatment tests to measure outcomes of two randomly selected groups. One of the two groups is treated while the other is not. By choosing the groups randomly to eliminate bias and comparing the changes in the treated group with those in the control group the research is designed to clarify intervention-specific benefits. Seen as a reliable method for measuring the outcomes of a programme, the RCT should be able to tell whether a programme has worked or not by producing broadly generalisable results concerning a fairly large population.

Although the RCT is called the 'gold standard' within healthcare evaluation, it seems to be marginalised in the evaluation of health and social care integration. In my literature search only two randomised studies were found, one of which was carried out in Italy. My experience echoes Dowling et al.'s (2004) literature survey in which none of the 36 studies which explicitly link partnership working with success use only quantitative methods.

The randomised study conducted in Rovereto, Italy (Bernabei et al., 1998) compares the outcomes of an integrated community care programme with those of conventional

community care services for older people. In this study, 200 older people who were already receiving conventional community care were randomly allocated to either an intervention or a control group. The 100 in the intervention group received integrated care management and care planning by general practitioners, care managers and the community geriatric evaluation unit consisting of a geriatrician, a social worker and several nurses. The other 100, in the control group, received primary and community care from the conventional and fragmented organisation of services including general practitioner services, nursing, social services, home aids and meals on wheels. The outcomes measured were the number of admissions to institutions, the use of health services and related costs, and the condition of service users' physical and cognitive functions. Service users were assessed at the beginning of the study and at the end of a year follow up. Data on outcomes such as admission to institutions and use of health services were collected every two months for a year. The results of this study show that the integration of medical and social care with care management programmes reduced both the number of admissions to hospitals or nursing homes and the length of stay once there; a reduction in the decline of physical and cognitive functions of older people living in the community; and a reduction of per capita health care costs. The authors noticed that close collaboration between all agencies and sufficient motivation of all the parties were essential prerequisites for achieving the results of the study (Bernabei et al., 1998).

The other randomised controlled trial (Burch et al., 1999; also Burch and Borland, 2001) compares the outcomes of two different models of day care for older people, one a medical model of day hospital treatment and the other an integrated health and social model of social services day centre rehabilitation. This blind randomised controlled trial randomly allocated 50 out of a total sample of 105 physically disabled older

patients living at home who had been referred either as outpatients or for day hospital rehabilitation or maintenance before being discharged from hospital to an NHS day hospital, while the other 55 were allocated to two social services day centres which formed part of two residential care homes and were augmented by visiting physiotherapists and health care support workers. At the day hospital, trial patients were collected by a two-person ambulance, assessed by a staff nurse on arrival, treated by both occupational therapists and physiotherapists and received treatment with equipment not available at the day centres. At the social services day centres, trial patients were collected by a volunteer ambulance driver, assessed by a visiting physiotherapist, treated by the physiotherapist and subsequently by two health care support workers. At the day centres there was neither occupational therapy input nor the range of equipment available at the day hospital. All patients were assessed twice at baseline and then at six weeks, three months and one year. The outcomes, including number of treatments, transport time, cost, death and permanent admission to nursing or residential homes, were assessed using a variety of instruments including the Barthel Index for self-care activities of daily living, the Philadelphia Geriatric Morale Scale and the Care-giver Strain Index, (Burch et al., 1999; Burch and Borland, 2001). The trial found that although attendance at both day hospital and day centres was associated with an improvement in the self-care activities of daily living and a reduction in carer strain, there were no statistically significant differences between day hospital and day centres in the outcomes of care in terms of activities of daily living, morale or care-giver strain. Day centre rehabilitation was less popular than day hospital treatment. The integrated day centre model encountered some practical difficulties during the trial (Burch et al., 1999; Burch and Borland, 2001).

From the above we can see that the RCT, a rigorous method of evaluating healthcare,

enables evaluators to confidently observe meaningful relationships, eliminate extraneous causes, clarify the intervention-specific benefits and eradicate bias (Davies et al., 2000; Dickinson, 2006). However, the RCT was unable to unlock the 'black box' - the inner mechanisms or internal workings of the programme - and examine the processes within the integration leading to attribution issues (Dickinson, 2008). The second report of Burch et al.'s (1999) study shows that further investigating the context and process of the trial with another qualitative approach enabled the evaluators to illustrate 'both the potential for, and the obstacles which impede, closer collaboration of health and social care staff in the day care environment' (Burch and Borland, 2001:21).

### *Non-randomised comparative design*

Like the RCT, the non-randomised comparative design compares changes in two groups – one treated, the other untreated – that are as similar as possible in characteristics in order to clarity the intervention-specific benefits. Unlike the RCT, the samples are not randomly assigned.

Non-randomised comparative design has been used in the evaluation of health and social care integration to compare clinical outcomes in patients served by integrated health and social care teams and the more traditional non-integrated general practice primary health arrangements. Like the RCT, non-randomised comparative design is a marginalised approach to the evaluation of health and social care integration. In my literature search I found just one sample study (Trappes-Lomax et al. 2006) (with two companion studies) using non-randomised comparative design only, and two sample studies (Brown et al., 2003; Davey et al., 2005) using a multi-method approach combining non-randomised comparative design with qualitative methods.

Trappes-Lomax et al. (2006) carried out a non-randomised controlled trial to evaluate the effectiveness of a joint health and social care rehabilitation unit for older people on discharge from hospital by comparing it with traditional non-integrated community services. This study was conducted in two neighbouring localities with similar populations, one with a rehabilitation unit staffed by care assistants and /or rehabilitation assistants supported by occupational therapists and physiotherapists with a range of rehabilitative services focusing on helping people regain independence, the other without. The intervention group spent six weeks in the rehabilitation unit while the control group was discharged home from community hospitals with traditional non-integrated ordinary health and social care services. Potential participants were 55 years or older and were 'likely to benefit from a short-term rehabilitation programme' (Trappes-Lomax et al., 2006:49). Occupational therapists identified potential participants who had been assessed in community hospitals as ready for discharge within one to three weeks and referred them to the researchers. From ten community hospitals 94 people were recruited to the intervention group and 112 to the control group, using identical procedures.

Prevention of institutionalisation was the primary outcome measure to which the number of days from baseline interview to admission to residential or nursing care or death was assessed. Secondary outcome measures were time to readmission to hospital over 12 months, quality of life and coping ability. Data were collected during interviews at the baseline, and then at 6 and 12 month follow-ups.

The findings suggested that there were no significant differences between a stay in a joint NHS and social services rehabilitation unit and being served by the 'usual' community care services in terms of the time that older people spent living in their own homes, readmissions to hospital, health-related quality of life, general morale and

well-being and coping ability. However, the rehabilitation unit appeared to facilitate earlier discharge from community hospitals.

The non-randomised comparative approach enabled the evaluators to measure and examine the clinical outcomes for patients served by integrated and non-integrated health and social care arrangements to determine whether the integrated arrangements achieved the intended outcomes. The study was 'a step towards building a more robust comparative evidence base for guiding policy and debate' on intermediate care which is otherwise mainly based on evidence from non-comparative studies (Trappes-Lomax et al., 2006:61). However, like the RCT, the non-randomised comparative approach is unable to unlock the 'black box' and to assess the processes within the integration through which the policies and actions produced direct effects (Dickinson, 2006). In addition to the sample bias issue that needed to be addressed, there was also the problem of how to capture the complexity of some social and health care integration programmes and to fully understand and explain service users' experiences and the outcomes of integrated services (Levin et al., 2002). The authors claim that their two parallel studies, one (Ellis et al., 2006) an economic evaluation, the other (Trappes-Lomax et al., 2003) a qualitative exploration of the views of older people concerning rehabilitation services, provided them with additional information which enabled them to precisely describe the inputs received by the intervention and control groups (Trappes-Lomax et al., 2006).

*Qualitative methods*

Qualitative methods are the predominant methods used in research into health and social care integration (Dowling et al., 2004). Case studies have been used to explore the factors that enhance or impede joint working (Johnson et al., 2003) and to assess

the impact of multi-agency working on professional groups, families and service users (Townsley et al., 2004; Abbott et al., 2005). Semi-structured interviews have been used to explore the perspectives of service users, professional groups and agencies (Hudson, 1999; Hudson and Callaghan, 2000; Cameron et al., 2007) and for quarterly project evaluation reports to assess the process and the implementation of integration projects (Cameron et al., 2007). Focus group discussions have been used to explore views of the processes of interaction between professionals and the impact of professional, organisational, and geographical boundaries on the provision of care services (Callaghan and Hudson, 2000; Hudson, 2002). Of the many studies using a qualitative approach, only the two reviewed below assess the impact of multi-agency working and integrated services on service users.

Using a qualitative approach, Townsley et al. (2004) evaluate multi-agency organisations working for children with disabilities and complex healthcare needs in six multi-agency services in the UK to assess their impact on the professionals, families and service users. Of the six case studies three were carried out in England, the other three in Wales, Scotland and Northern Ireland respectively. The studies explore the extent of multi-agency working for these children, with 26 services visited and data about their work collected. Semi-structured interviews were conducted with 115 professionals, 25 families and 18 children/young people involved in the six services (Abbott et al., 2005; also see Townsley et al., 2004). The findings of the study indicate that multi-agency services appear to provide effective and focused support to this group of children with complex health care needs at home and their families and improve the children's access to education. However, there is room for improvement in terms of social and emotional support for families and facilitating basic human rights for children and young people (Townsley et al., 2004).

The study of the professionals reported clearer and more efficient channels of communication and improvements in the quality of their work and in their relations with other professionals, agencies and the families of service users. Communication between the professionals improved and their knowledge of the work cultures of other agencies was enhanced. They were more able to look jointly at common issues and to create more effective ways of coordinating support and services for service users and their families. Yet some staff from social services were concerned about being marginalised in their role in a medical and health care-dominated situation. Barriers, poor relationships and conflicts between agencies and professionals remained due to different statutory frameworks, incompatible IT systems and lack of commitment from some agencies and individuals (Townsley et al., 2004; Abbott et al., 2005).

Cameron et al. (2007) employed a qualitative method to evaluate six Supporting People health pilots which integrate health, social care and housing support services for vulnerable people with complex needs including people with learning disabilities, those suffering from falls or with HIV, young people with dual diagnoses, older people and women wanting to exit the sex trade. The methods of data collection were quarterly project evaluation reports that included data about process and implementation and reporting on progress meeting health target- related objectives, and semi-structured interviews with service users and key informants of professional groups and agencies including commissioners, services managers, representatives of partner agencies and project workers.

The results show that integrated services work best when the services are established around the needs of those who use them rather than 'pre-existing organisational structures' (Cameron et al., 2007:9). Successful integrated services that achieved their aims and objectives were associated with professionals' understanding the aims and

objectives of the project, a history of joint working, clear governance and managerial arrangements and the degree of involvement of the statutory and voluntary sectors. The study found both specialist supervision and support and managerial supervision systems crucial for staff working across organisational or professional boundaries. Cameron et al. (2007: 8) suggest that 'the processes of "integration" would not in itself remove the historical boundaries between professions and improve joint working'. The voluntary sector seemed more able to provide flexible services around individual needs than statutory sectors.

The qualitative approaches above enabled the evaluators to explore multiple perspectives and assess the processes and contexts of multi-agency organisations working together. However, it was rather time- and resource-consuming to conduct semi-structured interviews with 158 people within 6 services and to visit 26 services across England, Wales, Scotland and Northern Ireland (Townsley et al., 2004; Abbott et al., 2005). Attribution issues were not resolved with this approach, as individuals were not able to identify what effects were caused by which policies and actions (Dickinson, 2006).

*Multi-method approach*

The multi-method approach combines both quantitative and qualitative methods to gain the advantages of both methods and overcome the weaknesses of a single approach. When applied simultaneously at multiple levels this approach is arguably the most suitable to evaluate health and social integration because of its ability to deal with the complexity of the phenomena under study and to cover the multiple perspectives of different stakeholders.

Using a comparative design and both qualitative and quantitative methods, Cumella et

al. (1996) carried out a series of evaluations of practice-based social work schemes, including a contact survey, a resource effectiveness survey, an organisational impact study, case studies and a national survey. These evaluations systematically compared the outcomes of services from five general practice-based social worker schemes and five practices in the same district with no practice-based social worker at the time of the survey. The contact survey compared the types and numbers of referrals, face-to-face contacts and care transitions of the two groups. The resource effectiveness survey compared the effectiveness of the services received by the users in the two groups by measuring the changes in service users' degree of disability, health status and mental state, and the receipt of services between referral, contact or transition point, and three months later. The organisational impact study, using semi-structured interviews with social workers based in general practices and social services' adult care services, social services managers, general practitioners and other members of primary health care teams, examined the implications of practice-based social work for both primary care and social services. The case studies were carried out to obtain details of past practice in practice-based social work schemes. The national survey identified national trends in the development of practice-based social work schemes. The study found that patients registered with practices with a practice-based social worker benefited from more accessible services in a non-stigmatised surrounding and had on average shorter hospital inpatient stays than those registered with practices that had no practice-based social worker. The practice-based social work model might offer a more cost-effective and efficient service than mainstream community care provision. However, the authors acknowledge that a low re-interview rate hindered cost comparison of different models of social work (Cumella et al., 1996). No other impacts of this practice-based social work model on users and their carers were explored.

Using a multi-method approach, Peck et al. (2001; 2002; also see Gulliver et al., 2000; Gulliver et al., 2002) evaluate the impact of Somerset Partnership NHS and Social Care Trust, the first combined mental health and social care provider in the UK, on the professionals, service users and their families. To identify the aspirations and beliefs of the agencies involved, annual interviews with members of the Joint Commissioning Board (JCB), which was established by Somerset Health Authority and Somerset County Council on the 1st of April 1999 to commission mental health services, non-participant observation of JCB meetings and document analysis of the minutes and papers of the JCB were undertaken. To assess the impact of the changes on the staff involved, an annual staff survey was conducted measuring their morale, role clarity, team association, professional association and team management responsibilities. To assess the impact of integrated mental health and social care services on service users and carers, 98 service users' health and social care needs and their level of satisfaction with the services and quality of life were assessed at pre-implementation and twice more during implementation using the Camberwell Assessment of Need Questionnaire, the Verona Service Satisfaction Scales and the Lancashire Quality of Life Profile (Peck et al. 2002:9). They also conducted focus groups with service users and carers in each of the four localities. The study found that frequently related to changes in culture was the initial aspiration and concerns of the directors and officers at the agencies involved. Although there was difficulty establishing a sense of identity for the new integrated organisation, Somerset achieved two major innovations – joint commissioning and integrated provision – without reducing the quality of its services. The integration led to some negative effects on staff satisfaction, morale and role clarity as also to some positive effects on service users' satisfaction with services and improvements in their mental health. Both service users and carers perceived improvements in co-ordination

(Peck et al., 2002).

Peck et al. (2001) explore the meanings of the concept of culture for different stakeholders and its taxonomy and application to and within the integrated Trust during the evaluation of the Somerset Partnerships Health and Social Care NHS Trust. To directors or managers of the Trust, the concept of culture, especially creating a shared culture, prompted the integration. It was assumed that the creation of an integrated organisation would spontaneously bring about cultural change and that this kind of shared culture would result in seamless service and joint working. Peck et al. (2001) found that the creation of the Somerset Partnerships Health and Social Care NHS Trust itself was not sufficient to create a shared culture and that the structural change might have reinforced existing professional culture. Some staff saw culture as socially constructed according to professional training and socialisation and as a tool for them to understand and work with the differences. For others, culture was ambiguous and was 'the ebb and flow of individual relationships' (Peck et al., 2001:324). Although Peck et al. identify a link between the integration of health and social care services and impacts on staff, users and carers through the multi-method approach, the causal link between the integration and its outcomes is 'inferred rather than proven' (Dowling et al., 2004:314).

Brown et al. (2003) evaluate the impact of integrated co-located health and social care teams on older people living in the community by comparing the clinical effectiveness of the services delivered and the service users' experiences and satisfaction (see details in Chapter 1), using both a quantitative non-randomised comparative design and the qualitative part of the interviews. They found that the degree of integration did not have an impact upon clinical outcomes for the service users and no major differences were found between the two groups of service users in their experience of asking for

help or their satisfaction with the services that they received.

Mixed methodology design was also adopted in a study by Levin et al. (2002) and Davey et al. (2005) (the two publications are by the same authors), which used both quantitative and qualitative methods. The quantitative method of non-randomised comparison was used to test the study hypothesis that closer co-operation between social services and primary care results in better outcomes for older people. To examine whether arrangements for the integration of social workers and primary care had detectable effects on outcomes, it compared two different models of integration of social services and primary care: one co-locating five social work teams for older people in health centres with some primary care professionals, district nurses and GPs and the other having a more traditional structure with five social work teams in community care centres and no co-location with community nurses or GPs. In all, 79 service users, 40 in the co-location area and 39 in the non co-location area, and 47 of their carers, were non-randomly selected from people aged 75+ who had been referred to the social work teams after the start of the study and who had remained at home but needed complex social care. At baseline the researchers assessed the service users' social circumstances, the services they had received and their mental and physical health, using the Mini-Mental State Examination and Geriatric Depression Scale (GDS-15). Six months after the initial assessment, information was collected about whether they were at home, in long-term care or had died. Qualitative methods were employed to explore the views of managers and practitioners and their experiences of the integration. The authors interviewed 69 managers and practitioners in social services and general practice and tracked and assessed the amount, type and quality of communication among the social workers, GPs, community nurses, older people and their carers from referral to entry into long-term care or at the six-month follow up if

the older people had remained at home (Levin et al., 2002; Davey et al., 2005).

The findings of this study suggest that co-location of health and social care staff might alter the extent of direct face-to-face communication but does not lead to substantially closer interprofessional working in terms of greater contact between social workers and GPs or social workers and community nurses. Factors affecting the outcomes for older people remaining at home were the degree of cognitive impairment, the intensity of homecare they were receiving and whether they lived alone. The authors report that older people with a lower degree of cognitive impairment were more likely to remain at home than those with a high degree of cognitive impairment; those who received more hours of homecare services were more likely to remain at home; and those living with others were three times more likely than those living alone to remain at home (Davey et al., 2005). The authors' experience also suggests that research like theirs, which sought to assess the outcomes of integrated social and primary care services for service users, was 'complex, labour-intensive and time-consuming' (Levin et al., 2002:27). Taking into account the varied and changing features in the integrated services, large studies, large samples, longer time-scales and large research teams are needed to compare more than two models of integration (Levin et al., 2002).

Levin et al. (2002) highlight some additional difficulties associated with this type of research. First, there was not an adequate sampling frame for the population under study and the computerised record systems used for selecting a sample of new referrals were not always up-to-date. Second, for ethical and legal reasons the social services departments would not provide the external researchers with personal contact details of service users before the researchers had been granted permission to do so. The samples had to be gathered through social workers and depended on their willingness to help. This caused some delay and frustration and could lead to sample bias. Third, 35% of

the older people declined to participate, as in other, comparable research, and 18% percent were excluded by social workers for health or family complications. By the six-month follow-up 13% percent of the older people had died and only 63% were re-interviewed.

### 2.4.3 Theory-led evaluation

Believing that theory and evaluation are separate, Scriven (1998) considers that evaluators are still able to understand the external theory of a programme (what kinds of intervention cause what kinds of effects) without knowing anything at all about its internal theory (how it produces the outputs). Therefore he considers it often 'a waste of time' to become informed about the internal theory (Scriven, 1998:60). Although this argument might be true for some small projects, as Patton (1997) points out, attention to programme theory can yield important insights because a 'theory can be the key that unlocks the door to effective action' (Patton, 1997:237).

Having reviewed and analyzed the strengths and limitations of a number of key approaches used to evaluate health and social care integration, Dickinson (2006) argues that theory-led strategies such as the theories of change and realistic evaluation, and especially a combination of the two, seem better able than the method-led approaches such as the randomised controlled trial, non-randomised comparative design, qualitative methods and multi-method approach to address the complexities associated with integration evaluation and to attribute outcomes to specific mechanisms and processes.

The importance of theory in evaluating a programme and the question of how theory can be incorporated into an evaluation process has been neglected (Chen, 1990). According to Chen (1990:43), theory-led evaluation grew out of programme theory,

which was:

> ...a specification of what must be done to achieve the desired goals, what other important impacts may also be anticipated and how these goals and impacts would be generated.

Theory-led evaluation emphasises the importance of identifying the contextual and intervening factors that influence the programme process and outcomes. Chen (1990) argues that theory is crucial in research, providing not only guidelines for analysing a phenomenon but also a scheme for understanding the significance of research findings.

Theory-led evaluation assesses the entire process of a programme and seems able to deal with various types of validity simultaneously (Chen and Rossi, 1987; Chen, 1990; Pawson and Tilley, 1997; Birckmayer and Weiss, 2000). It not only allows the evaluator to say confidently which part of the programme works well and which part works poorly, but also why and in what situations, whether there are any positive or negative effects which could not otherwise be identified (Pawson and Tilley, 1997; Birckmayer and Weiss, 2000), and whether there are any deficiencies of the programme for future improvement or development (Chen, 1990; Birckmayer and Weiss, 2000). As many integration programmes are set up to deal with 'wicked issues', which are complex, multifaceted and multilayered, theory-led approaches seem to be more suitable than method-led approaches in dealing with the complexities and the issues of attribution. As a result, theory-led evaluation has become a more popular alternative within integration evaluations (Chen, 1990; Dickinson, 2006).

The main theory-led approaches employed in health and social care evaluations are realistic evaluation, theories of change and a combination of the two.

### *Realistic evaluation*

One of a broader range of theory-led approaches to evaluation, realistic evaluation,

suggests that the outcomes of a social programme are the result of both generative mechanisms and the contexts of those mechanisms. Whether a social programme works and whether the mechanisms have effects is affected by the contexts of the social programme and of the mechanisms. There is no single individual-level intervention that works for everybody and there is no single institution-level intervention that works everywhere (Pawson and Tilley, 1997). By examining different combinations of mechanisms and contexts in relation to different outcomes, realistic evaluation is able to reach an understanding of which programme works for which individuals, in what context and why (Pawson and Tilley, 1997). Realistic evaluation is also able to overcome issues of attribution by specifying micro-level theories, and to deal with the complexity of some health and social care integration programmes.

Adopting the concepts of receptive and non-receptive contexts for change (Pettigrew et al., 1992) and realistic evaluation (Pawson and Tilley, 1997), Evans and Killoran (2000) evaluated the Health Education Authority's Integrated Purchasing Programme (HIPP). The HIPP was set up to provide practical support and guidance to health authorities, local authorities, and those working in primary care by establishing five different demonstration projects of integration in tackling health inequalities; offering consultancy, evaluation, a national practice exchange network, a learning and dissemination programme and building resources of knowledge. The evaluation was focused on understanding how project mechanisms worked in the context of national and local policy change and what lessons were learned for UK Health Improvement Programmes, Health Action Zones and Primary Care Groups (Evans and Killoran, 2000).

The methods of data collection for the realistic evaluation were semi-structured interviews with project managers, project sponsors and steering group members; non-

participant observation of project steering group meetings, seminars and other events; and documentation analysis. Data collection for each project was carried out during the first and last six months of a two-year period.

The concept of receptive contexts for change refers to 'features of context (and also management action) that seem to be favourably associated with forward movement', while the concept of non-receptive contexts for change refers to 'a configuration of features which may be associated with blocks on change' (Pettigrew et al., 1992:268). Drawing upon the concepts of receptive and non-receptive contexts for change, Pettigrew et al. (1992) generated six categories of enabling factors during the first six-month data collection period and developed a set of hypotheses which were tested and refined by an iterative collection and analysis of data. In the meantime, Pawson and Tilley developed a new evaluation methodology – realistic evaluation. They presented a critique of current evaluation practice and introduced a handbook, *Realistic Evaluation* (Pawson and Tilley, 1997), describing their new approach. After the publication of *Realistic Evaluation* Evans and Killoran (2000) conceptualised their initial hypothesis into Pawson and Tilley's model of Context-Mechanism-Outcome (CMO) configurations. They identified six aspects to which CMO configurations can apply: a) shared strategic vision; b) leadership and management; c) relations and local ownership; d) accountability; e) organisational readiness; and f) responsiveness to a changing environment. On analyzing these configurations they came to the conclusion that the integration of the projects within the mainstream processes of UK Health Improvement Programmes, Health Action Zones and Primary Care Groups was problematic and needed 'proactive negotiation and project championing' (Evans and Killoran, 2000:139). The study provides an example of using a theory-led approach in evaluating health and social care integration. The approach has the advantage of being

able to deal with complex and multi-project programmes and helps understanding of what project mechanisms work and how they work in the context of national and local policy change. Drawing upon Pettigrew et al.'s (1992) concepts of receptive and non-receptive contexts for change, Evans and Killoran (2000) seem able to overcome the difficulties realistic evaluators experienced in conceptualising the context (Dahler-Larsen, 2001; Calnan and Ferlie, 2003). However, their research embodies some of the limitations of realistic evaluation and the problems in identifying mechanisms and difficulties in differentiating mechanisms from context (Byng et al., 2005; Dickinson, 2006). Mechanisms are often micro-level psychological processes (Pawson and Tilley, 1997), but in Evans and Killoran's research they are interpreted as project activities (stakeholder events, community-based needs assessment and local champions, etc.) and human resources (locality teams and community development workers) (Evans and Killoran, 2000:131) rather than these factors, perhaps more appropriately being classified as context.

### *Theories of change*

Like realistic evaluation, the theories of change approach is one of a broader range of theory-led approaches to evaluation. Weiss (1995) defines the theories of change as a theory of how and why an initiative works, while Connell and Kubisch (1998:16) define it as 'a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative'.

The only study I found that employs only the theories of change approach in the evaluation of health and social care integration is the national evaluation of Local Strategic Partnerships (Office of the Deputy Prime Minister, 2005). Local Strategic Partnerships (LSPs) are a major innovation in the pattern of local governance in

England, bringing together public, private, voluntary and community interests to provide a strategic framework within which the partners work together more effectively to secure the economic, environmental and social well being of a local authority area and of those who live and work there. LSPs have oversight of the preparation and implementation of Community Strategies and (in neighbourhood renewal fund areas) of Local Neighbourhood Renewal Strategies, but they have wide discretion about how they organise themselves and arrange their businesses and on what issues they concentrate (Office of the Deputy Prime Minister, 2005) .

The national evaluation of LSPs comprises a feasibility study, a formative evaluation, an action research study and a summative evaluation. The feasibility study includes a survey of every English LSP in 2002. The formative evaluation, which assesses the processes, preliminary impacts and effectiveness of LSPs, is based on nine case studies, a major survey of all LSPs in 2004, a range of smaller targeted surveys and four 'call-down' studies – more specific research on related aspects. The action research study includes eight issue-based action learning sets, each bringing together approximately 12 LSPs to discuss one issue in depth and to develop more effective practice. The summative impact evaluation assesses the impact and 'added value' of LSPs on the achievement of local and central aims and objectives, linking the findings of action research and formative evaluation with evaluation of the impacts and effectiveness of LSPs, LSP activities and policies.

In the formative evaluation and action research the researchers adopt the theories of change which underpinned the introduction of LSPs by the government. Five key theoretical propositions are identified which appear to underlie the establishment and operation of LSPs and from which the research questions were derived. These five theoretical propositions are assumptions about process, vision and strategy,

implementation and delivery, and outcomes. A model of the LSPs' theories of change –
the virtuous circle related to the five theoretical propositions – was developed (see
Figure 2.2 LSPs theory of change: the virtuous circle). This model represents a linked
chain of causation of LSPs and it helped to draw together the findings from the
formative evaluation and guide the next stage – the summative evaluation.

There are two limitations to this model. First, LSPs' chains of causality are extremely
complex. The simple linear progress the model suggests does not reflect the
complexity of LSPs' processes. Secondly, the model does not reflect the different
theories of change that different LSPs or different stakeholders might have (Office of
the Deputy Prime Minister, 2005).

The evaluation of LSPs highlights some strengths of the theories of change approach.
It is able to deal with complex community initiatives, providing a set of agreed
perspectives to drive or guide the evaluation and specific information not only about
whether a programme produces effects, but also how, why, and what actual
mechanisms are related to good outcomes (Weiss, 1997a).

The theories of change is a relatively new evaluation framework and is not without
problems in practice (Sullivan et al., 2002). Combining the theories of change and
realistic evaluation may overcome some of the limitations of each used separately and
may be more fruitful in evaluating complex community programmes (Sullivan et al.,
2002; Dickinson, 2006). The following section discusses how Barnes et al (2005)
applied the theories of change approach in their national evaluation of Health Action
Zones, the problems they encountered and how they combined the theories of change
with realistic evaluation.

**LSPs Theory of Change : The Virtuous Circle**

**National Context:** Legislation, governance guidance, accreditation etc

**Local Context:** Regional/subregional/local socio-ecomic contexts; local politics and institutional arrangements; local partners attitudes and capacities

**(1) Changes to Governance**
- Enhanced strategic capacity
- Greater community legitimacy
- More effective external influence

**(2) Changes to Services**
- Organisational and cultural change in agencies
- Better value for money
- More joined up
- Better meet community needs
- Especially in priority neighbourhoods
- Better meet partners' targets + objectives

**LSP Added Value**
- Joined up knowledge information base
- Collective vision, co-ordinated strategy
- Co-ordinated policies, targets, PIs
- Joint initiatives and projects
- Pooled and re-focussed budgets
- Levered – in resources
- Resource synergy
- Innovation and good practice dissemination
- Stronger and more united local 'voice'

**Vision/Strategy**
- Community Strategy
- LNRS
- Others

**Actions / Delivery / Implementation**
- Delivering CS + LNRS
- Managing NRF
- LPSAs
- Rationalising plans and partnerships
- Projects and initiatives (centrally or locally driven)
- Performance management

**Capacity**
- Strategic
- Operational
- Learning

**Organisational Arrangements (Hard Systems)**
- Membership
- Board; theme and task groups, etc
- Staffing
- Financial Resources

**Institutional Arrangements (Soft Systems)**
- Partnership governance
- Leadership
- Rules of engagement
- Accountability
- Learning

TP1  TP2  TP3  TP4

Figure 2.4 LSPs theory of change: the virtuous circle
Source: Office of the Deputy Prime Minister (2005:29)

*Combining realistic evaluation and the theories of change*

Although combining realistic evaluation and the theories of change seems to promise to be 'the most fruitful' in dealing with evaluation difficulties associated with integration (Dickinson, 2006:375), and although Secker et al. (2005; 2007a) adopt a new approach of realistic evaluation incorporating the theories of change in evaluating a national pre-retirement health initiative (Secker et al., 2005) and a study of mental health, social inclusion and arts (Secker et al., 2007a), I had difficulty finding research literature on the integration of health and social care using this approach. The national evaluation of Health Action Zones (Barnes et al., 2005) was the only sample study I could find.

Health Action Zones are locality-based programmes introduced by the UK government in 1997. They aim to bring together all those in the public, private, voluntary and community sectors contributing to the health of the local population, to develop and implement locally-agreed strategies for improving health and reducing health inequalities among local people (Sullivan et al., 2002). In the national evaluation, the theories of change approach was used to learn about and examine the development of cross-sector collaborative capacity in Health Action Zones. A collaborative approach to evaluation was developed in order to complement the use of the theories of change. It also draws on realistic evaluation, especially its recognition of the importance of context.

Although the theories of change offers significant possibilities, practical, political, theoretical and systemic limitations to its use were experienced in applying it to evaluate Health Action Zones (Sullivan et al., 2002). First, in terms of practical

limitations it was impossible for the national evaluation team to seek an intensive relationship with 26 Health Action Zones throughout England and to start the evaluation process with the programme development process as required by the theories of change approach. Secondly, political limitations appeared in the tension between politicians' desire for 'far-reaching sustainable change' and their need for early gains (Sullivan et al., 2002:209). Thirdly, in terms of theoretical limitations, the theories of change require bottom-up development which has to emerge from the interaction of stakeholders. Sullivan et al. (2002:209) argue that this implies that 'the question that can be asked of the theories of change can only be derived once the theory-building process is complete' and they raise the question of whether evaluators can draw upon their knowledge of existing evidence and lessons. If evaluators should avoid drawing upon their knowledge base in the development of the theories of change, Sullivan et al. (2002) argues, this would be to fail in learning, a key aspect of the theories of change. Lastly, in terms of systemic limitation, Sullivan et al. (2002) argue that by emphasising bottom-up theory building, the theories of change limit the explanatory possibilities available from other theoretical perspectives. And its emphasis on the activities and strategies underpinned by the locally-defined rationale could overlook systemic factors which might affect the achievement of the objectives of Health Action Zones. Sullivan et al. (2002) believe that the systemic limitation of the theories of change approach is mitigated to some extent by drawing on realistic evaluation, which emphasises the importance of context as a key factor in understanding whether and how mechanisms lead to the intended outcomes (Pawson and Tilley, 1997). However, Barnes et al. (2003:269) suggest that the context of a complex system should be recognised as 'a part of the open system within which the programme is operating' and that the context is subject to change. They argue that

context should not be conceptualised as external to the programme being evaluated, nor should there be a one-way relationship between context, mechanism and outcome, as in Pawson and Tilley's formulation of realistic evaluation.

Although combining realistic evaluation and the theories of change appears promising, my literature search found it to be still new and not practically proven.

## 2.5 Conclusion

My review of the literature indicates that there is no generally-agreed definition of the term 'integration', which is referred to by a variety of interchangeable terms. There is no prescribed model of health and social care integration but there is a rich variety of initiatives of different depth, breadth and purpose. Previous studies of health and social care integration largely use qualitative methods and focus on issues of process and structure rather than outcomes. Very few studies examine the impact and effectiveness of specific integration. Evidence that integration works for service providers and users is, as yet, sparse. Although combining realistic evaluation and theories of change appears optimal, there is still a gap between using it and proving its worth. The implications of this review of previous research are considered in relation to my own study in the following chapter.

# 3 Methodology and research design

## 3.1 Introduction

This chapter explains and justifies the theory-led programmatic conceptual framework; the design of this research; the mixed-methods research strategy; the sampling process and methods used in each of the three phases; the research tools employed; ethical considerations, and the reliability and validity measures taken.

## 3.2 Methodology

### 3.2.1 The approach of this study to evaluation

As seen in the previous chapters, there is debate about approaches to evaluation. Some see randomised controlled trials as the 'gold standard' (Nichols and Crow, 2004:268) in evaluation or as the only valid evaluation (Farrington and Jolliffe, 2002). Others argue that a methodology should be based on scientific realism rather than positivism (Pawson and Tilley, 1997). Still others propose that theory-led approaches are better for dealing with the complexities associated with integration programmes (Chen, 1990; Dickinson, 2006).

The basic experimental evaluation design employs pre- and post-treatment tests to measure effects in two matching groups. One of the two matching groups is treated while the other is not. By comparing the changes in the treated group and untreated control group, it is possible to measure the impact of the programme. The traditional experimental research design of pre-test, treatment and post-test, is a reliable method for measuring the outcome of a programme. It can tell whether a programme has worked or not by producing broadly generalisable results over a fairly large

population. However, it only measures the outcome of a programme, telling us little about the process of a programme which could lead to attribution issues. It is inadequate for understanding how and why a programme worked or failed for whom and in what circumstances (Chen, 1990; Pawson and Tilley, 1997; Ho, 1999; Nichols and Crow, 2004; Secker et al., 2005), and is unable to unlock the 'black box'. Neither is it able to capture the outcomes of a programme that are 'long-term and influenced by a range of external variables' (Secker et al., 2005:393). This might lead to misleading and artificial results when used to evaluate a broadly aimed and highly changeable programme (Weiss and Rein, 1969).

An experimental evaluation design was not appropriate for my study for two reasons. First, I was not able to manipulate the situation by conducting an RCT. Second, in an RCT approach clinical and functional indicators are rigorously examined to seek the linkage between changes to the activities of integrated services and the changes in the measurement of these indicators. The integration of older people's health and social care services in Cambridge was set up to provide better services for users with chronic and complex conditions. Expecting a significant improvement in measurements of those users' clinical outcomes rather than maintenance of their functional level would be 'unrealistic' (Dickinson, 2008:70).

Qualitative methods help evaluators to understand multiple stakeholders' perspectives of the world which are created and constructed in the research process (Lincoln and Guba, 1985; Dickinson, 2006), and are able to highlight individual differences. They provide multilevel perspectives and different points of view which help evaluators to understand the operational process of a programme and context issues (Chen, 1990). However, the limitations of qualitative methods mean that it is difficult to make generalisations and to establish attribution.

Theory-led evaluation has become a more popular alternative within programme evaluation. It has moved programme evaluation from black box evaluation, which deals primarily with the relationship between input and output of a programme, to clear box evaluation, which emphasises an understanding of the transformational relationship between intervention and outcomes, as well as contextual factors under which the transformation processes take place (Chen and Rossi, 1989).

The common element that unites the theory-led approaches is the reconstruction of the programme theory or a causal model underlying a programme on the basis of different sources of information in order to unpack the box of the transformation process, to come to an understanding of how programmes bring about intended and unintended outcomes and why programmes work (Davies et al., 2000; Vaessen, 2006).

Programme theory, also referred to as programme logic (Funnell, 1997), is a set of beliefs or assumptions that underline programme activities. It is a relatively detailed description of the relationships between programme resources, activities, and outcomes, and shows the strategy, procedure and activities the programme has adopted so as to bring about the intended goals and objectives (Weiss, 1997a; Rossi et al., 1999; Stame, 2010). Within programme theory, two basic theory components are distinguished: implementation theory and programme theory. Implementation theory relates to the hypothesis of the steps to be taken in implementation and is 'what is required to translate objectives into ongoing service delivery and programme operation' (Weiss, 1995:58). Programme theory refers to the hypothesised causal links between mechanisms and their anticipated outcomes (Blamey and Mackenzie, 2007).

Weiss (1997a) claims that programmes are inescapably based on one or several theories. However, programme theories are rarely spelled out explicitly (Chen, 1990; Leeuw, 1991; Bickman, 2000; Rogers et al., 2000; Fear, 2007). When the programme theory is spelled out in some detail in a programme's documentation and is well understood by staff and stakeholders, the programme is based on an articulated programme theory. In many cases, the underlying assumptions and expectations inbuilt in a program's services and practices are not fully articulated and recorded and the programme is said to have an implicit or a tacit theory (Argyris and Schön, 1978; Rossi et al., 1999).

Programme theory must first be extracted and described clearly and completely through some appropriated means before it can be analyzed and assessed (Rossi et al., 1999). A variety of means for identifying tacit programme theories have been proposed by researchers.

The strategic assessment approach or strategic assumption surfacing and testing (SAST) methodology (Mason and Mitroff, 1981; Jackson, 1989) emphasises participation, dialogue and integration. It seeks to involve a wide cross-section of stakeholders and divides them into groups with minimised interpersonal conflict within a group and maximised divergence of perspectives between groups. During group-based discussions, programme assumptions are unearthed and rated as to their importance and certainty, and key stakeholders on whom the success or failure of their preferred strategy would depend are identified. An open dialectical debate is followed which focuses on assumptions and ratings which differ between groups. A synthesis is attempted to negotiate and modify assumptions. However, if no synthesis can be achieved, points of disagreement are noted and the question of what research might be done to resolve these differences is discussed. The SAST philosophy calls

for full participation of stakeholders from different organisational levels in theory generating. The main weakness of the SAST appears to be its dependence upon the willingness of participants to reveal their assumptions (Mason and Mitroff, 1981). It is criticised for being formal, complex and needing training in dialectics (Cosier, 1981).

Concept mapping technique (Trochim, 1989; Mercier et al., 2000) is a structured conceptualisation process that can be used to articulate programme theory. It is a six-step process. A wide variety of relevant stakeholders with a wide variety of viewpoints are selected and guided by a facilitator. Once the specific focus for the conceptualisation is decided on, a set of statements which represent the entire conceptual domain for the programme is generated through brainstorming. The statements are sorted, arranged and then structured according to their relationships and each statement is rated on some previously defined dimension. These statements are represented as concept maps which are then interpreted following a specific sequence of steps. Concept mapping is a useful procedure. It encourages a group to focus on the conceptualisation task, to produce easily understandable graphic concept maps which represent their own thinking and are comprehensible to all participants.

Cognitive mapping technique (Eden and Spender, 1998) may be used to elicit the cognitive maps which sought to represent the individuality of cognition and to surface the 'theories in use' – the deep knowledge and embedded norms and values, role definitions and the 'organizational recipe' (Van der Heijden and Eden, 1998:66). The theories in use may be elicited through a revision of the documentation of organisation's strategic intentions, observation of decision-making in action, getting involved in or working with managers in critical circumstances, and using interviews.

The policy scientific methodology (Leeuw et al., 1999; Rossi et al., 1999; Ehren et al., 2005; Olsson, 2007) identifies programme theory by steps. Social and behavioural mechanisms that are expected to solve the problem are identified. Statements are drawn from revision of programme documentation, interviews with officials, programme personnel and stakeholders, and observation of programme activities. The mechanisms are linked to the objectives of the programme under review. The underlying theory is reconstructed, and then the represented programme theory is assessed and validated.

Iterative process of Delphi inquiry (Christie and Alkin, 2003) is used to elicit programme theory. Extensive literature reviews are carried out to derive and ground conditions as a component of a more complex, explicit and detailed programme theory. All programme field staff are interviewed and their perceptions about the impact of each activity on each of the derived conditions are measured. Delphi technique is used to establish group consensus without the use of group meetings. Participants fill out questionnaires privately, with their consensus determined by the researcher. For those items where consensus is not reached, a second or a third questionnaire is given until a consensus is reached on virtually all items or until dissensus has been clarified. This iterative process results in a draft program theory.

Iterative and dynamic process (Parker and Shaver, 2010) articulates the programme's theory by eight hour-long interviews (six in person and two via telephone) with different programme stakeholders, relevant documentation review and meetings with the directors. The articulated theory is validated by presenting to those interviewed for review and discussion.

Finally, programme explication method (Bamberg et al., 2011) is a consultative method designed to assist services to identify and document key service components,

assumptions and their contribution to intended benefits of each activity and to compare the programme's theories against the relevant programme evaluation literature. The method identifies activities, resources and intended benefits by interviewing service staff and reviewing relevant documents. The identified programme theory is then documented and circulated to staff to be checked and corrected. A systematic literature search is to be carried out to select literature evaluating the programme assumptions relevant to the question(s) under study. Findings for all the included studies are finally synthesised to reach overall conclusions. Programme explication method provides a practical tool for clarifying and validating the programme's theories. Its literature search methodology could be restrictive due to different terminologies used within published descriptions of human service programmes. Its evaluation of each service component and activity may overlook the synergy between all components and activities, where the whole may be more than the sum of the parts (Bamberg et al., 2011).

While these approaches employ different data and techniques to elicit programme theory, all are highly participative and all use either interviews or group discussions involving different stakeholders. This diversity of input from a variety of different perspectives within an organisation is a valuable and necessary source (Mason and Mitroff, 1981). Differences are recognised instead of seeking consensus that might reflect power difference rather than agreement (Rogers, 2008). The second most common technique used is revision of programme documentation. Observation, working with or getting involved with managers is another frequently used technique of eliciting programme theory. The literature review process and the use of existing research to check for consistency is seen as a fundamental step in developing a programme theory (Chen, 1990).

There are a variety of ways to explicit theory or causal modal that links programme inputs and activities to intended or observed outcomes, and then use this theory to guard, at least partly, the evaluation activities (Rogers et al., 2000). These include theory-driven evaluation (Chen, 1990), theory-based evaluation or theories of change (Weiss, 1995; 1998), intervention logic (Nagarajan and Vanheukelen, 1997), theory-of-action (Schorr, 1997), realistic evaluation (Pawson and Tilley, 1997), impact pathway evaluation (Douthwaite et al., 2003), and programme theory-driven evaluation science (Donaldson, 2005). Theories of change and realistic evaluation are two important new developments in the field of theory-led approaches to evaluation. Developed in the 1990s, they are increasingly applied to the evaluation of health and social care partnerships, social care, youth and education policies and programmes (Dickinson, 2006; Van Belle et al., 2010) and have found favour in the UK in recent years (Blamey and Mackenzie, 2007).

The theories of change approach was devised to evaluate complex community initiatives designed to achieve change in multi-level systems including individuals, families, population, communities, and services (Connell et al., 1995). The main task of the evaluation is to reveal the implicit theory underlying the intervention in order to establish the links between intervention, context and outcome and identify the intended short-, medium- and long-term indicators of changes, if the theory is correct, so that it can provide evidence on which to base evaluative judgements (Connell and Kubisch, 1998; Barnes et al., 2003; Mason and Barnes, 2007). Mostly applied to programme evaluation, it is seen as reconciling process and outcome (Hughes and Traynor, 2000). The approach has won considerable support in the UK and the US. Because it addresses the question 'what works and why?', it appears to offer a 'way out of the attribution dilemma' (Barnes et al., 2003:266). It also appears

to have the ability to embrace complex initiatives that are dynamic and diverse (Sullivan et al., 2002).

The theories of change approach, being informative, is helpful to stakeholders who can use it to decide whether or not they should modify their goals and strategies. It is also useful to decision makers and funders and in the development of new programmes (Connell and Kubisch, 1998). It can generate a useful learning process from the initial planning of a programme, through the measurement of its outcomes and activities, to the analysis and interpretation of the data. Its planning and evaluation process can be used as a tool to promote collaboration and engagement at the community level.

Different stakeholders might have different theories of change and different perspectives about what outcomes they should achieve and why (Dickinson, 2008). As demonstrated in the National Health Action Zone evaluation (Barnes et al., 2003) and National Evaluation of the Children's Fund (Edwards et al., 2006), it is difficult and challenging to work with and accommodate these differences. Blamey and Mackenzie (2007) argue that the theories of change approach places a strange emphasis on implementation theory, and is also best suited to generating implementation theory. However, the theories thus uncovered are relatively superficial and are more likely not to get beyond implementation theory to uncover programme theory. Evaluation practitioners of theories of change approach have also been predominantly engaged with articulating implementation theory, and uncovering programme theory appears to be more aspirational than practical.

However, theories of change approach alone is neither sufficient nor completely suitable for my study. The theory requires that the researcher starts his or her research with the development process of the integration programme (see Weiss,

1995, Barnes et al., 2005); specifies how activities would lead to early, interim and long-term outcomes, and identifies the contextual conditions that might affect outcomes and what is to be measured and when. I could not start my research in this way because I had not had the opportunity to articulate an agreed theory of change concerning the integration programme with all the stakeholders at the outset of the integration programme. The top-level stakeholders and one of the programme designers had declined to participate in this study.

The realistic evaluation approach (Pawson and Tilley 1997) is an important contribution to the field of evaluation (Julnes et al., 1998). It has been adopted by researchers in the evaluation of health care systems, urban regeneration programmes, crime reduction interventions, health and social care integration, active labour market policies in Lithuania, UK government's practice-based commissioning policy, health promotion in schools in France, the implementation of early warning systems and training course for the recognition and treatment of acute life-threatening events in two hospitals in Northern Ireland, employment advice in primary care, English hospital discharge policy, and multifaceted practice development programme (Ho, 1999; Evans and Killoran, 2000; Blaise and Kegels, 2004; Coker et al., 2004; Nichols and Crow, 2004; Byng et al., 2005; Clark et al., 2005; Moskvina, 2008; Greener and Mannion, 2009; Pommier et al., 2010; McGaughey et al., 2010; Pittam et al., 2010; Manzano-Santaella, 2011; Melton et al., 2011). Within the framework of realistic evaluation, Boydell and Rugkåsa, (2007) developed a model for describing the benefits of working in partnership based on case studies of two health action zones in Northern Ireland, and suggest that these are valuable assets in enabling organisations to take action to reduce inequalities in health (Boydell and Rugkåsa, 2007).

In contrast to experimental evaluation that infers causation from input and output, realistic evaluation aims to map out the entire process (Pawson and Tilley, 1997), indentify the underlying generative mechanisms of the intervention, the influence of different contexts upon the outcomes and capture not only whether a programme works or not, but also why and how it works or fails and for whom and in what circumstances (Ho, 1999; Birckmayer and Weiss, 2000; Coker et al., 2004; Clark et al., 2005; Secker et al., 2005). By examining different combinations of mechanisms and contexts in relation to different outcomes, this model is useful for capturing 'the dynamic interplay of individual, institutional, processual and structural relations within a complex wider environment to inform policy implementation' (Coker et al., 2004:219).

The realistic evaluation employs a methodology to evaluate the effectiveness of a extant social programme targeted at specific social problems (Pawson and Tilley, 1997). The model was developed from the principles of critical realism, which view the social world as 'reproduced and transformed in daily life' (Bhaskar, 1989:4), and believe that 'social phenomena are produced by mechanisms that are real, but that are not directly accessible to observation and are discernible only through their effects' (Bryman, 2004:440). Pawson and Tilley (1997) argue that the outcome of a social programme or an intervention is the result of generative mechanisms and the contexts of those mechanisms. Whether a social programme is working and whether the mechanisms have effects is affected by the contexts of the social programme and contexts of those mechanisms.

There are usually three crucial ingredients in a programme: context (C), mechanism (M) and outcome (O). According to *Webster's Third New International Dictionary of the English Language* (Gove, 1961: s.v. *context*), context is 'the interrelated

conditions in which something exists or occurs'. The context of a programme is the situation, events or information related to the programme and the circumstances in which the programme is put into operation. A mechanism is a method or procedure for doing something, 'a theory which spells out the potential of human resources and reasoning' (Pawson and Tilley, 1997:68). A programme mechanism is the reasoning behind 'the desirability of the ideas promoted by a program' (Pawson and Tilley, 1997:66) and is the way the programme works. According to Pawson and Tilley, a programme mechanism has three key identifiers:

> (i) to reflect the embeddedness of the program with the stratified nature of social reality; (ii) to take the form of propositions which will provide an account of how both macro and micro processes constitute the program; (iii) to demonstrate how program outputs follow from the stakeholders' choices (reasoning) and their capacity (resources) to put these into practice. (Pawson and Tilley, 1997:66)

The outcome is the consequence. The outcome of a programme is the effect or result of the programme. The relationship of the context, mechanism and outcome is that 'causal outcomes follow from mechanisms acting in contexts' (Pawson and Tilley, 1997:58). The conceptual backbone to realistic evaluation is based on the basic realist formula: mechanism + context = outcomes (MCO) (Pawson and Tilley, 1997:xv).

Realist research designs follow the cycle of theory→hypothesis→observation→ programme specification. A realist evaluator begins by framing the theory by thinking about and identifying the programme mechanisms. Theories are framed by identifying and explaining how mechanisms are triggered in contexts in order to produce outcomes. The second loop of the cycle is developing the hypothesis, which involves breaking down the programme to identify what about the programme might generate change; which individuals, subgroups and locations might benefit from the

programme; and which social and cultural resources are necessary for the changes to happen. In short, hypothesising what might work for whom and in what circumstances (Pawson and Tilley 1997). The third loop of the cycle is observation, data collection and data analysis of the mechanism, context and outcome in order to test the hypothesis generated earlier. The fourth loop is programme specification. Realistic evaluation seeks to achieve specification. The evaluation findings take the form of specifying 'what works for whom in what circumstances' (Pawson and Tilley 1997:85). The circuit finally comes full circle with the generated knowledge feeding back into another cycle and further theoretical development. This might include revising the original hypothesis, employing different data collection methods and then gradually establishing outcome typologies and explaining the successes and failures of the whole programme.

When it comes to choice of methods, Pawson and Tilley (1997:85) are 'whole-heartedly pluralists' and support multi-method data collection and analysis. These realistic evaluators choose a range of research methods from a toolkit and ensure that their choices are suitable for testing the hypothesis developed in the evaluation cycle.

Realistic evaluation has been criticised for being overly linear in conceptualisation (Office of the Deputy Prime Minister, 2005); failing to address other types of knowledge development (Julnes et al., 1998); failing to uncover the implementation theory (Blamey and Mackenzie, 2007); and not representing 'reality', which is 'characterised by many more linkages and epitomised by emergent properties' (Dickinson, 2006:378). The CMO framework has been criticised for ignoring outputs (Fear, 2007) and not being 'a complete representation of what it is that evaluators really do' (Julnes et al., 1998:485). Compared with the theories of change approach, realistic evaluation deals less well with highly complex, multi-site interventions with

multiple outcomes (Blamey and Mackenzie, 2007). Realistic evaluation might not be able to address some of the issues, such as different interpretations of CMO configurations by different evaluation teams in a cross-site national evaluation. It might 'tease out' CMO configurations for all the projects within the same programme; accommodate multiple objectives and multiple projects; examine the local, regional and national hierarchal contexts and deal with the different interests in the programme implemented by multiple agencies (Ho, 1999:434). But there are some difficulties in applying realistic evaluation in a health and social care context: in identifying mechanisms and the outcomes of integration (Dickinson, 2006); distinguishing between mechanisms and context (Byng et al., 2005) and conceptualising context (Dahler-Larsen, 2001; Calnan and Ferlie, 2003). However, it is suggested that a combination of realistic evaluation and the theories of change approach, the two main theory-led approaches, might enable the researcher to deal with the difficulties associated with the evaluation of integration (Dickinson, 2006).

In evaluating the integration programme in Cambridgeshire, this research adopted a theory-led programmatic approach because the integration did not introduce any built-in evaluation framework. As an outsider, I could not manipulate the environment and was not in a position to carry out an experimental or quasi-experimental evaluation to test any changes that might have resulted from the programme by comparing situations with and without the programme. The integration programme had a complex structure and process with multiple projects and interventions, involving multi-disciplinary teams in a complex environment. Using theory-led programmatic approach, which is better for dealing with the complexity associated with integration programme (Chen, 1990; Dickinson, 2006), would enable me to employ multi-method data collection and analysis to capture a

richer picture of the complex social programme: the dynamic interplay of individual, institutional, processual and structural relations within the complex environment.

Theory-led programmatic approach places emphasis on examining the conditions of the programme implementation and mechanisms (Weiss, 1997b). It is able to unlock the 'black box' and can be used in good effect in case of a new type of intervention, such as the integration programme for which the understanding of the causal mechanisms needs to be established (Van Belle et al., 2010). It is useful for describing how a real social programme affects its users and whether a specific project works better for a specific target group.

Because a single theory-led approach was neither sufficient nor completely suitable for my study, using a theory-led pragmatic approach enabled me to incorporate the strengths of different theory-led approaches and to explore both the implementation theory and programme theory of the integration programme, which theories of change and realistic evaluation fail to do (Blamey and Mackenzie, 2007). It enabled me to deal with the evaluation difficulties that theories of change and realistic evaluation were unable to overcome.

This research was not concerned with evaluating all aspects of the integration programme. It elicits the theoretical underpinnings of the programme, the contextual conditions, implementation process, expected outcomes and causal mechanisms, which are vital for investigating its effect on service users.

The contextual conditions of a programme are the situation, events or information related to the programme and the circumstances in which the programme is put into operation. A theory-led evaluation approach considers contextual conditions that are crucial and must be considered as part of the evaluation because they can be the key

to uncovering the circumstances in which, and the reasons why, an intervention works. Both theories of change and realistic evaluation approaches specify that the impact of a social programme cannot be determined with any degree of confidence without a good knowledge about the contextual conditions within which the programme has taken place (Blamey and Mackenzie, 2007). The real-life programme implementers not only act in response to their own attitudes and beliefs, but live in specific contexts (Pawson and Tilley, 1997; Stame, 2010). Contextual conditions interact with the causal mechanism in the programme and lead to outcomes. These outcomes vary according to different places, times and circumstances (Pawson and Tilley, 1997). The literature shows that:

> Contextual conditions that facilitate or inhibit processes of change entail institutional arrangements, stakeholders' and target groups' attitudes and behaviours, and geographical and socio-cultural factors, either at meso- or macro level. (Van Belle et al., 2010)

According to *Oxford English Dictionary*, in social sciences 'process' is:

> The continuing interaction of human groups and institutions, esp. as observed and studied through its effects in social, political, cultural, etc., life, with the aim of finding underlying patterns of behaviour in the data available, freq. contrasted with the study of such aspects of society through its structures. (Simpson and Weiner, 1991: sv *process*: 5.b)

The implementation process of a programme refers to a series of actions, a sequence of operations, and the changes that the programme underwent for its implementation. Understanding the implementation process, programme design, delivery of service, ensuing changes and ongoing programme operation is seen as decisive for explicating implementation theory that relates to the hypothesised links between a programme's activities and its planned goals (Blamey and Mackenzie, 2007). Blamey and Mackenzie (2007) think that practitioners using the theories of change approach have been predominantly engaged with explicating implementation theory.

A mechanism is the method or procedure for doing something, 'a theory which spells out the potential of human resources and reasoning' (Pawson and Tilley, 1997:68). It is also a hypothesis or set of hypotheses which explains the behaviour of individual actors and their interaction with other actors (Hedström and Swedberg, 1998). A programme mechanism is the reasoning behind 'the desirability of the ideas promoted by a program' (Pawson and Tilley, 1997:66) and is the way the programme works. Theory-led evaluations indicate that not only programme activities but also the mechanisms by which those activities work produce outcomes (Weiss, 1997a).

The outcome of a social programme is the result of generative mechanisms and the contexts of those mechanisms (Pawson and Tilley, 1997). Theory-led evaluation practitioners identify and describe different causal mechanisms by which outcomes are achieved to make programme theory explicit, rather than just making inquiry into the activities or characteristics that are associated with the outcomes (Lipsey and Pollard, 1989; Weiss, 1997a).

The focus of this research was on the outcomes of the integration programme, the impact of the programme on service users. After eliciting and examining the theoretical underpinnings of the programme, the contextual conditions, causal mechanisms, implementation process, and expected outcomes, this research gauged the integration programme's impact on service users and found out what aspects of the integration programme worked for which user group, in what contextual conditions and why.

**3.2.2 Incorporation of concepts from social constructivism**

Theory-led evaluation approaches are criticised for its weaknesses and practical difficulties, which have been discussed earlier. Barnes et al. (2003) argue that theory-

led evaluation approaches cannot sufficiently embrace the significance of various meanings and values amongst multiple stakeholders within complex initiatives such as health and social care integration. Dahler-Larsen (2001) points out that it is important to see systems as open and constructed by social and institutional forces of which individuals are often unaware. Barnes et al. (2003) suggest that the incorporation of concepts from social constructivism, complexity theory and institutional theory benefit theory-led evaluation approaches like realistic evaluation and theories of change. Based on anti-foundationalist ontology, constructivism does not believe that the world exists independently of our knowledge of it, but rather that it is socially constructed by human actors (Grix, 2004). In this study, concepts from social constructivism are incorporated with theory-led programmatic approach in order to understand different meanings and values amongst different stakeholders within this complex integration programme.

My interviews with managers and staff members of the integration programme found evidence of different views about the drivers for the integration of health and social care, and about what changes the integration would bring to staff and service users, and how. In my interviews with staff and users, I was told different stories about the integration and about receiving the integrated care services. Different interviewees expressed their different knowledge, meaning or interpretation of the integration programme and integrated care services based on their views and experience of them. This multiplicity of meanings and values from multiple actors within this complex system could not be embraced by a simple explanation which is the aim of theory-led evaluation.

The integration programme in Cambridge was a complex social programme. From the point of view of social constructivism, the knowledge or reality of the integration

programme was socially constructed by different stakeholders through their daily social actions between each other, and was constantly changing. Understanding the different meanings or values of the integration programme and its impact was a process of interpretation. The incorporation of concepts from social constructivism in the study, especially in the semi-structured interviews and qualitative data analysis described in sections 3.3.5 and 3.3.6, helped me to understand how different meanings and values had created different realities and how different actors constructed or made sense of the programme in which they were engaged.

**3.2.3 Quantitative and qualitative research strategies**

This research used multiple research methods including both quantitative and qualitative research methods, as supported by method-neutral theory-led evaluation model (Van Belle et al., 2010).

According to Flick (1998) and Strauss and Corbin (1998), the starting point of quantitative research is theoretical knowledge taken from the literature or earlier empirical findings. Hypotheses are then derived from the theory, data are collected and the hypotheses are tested (Flick, 1998; Strauss and Corbin, 1998). The theory-testing process is linear and deductive. In contrast, qualitative research starts without any theoretical premise but with data collection; hypotheses are then formed from the collected data and the researcher might go back to data collection. Theory is inductively developed at the end of the circular process. Denzin and Lincoln (2000) contrast qualitative and quantitative research approaches as:

> The word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the

situational constraints that shape inquiry. Such researchers emphasise the value-laden nature of inquiry. They seek answers to questions that stress how social experience is created and given meaning. In contrast, quantitative studies emphasise the measurement and analysis of causal relationships between variables, not processes. Proponents of such studies claim that their work is done from within a value-free framework. (Denzin and Lincoln, 2000:8)

I did not adhere to either a qualitative or a quantitative research strategy in investigating all my questions but moved between these two broad approaches, choosing the most appropriate methods from them. In other words, I adopted a mixed-method approach (Clough and Nutbrown, 2002).

## 3.3 Research design

This research evaluated an organisationally-led social programme for older people in the Cambridgeshire County Council area. The essential question the research sought to answer was what impact the integration of social and health care services in Cambridge had on service users. The research consisted of three phases (see the research design in Table 3.1): Phase One was elicitation of the theoretical underpinnings of the programme; Phase Two examined service users' awareness of the programme and their satisfaction level; Phase Three explored the views and experiences of users.

In Phase One, the contextual conditions, process of the integration programme implementation, and the causal mechanisms of the project were identified and examined. Efforts were made to examine the problems in the previous structures, the background of the project, the pre-project, how it fitted into the government's policy agenda, what resources and choices were available, how this new service was organised, how it worked, what it proposed to achieve and how the adopted strategy, procedure and new service brought about the intended goals and objectives.

A qualitative approach, including documentary analysis, 'shadowing', informal interviews and semi-structured interviews, was adopted to elicit underlying theory of the integration programme and to understand the generative mechanism, the complex context and process in which this social or organisational programme had been developed and implemented, including the diverse viewpoints of the different stakeholders.

In Phase Two, the contextual condition, intended goal and achieved outcome of the integration programme were identified and examined. A quantitative approach, a users' survey, was used. Service users' awareness of the integrated care system and of the different ways of accessing the new integrated care system, the routes they had followed to gain access to the new care system and how quickly their health and social care needs were assessed after they had made contact, whether they thought they had received the right services at the right time once their care needs had been assessed, and their level of satisfaction with the new system were examined.

In Phase Three – exploration of the views and experiences of service users – a qualitative method, semi-structured interviews, was used to explore the experiences and views of the users of the new integrated service. Service users' perspectives of achieved outcomes of the integration programme were examined. The theories of the integration programme were built, explained, tested and refined.

When the integration programme was introduced, there were four PCTs in Cambridgeshire: South Cambridgeshire PCT, Huntingdonshire PCT, East Cambridgeshire and Fenland PCT and Cambridge City PCT. This research focused on Cambridge City PCT. In September 2004, Cambridge City PCT and South Cambridgeshire PCT merged their senior management structures and started working under the new name Cambridge City and South Cambridgeshire PCTs. The original

director of Older People's and Adult Services for South Cambridgeshire PCT became director of Primary and Community Services for Cambridge City and South Cambridgeshire PCTs. Because the practice structures of the two PCTs were still separate and unchanged, the focus of my research remained on Cambridge City PCT.

In line with the national PCT reorganisation, Cambridgeshire PCT was created on 1 October 2006, replacing the former separate PCTs of Cambridge City, East Cambridgeshire and Fenland, Huntingdonshire and South Cambridgeshire (Cambridgeshire Primary Care Trust, 2006).

Table 3.2 Research design

| Phase | Aim | Unit of analysis | Subjects & participants | Technique | Methods | Goal |
|-------|-----|------------------|------------------------|-----------|---------|------|
| One | Elicitation of the theoretical underpinnings of the programme | Programme Projects Individuals | Literature Documents Reports Research notes Managers Staff | Qualitative | Analysis of documents Shadowing Informal interview Semi-structured interview | Identify and examine the contextual conditions, programme design, implementation process, and the causal mechanisms |
| Two | Examine the satisfaction level of service users | Individuals | Service users | Quantitative | Users' survey | Map of who the users are Measure the improvement. |
| Three | Explore users' views and experiences | Individuals | Service users | Qualitative | Semi-structured interview | Explain, test and refine and develop a theory. |

### 3.3.1 Multiple research methods used

The social and health care integration in Cambridge was a complex reform programme. Complex intervention and multi-method data collection and analysis was required to understand the programme, to identify and examine its contextual conditions, implementation process, and the causal mechanisms, and to build, test and refine the theory of the programme. This provided me with broader and different views of the integration programme from different perspectives and a more comprehensive knowledge of it, enabling me to gauge the programme's impact on service users and to create a more accurate picture.

As the integration programme was constantly changing, using mixed methods could reveal different 'peculiar elements of symbolic reality' on different 'lines of action' (Denzin, 1970:298). Interviewing service users could provide a past and present picture of their perception of the impact of the integration programme on them. Analysing documents and interviewing policy makers and service providers could provide a picture of the past, present and future features of the integration programme. Using both quantitative and qualitative methods enabled me to collect rich data from different sources, including numeric and textual data, to capture a broad picture of the integration programme, to interpret the integration programme from different angles and to reach a more coherent, and more comprehensive understanding of it.

A mixed methodology can obtain a convergence of results in research. This mixed-method research was divided into three phases and was sequential in its implementation (qualitative method first, then quantitative method followed by qualitative method) (Morse, 1991; Carpenter and Jenks, 2003; Creswell, 2003). I

made sure that all the standards of each method were met. For the quantitative methods, I ensured that sample size was adequate and that the sample was randomly selected. For the qualitative methods, my sampling was purposive and generated data until saturation occurred (Carpenter and Jenks, 2003:304). Validity and reliability measures were used appropriately in both methods. Data from both methods were analysed separately using appropriate techniques. The diverse findings from the different methods were integrated at the data interpretation stage in the research project (Carpenter and Jenks, 2003; Creswell, 2003). The emphasis of this research was on the qualitative part and was inductive (Morse, 1991).

The purpose of this mixed-method study was to better understand the complex integration programme and its impact on service users by eliciting and understanding first the theoretical underpinnings of the programme, then descriptive and quantitative results from a larger sample, following this up with a smaller sample of service users to explore those results in depth.

### 3.3.2 Phase One

In Phase One I used documentary analysis, shadowing, informal interviews and semi-structured interviews to identify and examine the contextual conditions, programme design, implementation process, and the causal mechanisms of the programme regarding meeting the care needs of and improving care services for older people. Information follows about how the data were collected for each of the above methods. The methods of data analysis are described in the following section.

***Documentary analysis***

A total of 29 relevant policy documents were collected from Cambridgeshire County Council (n12); Cambridge City and South Cambridgeshire PCTs (n9);

Cambridgeshire PCT (n5) and Strategic Health Authority (n3). Seventy-six minutes of Cambridge City and South Cambridgeshire PCTs Integration Steering Group meeting and Integration Project Board meetings dated October 2003 to March 2008 were also collected from Cambridge City and South Cambridgeshire PCTs.

### *Shadowing*

From 6th March 2006 to 31st March 2006 I worked with Cambridge North City Integrated Locality Team and shadowed all the members of staff there. The shadowing was a requirement for obtaining the Research Governance Approval from the Research and Development Department at Cambridge City PCT. The aim of the shadowing was for me to obtain a certain level of understanding of what the integration programme was about, how the integrated services were organised, the programme activities, target groups and intended outcomes. During the shadowing I talked with the integration team and asked about their beliefs and views; I observed staff, service users and the office building; I visited eight service users along with the staff, in the company of either a care manager, a care review worker, an occupational therapist, a physiotherapist or a district nurse, to assess the service users' care needs, review their care package and see how care or therapy was provided to them. I attended four different meetings: an Integration Steering Group meeting, a Continuing Care Panel meeting, a Social Care Panel meeting and a business meeting. During the shadowing I took the most detailed notes possible. I wrote down what I heard, saw, felt and thought.

### *Informal interviews*

Informal interviews were used with 15 staff of the integration programme, of which seven were staff members in the two Integrated Locality Teams; two were district

nurses at two GP surgeries; one was an occupational therapist at a medical centre; two were staff members of the Discharge Planning Team; two were staff members at the Cambridgeshire Direct Contact Centre, and one was an manager in the Cambridge City and South Cambridgeshire PCT office.

At the beginning I approached the prospective research participants during the shadowing, explaining the research to them and asking whether I could talk to them and asked them some questions. These informal interviews took place in staff offices, meeting rooms and once in a staff member's car. No tape recorder was used during the informal interviews. I took the most detailed notes possible and expanded them afterward. I did not take notes during the informal interview in a staff member's car and wrote the most detailed notes possible afterwards.

***Semi-structured interviews***                                   Semi-structured interviews were used in Phase One of the study with the three local NHS managers and five frontline staff of the integration programme. The three NHS managers were one of Assistant Directors of Primary Care and Community Services for Cambridge City and South Cambridgeshire PCTs and two Integrated Locality Team managers. The five staff members were a care manager, two care coordinators, a health care assistant and a physiotherapist.

Snowball sampling was used for semi-structured interviews with managers and staff in Phase One. Snowball sampling is non-probability sampling and a convenient sampling method (Bryman, 2004). I chose it for eliciting the theoretical underpinnings of the programme because since I did not know the nature and structure of the programme at the outset, I could not create a sample frame from which to draw the sample. It was a practicable method of tracing suitable and relatively representative key informants from the integration programme. Through

the Research and Development Department of Cambridge City PCT, I first contacted one of the Assistant Directors of Primary and Community Services who sat on the top managerial team of the integration programme. I asked her to name suitable respondents who would be willing to brief me on their work and discuss their views with me and then put me in contact with them. Then I asked these respondents to name other suitable respondents. To avoid these key informants feeling imposed upon or obligated because they were asked by their manager, I approached them first, explaining about the research and asking them whether they were willing to participate in it. I gave them a copy of my research proposal, an information sheet and a consent form. They were given two to seven days to decide whether or not to participate. Seven staff and managers of the Integrated Locality Team were selected through snowball sampling. They were purposely selected to represent the staff of the four different professional groups – intermediate care, social care, physiotherapy and occupational health services – in the Integrated Locality Team. None of staff and managers selected through snowball sampling declined to be interviewed.

The key informants and staff provided insights into their beliefs and views and how they felt they could contribute to the new project. They were also able to provide rich data from which I drew the managers' and staff's perspectives of the actual implementation process, the contextual condition, causal mechanisms, intended outcomes and achieved outcomes of the programme. As I was unable to recruit the top level stakeholders and the programme designers, with whom I could have explored the designer's interpretation of the programme theory, I had to interview the staff members and asked them what they thought the linkage between the integration and the outcomes, the underlying mechanisms and the rationale of the integration programme were. They answered questions such as what changes the new project

was intended to make; how this new service was organised and how it worked; which intended outcomes had been achieved and which had not; what improvements they perceived in older people's care services; and the impacts of the integration programme on service users and on staff members that they had found. They were also asked about their good and bad experiences in working cooperatively.

The staff interviews took place in the office of the assistant director, the offices of managers of integrated locality teams and the meeting room. The interviews were one-to-one, with a high level of privacy and lasted approximately 23-45 minutes each. All the semi-structured interviews were tape recorded and all the recoded interviews (289 minutes in total) were fully transcribed.

### 3.3.3 Phase Two

In Phase Two of the study, a users' survey was used to map who the service users were, their care needs, what care services they asked for, how satisfied they were with the services they had received, whether they were aware of the integration programme, whether they had used care services before the organisational integration, and if they had, whether they had noticed any differences since the integration.

***Random sampling***

Random sampling was used in the quantitative part of the research to draw a sample of 100 older care service users in four different groups who had received integrated care services in the City of Cambridge: 22 in social care, 31 in intermediate care, 24 in physiotherapy services and 23 in OT services. There were two Integrated Locality Teams in Cambridge City. Of the 100 participants, 54 were from the North City Integrated Locality Team and 46 from South City Integrated Locality Team (see

Table 3.2).

Table 3.3 Number of participants

| Service Types | North City Team | South City Team |
|---|---|---|
| Intermediate care | 20 | 11 |
| Physiotherapy | 14 | 10 |
| Occupational health services | 10 | 13 |
| Social care | 10 | 12 |
| Total | 54 | 46 |

A sample of 100 from the population of 14,361 older people living in the City of Cambridge (Neighbourhood Statistics, 2004) would provide adequate descriptive information relating to who the users are and the outcomes of the integration programme. A sample was drawn from the 2,718 users of services between 1 April 2005 and 30 March 2006 from both South and North City Integrated Locality Teams. A sampling frame of each of the eight groups was formed on the basis of each group's total population for the tax year 2005-2006. Eight complete lists of service users were drawn up on the basis of all the records of the eight groups. Each person was given a unique number, starting at 1. Eight samples were then selected from the eight lists at random intervals. The use of a complete list of service users as a sampling frame increased the likelihood that the findings were generalisable to the wider population.

Because the data available varied in terms of accessibility and accuracy, I found it extremely difficult to get the same complete list of service users from the four professional groups. This resulted in different sampling frames being chosen for the four professional groups (see Table 3.3).

The inclusion criteria for the quantitative sample were people over the age of 65 living in the City of Cambridge and with an Abbreviated Mental Test Score (AMTS) (Hodkinson, 1972) of 3 and above. In order to be as inclusive as possible, the sample

included older people with learning disabilities, mental illness, terminal illness and dementia who were able to understand what the research was about and the research questions and assess the information given, and could refuse to participate or decide to withdraw from the research and form an opinion. Some of the people from the above categories who were not held fully responsible for their own actions and had an AMTS of 2 and less were excluded from the research. As some research participants might be offended if they could not continue the interviews due to their low test scores I carried out the AMTS after the interviews to minimise offending them.

Table 3.4 Professional groups and sampling frame

| Professional groups | Sampling frame |
|---|---|
| Intermediate care | People who received the services |
| Physiotherapy | People referred to the teams |
| Occupational health services | People who were assessed |
| Social care | People who were assessed |

Research governance approval was obtained from the Research and Development Department at Cambridge City PCT and, after passing a Criminal Records Bureau (CRB) and occupational health check, I signed an Honorary Contract with Cambridge City PCT commencing on 1st June 2005 and expiring on 1st June 2009 which enabled me to work in the integrated locality teams and access the records stored in the offices of locality teams as an honorary staff member. I was assigned a badge which stated that I was a research student from Anglia Ruskin University working at Cambridgeshire NHS PCT. This badge was also my ID card when I visited staff or users of the integration programme. I also received formal research governance approval from Cambridgeshire County Council. With this approval and after receiving training on how to use the Social Services' computerised record system as well as an account with a username and password, I was able to access Cambridgeshire County Council Social Services' SWIFT computer system and the

information about all the social care and occupational health (OT) service users stored in the system.

The random sampling numbers were generated by using a computer programme, Research Randomiser v3.0 (Randomiser, 2006), in order to generate a sample randomly and to eliminate sample bias. I talked to social care, intermediate care, physiotherapy and occupational health services staff to identify whether the randomly selected potential research participants met the inclusion criteria. With the help of the administration staff I checked the randomly selected potential research participants against the SWIFT system to make sure they were aged 65 or over (because occasionally people under 65 receive physiotherapy and intermediate care services from these two teams) and were alive and well before approaching them. The staff initially approached potential research participants living in care homes, warden-controlled houses, sheltered or very sheltered housing and then I visited them. If they were living in their own home I approached them directly. I rang them up to explain who I was, the purpose of the research, what would happen if they took part and that they did not have to take part. I turned down the suggestion of recruiting samples through the staff of locality teams as I thought this would create additional work for the staff and put me in a passive position, and the formal approvals I received and the honorary contract I signed with Cambridge City PCT allowed me to gain access to paper and computer records, search for information online and recruit samples myself. Research participants were given two to seven days to decide whether or not to participate. If they agreed to take part a visit was arranged. During the visit I gave them the information sheet, explained the research and then gave them a consent form. No interview was conducted before the research participant had signed the consent form. An AMTS was carried after the interviews. If someone did

not meet the inclusion criteria because he or she did not have any record and contact details, or because he or she had died, could not be reached despite several attempts, could not be interviewed or did not wish to be interviewed, would not give written consent or had an AMTS of 2 and below, the next person on the sample list was selected (see Figure 3.1 sampling process). This sampling process might generate a modified random sample. However, because 82% (n446) of the potential research participants declined or were excluded during the sampling process it was impossible for me to repeatedly run the Research Randomiser to repeatedly generate random samples.

Table 3.4 lists the breakdown of recruitment for this survey. A key factor in the recruitment problems was that I found that one in five (n = 110, 20%) of the 546 selected service users for the financial year 2005 to 2006 were dead when I checked each selected name against the SWIFT system. This shows that many community care service users are very ill older people.

Of the 546 service users selected and checked, 295 were initially contacted by telephone. The second recruitment problem I met was that 85 of the 295 users (28.8%) could not be reached by telephone. Some older people kept the answer phone on all the time. It was difficult to know in how many cases the answer phone was on in order to record messages when the owner was away and in how many cases it was used in order to answer some of the incoming phone calls selectively. Some older people had switched to fax machine and only received fax messages. And 41 (48%) of those that could not be reached just did not answer the telephone no matter when or how many times I called. It was difficult to find out why these older people did not answer telephone calls. Maybe they had hearing or speech impairments, were immobile, had difficulty with the English language, had a mental

disorder, or perhaps they received too many unsolicited telephone calls and just could not be bothered to listen to them. Two staff from the care team told me that even the staff found it difficult to contact some of their clients by telephone.

Forming a sampling frame

↓

Randomising sample

↓

Finding each record ——————————→ No record

↓

Checking age ——————————→ 64 and under

↓

Checking address ——————————→ Moved out of Cambridge

↓

Checking on SWIFT ——————————→ Deceased

↓

Obtaining contact details ——————————→ No contact detail

↓

Initial contact – phone call ——————————→ Declined

↓

Arranging a home visit ——————————→ Declined  Phone interview

↓

Home visit                                    Declined phone interview

↓

Obtaining written consent ——————————→ Declined

↓

Interview – completed questionnaire

↓

——————————→ Called off in middle of interview or withdrawn after completion of a questionnaire

↓

Abbreviated Mental Test ——————————→ Low AMT score

↓

Completion

Figure 3.5 Sampling process
Table 3.5 Results of users' survey recruitment

| Service users | North city care team | South city care team | Total |
|---|---|---|---|

| | | | |
|---|---|---|---|
| No records (PT) | 33 | 11 | 44 (8%) |
| Not on SWIFT/ file closed on SWIFT | 1 | 9 | 10 (2%) |
| Died | 75 | 35 | 110 (20 %) |
| Duplicated | 21 | 24 | 45 (8%) |
| Moved away | 7 | 3 | 10 (2%) |
| Aged under 64 | 18 | 14 | 32 (6%) |
| Contact could not be achieved | 33 | 52 | 85 (16%) |
| Declined to participate | 42 | 31 | 73 (13%) |
| Ill / in hospital | 4 | 3 | 7 (1%) |
| Relatives unwilling to participate | - | 2 | 2 (0.4%) |
| Dementia or mental confusion | 8 | 8 | 16 (3%) |
| No services needed | - | 6 | 6 (1%) |
| Unwilling to give written consent | 2 | - | 2 (0.4%) |
| AMT score 2 or below | 2 | - | 2 (0.4%) |
| Withdrawal after interview | 1 | 1 | 2 (0.4%) |
| Total excluded (% of the sample) | 247 | 199 | 446 (82%) |
| Total included | 54 | 46 | 100 (18%) |
| Total names checked | 301 | 245 | 546 (100%) |

The third recruitment problem I met with, was that 73 of the 210 users (34.8%) reached by telephone declined to participate. My study population (aged 65 and over) had a wider range than that of Levin et al.'s (aged 75 and over, see Levin et al., 2002). I had a similar rate of those declining to participate (34.8%) as Leven et al.'s 35%.

*Phase Two data collection*

Of the 291 users initially contacted by telephone, 93 agreed to be interviewed face-to-face and 14 agreed to be interviewed over the telephone. All 93 older people were

visited, but only 92 face-to-face interviews were successful because one interviewee withdrew in the middle of the interview, and all 14 telephone interviews were successful. So a total of 106 users (19% of the 546 selected users and 36% of the 291 contacted users) were interviewed and I completed 106 questionnaires. Of the 92 face-to-face interviewees, six were eventually excluded from the survey (two refused to give a written consent, two had severe cognitive impairment, their AMTS being two or less, and two withdrew after the interview). So the total number of people in the sample was 100, with 86 face-to-face interviews and 14 telephone interviews.

## 3.3.4 Phase Three

In Phase Three I used semi-structured interviews to explore service users' perspectives on their care needs and the meaning of the care service improvement, to explain, test, refine and develop the programme's theory.

### *Phase Three sampling*

Theoretical sampling was used in Phase Three of the research. A sample of 27 service users was collected theoretically. The sample was collected according to the criteria of 'good' and 'most experienced' survey participants who had lots of experience, lots to tell and the will to tell (Morse, 1991:122). The inclusion criteria for the qualitative sample were older people (over the age of 65) living in the City of Cambridge, were new integrated service users who had contacted and used the new services and had an AMTS of 3 and above. I had identified and recruited them when I carried out the users' survey with them, asking them whether they were willing to participate in the next stage of the research to tell me their views and experiences of the care services they received.

### *Phase Three data collection*

Semi-structured interviews were used for Phase Three's data collection. The twenty seven service users were interviewed face to face. The interviews took place at the homes of participants, and at day centres and care homes. One participant was interviewed in a quiet room of a day centre which she attended three days a week. The interviews were mostly one to one, with a high level of privacy, and lasted between seven and 32 minutes each. Family or friends were allowed to attend the interview if they wished, but were not asked any interview questions.

*Phase Three recording*

A digital recorder and a tape recorder, as backup, were used in the interviews. All the recorded interviews (420 minutes in total) were fully transcribed.

In this thesis, each item of the qualitative data is presented citing its ID number (see Table 3.5 for a list of data sources).

For example, C9 is the ninth of the twelve documents of Cambridgeshire County Council. Since there was only one team manager for the Cambridge City North and South Locality Teams and some of the staff in the locality teams knew who I interviewed, for the sake of anonymity staff interviews are presented by their ID numbers without indicating their level or role. As there were several assistant directors of Cambridge City and South Cambridgeshire PCTs, citing an interviewee as an assistant director does not reveal this person's identity.

Table 3.6 List of data sources

| Source of qualitative data | ID | Amount |
|---|---|---|
| Policy documents of Cambridgeshire County Council | C | 12 |
| Policy documents of Cambridge City and South Cambridgeshire PCTs | P | 9 |
| Policy documents of Cambridgeshire PCT | CP | 5 |

| | | |
|---|---|---|
| Policy documents of Strategic Health Authority | SH | 3 |
| Minutes of Cambridge City and South Cambridgeshire PCTs Integration Steering Group meeting and Integration Project Board meetings | M | 76 |
| Informal interviews | II | 15 |
| Answers to open questions in user survey | OQ | 69 |
| Staff interviews | S | 8 |
| User interviews | U | 27 |
| **Source of quantitative data** | **ID** | **Amount** |
| Users' survey | | 100 |
| North city intermediate care user survey | NI | |
| North city Physiotherapy user survey | NP | |
| North city Occupational health services user survey | NO | |
| North city Social care user survey | NS | |
| South city intermediate care user survey | SI | |
| South city Physiotherapy user survey | SP | |
| South city Occupational health services user survey | SO | |
| South city Social care user survey | SS | |

## 3.3.5 Research tools

*Abbreviated Mental Test (AMTS)*

The AMTS was introduced by Hodkinson (1972) to rapidly assess older people for the possibility of cognitive impairment. It is commonly used and is the simplest and longest-established cognitive status test. A series of questions examine the basic cognitive functions including orientation, memory and concentration (Hodkinson, 1972). It is short, easy to use and suitable for older people. It was designed for use in hospital. I adapted the questions identifying a doctor and nurse and the name of the hospital concerned to identify the user's GP and carer and the name of the street where they lived (see Appendix 3). The test took five minutes to complete. A score of less than seven out of ten in a cooperative patient suggests cognitive impairment (Holmes and Gilbody, 1996).

*Questionnaire*

The method of data collection in Phase Two of this research was a questionnaire designed to survey who the service users were; what care services they asked for; how they accessed the new integrated care system; how quickly their health and social care needs were assessed and how soon they received care services; whether they thought they had received the right services at the right time once their care needs had been assessed; how satisfied they were with the services they received; whether they were aware of the integrated care system and the different ways of accessing it; whether they had used care services before the organisational integration and if so, whether they saw any differences since the integration (see Appendix 4). I tested the questionnaire on one of my colleagues and piloted it on ten new integrated care services users. I refined it several times after discussing it with my supervisors, colleague, practice supervisor at the City PCT and two members of staff at the Integrated Locality Team, and after the pilot test.

Interviewees were asked to answer the questions independently when there were family or friends attending the interview. On two occasions the wives of interviewees tried to intervene to correct the answers given by the interviewees about satisfaction level, saying 'I think it was better than that' and 'I think it was very satisfactory'. In these cases I said to the interviewees gently: 'That's quite alright; you can have a different opinion about it', noted down the interviewees' answers and carried with on the interview.

*Semi-structured interview*

Semi-structured interviews were one of the methods used to collect data from staff and services users in phases One and Three of this research. Semi-structured interviews are less standardised, less formal, more flexible and provide more breadth

of data than structured interviews in the way the questions are asked and answered (Fontana and Frey, 2000) and are less likely to provide irrelevant data than unstructured interviews. This study was interested in the experiences and opinions of staff and service users. It did not intend to capture 'precise data of a codable nature in order to explain behaviour within pre-established categories' (Fontana and Frey, 2000:653). To collect a greater breadth of data and avoid too much irrelevant information, the semi-structured in-depth interview was selected to be aligned with the research strategy, purpose and research questions.

The interviews were seen as a process of mutual construction rather than one of uncovering true facts or realities. During an interview both the interviewer and the interviewee were actively engaged in constructing events, people and meaning (Kitzinger, 2004). What the interviewees said during the interview should not be treated as evidence of their experience but of the world they described, because 'experience is never 'raw' but is embedded in a social web of interpretation and re-interpretation' (Kitzinger, 2004:128).

There was a power relationship between me and the people I interviewed. As the interviewer, I held power over the interviewees because I asked them the questions and I was actively engaged in constantly choosing and deciding which theme or topic to continue and which to stop or close (Rapley, 2004). However, as a middle-aged foreign female postgraduate researcher I had a balanced power relationship with the interviewee and was closer to the people I interviewed because I presumed that to them, I was a woman, not physically strong and less powerful than a man; I was middle aged, approaching their own age; a foreigner with a language barrier; a student and learner with less knowledge and experience than them. During the interview I took a passive position and did not interrupt, nor did I give any

provocative verbal or none-verbal replies (Rapley, 2004). I encouraged the interviewees to talk by looking at them, smiling or frowning, showing my interest in what they were talking about by nodding my head and saying 'mm', 'yes', and asking them to 'tell me a little bit more about it'.

## 3.3.6 Data analysis

This research collected both quantitative and qualitative data, which were analysed separately. SPSS Version 13.0 for Windows was used to analyse the quantitative data. SPSS is a comprehensive statistical programme and one of the most widely-used in the social sciences. It can be used to score and analyse quantitative data very quickly and in many different ways. It can also be used to carry out complicated statistical analysis (Bryman and Cramer, 2005).

Computer-assisted qualitative data analysis software (CAQDAS), NVivo 7 was used to assist analysis of the qualitative data. NVivo 7 was developed out of an earlier version of QSR NUDIST (Bryman, 2004). I used it in my qualitative data analysis for several reasons: a) it is the most-used computer software in qualitative data analysis (Richards, 2005), b) it made the coding and retrieving fast and efficient, c) it made qualitative data analysis more transparent (Bryman, 2004), d) it was relatively simple to use, e) it can import documents directly from a word processing programme for coding on screen, and e) you can write memos within the software and link the memos with relevant data (Welsh, 2002).

### *Analysing quantitative data*

The data from the 100 questionnaires were entered and analysed using SPSS to provide descriptive information about service users and their level of satisfaction. I

carried out univariate analyses first to display each variable's frequency and central tendency and to produce frequency tables, bar charts, pie charts and histograms (Bryman, 2004). I also carried out bivariate analyses to display some of the non-causal relationships such as the correlations between age and using multiple services; gender and using multiple services; living alone or with someone and using multiple services; Locality Teams and satisfaction levels; Locality Teams and waiting times; professional groups and waiting times and professional groups and satisfaction levels.

Because the method of data collection for the survey was face-to-face interviews and interviews through the phone, test was done to see whether there was any difference in these two ways of data collection. The hypothesis that face-to-face interviewees had higher satisfaction scores than telephone interviewees was tested and result of the test showed that there was no difference in these two ways of data collection.

### *Analysing qualitative data*

The qualitative data in this study included policy documents (n29), minutes (n76), informal interviews (n15), the answers to the open questions on the users' survey (n69), staff interviews (n8) and user interviews (n27). There are many different approaches to analysing qualitative data (Welsh, 2002). Thematic analysis is widely used 'for identifying , analysing and reporting patterns (themes) within data' (Braun and Clarke, 2006:79). I took the thematic analysis approach because it can 'potentially provide a rich and detailed, yet complex, account of data' (Braun and Clarke, 2006:78). It was a useful foundational method for qualitative analysis. It was flexible, being independent of theory and epistemology, and could be freely applied to arrange theoretical and epistemological approaches. It could be fitted into the theory-led programmatic approach and constructionist position. From a

constructionist standpoint, the views and experiences of service users are socially

constructed and reconstructed rather than inhering within individuals (Burr, 1995).

Thematic analysis within a constructionist framework tries to:

> theorize the sociocultural contexts, and structural conditions, that enable the
> individual accounts that are provided.(Braun and Clarke, 2006:85)

In qualitative data analysis the emphasis is on how interviewees' understandings or

interpretations are understood or interpreted.

Qualitative data analysis using NVivo comprised eight steps (see Table 3.6, Steps of

qualitative data analysis). There are some concerns about analysing qualitative data

using CAQDAS. Too much emphasis on its coding and retrieving process can cause

a 'fragmentation of the textual materials' leading to loss of the 'narrative flow'

(Bryman, 2004:419) or decontextualisation of the data (Buston, 1997; Fielding and

Lee, 1998). To avoid decontextualising the data or losing the narrative flow during

the analysis, I related my uncoded and coded text to relevant socio-demographic and

personal information, referred to as 'face-sheet variables' (Mangaberia 1995, cited in

Bryman, 2004:420), such as staff job titles and service users' completed

questionnaires. Because the sample for the Phase Three semi-structured interview

was derived from the Phase Two users' survey, each of the interviewees in Phase

Three had already been surveyed and had completed a questionnaire. I attached these

relevant socio-demographic and personal information and research notes to their

interview transcriptions. I read this information first so the context of the data would

be in my mind during the analysis. This not only prevented me from

decontextualising data or losing the narrative flow during the coding, but it also

helped me to understand and interpret data in a broader context.

NVivo calls codes 'nodes'. Nodes are coded related materials that represent themes,

ideas, people or places and are created by collecting and assigning the related materials during the NVivo data analysis process. They can be refined or removed at any point. Nodes consist of distinguished free nodes and tree nodes. Free nodes are not part of a hierarchy; they are either an initial coding or a node that has no logical connection with other nodes. Tree nodes are organised into a hierarchical structure with a parent node containing multiple child nodes. The tree nodes helped in locating nodes quickly and did not necessarily have to represent axial coding or other qualitative methods. The eight steps of my qualitative data analysis process are described below.

Table 3.7 Steps of qualitative data analysis

| Steps | Description of the process |
|---|---|
| 1. Set up NVivo project | Input all data into NVivo project. |
| 2. Familiarise myself with data | Transcribe, read and re-read the data with relevant notes. Note down initial ideas. |
| 3. Open coding | Go through the entire document. Code interesting features of the data by creating nodes and apply nodes to relevant segments of text. They were free nodes. |
| 4. Search for themes | Collate nodes into the five themes of contextual conditions, mechanism, implementation process, intended gaols and achieved outcomes. Try to gather all data relevant to each of the three themes. |
| 5. Review themes | Check all the extracts coded at each theme, read through them. Check the entire data in relation to themes. |
| 6. Categorise themes | Analyse the nodes under each theme. Categorise and then subcategorise nodes under the main themes. |
| 7. Generate theoretical ideas | Link coded extracts with memos and with the interrelationship between nodes within each theme, and between themes. Generate theoretical ideas across the data. |
| 8. Check theoretical ideas | Check through the data and whether coded extracts are relevant to identified theoretical ideas. |

*Step one: Setting up NVivo project*

After setting up my NVivo project I inputted all the data into the project and numbered each document, minute and interview.

*Step two: Familiarising myself with the data*

I collected all the data and transcribed half the verbal data myself. The other half was transcribed by others, but I checked their transcriptions against the original audio recordings and corrected them. The process of transcription and checking is 'a key phase of data analysis within interpretative qualitative methodology' (Bird, 2005:227). It provided me with some prior knowledge of the data. I started the process of data analysis by transcribing it and reading and re-reading the transcriptions. I read the transcription with relevant 'face-sheet variables' (Mangaberia 1995 cited in Bryman, 2004:420) and research notes in order to familiarise myself with the data and gain an understanding of both data and context. I also noted down initial ideas.

### Step Three: Open coding

I went through the entire document I was analysing, coding interesting features of the data by creating nodes and applying each new note or existing note to relevant segments of text. These were free nodes. For example, I highlighted the following text: 'They are in such a hurry. They want to get done and out.' (U2), created a node for 'hurry', and then applied the hurry node to the highlighted area.

### Step four: Searching for themes

Searching for themes also involved building a nodes tree. After analysing the five longest user interviews, I went through the nodes and coded data and collated the nodes into five themes (contextual conditions, mechanism, implementation process, intended gaols and achieved outcomes). Then I tried to gather all the data relevant to each of the five themes.

### Step five: Reviewing themes

Having completed the open coding of all data with 1496 tree nodes and free nodes, I went back to check each node by gathering all the extracts coded at each node and reading through them. I checked themes and every node in relation to the coded extracts. I then recoded or uncoded some of the extracts and renamed, merged, moved or deleted some nodes accordingly.

*Step six: Theme categorising*

I analysed the nodes under each theme and linked nodes with relevant information, research notes and memos to identify any interrelationships between nodes and how they linked together, categorising them under the themes into subthemes. Initially I categorised the nodes under the theme of contextual conditions into seven subthemes, namely national; county; agency; user; political; population; and social and environmental contexts. I also identified another sub-theme of contexts, 'barriers to the integration'. It turned out that these categories of contexts were messy and failed to explain anything. After analysing the nodes and all the extracts coded at each node under the contextual conditions theme to identify any interrelationships between them, I then recategorised the nodes under the contextual conditions theme into three new subthemes, namely, background of the integration, enabling factors and obstacles to the integration. I adopted the concepts of change outcome, maintenance or prevention outcome, and service process outcome from Qureshi et al's (1998) outcome study during data analysis to categorise all the nodes under the outcome theme because I found that all the nodes under the outcome theme could be fitted into Qureshi et al.'s three main groups of outcome, or the three subthemes. Then I subcategorised the nodes under the subthemes. For example, six nodes were subcategorised under the subtheme 'enabling factors'. These were shared value and vision; a good level of trust between stakeholders; previous positive experiences of

integration; the structure of the integration programme and the model of service; pooled budget; and culture of integration programme. In NVivo language, this process was to create the child nodes and grand-child nodes and build a nodes tree.

***Step seven: Theoretical idea generating***

I linked coded texts with memos and with the interrelationship between nodes within each theme and between the themes, pulling out theoretical ideas across the data.

***Step eight: Theoretical idea checking***

I went through the data and checked whether coded extracts were relevant to the theoretical ideas identified to validate the research results (Welsh, 2002).

## 3.4 Ethical considerations

All my research activities complied with the *Research Governance Framework for Health and Social Care* (Department of Health, 2001b, and the second edition Department of Health, 2005b) and followed Anglia Ruskin University's ethical guidelines and procedures. Formal ethical approval was obtained from the Cambridge Local Research Ethics Committee (LREC) and Anglia Ruskin University's Research Degree Committee. Research Governance Approval was obtained from Cambridge City and South Cambridgeshire PCTs and an Honorary Contract with Cambridge City PCT which commenced on 1st June 2005 and expired on 1st June 2009 (passed CRB check and occupational health check) was signed. The Research Governance Approval was also obtained from Cambridgeshire County Council. No research activities were undertaken until ethical approval and research governance approval were obtained.

There were four ethical issues with the study:

First, consent to take part in this research was based on adequate information and given voluntarily. Informed consent was obtained from all prospective research participants with the exception of the informal interviewees, who were staff members of the integration programme. As the staff members were not a vulnerable group of people and were well aware of the research, their verbal consent was deemed sufficient. Every research participant was given an information sheet. All research participants were given adequate verbal and written information and advice about the study, such as its aims, the involvement of the participants and the dissemination plan. As this research involved older people with learning disabilities, dementia and audio or visual impairments, the information sheet was read and explained to them in language suitable for a layperson to ensure that they fully understood the research and research questions. All research participants received advice about voluntary participation. There were no sanctions for leaving the research at any time. Contact details were given in the information sheet for any inquiries or further information. Prospective research participants were given two to seven days to decide whether or not to take part in the research. A signed record of consent was obtained from all research participants.

A volunteer interpreter (the daughter-in-law of the person in question) was used to explain the study, the content of the information sheet, the consent form and research questions to her father-in-law, who was not a native English speaker and could not communicate in English. A large-print information sheet and large-print consent form were provided for two research participants with visual impairment. One participant who had hearing impairment was given a printed questionnaire and written questions. Eight participants with learning disabilities or dementia had the information sheet, consent form and research questions read and explained to them in

language suitable to ensure that they fully understood.

The second ethical issue was data protection. All primary data collected during this study were treated as strictly confidential. All data stored on the computer were password protected and data recorded on paper were stored securely in a locked cupboard. Each participant was given an ID number and the key to the names and IDs of the participants was kept separately. All publications and other outputs use anonymous data. However, Research Governance Approvals I gained from Cambridge City and South Cambridgeshire PCTs (see Appendix 5) and from Cambridgeshire County Council (see Appendix 6) did not place restrictions on naming organisations. Organisations closely related to this study are referred to in name in this thesis.

The third ethical issue was that during the interviews I made sure that the research participants had privacy and were comfortable. One research participant became upset during the interview after receiving a telephone call from her daughter telling her that she had fallen ill. I talked to the participant, comforted her and discontinued the interview as the research participant wished. One research participant became distressed after the interview and the mental test. I talked to her, comforted her and reported the incident to the live-in warden, with the interviewee's consent. On two occasions, unexpected serious problems with care staff were revealed by two interviewees, which were not relevant to the research. After discussion with the research participants, what they had said was recorded and kept confidential. No action was taken as the interviewees did not give explicit instruction for me to do so and they had already reported their concerns to the appropriate authority. It was written in the information sheet that if any serious problems such as criminal activities or abuse were discovered during the research they would be reported to the

appropriate authority. In the course of the interviews no such thing happened.

Finally, I told each research participant that I was not a member of their care team and the research was not a part of the care they received. During the interviews with older people I was sensitive and did not ask personal questions or questions that might upset them.

## 3.5 Reliability and validity issues

Reliability and validity are important criteria in evaluating the quality of quantitative research and have been adapted for evaluating the quality of qualitative research in very similar ways (Bryman, 2004). Reliability refers to the reproducibility and consistency of measures. Validity refers to the issue of 'whether an instrument measures what it aims to measure' (Bowling, 2002:147) or 'the extent to which an account accurately represents the social phenomena to which it refers' (Hammersley, 1990:57). Reliability affects validity. An unreliable instrument has low validity (Bowling, 2002).

*Reliability*

In this research, measures were taken to improve reliability. All the survey samples were randomly selected using the computer programme Research Randomiser V3.0 (Randomiser, 2006) to ensure that every member of the population of interest had a calculable chance of being selected in the sample and each of the eight groups of service users in the two Integrated Locality Teams in Cambridge City PCT was included to make the sample more representative and to reduce random error (Litwin, 1995) or sampling bias (Bowling, 2002). As I was the only researcher doing the coding there was no problem of 'inter-observer consistency' (Bryman, 2004:71),

which refers to lack of consistency in different researcher's different decisions. I had

one of my supervisors check the coding of my first five interviews and compare how

she would code my analysis of the same data in order to improve the reliability of the

qualitative data analysis. She agreed with my understanding of the data, although she

would have given the codes different names. However, from a constructivist point of

view, people from different social and cultural backgrounds may have different ways

of understanding the world (Burr, 1995) and it is very possible and reasonable for

different researchers to have different understandings and interpretations of the same

data (Welsh, 2002).

### *Validity*

Several measures were taken to establish the validity of the study:

Face validity, which refers to casual review of an instrument by untrained individuals

(Litwin, 1995), was established by asking a staff member of the Integrated Locality

Team to look at the questionnaire to see whether on the face of it she thought it made

sense.

Content validity, which refers to more formal and systematic assessment of an

instrument than face validity by experts (Litwin, 1995), was established by asking

two members of staff, one a research coordinator and the other my practice

supervisor at Cambridge City PCT, to check the content of the questionnaire. One

staff member suggested that I could ask service users whether they had used the

service before the organisational change and to compare the services if they had used

them both before and since the change. I accepted this suggestion and added it to the

questionnaire. My practice supervisor pointed out that service users might not know

who their care coordinator was, even if they had one. So I changed the question 'do

you have a care coordinator?' to, as she suggested, 'Who is responsible for your care?'

There are some threats to reliability and validity in research. Some common biases and errors such as sampling bias, acquiescence response set, evaluation apprehension and interviewer bias were constantly eliminated (Bowling, 2002). When I piloted the questionnaire I found that some interviewees answered my questions before I finished the whole question. In the questionnaire, questions 11, 14, 15, and 18 offered the same set of satisfaction level response: *very satisfied*, *satisfied*, *neither satisfied nor dissatisfied*, *dissatisfied*, *very dissatisfied* and *not applicable*. Question 19 had a different quality response set: *excellent*, *good*, *satisfactory*, *poor*, *very poor* and *can't say*. Some interviewees immediately answered 'satisfied' to questions 11, 14, 15, and 18 when I had just uttered the first two responses for them to choose from - 'very satisfied? Satisfied?'. It was the same with question 19. Some immediately answered 'good' when I had only uttered the first two responses for them to choose from - 'excellent? good?'. There may be two reasons for this: first, the interviewees might feel that the word they have heard express what they really feel and so they give their true response, second, because of the 'acquiescence response set' or 'yes-saying' bias, research participants 'more frequently endorse a statement than disagree with its opposite' (Bowling, 2002:153). In order to eliminate the bias I changed the order of the two response sets (see Appendix 4 Questionnaire) and printed two cards in large font with the two reversed response sets (see Appendix 7 Satisfaction level responses card and Appendix 8 Quality responses card). I presented these two cards to every respondent who was to be interviewed to help them to complete the questionnaire. I found the cards very effective in encouraging them to read the response sets carefully before pointing out their answers to me (Litwin, 1995).

Before the interviews, I told the staff who were to be interviewed that this research was neither funded nor organised by the PCT and that I was an independent researcher, and I told the service users who were to be interviewed that I was not a member of their care team and that the research was not a part of the care they received. I did not give them any hint of what my own opinion was or what I stood for. I made them comfortable and told everyone that taking part in this research was voluntary and that they did not have to answer any question if they did not want to. I did all this to try to reduce any anxiety which may be generated in people when they are tested, because the anxiety might have caused them to try to give the answer they thought I wanted to hear rather than their true response. This is called evaluation apprehension (Bowling, 2002). During the interviews I tried not to ask any leading questions or to reveal my own opinions in order to reduce the possibility of interviewer bias.

# 4 Findings

## 4.1 Introduction

This chapter presents the findings of the study – the contextual conditions,

implementation processes, causal mechanisms, planned goals and achieved outcomes

of the integration of health and social care services for older people in

Cambridgeshire, and explains why some of the intended aims were not achieved. The

contextual conditions, implementation processes, causal mechanisms and the

intended outcomes of the integration programme were derived from analysis based

purely on qualitative data and the achieved outcomes were derived from analysis of

both qualitative and quantitative data (see Figure 4.1).
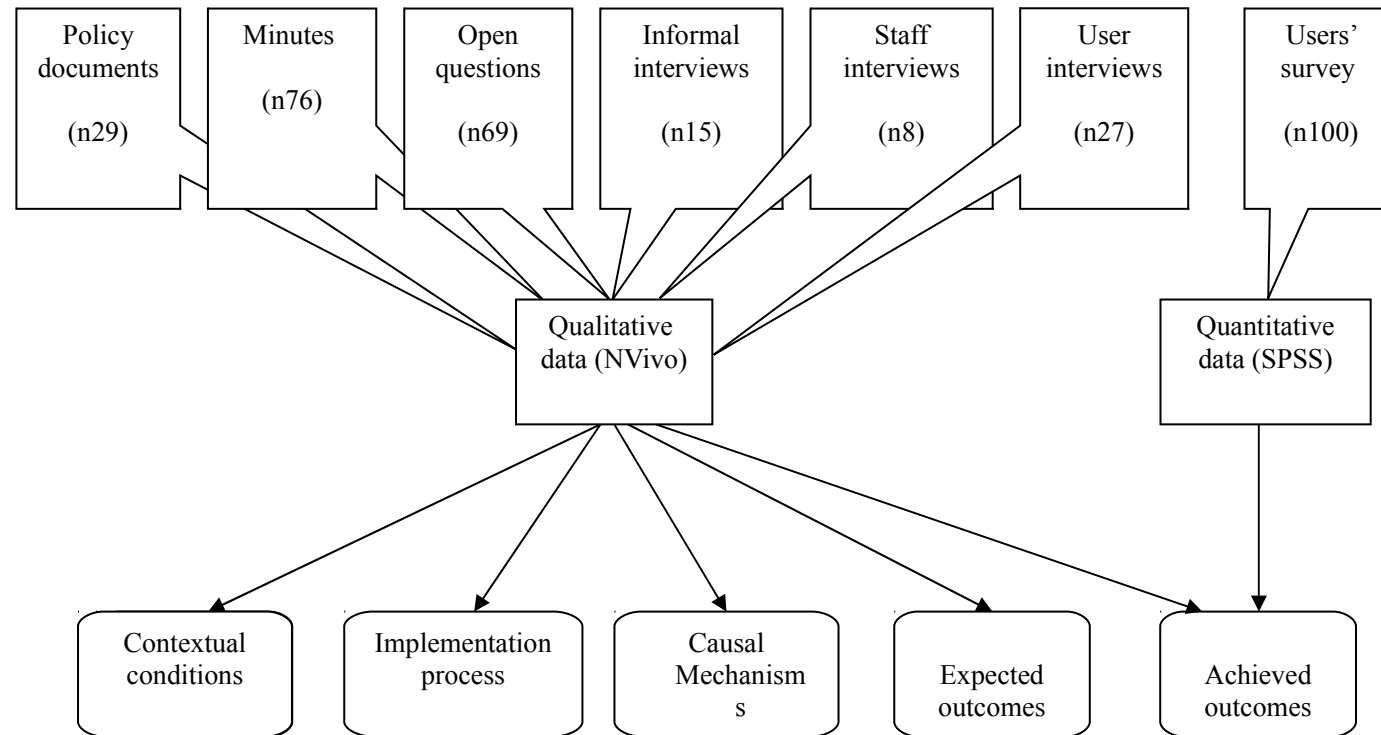
Figure 4.6 Methods of data analyses

## 4.2 Contextual conditions of the integration

The contextual conditions of the integration programme under study were why and in what situation or circumstances the integration programme was put into operation and in what situation or circumstances the outcomes were triggered by its mechanisms. The study explores both the inner contexts – the ongoing strategy, structure, culture, management and political process – and the outer contexts – the national economic, political and social contexts (Pettigrew et al., 1992) – as well as the enabling factors and the obstacles, which are characterised as constantly changing. Political, national, local, and user contextual conditions of the integration programme were identified from the data and originally categorised as such. By examining these identified contextual conditions in relation to causal mechanisms and different outcomes, these contextual conditions were conceptualised as background, enabling factors and obstacles to the integration (see Table 4.1).

Table 4.8 Contextual conditions of the integration programme

| |
|---|
| **Background to the integration** |
| 1 Government policy was increasingly calling for a more effective joined-up approach |
| 2 Other authorities had taken steps towards greater integration |
| 3 Research had shown that there were many advantages to integration |
| 4 Increasing care needs of local older people |
| 5 Calls for improvement to the standard of social care service in the County |
| 6 Users in favour of closer working across agencies |
| **Enabling factors for the integration** |
| 1 Shared values and shared vision |
| 2 A good level of trust between stakeholders |
| 3 Previous positive experiences of integration |
| 4 The structure of the integration programme and the model of service |
| 5 Pooled budget |
| 6 Culture of integration programme |
| **Obstacles to the integration** |

| 1 Structural disadvantages for the development of small disciplines |
|---|
| 2 GPs unable to get used to the structural change |
| 3 Impact of change on staff |
| 4 Information and communication technology incompatibility |
| 5 Financial recovery: Turnaround Plan |

**4.2.1 Background to the integration**

Background contextual conditions refer to the situation or environment previous to the integration programme. From the data, six background contextual conditions were identified, as presented below.

***Government policy was increasingly calling for a more effective joined-up approach***

Judging by the five policy documents and four sets of minutes that I had access to and the two staff interviews and one informal interview with a member of staff I had conducted, there was a strong sense that the introduction of the integration of health and social care services for older people in Cambridgeshire was government policy-driven or in response to the calls of government policy makers for enhanced and more effective joined-up working. In one of the policy documents, one of the reasons for the integration, given by the Cambridgeshire County Council, is:

> Government policy also supports a more joined-up approach. The recent Green Paper following on from the Victoria Climbie enquiry recommends much closer working relationships between Health, Education and Social Services. Both the White Pater on Social Services from 1998 and the Health and Social Care Act 2001 project similar messages for adult services. (C4)

One staff member believed that 'the integration is statistics driven by the Department of Health' (S7).

Members of Integration Steering Group considered the integration programme

consistent with the government's health and social care agenda which supported the integration of health and social care. When the Department of Health published *Our Health, Our Care, Our Community: Investing in the Future of Community Hospitals and Services* (Department of Health, 2006) and *Your Health, Your Care, Your Say: Research Report* (Opinion Leader Research, 2006), the directors and managers at the meeting of the Integration Steering Group, Cambridge City and South Cambridgeshire Primary Care Trusts cheered, saying 'We are completely on the right road!' (M36).

### Other authorities had taken steps towards greater integration

One policy document (C4) and two members of staff (II 12, II 15) pointed out that other authorities in England had already taken steps towards greater integration, and this was another reason for introducing the integration programme in Cambridgeshire. It seemed that Cambridgeshire County Council and the four Primary Care Trusts did not want to be left behind. During an informal interview I asked one of the senior staff members whether she was sure that the integration of health and social care for older people in Cambridgeshire was a unique form of integration in the country. She said proudly:

> Yes, we are. Other counties are working partnerships. They do not transfer staff on the NHS payroll. We are unique in the country. I presume Cambridge wants everything to be different from others. (Extract from my notes of informal interviews II 15)

### Research had shown that there were many advantages to integration

Although only one of Cambridgeshire County Council's policy documents stated that 'research has shown that the advantages are many' (C4) and none of the staff interviewed said anything about previous research, the designers or decision makers

of the integration programme seem to have considered the results of previous research in the field even though there was no evidence of this. From this point of view the introduction of the integration programme was evidence-based.

***Increasing care needs of local older people***

Two policy documents (CP2 and C9) assessing the care needs of local older people point out that an increase in the age of the Cambridgeshire population was accompanied by an increase in care needs. In these documents there is a sense of urgency about meeting these needs.

According to policy document CP2, over the last two decades Cambridgeshire experienced considerable population growth. From 1995 to 2007, the population (all ages) registered with the 76 GP practices in Cambridgeshire increased from 524,000 to 598,000. Since 1995, 16% of this population growth was in over 65-year-olds. Between 2006 and 2011 Cambridgeshire's population was projected to grow and the greatest proportional population change will be in those aged over 75 (by 9%). The population aged 75-84 is forecast to increase by 24% by the year 2016 and 54% by the year 2021and the population aged 85 and over will increase by 57% by the year 2021.

The increase in age of the local population is accompanied by an increase in care needs. Older people made up 72% of all social services clients. Of the 4,140 people of all ages who made new contacts and completed assessments in 2006/07, 3,290 (79%) were 65 and over and 2,680 (64.7%) were 75 and over (CP2).

***Calls for improvement to the standard of social care services in the county***

As was clearly reflected throughout the policy documents that one of the main

objectives of the integration programme was to improve the quality of care services.

Although no indication of a low standard of social care service in the county prior to

integration was found in the policy documents I analysed or in the staff interviews I

did, during an informal interview a member of staff of Cambridgeshire County

Council (not of Cambridge City PCT) told me:

> Integration is supposed to integrate good practices. But [social services]
> were slim, overspent, not good and had nothing to offer. The County
> Council just chucked it away. (Extract from my notes of informal interview
> II 12)

She indicated that the standard of social care service in Cambridgeshire County

Council prior to the integration was low and that the County Council had taken the

opportunity to pass the provision of care services to the PCTs. In any case one of the

aims the Cambridgeshire County Council was trying to achieve through the

integration was to improve the standard of social care services in the county.

***Users in favour of closer working across agencies***

During the initial integration consultation period local discussions with service users,

carers and representative groups showed that users were 'in favour of closer working

across agencies' (C4). Users' expectation of good-quality care services was growing.

> Public awareness and expectations are growing and older people want to be
> supported to live in their own homes and communities for as long as
> possible and to avoid institutional care wherever possible. (C9)

**4.2.2 Enabling factors for the integration**

Enabling factors for the integration here refer to factors that made the integration

programme possible and the contextual conditions of the integration programme in

which its mechanisms worked to produce outcomes. This research found the six

enabling factors listed below.

*Shared values and shared vision*

The terms 'vision' and 'value' appear frequently in the policy documents and minutes, with 'vision' appearing 43 times (27 times in seven policy documents and 16 times in 11 minutes) and 'value' (excluding 34 instances of 'best value') appearing 37 times (33 times in 11 policy documents and four times in four sets of minutes). Compared to the policy documents and minutes, in the interviews 'vision' and 'value' were each mentioned once, the former in an informal interview, the latter in a staff interview. Having realised the disadvantages of the compartmentalised' approach, a broad consensus in favour of closer working across agencies was reached by all parties concerned. It was claimed that a vision and values shared between stakeholders and staff of the integration programme had been agreed upon and developed. A Cambridge County Council's document stated:

> If organisations and the staff within them are to work together effectively, it is vital that we have a shared statement of our vision and values to make our purpose clearer for both service users and staff and to build trust and understanding amongst the organisations.
>
> We have started to develop this shared vision for older people's services and seek to develop it further through this consultation process. The vision will form the basis of all the developments we collectively pursue in the future. (C2)

The shared vision and value for Cambridgeshire was stated as:

> ...to create services for users that are fully integrated and focused on their needs. This includes designing and delivering services around individual needs and promoting independence in all our services. (C5)

This shared vision and values of the integrated service was the result of consultation with a large number of stakeholders including older people, carers and staff working in the NHS and the Social Services. It was described as 'clear', 'wonderful', 'valid'

and 'Utopia' by the participants of *Improving Care Through Integration* focus groups conducted by Age Concern Cambridgeshire during the consultation period (Age Concern Cambridgeshire, 2004:9,15).

### *A good level of trust between stakeholders*

A good level of trust between stakeholders was regarded as a key enabling factor in the integration. One of Cambridge County Council's documents claimed:

> We are able to embark on this programme of work because of the good level of trust and collaboration between Social Services and the NHS that is present in Cambridgeshire. (C1)

Apart from the above policy document, two members of staff also mentioned the word 'trust' during their interviews:

> ...it's a very trusting sort of work environment, it's not very controlling; it's very trusting management. (S4)

> I think joint working is – people have to trust each other and each other's roles. But if you got that trust and understanding, then it's have to be, they have to find the special way of working. They certainly seem to. (S7)

Creating and maintaining trust among stakeholders has been identified as one of the key issues in achieving more effective integration (6 et al., 2006). From policy document C1 and two staff interviews, a good level of trust appeared to exist not only among Social Services, Cambridgeshire County Council and Primary Care Trusts in Cambridgeshire but also among different professionals that had been integrated into the integrated locality teams and between the manager and staff of the locality team I studied.

### *Previous positive experiences of integration*

The integration of services had already taken place in a few areas in Cambridgeshire before the integration of health and social care services for older people.

In 2001, the Cambridgeshire and Peterborough Mental Health NHS Trust was formed. It is responsible for services for people with mental health problems which were formerly provided separately by Social Services and by the Health Service.

The Cambridgeshire Learning Disability Partnership similarly brings together social service and health professionals into joint teams to provide seamless services for people with learning disabilities. (C4)

During informal interviews three members of staff (II 3, II 9, and II 13) told me about their experiences of previous integrations. In 2001, occupational health equipment provision was integrated by merging six different sources – hospitals, the Red Cross, Social Services, Cambridgeshire County Council, district nurses, the occupational health equipment store and physiotherapy – into a single computerised provider, the Anglia Support Partnership, with a pooled budget. After Phase One of the occupational health integration, five-day equipment delivery had achieved 80 percent and demand for equipment increased substantially.

On 1 April 2003 the Primary Care Trusts took responsibility for the provision of all community occupational therapy services in their areas, integrating acute occupational therapy services in Hinchinbrook's Hospital, Social Services occupational therapy services in Cambridgeshire County Council and NHS occupational therapy services in the community. Staff from Social Services were transferred to the Primary Care Trusts so that integrated teams could be set up. The outcome of phase two of the occupational health integration reduced the waiting list from 17 to six months.

*The structure of the integration programme and the model of service*

The structure of the integration programme, especially the co-location of the different professional teams in the same office, was crucial to integrating care services and

was viewed by staff involved as the most important aspect of the work to integrate care services. All of the eight staff interviewed believed that co-location of the different professional teams in the same office had naturally improved face-to-face communication and created a much better cooperative working relationship with everybody. One member of staff explained to me:

> ... it should facilitate easier liaison between the disciplines, so rather than having to ring up the social worker, for example, to talk about Mr B, you see the social worker every day of your life, so you talk about Mr B and that actually means that you actually communicate about some things, um, that it's better for the patient to have communicated about him, but perhaps wouldn't have actually got you to the point of picking up the phone or writing a letter as previously. (S4)

The structure of the integration programme was one of the elements of its inner context (Pettigrew et al., 1992). The older people's health and social care services in Cambridgeshire were not integrated at County Council, primary care trust, city or district level, but at the local level. In Cambridge, integrated care services were developed at two localities, North City and South City. Both integrated locality teams in Cambridge were, in time, fully integrated with co-locating social care teams, community nursing teams, physiotherapy teams and occupational health service teams in the same team office. My interviews with staff suggested that structural integration with the co-location of the different professional teams in the same office had led to better communication and ensured closer collaborative working.

### *Pooled budget*

There was a pooled budget for the provision, commissioning, and purchase of services relating to the care of older people in each of the four PCTs in Cambridgeshire. Each budget was provided jointly by Cambridgeshire County Council and the respective PCT. The pooled budget avoided disputes about which

organisation was responsible for paying for which specific elements of care and

made it possible for the budget to be used:

> ... to meet the needs of an eligible individual regardless of the funding source (C2).

As one of the Assistant Directors (the only member of staff who mentioned the

pooled budget) said in the interview:

> ... now we have got one pooled budget, so we don't have to worry about 'Well actually that should be funded from here, that should be funded from there'. And because we are able to look at the pooled budget over the whole spectrum of services that we can offer, so we can decide, you know, as an integrated service to care better for this person at home, and we provide some of the care from our integrated teams, and we put some care in from a domiciliary agency, or it's better for them to go into a residential home. (S5)

### *Culture of the integration programme*

The culture of an organisation is part of the inner context (Pettigrew et al., 1992).

Among the policy documents I analysed, only one mentioned bringing together the

different cultures of the NHS and social services:

> Integrating health and social services for older people will involve bringing together two cultures, each with many years experience of improving the quality of life of the people we work for. We need to ensure that the best of both organisations is identified and taken forward in the new integrated way of working. The organisational development programme being put together will be crucial in ensuring that this happens. (P1)

Three members of staff (one informal interview and two staff interviews) also talked

about the cultural differences and felt the challenge of having different ways of

working in the same office. One of the staff told me:

> I think staff are really enjoying it. It's been a huge challenge. I think to start with it was very difficult because it was two different cultures. You know, health is very much a can-do and you just push all the boundaries, and your problem's resolved. And you just get on with it, and you do it. And, I don't know, I hope I'm not putting down my social care colleagues but it always

seemed they were much more linear in their approach. You know, they went down very structured processes, they had lots of business processes. We've never had businesses processes in health. We just said 'OK, this is the problem. We have to deal with it. We've got on and dealt with it.' And I think that was very frustrating to start with. But I think now we've both mellowed a bit. We both understand, yeah, we can move a bit this way with that and we can move a bit that way with that. So I think it's helped us both to understand, we can't just do we want to do. So that's helped us by looking at social care. I think it helps the social care to say: 'Actually it doesn't all have to go down a process route, you can actually be a bit flexible with what you do'. So I think for staff it's been a real learning, you know, to see what the other people do, you know, and frustrating, very frustrating at times, but I think, you know, I think the teams really are coming together and, you know, they're enjoying being big teams. (S5)

During an informal interview a member of staff told me about her experience of cultural conflict during the integration of the NHS, occupational therapy and social services occupational therapy:

There were cultural differences between them. The health OT was more people orientated: the emphasis was on people's body functional rehabilitation and Social Services' OT was more building orientated: the emphasis was on providing assistive equipment. Both sides had got used to their way of working. Some thought their way of working was best or more important. (Extract from the notes of informal interview II 5)

From the above two interviews, professional subcultural differences were found to be a double-edged sword. They could be enabling when they got people to work closely together, but could also be an obstacle to integration when it caused difficulties or frustration among the staff. While I was shadowing, a member of the social care staff showed me an assessment completed by a district nurse and complained that it was too health- and symptom-orientated, too simplistic, not much use, and that assessments by care managers or social workers would be more socially-orientated, much more comprehensive and holistic and would tell the whole story of a service user. At first some social workers did not want to be transferred and others left because they were concerned about losing their specialist roles and professional

standing when the integration took place. Two years after the integration began, a member of staff made the following comment about the changes in the professional subculture and the differences she felt in an integrated locality team:

> S6: It's been really hard. It's been really very hard. Um, the first six months, um, moving the social care staff, moving social workers from their base in north city to this, has, was very hard for them. Some of them have settled into it quite well. But, um, we initially lost two senior social workers.
>
> Me: They just don't want to move?
>
> S6: They didn't, didn't want to move. And one didn't, actually, actually left before she moved, didn't really want to move bases. Um, and, um, the other one – it was difficult for her to, to um, understand integration, I think. It is a very different way of working for the social workers, certainly. And I think, although they feel as if, perhaps they have been, um, the social workers feel they have been perhaps, um, they'd lost their professional standing maybe. They feel as if they, they've integrated into health and they've lost their, their specialist roles. (S6)

### 4.2.3 Obstacles to the integration

Obstacles to the integration here refer to either the factors that hindered the integration programme or the contextual conditions of the integration programme in which the mechanisms of the programme were prevented from producing the intended outcomes. This research found five obstacles to the integration as presented below.

***Structural disadvantages for the development of small disciplines***

During my shadowing only one member of staff (II 5) expressed her concern about the structure of the integration programme as we talked in her car after visiting some service users. I could sense her unease as we sat in the car in a quiet car park. She felt that the structure of the integration programme discouraged the development of small disciplines and that different disciplines found working together challenging. A small

discipline such as occupational therapy was disadvantaged in its professional development. The managers or assistant managers of locality teams were either social workers or district nurses; none were physiotherapists or occupational therapists. Occupational therapists in the PCT used to have their own professional meetings, but since the integration they had been allocated into locality teams. Their line managers were either social workers or district nurses who knew nothing about occupational health services and could not provide professional guidance or support. She felt that occupational therapists had lost their professional managerial support and peer support. Although they were still having a regular informal PCT-wide occupational therapists meeting, they did not have an official leader. She claimed that the structure of the integration affected occupational therapists' personal and professional development and the development of occupational health.

### *GPs unable to get used to the structural change*

The structural change of the integration caused a problem between GPs and district nurses. Before the integration district nurses had been employed and worked at GP surgeries. The integration moved them from GP surgeries into locality teams along with the other disciplines. Their line managers became the managers or assistant managers of locality teams who worked as district nurses at the same time. They had regular locality-wide district nurse meetings and took part in locality team meetings. As some surgeries were too small for a district nurse's office, some surgeries' district nurse teams had their offices in the building of the North City Integrated Locality Team. Other district nurse teams' offices were still in GP surgeries. District nurses were working closely with other members of locality teams and GPs. However, the GPs seemed unable to get used to the change. Talking about the integration, a

member of office staff of Cambridge City and South Cambridgeshire PCTs (not a district nurse) told me:

> GP are the problem, aren't they? They don't see the integration. They don't see the district nurses are integrated. GPs still think district nurses belong to their surgeries: 'I want you to see such and such a patient'. That's the problem. (Extract from notes of informal interview II 15)

### *Impact of change on staff*

The staff members I interviewed told me about all the changes the integration had brought to them. Social care staff were transferred from Social Services to the NHS, changing their employers. Many members of staff had changed jobs, roles, ways of working, offices and the people they worked with. Nine members of staff (eight staff interviews and one informal interview) talked about how the integration had changed how they worked. One (S2) talked about the new policies and guidelines they had to follow; six (II 5, II 12, II 14, S2, S5, and S8) said that it was good that the integration of health and social care made health and social care and other disciplines learn from each other; and one member of staff and one service user told me that the reconfiguration of the homecare service introduced by Cambridge City and South Cambridgeshire Primary Care Trusts in November 2005 required all homecare staff to work unsocial hours, including evenings and weekends, and to be able to drive to work. Homecare staff who could not work flexible hours or could not drive to work had either left voluntarily or been made redundant. A service user noticed the change and told me:

> They are cutting down the staff. Four staff made redundant last year because they could not drive. They were on bikes. One of the staff was only given one month's notice. (Extract from notes of user survey NI 23)

A member of staff told me that she thought the redundancies in both North and South

City Integrated Locality Teams could have taken advantage of natural wastage:

> Yeah, some of our staff as well, they've made redundant. I think it could have been done as natural wastage. I am not the manager so – that came from the higher-ups, but I think natural wastage could have been [used], really. (S8).

Another member of staff told me about their agenda for change:

> We've just had the agenda for change. The agenda for change is to look at people's job specification, and they've all been put into the NHS banding. Lots of us are not happy with the banding, some people are happy with the banding. So that makes staff a little bit uneasy and on edge at the moment. (S1)

The staff coped with the changes differently. Four members of staff told me in their interviews that some of the social care staff did not want to be transferred and had simply left. One member of Social Services staff that I talked to had changed her job in order to avoid being transferred to a PCT and to stay in the Social Services under Cambridgeshire County Council. Still angry about the transfer, she said:

> We have lost lots of good experienced staff. The Council badly handled the staff transfer. Staff felt they were thrown out. (Extract from notes of informal interview II 12).

Three members of staff told me about how differently staff members were coping with the changes. Two recalled the time when social care staff were moved into the integrated locality teams:

> Some staff just can't cope with change at all. Some people can cope with it, but very slowly. Some people, occasionally you get people what really like change, there was one person I think that was really looking forward to the move, but everybody else didn't really want to. (S4)

> People are struggling with it. Some people take it on better, try to get on with others and learn from others. But some are not and are quite struggling. (Extract from the notes of informal interview II 12)

The ability to cope with changes varied with the individual. One staff member (S2)

was enthusiastic about the changes for two reasons: first, she had not been recruited to participate in this study by me directly but by her line manager, the care coordinator and the homecare team manager. She might have felt obliged to tell the positive side to please me and her managers. Secondly, she had worked as a qualified nurse in another European country and could not register as a qualified nurse in the UK when she moved here many years ago, as she could not provide some of the documentation required. She had been working as a care assistant in the Council's Social Services Homecare Team for some years before being transferred to Cambridge City PCT. All these changes and the more health-oriented tasks and training might have made her feel much more professional and excited because they raised her status and gave her a sense of achievement.

### *Information and Communication Technology (ICT) incompatibility*

ICT incompatibility was an irritating obstacle to the integration and was discussed and clearly stated in many policy documents and minutes. From the commencement of the integration programme until the time my field work started it was not possible to access NHS applications from a Cambridgeshire County Council PC nor Cambridgeshire County Council applications from a NHS one (C11). I was given a list of eight different IT systems used by the different professionals involved in older people's health and social care (see Table 4.2).

Due to this ICT incompatibility different professionals in the integrated locality team had different referrals, case management and case record systems. Social care and the occupational health service received their referrals from Cambridgeshire Direct Contact Centre directly through the computer and managed and recorded their cases using the SWIFT system. Physiotherapy referrals were referred to Chesterton

Hospital, and physiotherapists received their referrals by post twice a week from there, managed their cases through the COMWISE system and kept handwritten records in notebooks and individual folders. District nursing cases were managed through COMWISE and recorded by hand in individual records. Intermediate care cases were managed and recorded on a countywide intermediate care monitoring computer system.

Table 4.9 IT systems by different health and social care organisations in Cambridge

| Users | IT systems |
|---|---|
| Social Services | SWIFT |
| Hospital | HISS |
| GP | EMIS |
| GP | VISION |
| GP out of hours | ADASTRA |
| Community Equipment Services | MEASALS |
| Community (District nurses/occupational therapists/physiotherapists) | COMWISE |
| Cambridgeshire Direct Contact Centre and care provider | ONESERVE |

Staff seeking the records of a person who had used a different care service had either to go to a different computer and enter a different system or go to a paper folder. It was not difficult to imagine how they felt about this. One member of staff complained:

> No real change, only a few boring sort of irritating changes, like for example, cause we're on different computers here we can't access the public folders that we could from health computers. So it just means we have to go to a health computer to do that, which isn't convenient, you know, it's not easy, so there are irritating things like that. (S4)

***Financial recovery: Turnaround Plan***

In 2006, news came through BBC News (24 July 2006) and Cambridge weekly News (16 August 2006) (Cambridge City and South Cambridgeshire Primary Care Trust, 16 August 2006) that Cambridge City PCT was among the worst performers with a 9.8% overspend. Its serious financial imbalance is discussed and stated in

some of the policy documents (C12, P8) and minutes (M16, M50, M52, M72, M75) from April 2005 to February 2008. Cambridge City and South Cambridgeshire PCTs had spent more money than allocated by the Department of Health. The *Cambridge City and South Cambridgeshire PCTs' Turnaround Plan* was produced for submission to the Department of Health on 30 June 2006. The Turnaround Plan identified action that would return the PCTs to recurring financial balance from March 2007 by reducing their annual expenditure by £27.9 million and repaying an additional £18 million loan received in 2006 by March 2009. Significant progress had already been made in achieving a financial balance, including the £21.9 million cost reductions identified in 2005/06 (C12 and P8). There were reductions and cessations of staffing and services (M27, S1 and II 14). This caused great concern and anxiety for both staff and service users (C12). Four members of staff (S1, S4, II 4 and II 14) expressed their concern during their interviews.

To some of the staff this meant worries about their jobs or further transfers. Two members of staff told me that people were worried about their jobs:

> S1: I think the disadvantage of it is the over-spend of the budget. It's quite uncertain at the moment on jobs and how it's all going.
>
> Me: You mean here?
>
> S1: Yeah, I don't think they really know how it's going to go. They might have to sort of put people in different teams to, um, you know, to counter balance really, the skill mix. We've got unskilled; we've got skilled, qualified, things like that. Some of the teams haven't. They haven't got the right ratio for the team. We're a bit uncertain at the moment of what's going to happen. (S1)

I visited South City Integrated Locality Team, where the Community START team was located, on January 13 2006. This team administered intravenous (IV) antibiotics and other similar highly-skilled tasks across the entire city. After walking into the

building, I was told by a member of staff (II 14) not to go into the Community START office because members of the team, district nurses and health care assistants were very unhappy at the moment. There had been a meeting at Cambridge City and South Cambridgeshire PCTs the day before at which it was decided that the Community START team was going to cease to exist and staff nurses on the team would be transferred into locality teams, to which some originally did not want to go. Some members of the team had been transferred from Marlow House (an inpatient rehabilitation ward for older people at Fulbourn Hospital, Cambridge) when it had been closed not long before.

To some of the staff this financial imbalance meant more work or less pay. Most of the posts, especially managerial ones, were frozen. When somebody left their post, fewer staff had to cover more jobs. A staff nurse (II 4) told me that because only one high-grade district nurse in the whole PCT was allowed on duty at weekends she was forced to do fewer weekend shifts and as a result lost her special rate of weekend pay.

The service users were concerned that some services had been cut. Apart from Marlow House, the rehabilitation inpatient beds and the Community START team, some of the rehabilitation beds at Brookfields Hospital were closed (C12). Although it was claimed that this would result in increased efficiency in the remaining wards as well as an enhanced range of community-based services, and that there would be no impact on either the number of delayed transfers of care or the number of people awaiting transfer from Addenbrooke's for rehabilitation (see C12), the anxiety among staff was obvious. One staff member said:

So I would take from that, that I think the stressful bit is over, in terms of

integration. The stressful bit now is the prospect of it all falling apart because of the funds. [Laughs] That's the stressful bit now. And it's more stressful because we've got further to fall because we've just got there. We've just sort of got to the point where, yeah, we're really noticing that this is working for the users' benefit. And then you sort of think, 'How long is this going to last?' (S4)

Contextual conditions can be a critical shaper of implementation process and can therefore be constructed through processes (Pettigrew et al., 1992). The next section explores the implementation process of the integration.

## 4.3 The implementation process of the integration

The implementation process of the integration programme refers to a series of actions, a sequence of operations, and the changes that the integration programme underwent from its onset to the point when this study started. The implementation process of the integration included setting up Cambridgeshire Direct Contact Centre, designing the service user journey, establishing the management structure of the new integrated directorate, reconfiguration of the homecare service and rolling out the Vulnerable People's Programme.

### 4.3.1 Setting up the Cambridgeshire Direct Contact Centre and designing the service user journey

The Cambridgeshire Direct Contact Centre Social Care Older People's Team started operating in May 2003 along with a number of other services including library and waste management to join up services and create one-point access, thus avoiding passing service users around. Before May 2003, there had been four social services social care duty desks in Cambridgeshire, one in each of the social care older people's teams in Cambridge City, South Cambridgeshire, East Cambridgeshire, and Fenland, offering inconsistent services in the county, especially in terms of priority.

Service users were passed around. When the Cambridgeshire Direct Contact Centre Social Care Older People's Team was set up the duty work was moved to the Contact Centre and the duty desks in Social Care Older People's Teams became the backup.

On 1 April 2004, the Cambridgeshire Direct Contact Centre became the initial contact through which older people accessed the Older People's Integrated Health and Social Care Teams. Opening from 8am to 8 pm from Monday to Saturday, staff there took public and professional social care and occupational health referrals, prioritised the referrals and passed them to integrated locality teams.

Apart from the Cambridgeshire Direct Contact Centre there were two other first contact points where service users could access the new integrated health and social care services: hospital team referrals and community professional referrals (see Figure 4.2)

In June 2006, the Cambridgeshire Direct Contact Centre filtered occupational health equipment applications for simple equipment. Staff there completed the assessment and provided the equipment within seven days in order to reduce the occupational health waiting list in Cambridgeshire.

**4.3.2 Establishing the management structure of the new integrated directorate**

On 1 September 2004 Cambridge City PCT and South Cambridgeshire PCT merged their senior management structures and started working under the new name of Cambridge City and South Cambridgeshire PCTs. A single directorate of the Primary Care and Community Services was created and a single Director of Primary and Community Services for Cambridge City and South Cambridgeshire PCTs was appointed. The process of establishing the management structure of the newly-integrated Directorate started in November 2004. The Directorate was divided into

five integrated locality teams - three in South Cambridgeshire and two in Cambridge City (P10) (see Figure 4.3).

The integrated locality teams were newly-designed, integrated multidisciplinary teams. They worked with GPs and liaised closely with all other integrated interface teams and community specialist service teams. Integrated locality teams provided health, therapy and/or social care support to service users so that they could manage their current condition and/or cope with a chronic illness. A locality team manager and assistant locality team manager were appointed for each team (the South City team had two assistant locality team managers) which consisted of administration staff, district nurses, community staff nurses, health care assistants, senior social workers, care managers, review workers, physiotherapists, occupational therapists, therapy assistants, and homecare staff comprising care co-ordinators, assistant care co-ordinators, and care assistants (see Figures 4.4 and 4.5).
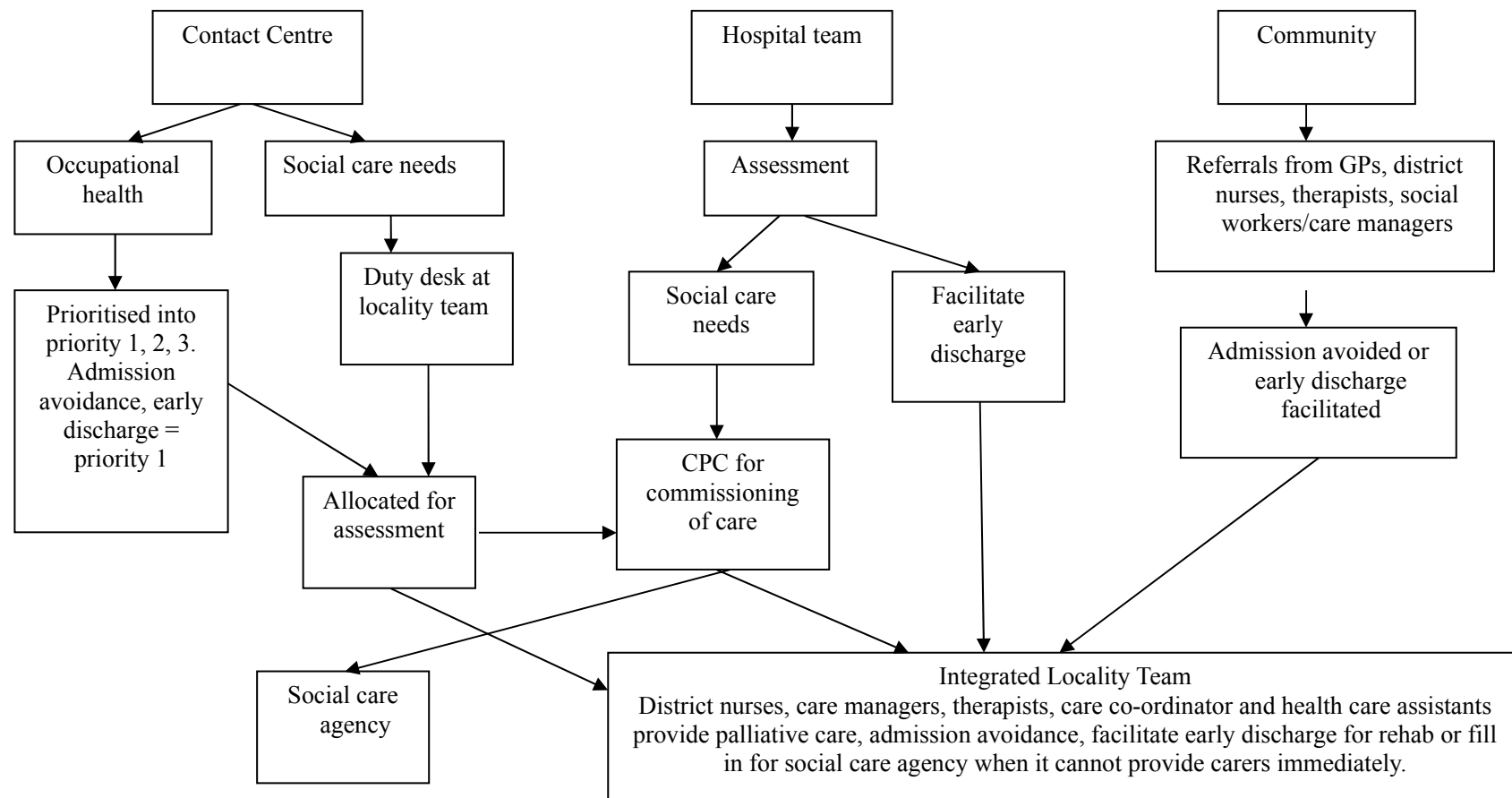
Figure 4.7 First point of contact for patient/service user access into Integrated Locality Teams, March 2006

**Cambridge City and South Cambridgeshire PCTs Integrated Locality Teams and their localities**

**South City Integrated Locality Team**

- Cornford House Surgery
- Queen Edith Medical Practice
- Petersfield Medical Practice
- 281 Mill Road Surgery
- Brookfields Health Centre
- Trumpington Street Medical Practice
- Woodlands Surgery
- York Street Medical Practice
- East Barnwell Health Centre
- Newnham Walk Surgery
- Lensfield Medical Practice

**North City Integrated Locality Team**

- Nuffield Road Medical Centre
- Red House Surgery
- Arbury Road Surgery
- Huntingdon Road Surgery
- Bridge Street Surgery

**South Cambs North Integrated Locality Team**

- Bar Hill Health Centre
- Swavesey Surgery
- Over Surgery
- Milton Surgery
- Waterbeach Medical Practice
- Firs House Surgery, Histon
- Cottenham Surgery
- Willingham Surgery

**South Cambs West Locality Team**

- Monkfield Medical Practice, Cambourne
- Comberton Surgery
- Boun Surgery
- Orchard Surgery, Melbourn
- Harston Surgery

**South Cambs East Locality Team**

- Sawston Medical Practice
- Shelford Medical Practice
- Linton Health Centre

Figure 4.8 Integrated Directorate of Cambridge City and South Cambridgeshire PCTs
(Source: P10)
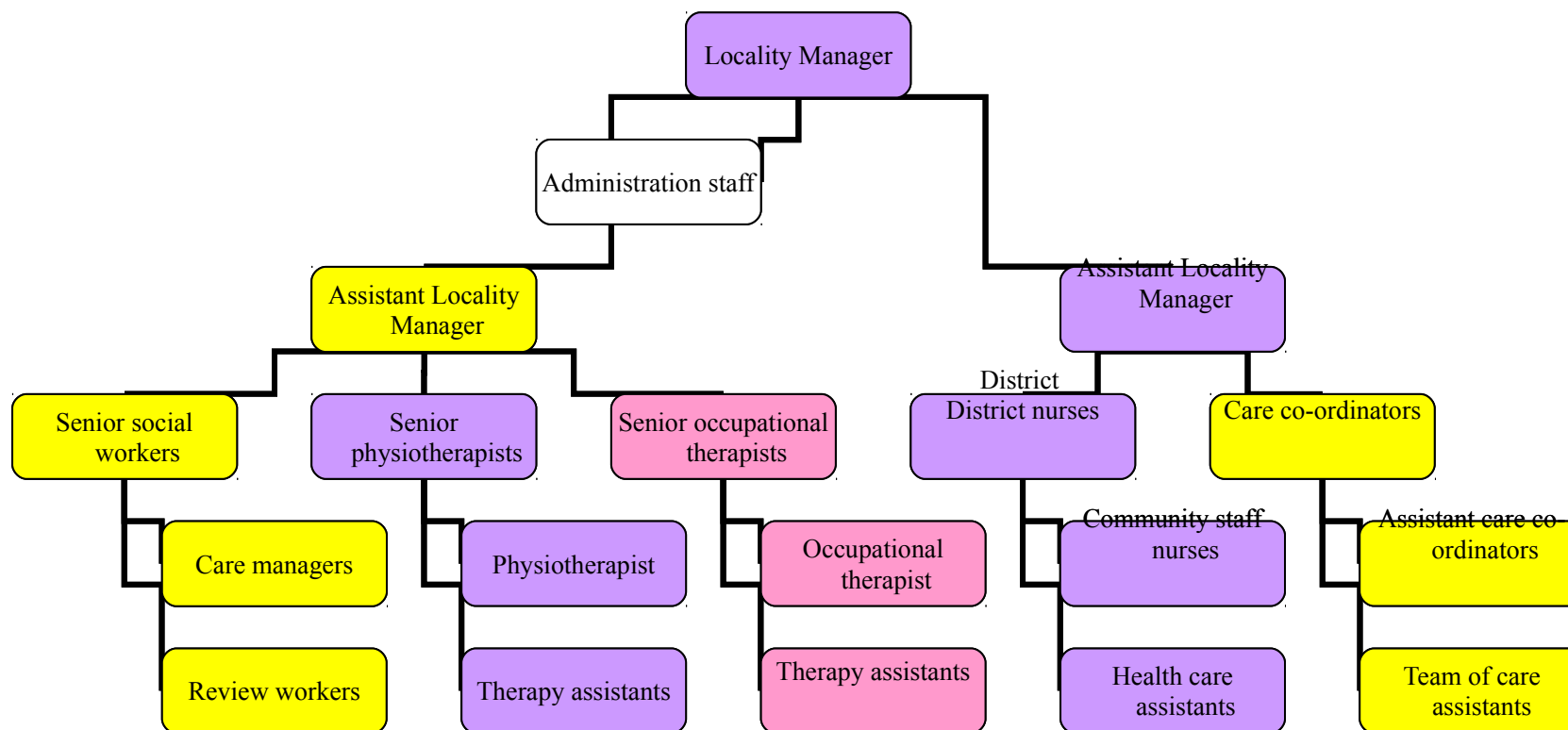
Figure 4.9 Structure of Cambridge City/South Integrated Locality Team, June 2006
(Source: P12)

☐ Staff from NHS
☐ Staff from Social Services
☐ Occupational health service teams integrated since 2003
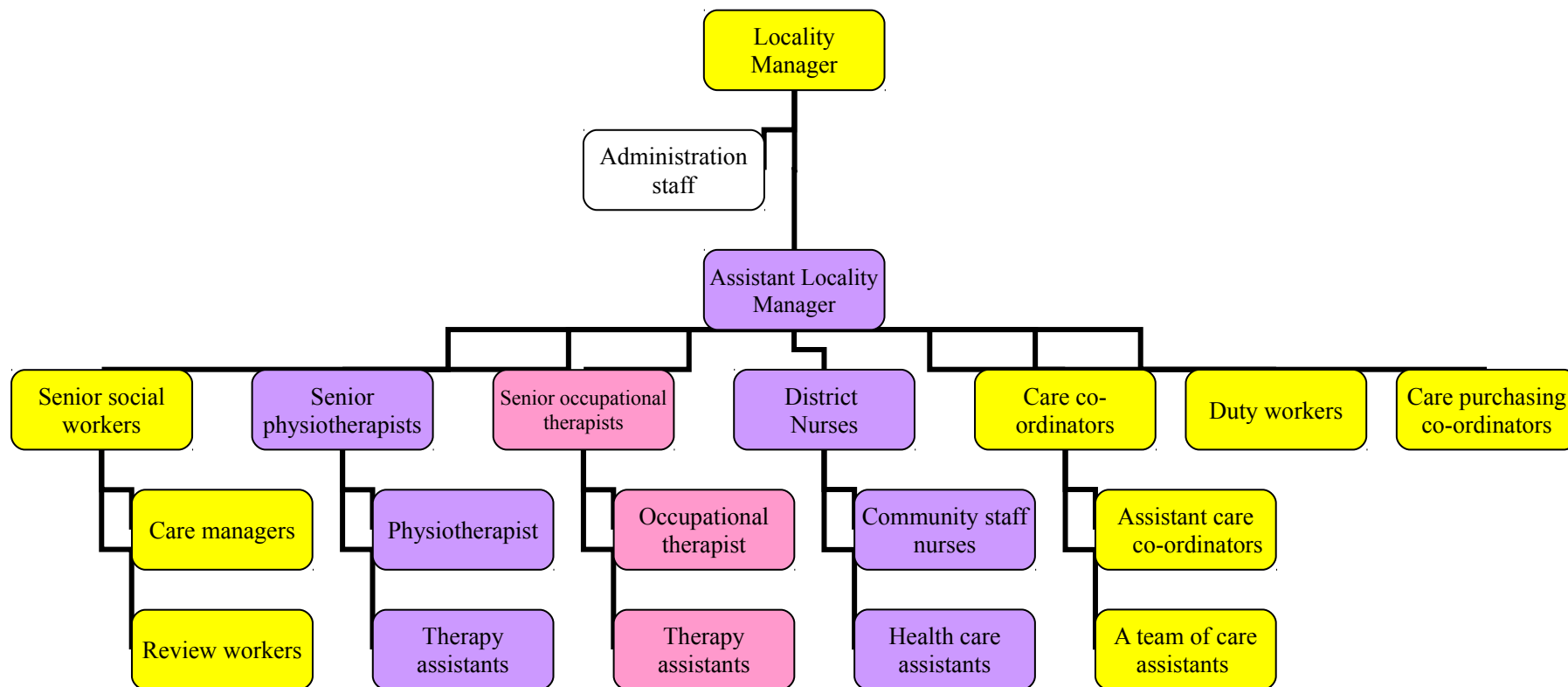
Figure 4.10 Structure of Cambridge City/North Integrated Locality Team, June 2006

- Staff from NHS
- Staff from Social Services
- Occupational health service team integrated since 2003

In Figures 4.4 and 4.5 the purple boxes indicate members of the integrated locality teams integrated from the NHS; yellow boxes show those from Social Services' Older Peoples' Services, Cambridgeshire County Council; pink boxes indicate those already integrated with professional teams. Occupational health teams from both the NHS and Social Services were integrated a year earlier in April 2003. The manager and assistant managers of the integrated locality teams could be from either the NHS or Social Services. The manager of North City Integrated Locality Team was a social worker and the assistant manager a district nurse. The manager of South City Integrated Locality Team had an NHS background as a district nurse; one of the assistant mangers was a social worker from Social Services and the other also had an NHS background.

There were two additional groups in the North City Integrated Locality Team building, but not in the South City Integrated Locality Team building. These were social care duty workers, who had been transferred to the locality team from the former Social Services' Older People's Service, and care purchasing co-ordinators who would refer cases to the financial assessors at Cambridgeshire County Council and approach independent care providers to request a service (see Figures 4.4 and 4.5).

Interface services subdirectorates were also created. Integrated interface service teams (see Table 4.3) and community specialist service teams were created to work across the five localities and support locality teams. Community specialist service teams were composed of the community specialist palliative care service, the community diabetes team, community stroke team, Parkinson's disease team, community heart function service and tissue viability team (P10).

Table 4.10 Integrated interface teams
(Source: P10)

| Integrated interface teams | Definition | Services provided |
|---|---|---|
| STARTeam Community, including night nursing team and hospital support team<br><br>(STARTeam Community daytime team ceased in June 2006 due to financial difficulties. All its district nurses were transferred to locality teams. | A mobile multidisciplinary team supporting the STARTeam in A&E, General Practice and locality teams | 24 hours x7 days a week service, including assessment, short term rehabilitation, treatment (IV, antibiotics, etc) and management of patients at home by home visits to provide planned care, continuing care and palliative care in order to prevent unnecessary emergency admissions and/or support early discharge. This team took category C calls from the ambulance service and provided additional support for residential and nursing homes. |
| STARTeam A&E | A multidisciplinary team working with patients at A&E, Medical Admission Unit and Medical Observation Unit of Addenbrooke's Hospital in Cambridge who could be safely discharged in less than a day | Assessing, treating and organising care for patients in A&E, MAU, MOU who could be safely returned home with interventions from experienced community nurses, therapists and/or social care |
| Discharge Planning Team | Multidisciplinary team | Assess and monitor discharge progress and give advice and support on discharge planning to hospital ward staff and patients with complex health and social care needs. Collect data on delayed transfers of care and admissions to care homes |
| Inpatient facilities at the Brookfields | Inpatient intermediate care beds | More health support than could be provided in patients' own homes |
| Community Specialist Palliative Care Service | Inpatient beds or specialist palliative care advice via Arthur Rank House hospice<br><br>Community specialist nursing support and advice<br><br>The Hospice at Home nursing care | Inpatient beds or specialist palliative care advice<br><br>Specialist palliative care advice<br><br>24/7 nursing care |

### 4.3.3 Reconfiguration of the homecare service

In November 2005 the reconfiguration of the homecare service was introduced by Cambridge City and South Cambridgeshire Primary Care Trusts. Social Services' homecare teams were transferred to the South City and North City Integrated Locality Teams. The changes introduced by this reconfiguration were the transfer of long-term, in-house homecare packages to the independent sector and the in-house homecare service working in an integrated way with health care assistants. The changes would enable the in-house homecare service to offer more flexible hours, including weekends, evenings and bank holidays, to support the 24 hour, seven days a week care delivery service, and to provide rapid short-term rehabilitative care for two to six weeks (P11).

There was a change to the way of working, roles and key requirements of homecare staff. Homecare assistants would now work in an integrated way with health care assistants, their roles having changed from performing social care only to more rehabilitative care and an enabling role, performing both social and health care tasks. A new foot care role was introduced for care assistants with an NVQ II qualification and a commitment to undertake a one-day accredited foot care course so that they could carry out basic foot care duties like nail cutting where the service user had no underlying medical condition affecting their feet. There were also additional roles for senior care assistants, including inductions, NVQ assessment, formal moving and handling and undertaking complex delegated nursing tasks. The clients they took on would have more complex conditions and be more dependent. Homecare staff were required not only to be flexible about the hours and days they were able to work but also to be able to travel independently across the localities without the additional cost

of drivers and without the need of an additional staff member to provide single calls (P11).

The aims of this change were to provide more responsive and integrated services, support more people living at home, facilitate timely discharge and reduce the number of admissions to hospitals or care homes (P11). After the reconfiguration of the homecare service the role of the whole integrated locality team was focused on providing short-term rehabilitation or assistance with personal and health care and assessing long-term social care needs to organise, purchase, overview and review long-term social care services. Through the services it provided, the integrated locality team aimed to enable service users to go home from hospital sooner than they would have before the integration or to stay at home instead of going to hospital (P13).

### 4.3.4 Rolling out the Vulnerable People's Programme

The Vulnerable People's Programme was piloted in 2003/2004 in two general practices – one in Cambridge City, the other in South Cambridgeshire – to create a register of vulnerable people who had registered with the practices. The people on the register were given a range of assessments, advice and support to prevent them reaching a crisis state. This programme started in January 2005 in all interested general practices. By March 2006, fourteen general practices were participating in the programme, which was linked with the new integrated locality teams and other community teams that might have contact with a vulnerable older person (e.g. CAMDOC's out-of-hours GP service). At each participating general practice, GPs and district nurses, physiotherapists, occupational therapists and social workers linked to general practices worked together to identify vulnerable people who tended

to be admitted to hospital several times a year, register them and allocate a key worker to them who would organise care for the person and try to keep them in the community and avoid their admission to hospital.

Table 4.4 summarises the projects and activities the integration programme implemented and the intended goals it planed to achieve.

Table 4.11 Programme activities and their planned gaols

| Projects and activities | Planned gaols |
|---|---|
| Creating integrated multidisciplinary locality teams and integrated interface service teams | A single unified care system which would be easy and simple for service users to understand and access. Reducing the risk of users falling between two services Promoting the wellbeing of older people in all aspects of their lives. |
| Developing three new care pathways, access to services, assessment, and co-ordination of care. | Simple, clear and straightforward access to services. Quick and integrated assessed within 14 days. Allocating a single key worker to guide older people with complex needs through the services and ensure co-ordination of interventions |
| Developing Cambridgeshire Direct | Giving the public simple, easy and quick access to the care systems. |
| A pooled budget | Making better and more economical use of resources. |
| Reconfiguration of homecare service | Providing rapid short-term rehabilitative care for two to six weeks. Providing more responsive and integrated services. Supporting more people living at home. Facilitating timely discharge. Reducing the number of admissions to hospitals or care homes. |
| Vulnerable People's Programme | Giving vulnerable people who tended to be admitted to hospital several times a year a range of assessments, advice and support to prevent them reaching a crisis state and keep them in the community. |

## 4.4 The causal mechanisms of the integration

Analysis of the qualitative data collected from 33 policy documents, 76 sets of meeting minutes, 15 informal interviews with staff of the integration programme and 8 semi-structured interviews with the director, managers and staff of the integration programme revealed four main causal mechanisms: efficiency; empowerment; bringing down barriers; and synergy. Three of these had sub-mechanisms. Efficiency and empowerment were acknowledged by interviewees or written in policy documents. Bringing down barriers, synergy and all the sub-mechanisms evolved during the process of analysing the qualitative data. The next sections present the four causal mechanisms and their sub-mechanisms.

### 4.4.1 Efficiency

One informal interviewee (II 9) and four members of staff (S4, S6, S7, S8) interviewed believed that the causal mechanism of the integration programme was efficiency, and two policy documents (C2, C3) and one set of minutes (M59) also indicated this. The introduction of health and social care integration was thought to be able to break the barriers between health and social professionals and make health and social care staff work together more effectively. It was interesting to notice that all the five members of staff who believed that the causal mechanism of the integration programme was efficiency were in senior positions: managers and leaders of their professional teams. These senior staff held views identical to those in Cambridgeshire County Council's two main consultation papers regarding the integration programme in 2003. The mechanism of efficiency or programme theory appears to have been passed from the top (the designer of the programme) down (managers or services organisers). When I asked a member of staff what she thought

the causal mechanisms of the integration program were, she answered:

> As I said before, efficiency really – I think that we need to sort of break down barriers between different teams, and to have quick accessible, um, access into to, to provide services for our service users without any barriers. (S6)

Efficiency was one of the expected benefits of integration. A Cambridgeshire County Council's consultation paper regarding the integration programme in 2003 states:

> From an organisational and managerial perspective there are also benefits to integration:
>
> …
>
> - Resolve day-to-day operational problems more quickly and closer to where services are provided
>
> - Improve managerial efficiency by removing barriers between agencies and avoiding duplication
>
> …
>
> - facilitate multi-agency teams and services working toward the same goal, such as the elimination of delayed discharges from hospital. (C2)

It was expected that the integration would lead to a reduction in the duplication of referrals and assessments which would save staff time, make access to services faster, resolve operational problems more quickly, eliminate delayed discharges from hospital and produce more effective services. Integration would reduce costs by reducing duplication. A member of staff said:

> I imagine there is also an economic argument for it: that it should save on duplication of some of the things we do. That's my idea of what's behind it really. (S4)

The integration of seven different occupational health equipment provision services into one would not only reduce costs but also increase service efficiency. When the senior staff told me about her experience of the three phases of occupational health services integration, she was very confident:

The mechanism of OT Phase One integration was cost effectiveness. The outcome was that five days delivery after assessment reached 80 percent and equipment demand increased a lot.

…….

The mechanism of the OT Phase Two integration was also cost effectiveness. The outcome was reducing the waiting list from 17 months to six months. (Extract from notes of informal interview II 9)

The integration of health and social care created integrated multidisciplinary locality teams which had good relevant skills to provide better services to service users and enable them to stay in their own homes if they wished, and made efficiency savings by reducing the use of acute hospital beds and care home beds. As one member of staff put it:

A long time ago you'd get where people would have, couldn't stay in their own homes because there wasn't services there and we've got, and we have to have a good skill match for all the carers, ourselves to provide the service, um, and it must be much more cost effective than actually for those people to be in hospital, or even go into residential. ... So that's what it's about, it's bringing all the services together and just provides a quick efficient service for the patient or client. (S8)

For the efficiency mechanism, see Figure 4.6 below.
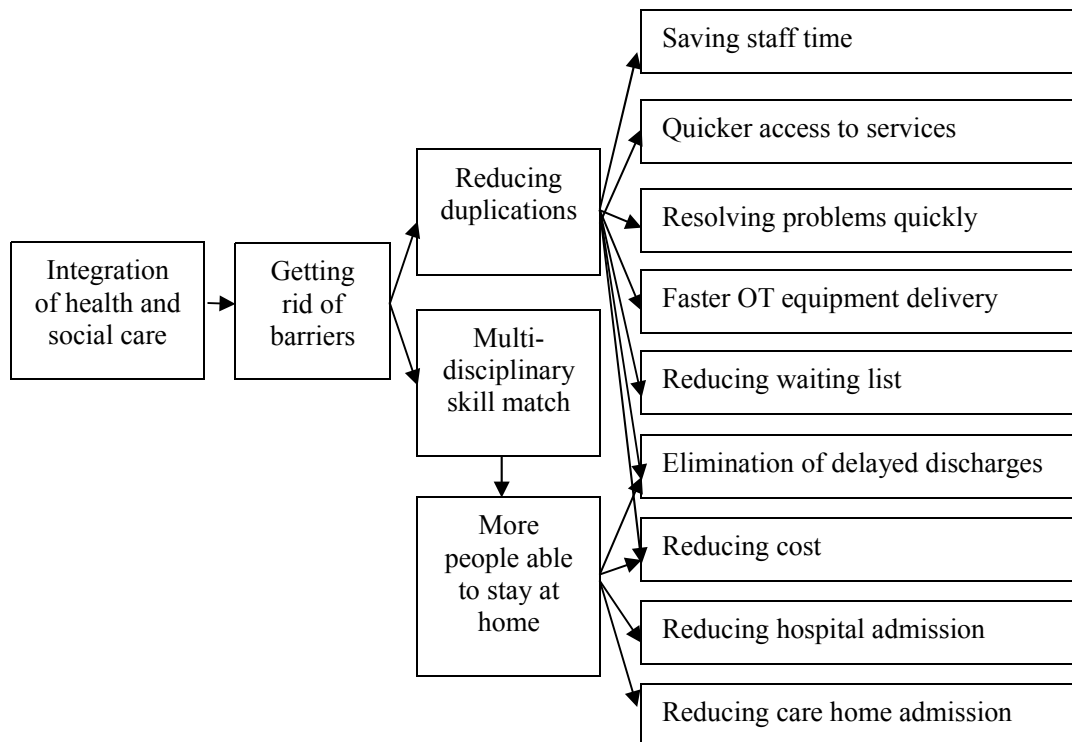
Figure 4.11 Efficiency mechanism

**4.4.2 Empowerment**

Empowerment was another integration programme mechanism derived from the data, and includes the empowerment of both staff and service users. The integration of health and social care in Cambridge was seen as empowering the staff in four ways: by giving them a sense of ownership, allowing them to access other services, improving their skills and competencies, and removing the stigma from social care staff. All eight members of staff interviewed thought that the integration had empowered the staff in one way or another. The view that it enabled staff to access other services and empowered them was held by five of the eight members of staff interviewed. Three members of staff agreed that it improved staff skills and competence; two acknowledged a sense of ownership; and one acknowledged the removal of the stigma of being social care staff.

One policy document (P3) suggested and two members of staff (S5 and S7) believed

that the integration programme provided staff with a sense of ownership or a feeling

of being part of the programme. As a policy document states:

> The development of the integrated programme through an action research and community based strategy gives the new integrated teams a framework and sense of direction in which both workers and users can participate. This participatory approach has been used in the initial phase of planning the steps which encourage the changes required. For all stakeholders to be involved in identifying what is needed promotes a sense of ownership and can lead to a common understanding between staff coming together from different backgrounds in teams. (P3)

Talking about the integrated locality team, a member of staff reported:

> I think the teams on the ground really are working well together ... You know, it's made them feel more part of a service rather than two services that didn't quite know what the other bit was doing. (S5)

One policy document (P3), one set of meeting minutes (M42) and five members of

staff (S1, S2, S3, S6, S8) interviewed suggested that the integration had increased

staff awareness of the whole range of services available from all sectors and

increased their ability to access these services and provide services to users more

quickly. A member of staff explained:

> And asking each other, you know, professionally asking people, you know, [their] opinions: 'How can I make this better?' I suppose that's probably most frequently the care team because they are able, they feel empowered enough to be able to ask another professional, someone in the building, their opinion: 'Can you help me with this?' You know, 'I've noticed Mrs J can't get out of her chair'. For them to then be able to go up to an occupational therapist to say 'She can't get out of her chair, what do you think I should do?' That's nice to be able to see them, they're not frightened of doing that. (S6)

Three policy documents (C2, C6, C9) claimed and three members of staff (S4, S5,

S8) interviewed believed that the integration had improved their skills and

competencies. In a policy document Cambridgeshire County Council and the four

PCTs stated:

> The White Paper 2006 and A New Ambition for Old Age provides evidence
> that suggests having a clear picture of what integrated services are trying to
> achieve through improving skills and competencies across the workforce in
> order to achieve the desired outcome. (C9)

An assistant director of Cambridge City and South Cambridgeshire PCTs I
interviewed believed that the integration had enabled social care staff from the
homecare team to take on some health care duties and that the staff loved the change
because it made them feel that their jobs were more skilled than just the domestic
tasks they did before and they had become more confident and competent in their
work. She explained:

> And I think the social care staff, some of them, have taken on some health
> care duties. And they really love that. So some of the home carers used to go
> in and they just went in and washed and dressed people. And now they are
> able to, you know, do a little bit of health, like change a simple dressing or,
> you know, so things that make them feel it's a little bit more of added value
> to their jobs. So I think, yeah, it's good. (S5)

A senior member of staff talked about how care staff of the homecare team became
interested and had learned and gained some new physiotherapy skills. She reported:

> I've actually got involved with physio a bit with [a physiotherapist], um,
> because, um, you know, we've got some care staff interested and I've been
> working with [a physiotherapist] to also provide physio and our care staff
> doing that. So they are actually now gaining skills in physio as well. And
> that can release [a physiotherapist] to do some more complex cases. So I
> think as time goes on we need to get them involved in everything; the carers
> as well, plus ourselves, can have some learning skills. (S8)

One member of staff thought the integration of health and social care had taken away
the stigma from social care staff. She put it,

> S5: I think social care as well sometimes felt they were almost the poor
>      relation. You know, health always got the kudos, people always want

health to looked after them. But having social care was always a bit of a stigma, if you have to have Social Services.

Me: That's right.

S5: Whereas I think bring it all together; people just see it as health and social care team now. So it's taken away that stigma a bit really, which is good.

The integration was seen as having empowered service users in three ways: by giving them better information about local care services; more choice; and greater access to different services. One set of meeting minutes (M42) indicated and a member of staff (S4) believed that the integration had made service users better informed about local care services. During her interview a member of staff expressed her interest in how I was going to evaluate the impact of the integration programme on service users and what I was looking at. She suggested that I look at whether service users felt they were better informed and better supported since the integration:

> It interests me how you are going to try and capture it, 'cause I don't really know what you would look at – quality of life I guess, in terms of how well they feel supported, how confused are they by the system, or unconfused, you know. They need to be clear about who they go to for what. They need know what they are eligible for, and these sorts of things. And I guess it's, I guess they would feel um, things had improved. If a year ago, somebody living with um, somebody, sort of, trying to look after somebody who's got long-term conditions or ongoing health or social needs, maybe, if they were sort of confused about who to ask for what a year ago and they're not now. That would be improvement. (S4)

This member of staff believed that the integration made service users clearer about what they were eligible for and who they could go to for what help. She claimed.

> That is what's they need. I think that is what's empowering to people. I think people either need to feel they get all the support that they need, or at least that they know where to go when they need a bit more support, if they are getting all that they are entitled to now and they are barely coping, then they do need to know when they became eligible for any more, under what circumstances, and who they are going to get that help. (S4)

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One member of staff thought the integration provided service users with more choice in the services available to them, more information about who provided the services and where they could receive them, giving them more control in their own lives. She explained:

> So I think for older people it's given them more choice. Instead of being picked up by the ambulance and taken into hospital, we've been able to, you know, manage them at home a bit more, and as I say, not have to go into institutionalised care if it's not absolutely necessary. And also, I think, as part of integration we've got, one of our assistant directors is part-funded by South Cambridgeshire District Council and he's done a lot of work on very extra care housing, you know, saying 'What do we need with the population changes?' you know. Some extra care, very sheltered accommodation would be great, so that older people can go into a house which they can stay in until they die, they don't have to move to the residential or nursing homes. (S5)

One member of staff believed that since the integration service users have gained greater access to different care services:

> I think they have greater access to different services, like occupational, like physiotherapy in their own home. The training we're getting is so much improved now, and wider. I'm at the moment on a course with a Thames Valley University to do foot care. I mean I won't be a chiropodist, but just simple foot care and nail-cutting and stuff like that, so I'm learning it at the moment. So they will have greater access to that. (S2)

The empowerment mechanism is summed up in Figure 4.7.
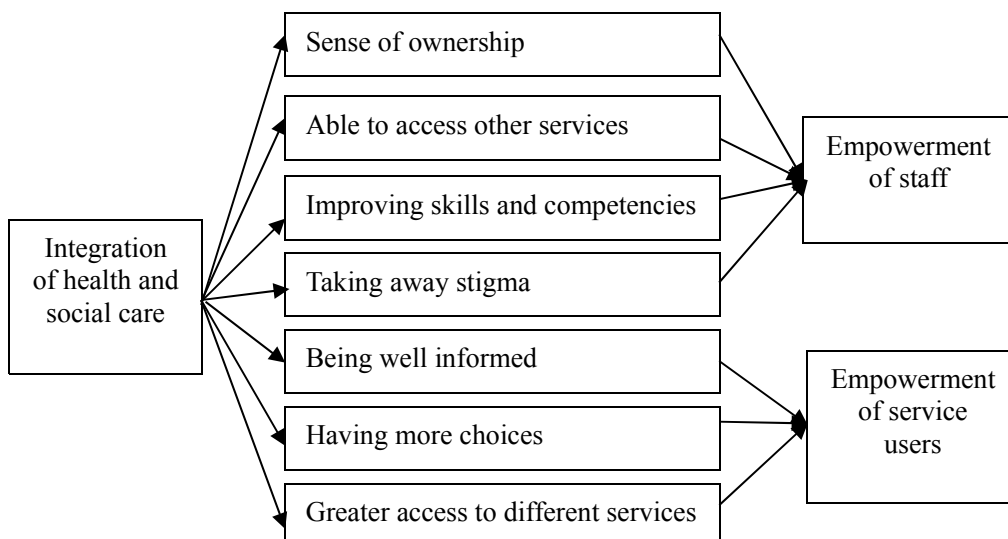
Figure 4.12 Empowerment mechanism

### 4.4.3 Bringing down barriers

All integrated locality team staff, especially those of the North City Integrated Locality Team, found that one of the biggest changes the integration brought them was being co-located from different locations into one big office. Being in the same office with everybody else had had a significant impact on members of the two integrated locality teams. Every team member I talked to said that co-location with other disciplinary teams into the same office had changed them. It had brought down barriers and generated five secondary mechanisms: promoting communication; building trust; sharing roles; promoting joint working; and helping teams to 'gel'. These secondary mechanisms were complementary to the main mechanism – 'bringing down barriers', were derived from it and would all consequently generate outcomes of their own. Like the complex, messy integration programme itself, these main and secondary mechanisms were also complex and messy.

Four members of staff (S2, S3, S4, S6) said that the basic idea of the integration was to get rid of barriers between different disciplinary teams and make them work together to produce better services. The co-location of everyone into the same office brought down not only the physical walls but also the mental barriers separating them. A member of staff said:

> I think the idea is to get rid of the barriers there are between the different professionals of health and social services to provide, um, a better service really for the clients or patients. (S4)

Three policy documents (C2, C3, C5) and two members of staff (S4, S8) claimed that

being co-located in the same office had made face-to-face communication between the disciplines much easier and more convenient. More face-to-face communication was taking place. A member of staff said:

> So before integration, I would say the important communication did take place even though we weren't in the same office. More communication is liable to happen instantly just because you see someone and you tell them something else that could be useful to them or they might tell you something that's useful to you that you possibly wouldn't have communicated before. So I would see that the advantage really should be for the client user, should be in essence a better service, um, and I guess for the staff, it should be more satisfactory, a more satisfying job because you're actually communicating more with the rest of the team. So, that's more overt shared responsibility, I guess. (S4)

A member of staff thought that being co-located in the same office was very conducive to building a trusting work environment and to good teamwork. She reported:

> But I certainly think being in the same office together and the management style that is here very conducive to good team working, it's a very trusting sort of work environment; it's not very controlling, it's very trusting management. So, you sort of, um, I think everybody really works very hard here. And I feel that it definitely is happening here, yeah, which is good. (S4)

A member of staff thought that being in the same office made it difficult for some staff who had tried to keep their role separate from those of other disciplines. Being in the same office made it easier for them to know other people's roles and to share roles with others. She said:

> Well, I think you have to work at it. I don't think you can keep your role completely separate. (S1)

This staff member was one of the nine hundred transferred from Cambridgeshire County Council Social Services into primary care NHS trusts. It was interesting to hear her say that the old Social Services' way of working was not able to continue.

She told me:

> S1: Some people really still like to keep their roles separate in the old Social Services way, and you can't do that now. You've got to give.
>
> Me: You've got to do –
>
> S1: Some people are very protective of their roles: 'Oh, that's what I do'. But it's interesting to see other people's roles anyway, more health, district nurses, and things like that. I think we've worked at it very hard in this team and it's a very happy team. And it works well.

Three members of staff (S4, S6 and S7) said that the co-location of different disciplinary teams in the same office and having tea breaks and staff meetings together was important for them to understand each other's roles. It helped them change their practice to more joint working or to co-organise care with other disciplines. A member of staff explained:

> I think that's fundamental to it. And fortunately in North City we have co-location. I think that's important. So having therapists, care managers and intermediate care team all in one building and that actually helps. Because the buildings, we have the meeting room and so on that the district nurses are coming into and so on. There is very much more joint working. (S7)

When I asked one member of staff what had made her work with those of other disciplines, she said:

> What made me change practice? I suppose it really is being literally desks away, you know, in the same office, also going to more meetings where these people are, starting to overhear things, and starting to understand more of their roles, what they get involved with, and it's actually happened, to be fair. (S4)

Two senior members of staff (S1 and S6), one from of the two Cambridge City integrated locality teams, felt that being in the same office helped the integrated locality teams to gel. They both claimed that both integrated locality teams were beginning to integrate together. One claimed:

It's beginning to gel. As far as care teams are concerned, it's excellent, absolutely excellent, because they have been brought in and they actually feel part of the team. (S6)

When I asked her: 'What's the sign of gelling?' she continued:

Just banter I suppose, just seeing them talking to each other, um, learning from each other, having a cup of coffee together, that sort of thing. And um, and asking each other, you know, professionally asking people, you know, people's opinions. (S6)

Figure 4.8 illustrates the 'bringing down barriers' mechanism and its five secondary mechanisms. However, putting everyone in the same office did not mean that they would work together. A member of staff recognised that getting human beings to work together was and would continue to be a challenge. She said:

But has it been an easy ride? No, it hasn't been easy at all. Getting everybody to think about a different way of providing care. I think that most people would appreciate that it's much easier to get care. But getting human beings to work together has been quite a challenge. And I am sure it will continue to be a challenge because everybody is individual and everybody comes with their own agenda. (S6)
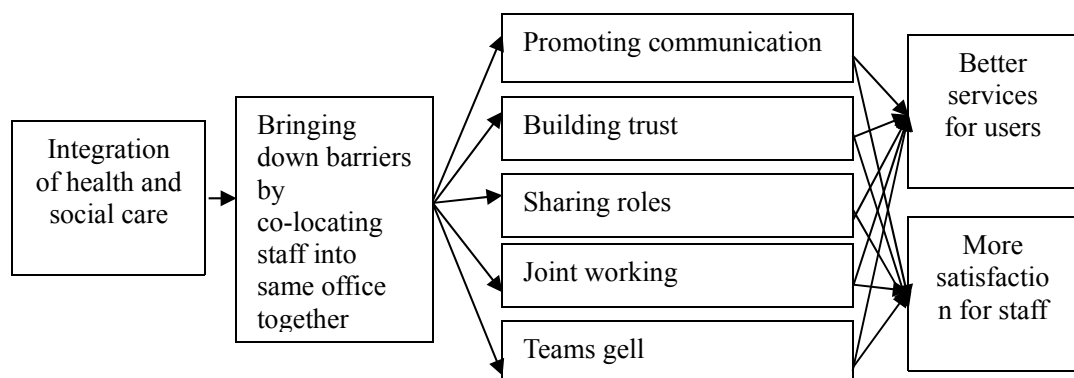


Figure 4.13 The 'bringing down barriers' mechanism

### 4.4.4 Synergy

Synergy was another mechanism of the integration programme derived from the data from two staff interviews (S4 and S5). In synergy or collaborative advantage

(Dickinson, 2008), bringing all different disciplinary teams together into big locality teams to work together the integration programme might achieve more or provide better services than the teams could do separately. The two members of staff suggested:

> If you've got social workers, therapists, doctors, nurses, care mangers, carers, all these people working together, they will make a better service for the service users (S4)

> So bringing it together enabled you to have this bigger team that worked more collaboratively in the way that they could provide care. And we were able to blur the edges a bit, so you could have a nurse who could do a care assessment, and you know when, you were able to say, instead of having another person coming into the home, you were able to do several things with one actual professional. So it wasn't just the boundaries, whether you were health or social care, that were blurred, it helped with individuals at home. (S5)

A staff member thought inspiration could be the mechanism of the integration programme. She said,

> S5: The mechanism for making it happen?

> Me: Uh-huh

> S5: What was the mechanism for inspiration? People getting together and discussing about why it would be a good ideal and looking at policies and understanding different budget streams, and coming to the conclusion that by putting the budget together and by moving the stuff together you'd have a better approach to the single delivery service. So I guess the mechanism was an understanding that it had to be better not to have fragmented services. To have a service that put the patients in the centre rather than having disparate services around the patient, so one service to deliver. (S5)

I did not include inspiration in my list of mechanisms because I thought that inspiration is neither a theory that can explain how outcomes were achieved nor an arrangement and action by which a result is produced. Inspiration is related to synergy or one of the collaborative advantages rather than standing alone as a causal mechanism of the integration programme. Because the integration brought all the different disciplinary teams together and made it possible for people to discuss things

together, people could be inspired to create thought, to bring up good ideas and to create a better service for older people. This would lead the integration programme to achieve more and provide better services than before the integration.

## 4.5 The outcomes of the integration

The outcomes of the integration programme refer to the impact on service users of the programme. Taking a theory-led programmatic approach, this study not only inspects the outcomes of the programme but also examines how these outcomes were produced. The outcomes were analysed not simply to see whether the programme worked or not but also to determine which of outcomes worked on whom and in what context. The intended outcomes designed and planned by this integration programme were examined and analysed against the achieved outcomes.

The intended outcomes were determined by analysing the qualitative data, including policy documents, meeting minutes, informal interviews and staff interviews. Each of the eight members of staff interviewed was asked what they thought the intended outcomes of the integration programme and its impacts on service users were. The achieved outcomes for service users were derived from both the qualitative data – service user interviews, staff interviews, informal interviews, policy documents and meeting minutes – and the quantitative data – the user survey.

At step six of the qualitative data analysis, open coded nodes were categorised under the themes of contextual conditions, mechanism, implementation process, intended gaols and achieved outcomes of the integration programme and the nodes under the main theme 'achieved outcomes' were then subcategorised into three groups, identified by Qureshi et al. (1998) and Glendinning et al. (2006) as important social

care outcomes for older people. These are change outcomes, maintenance or prevention outcomes, and service process outcomes.

The important distinction between change outcomes and maintenance or prevention outcomes is identified by Qureshi et al. (1998), who claim that the majority of social care services (85% from their informal estimates) aim to continually maintain an acceptable quality of life rather than to achieve change and improvement. The different outcomes that health care and social care were intended to achieve are discussed in the discussion chapter.

### 4.5.1 Change outcomes

Change outcomes refer to changes or improvement brought about by receiving integrated care services. The data show that there were three change outcomes of the integration programme, namely improvement in physical functioning, promotion of faster recovery from illnesses, and improvement in satisfaction with services. The first two outcomes were solely identified from service user interviews, and greater satisfaction with services was evidenced both in service user interviews and the user survey.

*Improvement in physical functioning*

The improvement in physical functioning achieved by service interventions was identified from semi-structured interviews with services users. Judging by the care services they had received, seven service users believed that their physical functioning had improved. All seven had received one to four pieces of occupational equipment and/or adaptations ranging from handles, transferring boards, raised toilet seats, raised settees, a pressure relief cushion, wheelchairs, a bath chair lift, a wet

room and hospital beds. Apart from the occupational equipment, three service users also received physiotherapy, social care and respite care, and one also received physiotherapy and social care. Of the seven improvements in physical functioning, five (U9, U10, U17, U19, U22) were through the provision of equipment and/or adaptations. Service user U17 told me about her experience of the occupational health service and how the final solution, a wet room, had solved her problems and benefited both her and her husband:

> U17: I have arthritis in me knees and me shoulders and me back, and was unable to get down into the bath.
>
> Me: Uh-huh
>
> U17: If I got down into the bath, because I've got arthritis in me knees, I wasn't able to turn over and to get meself out.
>
> Me: Oh I see.
>
> U17: My husband couldn't pull me out, 'cause he suffers from his heart, and they tried me with a bath seat to lower down. But I hadn't got feeling in my feet. And it was dangerous because I could have caught me toes on the edge of the hand basins.
>
> Me: That's right, yes.
>
> U17: And I couldn't get me legs up, to get them over the bath.
>
> Me: That's right, yes.
>
> U17: So, um, they, they tried everything and they come up with um, the only solution we could have, would, would have, um, a wet room put in.
>
> Me: Do you mean walk-in –
>
> U17: Walk in bathroom, with the shower.
>
> Me: Walk-in shower, yeah.
>
> U17: What they call a wet room.
>
> ……
>
> Me: Ok. So what do you think of this equipment you were offered? ….
>
> U17: It's marvellous.
>
> Me: Yeah.
>
> U17: Absolutely marvellous. It helps me and it helps my husband too because I can shower and I can help him shower.

Of the seven improvements in physical functioning, two (U6 and U18) were through

both improvement in individual mobility and the provision of equipment and/or adaptations. Service user U6 lived alone in a sheltered housing. Occupational health services provided him with a wheelchair, a toilet seat, a walking frame and a pressure relief cushion, and heightened all the settees in his flat so that he could get up from, so he could sit and get around more easily. These greatly improved his mobility, preventing the development of pressure sores and enabling him to live independently. I thought it was rather good that the settee in his sister's house was also raised for him so that he could visit his sister and have a short stay there regularly:

> U6: So I stayed around there [for a weekend after coming out of hospital].
> Me: Oh, very good.
> U6: I only sleep on the settee. But her settee's been raised as well.
> Me: Just for you?
> U6: Yeah.
> Me: Oh, how lovely.
> U6: Yeah, they did that one before they did this one.
> Me: So, they did that for you.
> U6: Yeah, yeah.
> Me: Oh, how lovely.
> U6: So they have done those two. Just make it that much easier to stand up, you know.
> (U6)

From the above data we can see that the three stages of occupational health services integration reduced duplication and increased efficiency, saving staff time and money and bringing shorter waiting times, better needs assessment and faster delivery. These enabled users to have equipment and/or adaptations when they most needed them, thus improving their physical functioning. Although the empowerment mechanism appears to have had less effect in generating this outcome, when users were well informed about their entitlement to equipment and/or adaptations and the availability of resources, and when they were able to make decisions with staff, their

needs were more likely to be met. As the case of service user U17 illustrates, only the right solution with the right equipment could solve her problem and achieve the desired outcome. Because service user U19 was well-informed about the procedures and the development of her application, the satisfactory outcome was achieved even though she had to wait about five months for the wet room. When I asked her what she thought of having to wait for five months, she explained:

> U19: I think I was happy about it because [a member of staff] and me sort of kept in touch as to what was going on. Yes, she told me all about the procedures.
>
> Me: That's good.
>
> U19: And why it takes so long, you know.

Service user U19 was fully aware of the importance of the contextual condition, budget. She thought that she had received the equipment she needed quickly partly because her case was dealt with at the beginning of the financial year when the budget was put in and money was available. She explained:

> U19: I suppose I was lucky, because it was um, April time when she assessed me, I think, the financial year.
>
> Me: New financial year, year start.
>
> U19: So I think that's why I was lucky.
>
> Me: So you think you got money at the beginning of financial year. So you were quick.
>
> U19: Yes, because my neighbour has to wait over a year for hers.

### Promotion of faster recovery from illness

Only one service user (U27) believed that the care services he had received had helped him to a quick recovery from a hip operation. Service user U27 had received physiotherapy and nursing care from district nurses and some occupational equipment like a raised toilet seat and 'bath things' immediately after he was

discharged from hospital following his operation. The occupational equipment was delivered to his house during his six-day stay in the hospital. He said:

> U27: I went in [to hospital], I was in there, I don't know, I was in there a week, about six days. When I came out, that was done.
>
> Me: So you were very happy about it?
>
> U27: Oh, yes, yes. I didn't even see the man come. The work was here. But I didn't see anybody.

Service user U27 received not only fast delivery of the occupational equipment but also a quick response from physiotherapists and district nurses. When I asked him to tell me his story of using care services, he said:

> U27: Oh yeah, I come out…
>
> Me: Tell me your story about that.
>
> U27: I came out [of hospital] on the Friday afternoon, late afternoon. When I left hospital they gave me a folder. And that was for the nurses, and for the physio.
>
> Me: Yes.
>
> U27: On the Saturday morning they came in and they both dressed me, dressed my hip for me.
>
> Me: Uh-huh.
>
> U27: The physio gave me the exercises.
>
> Me: Uh-huh.
>
> U27: And then … she missed the Sunday, came on the Monday. And I think she came on the Wednesday. She came in on the next Saturday. And she had done that for the next week as well. And then she said, 'You're alright now, fine.' And I carried on with the exercises and that was lovely. No problems at all. I went back to the hospital after two months and I had x-rays and the hip was perfect.
>
> Me: So, you think without the services you wouldn't recover so quickly?
>
> U27: Oh no. I wouldn't. No, no. As I said before, if you don't do what they tell you, you stiffen up and you'd be, well I knew men who had done it. They limp the rest of their life with that, because they don't do the exercises.

***Improving satisfaction***

According to Qureshi et al. (1998) and Glendinning et al. (2006), service users feel happier or more satisfied if they receive services that meet their needs and address their problems, which then improves their confidence and morale. Whether integration programme service users received appropriate services which met their needs and whether they felt happier or more satisfied with the services they received was assessed through both the user survey and the user interviews, generating quantitative and qualitative data respectively.

Of the 100 service users surveyed, 75 thought that they had received the appropriate services that they needed. One said their needs were met sometimes. Ten did not think that the care services they had received were appropriate. Eight were not sure and for six this question did not apply.

In the user survey service users were asked to rate the quality of their overall experience of using care services. Of these, 89 rated this as either satisfactory, good or excellent; nine rated it as either poor or very poor; and two could not answer the question (see Table 4.5).

Table 4.12 Quality of overall experience of using care services

| Quality | North care team | | South care team | | Total | |
|---|---|---|---|---|---|---|
| Excellent | 12 | 22.2% | 6 | 13.0% | 18 | 18.0% |
| Good | 15 | 27.8% | 13 | 28.3% | 28 | 28.0% |
| Satisfactory | 21 | 38.9% | 22 | 47.8% | 43 | 43.0% |
| Poor | 2 | 3.7% | 1 | 2.2% | 3 | 3.0% |
| Very poor | 3 | 5.6% | 3 | 6.5% | 6 | 6.0% |
| Can't say | 1 | 1.9% | 1 | 2.2% | 2 | 2.0% |
| Total | 54 | 100.0% | 46 | 100.0% | 100 | 100.0% |

Of the 100 users surveyed, 70% were either satisfied or very satisfied with their assessments (see Table 4.6).

It appeared that older men were less satisfied with the care services than older women; people aged 80 and over were more satisfied with their care services than people of 65–79, and service users who had waited for assessment longer than a month were less satisfied with the care services than those who had waited for less than one month.

Table 4.13 Level of satisfaction with the assessment

| Level of satisfaction | North team | | South team | | Total | |
|---|---|---|---|---|---|---|
| Very Satisfied | 15 | 27.8% | 18 | 39.1% | 33 | 33.0% |
| Satisfied | 20 | 37.0% | 17 | 37.0% | 37 | 37.0% |
| Neutral | 7 | 13.0% | 3 | 6.5% | 10 | 10.0% |
| Dissatisfied | 2 | 3.7% | 1 | 2.2% | 3 | 3.0% |
| NA | 10 | 18.5% | 7 | 15.2% | 17 | 17.0% |
| Total | 54 | 100.0% | 46 | 100.0% | 100 | 100.0% |

The 100 users were asked to rate the services they had received separately. Service users of occupational health services gave the highest rate of satisfaction, with 85% (n =50 out of 59) satisfied or very satisfied (see Table 4.7).

Table 4.14 Level of satisfaction with occupational health services

| Level of satisfaction | North care team | | South care team | | Total | |
|---|---|---|---|---|---|---|
| Very Satisfied | 10 | 35.7% | 18 | 58.1% | 28 | 47.5% |
| Satisfied | 12 | 42.9% | 10 | 32.3% | 22 | 37.3% |
| Neutral | 4 | 14.3% | 1 | 3.2% | 5 | 8.5% |
| Dissatisfied | 2 | 7.1% | 1 | 3.2% | 3 | 5.1% |
| Very Dissatisfied | - | - | 1 | 3.2% | 1 | 1.7% |
| Total | 28 | 100.0% | 31 | 100.0% | 59 | 100.0% |

The level of satisfaction with the physiotherapy service was the second highest. Of the 44 physiotherapy service users, 82% (n = 36) were satisfied or very satisfied (see Table 4.8).

The satisfaction levels for both occupational health services and physiotherapy are

much higher than the score of 77% in Chesterman et al.'s (2001) study and the

satisfaction level (76%, n = 29) of 38 intermediate care users (see table 4.9) is in line

with their study (Chesterman et al., 2001).

Table 4.15 Level of satisfaction with physiotherapy

| Level of satisfaction | North care team | | South care team | | Total | |
|---|---|---|---|---|---|---|
| Very Satisfied | 7 | 33.3% | 13 | 56.5% | 20 | 45.5% |
| Satisfied | 7 | 33.3% | 9 | 39.1% | 16 | 36.4% |
| Neutral | 5 | 23.8% | 1 | 4.3% | 6 | 13.6% |
| Dissatisfied | 1 | 4.8% | - | - | 1 | 2.3% |
| Very Dissatisfied | 1 | 4.8% | - | - | 1 | 2.3% |
| Total | 21 | 100.0% | 23 | 100.0% | 44 | 100.0% |

Table 4.16 Level of satisfaction with intermediate care

| Level of satisfaction | North care team | | South care team | | Total | |
|---|---|---|---|---|---|---|
| Very Satisfied | 9 | 42.9% | 6 | 35.3% | 15 | 39.5% |
| Satisfied | 6 | 28.6% | 8 | 47.1% | 14 | 36.8% |
| Neutral | 4 | 19.0% | 1 | 5.9% | 5 | 13.2% |
| Dissatisfied | 1 | 4.8% | 1 | 5.9% | 2 | 5.3% |
| Very Dissatisfied | 1 | 4.8% | 1 | 5.9% | 2 | 5.3% |
| Total | 21 | 100.0% | 17 | 100.0% | 38 | 100.0% |

However, the 46 social care users gave distinctly lower ratings of satisfaction (54%,

n = 25) (see Table 4.10) than those in Chesterman et al. (2001) and they were also

considerably lower than those of the other three groups in this survey.

Table 4.17 Level of satisfaction with social care

| Level of satisfaction | North care team | | South care team | | Total | |
|---|---|---|---|---|---|---|
| Very Satisfied | 7 | 28.0% | 5 | 23.8% | 12 | 26.1% |
| Satisfied | 6 | 24.0% | 7 | 33.3% | 13 | 28.3% |
| Neutral | 11 | 44.0% | 5 | 23.8% | 16 | 34.8% |
| Dissatisfied | - | - | 4 | 19.0% | 4 | 8.7% |
| Very Dissatisfied | 1 | 4.0% | - | - | 1 | 2.2% |
| Total | 25 | 100.0% | 21 | 100.0% | 46 | 100.0% |

The ratings of the users of social care only were examined to see whether their satisfaction levels were lower than that of all social care users. Eight users had received only social care. Of these, three (37%) were satisfied, four were neutral and one was dissatisfied. These eight social-care-only users gave an even lower satisfaction level than that of all social care users.

From the qualitative data, five users interviewed (U2, U9, U15, U17, U20) and one that was surveyed (SI 1, answer to open question) felt happy and satisfied with all or some of the services they had received (see Table 4.11).

Table 4.18 Feeling about services received

| Users | Inter-mediate Care | Residen-tial Care | Occupation-al Health | Physio-therapy | Social Care | District Nurse | Day Care |
|-------|--------------------|-------------------|----------------------|----------------|-------------|----------------|----------|
| SI1 | Happy | | | | | | |
| U2 | | | Happy | Happy | Not happy | | |
| U9 | | | Happy | Happy | Happy | Happy | |
| U15 | | Happy | | | Not happy | | |
| U17 | | | Happy | | | | |
| U20 | | | Happy | | | | Happy |

The qualitative data gave a similar picture. The occupational health services had the highest happiness rating and social care the lowest. Service user U9 had been diagnosed with Parkinson's disease 11 years before. He had received social care from a care agency twice a day and then changed to a live-in carer. He had physiotherapy, occupational equipment such as a hospital bed; had his hand rails fixed; had a wheelchair, and district nurses came to change his dressings. He thought himself an atypical participant in my research because:

> I was the number two and then number one executive at [name] hospital. I know this system. I have done my service and now it is my time to use the services. I know how this system works and know what to ask for and who to contact. (U9)

He was quite happy with all his care services and thought that 'there have been some very good successes in term of community care' (U9). He was also quite happy with the care services received by his son, who had Down's syndrome and lived in a community home. He told me:

> I think that the kind of service that he gets in that home is excellent. You know; it's, um, it makes you feel very happy. (U9)

When I asked him what he would do if he was not happy with his live-in carer, he said:

> U9: I would talk to my social worker and say: 'The carer from the agency is not doing what they're supposed to do, can you do something?'
> Me: Do you feel you are in control of your own care?
> U9: Yes, I do.

Service user U20 lived with her younger daughter, a single mother with three children. She had received a walking stick, a walking frame, a stair lift, a commode and a wheelchair. She went to a day centre three times a week and was very happy with the services she received, although she wished she could attend the day centre more often and could go for a holiday. She told me about the services:

> I found out it helped me a lot, yes, and helped me to get over losing my husband and everything, well satisfied. (U20)

Service user U2 was one of the two who were very happy with other care services but not with social care or with carers from a certain care agency. She told me about the experience of her late husband using care:

> Well, some people my husband had, they were young people, they come in, perhaps two of them come, they're ripping his clothes off, you know, want to use the commode because he couldn't use it in bed. They would stand over him, he would say: 'Have you finished, have you finished?' Well, I said, 'Give him time. Leave him for a minute', you know, but not with the

[name of a care agency]. They never lie there. But, they are all the same. The young people come. They want to get it done and out. (U2)

Service user U15 was the other interviewee who was unhappy with the social care she received. She got rid of the carer who visited her every morning because she did not like the carer, who 'sat on the chair, all nicely dressed, but wasn't there to help'. Later she had a fall, broke her hip and ended up in a residential home where she found perfect satisfaction with the service there.

Of the 100 service users surveyed, 25 had used care services before April 2004 when the new integrated care services started in Cambridgeshire, 67 had not used them before and eight were not sure whether or not they had used them before. The 25 who had used the care services both before and after April 2004 were asked how they would compare services before and after that date. Of these users, 28% (n7) thought that the care services since April 2004 were better than before, 28% (n7) thought they were the same, 8% (n2) thought them worse, and 36% (n9) were not sure. From the qualitative data, of the 27 service users interviewed, only one (U14) who had used the multidisciplinary care services before the integration commenced thought the services had improved. Service user U14 received social care and occupational equipment and was later placed in a residential home. When I asked her how she thought of the care services at that time compared with how they were before 2004, she said:

U14: Oh, yeah, I think it's improved.
Me:  In which way?
U14: Oh, for the better.
Me:  All right.
U14: Yes.
Me:  Yeah, you think it's improved.
U14: Yes.

Me: Do you have any good example to tell me? You think it's better than before?

U14: Oh, no. I can't think now.

### Barriers to change outcomes

Barriers to change outcomes were identified by interviewing service users. Perceived poor treatment in hospital and suffering from pain could prevent service users from experiencing improvement in physical or emotional functioning. Although in-hospital services were not included in the integration programme, three service users (U1, U10 and U24) thought that their bad experience in hospital had affected them adversely. One service user (U10) caught hospital-acquired infections one after another and was put into a side room. The infections worsened her condition and delayed her heart operation.

U10: While I was in [hospital A], I was waiting to go to [hospital B] to be assessed and I think I had cold sores all the way around here.

Me: Oh yeah.

U10: They sent me to [hospital B] to have it done and [hospital B] was very cross that they'd sent me. I should have stayed. And then they gave me some drugs, and I got another infection, and they affected me, so they put me in the side ward.

Another service user (U24) was very depressed after the hospital dislocated her shoulder, which affected her physical and emotional functioning for a long time.

Me: What's wrong? What did you go to hospital for?

U24: Sciatica.

Me: Oh, I see.

U24: In one leg.

Me: Then?

U24: And they in turn dislocated my shoulder.

……

Me: So you went to hospital for your legs…

U24: Yeah.

Me: Then the hospital damaged your shoulder?

U24: Yeah… Yeah. I was very, very down and depressed.

Me: Mm-hmm, because they damaged your shoulder.

U24: Yeah. And I was so depressed when I was in hospital because I wasn't treated very nicely.

The husband of a bedbound service user (U1) was not happy with his wife's experiences in two hospitals. His wife was transferred from ward to ward in hospital A and he thought nobody in the hospital was interested in her care.

Husband: I think when you go in, [hospital A] is fine if you can still stand on your feet and you're just in for either one operation or one thing and you stay in one ward.

Me: Mm-hmm

Husband: Because the doctor knows you then. But if like my wife, you get pushed around, in and out and so forth, there's nobody who is responsible.

Me: Mm-hmm

Husband: There is no doctor who says 'Oh, I'll make sure your wife … if she transfers, I'll make sure that everything goes [moves] on [with her]'. On the whole, there's nobody responsible once you start moving.

He had tried to make a complaint:

It took me three weeks before I got in contact with matron. Why isn't the matron coming around, if even once a week seeing everybody? I can't understand. Why after three weeks does the matron notice you are undernourished and depressed? And doctors don't all come most days. It's all vague. The whole thing is vague. (Husband of U1)

He strongly believed, and his wife, the user, who had asked her husband to tell me the story and kept nodding her head while he was talking, also agreed that if the physiotherapist in a district hospital rehabilitation ward had been efficient, if there had been more physiotherapists, if the physiotherapists had done more rehabilitation, his wife would still be able to walk. He said angrily:

Physiotherapy in [name] Ward was inefficient. There were only two physiotherapists in the ward. For being a rehab ward they are not doing enough rehab. Physiotherapists there do not touch people. They do not push people to walk. They diagnosed my wife as 'unwalkable'! (Husband of U1)

When I visited this couple that day the wife had just been seen by some care assistants and then district nurses. She had been washed and changed and was lying comfortably in bed by the window of the downstairs sitting room. She did not complain about the social care or nursing care she had received. But they were not happy with the two hospitals and obviously could not accept the diagnosis of 'unwalkable' which the wife had been given by the hospital physiotherapists. They both looked miserable and helpless.

Suffering from chronic and uncontrolled pain appeared to be another barrier to service users' improvement in physical or emotional functioning. During the interviews three service users (U8, U15 and U25) told me that they were feeling pain.

U15: I've got a pressure sore.

Me: Have you?

U15: At the base of my spine.

Me: Oh, dear.

U15: And it's very painful.

Me: It must be.

U15: And I'm lying like this, because the hip

Me: Yeah

U15: won't allow me to lie on my side.

Me: No, no.

U15: Everything is the wrong place [laugh] so what I have to do is this.

Me: Just tilt. Yeah, a little bit. Yeah.

U15: A little bit.

Me: Yeah.

U15: I hold it with my hand,

Me: Oh.

U15: And then my hand gets full of pins and needles.

Another service user (U8) suffered from multiple arthritis. Her pain prevented her from sleeping in an ordinary bed and trapped her in a chair for years. Her pain made her struggle to use the toilet with or without the raised toilet seat provided by occupational health services and prevented her from going out, because going over speed bumps with her husband's carefully driving their car gave her 'considerable mental pain' (U8). The sad thing was that the three service users felt that they had to put up with it as their doctors could do nothing to stop their pain.

> They put a change in the pain killers, but we don't see they do a lot of good. Um, you don't know – all they do is give you constipation usually or something like that, you know. (U8)

> U25: It's like, um, a knife –

> Me: Oh, dear.

> U25: Sticking up from the waist, right the way down. But, that's what I can't understand. I can't feel when they stick pins in.

> Me: Mm.

> U25: But I can feel the pain. But that's the osteoporosis, isn't it?

### 4.5.2 Maintenance or prevention outcomes

Maintenance and prevention outcomes are related to maintaining older people's physical and mental functioning, wellbeing or quality of life, or preventing it from deteriorating. They include meeting basic physical needs, living in a clean and tidy environment, access to social contact and company, having control over everyday life and personal safety and security.

*Meeting basic physical needs*

Ten service users interviewed said the integrated care services had met their basic physical needs of being clean and presentable in appearance, which were important

to them. The care services which met their care needs included being given a shower (U24 and U25) or a bath (U2 and U15), being washed, dressed, being helped out of bed in the morning and put to bed in the evening (U4), being seen by a chiropodist (U4, U20 and U22), having their hair done at home (U23 and U26), cream being applied to legs and shoulders (U24), being helped with putting on stockings (U25) and being provided with a wet room (U17). When I asked a user what she thought of the care system, she said:

> I think it's very good, because it helps people who, who are in the position not to be able to afford to buy these luxuries like having the bathroom done. Um, um, they, they can keep themselves clean too, which is essential. (U17)

Two users (U23 and U26) were interviewed who could not go to a hairdresser due to their condition. They had arranged for their hairdressers to come to their houses to have their hair done regularly. Although hairdressing was not part of the integrated care services, finding a hairdresser willing to visit older people's houses for a reasonable price is increasingly a need to be met. User U23 used to perm her hair herself. After having many strokes, she started going down to the village to have it done there. She told me:

> I suppose it's arthritis or something – I can't often move my neck around properly. And they only had back-wash basins. But that was agony. But now I have somebody that, you know, will come to the house about every time. (U23)

Some older people, especially those who lived alone, found it difficult to cut their own toenails because they had no children or relatives to do it for them. Three service users received free NHS chiropody because they had certain medical conditions such as diabetes.

A very thin service user slept a lot in a chair. Occupational health services provided him with an air mattress and an air cushion, which not only ensured his physical comfort but also prevented him from developing pressure sores. When I asked him what he thought of care services for older people in Cambridge he said he did not know about other people but his needs had all been met. He happily showed me the equipment he had received.

> U6: Oh, they also gave me one of these, um, blow-up mattress covers.
> Me: Yeah, yeah,
> U6: You know the –
> Me: Yeah, yeah,
> U6: and a seat, one here I'm sitting on.
> Me: To relieve the pressure?
> U6: Yeah, because they're worried about the bed sores.

So the basic physical needs of some social care users and occupational equipment users had been met. However, the basic physical needs of ten of the service users surveyed (SO3, NS10, NS8 and SS10) and interviewed (U4, U14, U15, U17, U23 and U24) had not been met. The unmet needs were diverse and each was experienced by a small group of users (see Table 4.12).

Table 4.12 shows that three users' basic need to be clean was not met. This is fewer than those whose basic need to be clean was met. Four were not happy with the Choice of Meals service; one did not like the food in the care home; one experienced difficulty finding a cheap affordable hairdresser and chiropodist; one couple (the wife was visually impaired and the husband had dementia) found it difficult to cope when they were put into separate bedrooms in a care home. One user found it hard to keep her house warm in winter.

The outcome of meeting basic physical needs was a complicated picture. The need to be clean was met in more users (n5) than not (n3), with one user's (U24) need for a shower or bath met in the community but not in hospital. There were more users whose nail care and home hairdressing needs had been met (n3 and n2 respectively) than not (n1 and n1). Of the 100 service users surveyed, 15 (3.5%) had used the Choice of Meals service, and of these, four were not happy with it. Basic physical needs had been met for some social care users and individual OT equipment users. All those whose basic physical needs had not been met were social care users.

Table 4.19 Unmet basic physical need

| User | Needs not met |
|------|---------------|
| SO3 | "Carers could not give her a bath at the time she wanted to be done." |
| NS10 | "The carers they've got don't do bed baths." |
| U24 | "I never had a shower or bath in hospital" (during a four month stay) |
| NS8 & U17 | "Choice of Meals does not have many choices." |
| U14 | "I did not like Choice of Meals." |
| U4 | Choice of Meals was "not enough for a big man to eat." |
| U15 | Food in the care home "didn't suit my taste." |
| SS10 | "It would be nice if we can have cheap, affordable hairdressing and hand, nail care for old people." |
| U4 | "We [husband and wife] would like to sleep together." |
| U23 | "In the winter the house feels cold." |

*Living in a clean and tidy environment*

Having a clean and tidy house and garden can help older people feel confident and uphold their self-esteem and social inclusion (Glendinning et al., 2006 ). Six service users interviewed were able to keep their house clean and tidy by employing private cleaners (n5) or with the support of relatives (n1). Four service users were able to keep their garden tidy with the support of neighbours (n2), relatives (n1) or the City Council (n1). However, two users (U8 and U23) found it difficult to keep their

houses clean and tidy. User U8 was chair-bound, suffering from arthritis and in pain.

Her husband was her main carer and they did not have any support from their

relatives. They felt ashamed when I visited their dusty and untidy house. He said:

> The place could be a lot cleaner. But there's plenty of dust about. But …
> we don't always get time to rush around with the duster and things like
> this. Um, like I say, just occasionally and that's it. (U8)

Two users (U22 and U23) found it difficult to keep their gardens tidy as they could

not do it themselves. Talking about the households of three other older people in the

neighbourhood who could not do their gardens, user 22 said:

> U22: They wish they could get help.
> Me: Uh-huh.
> U22: That sort of thing.
> Me: Yeah.
> U22: Yeah, like the elderly,
> Me: Mm.
> U22: Sort of can't do their own gardens.

Four service users interviewed (U7, U10, U23, U26) lived in council houses. The

City Council was supposed to help older people with their gardening and this service

was listed in the City Council's tenant's booklet. However, these four users found

that the Council was not doing what it was supposed to do and felt let down by it.

Their gardens were either left untended or done by a private gardener.

> U10: They [City Council] are supposed to come every month, but they don't
> – and they say they do the hedges and weeding, but when my sister
> rang up, 'Oh, no, we don't do that' she said, 'Well, this is what you've
> got on our leaflet.'
> Me: That's right.
> U10: But, you just can't get through. They keep passing you on and you get
> nowhere.

The integration of social and health care, especially the implementation process of

reconfiguration of the homecare service, is associated with older people achieving

the outcome of living in a clean and tidy environment. I visited one intermediate care

and social care service user, asked her some questions and asked her to fill in a

questionnaire for my user survey. This user (NI8) happened to have used social care

services before April 2004, the commencement date of the integration programme.

Below is our conversation:

> Me:  You used social care services before 2004. There were some changes
>        during 2004. What do you think of the services now compared with
>        it before 2004? Is it better, worse, same or not sure?
>
> NI8:  That's why the care services have gone downhill.
>
> Me:  Why?
>
> NI8:  Because they used to do everything, cleaning, showering, shopping for
>        me, everything I wanted to be done. Homecare was alright.
>
> Me:  When did you use Social Services' social care services?
>
> NI8:  From 1976 to 2002 I've been using homecare services. The quality of
>        [name of a care agency] is very poor. They, including homecare
>        team, do not do domestic tasks. They just see you.
>
> (Extract from notes of the survey with user NI8)

Unfortunately, this user declined to participate in the second stage with a semi-

structured interview. From her comment I could see that she preferred the old

domestic task-oriented Social Services' homecare service to the non-domestic task-

oriented new model, which includes both short-term intermediate care provided by a

homecare team in each locality team and long-term social care provided by

independent care agencies. Two other users (NI 5 and NI 8) who had used first

intermediate care and then social care also did not understand why the carers did not

do domestic tasks that needed to be done.

From the above we can see that the outcomes of living in a clean and tidy

environment were not achieved by users who had no or little help from others and

were only achieved by those who had the help of private cleaners, gardeners, neighbours, relatives or the City Council. Such help was not provided by the integrated services.

### *Access to social contact and company*

Access to social contact and company are essential to older people. One intermediate care and physiotherapy service user (U3) interviewed lived alone and valued the social contact with homecare staff particularly:

> U3: I mean people like me, 80 years old, just having someone knock on the door and say, 'Are you alright? I'll make you a drink'. Make a drink and go. That's all, a little thing, just tiny. But you know then somebody just keeps an eye that you're alright, you got out of bed, you know.
> Me: So you think this is what you need?
> U3: I think most people need it.

A good quality social relationship with neighbours or care home staff was seen by three interviewed service users as a very important outcome. Two users (U2 and U24) had developed close social relationships with neighbours and they had been looking after each other for many years. One user (U15) used social care and permanent residential care. She had achieved a very good social relationship with the staff at the care home. She proudly told me that a member of staff took her to buy fish and chips, which she had not had for eight years:

> U15: I was taken out yesterday, for the first time.
> Me:  By who?
> U15: By one of the carers.
> Me:  OK.
> U15: And she was very good. She took a day off and took me out. And that was very kind.
> Me:  Yeah.

U15: I hadn't asked her. She offered to do it.

Me:  All right. Where did you go?

U15: I get on well with them.

In contrast with the three users who felt able to access social contact and company in certain ways, ten service users (nine interviewed and one surveyed) complained that they had little or no social contact. During the interviews, eight users told me that they had nobody to talk to. One (U3) said that she was extremely happy that I was visiting her because she did not leave her room and did not see anybody. Two (U1 and U10) wished they had a social worker to talk to:

> It would be good if I could have a social worker to talk to. Sometimes things get up to there [indicating her throat]. You just haven't got anyone to talk to. (U10)

One user wished he had 'somebody who is specialised in those types of things', 'someone you could talk things through with' to 'tell our nuisance' (U7). Three users told me that nowadays they had no nice neighbours to talk to, to socialise with or to ask for help. Their neighbours were either too busy: 'You are in, in the day, they are out' (U1); 'There are foreigners live around and they couldn't speak English' (U23); or one of the neighbours has 'mental health [problems]' and 'causes lots of trouble' (U19).

When I asked the interviewees what they thought should be done to improve care services for old people, three users suggested the same thing: that somebody should go around and check on older people to 'see how they are living' (U14), or '... just checking to see you're still alive' (U3).

U20: Like you have district nurses.

Me: Yes.

U20: You should have district social worker to check on people at certain ages.

It is very important for isolated older people to have access to social contact and company and to build a good quality social relationship with staff in residential care settings or in their homes. However, the integration programme was not designed to achieve this outcome. Therefore for one third of the service users I interviewed, the need for access to social contact and company remained unmet.

*Control over everyday life*

Being in control of one's everyday life was indicated as an outcome of the integration programme, meaning that older people should be able to decide how and where to receive services and/or where to die.

Six users interviewed and one user surveyed said that they would like to stay at home until the end. One told me firmly: 'I want to stay here till they carry me out!' (U2). Three (U10, U25 and NP9) said they would rather stay at home when they were ill than go to hospital. Five users interviewed (U1, U9, U10 and U16 were living at their own homes and U17 was living at a sheltered housing) believed that the care in care homes was dreadful and they were definitely not going to stay there. One said:

> People are now feared to go to care homes because care in care homes has
> gone down the hill. They want to stop at their own homes. (U17)

The integration programme introduced the holistic community-based approach to service provision as an alternative to hospital admission in order to:

> ... provide integrated services to promote faster recovery from illness,
> prevent unnecessary acute hospital admission, support timely discharge and
> maximise independent living. (P3)

Enabling older people to come home from hospital and to stay at home instead of going into hospital are the main aims of the integrated locality teams. These aims are clearly stated on the front page of each user's care record folder, which they keep in

their home (P13).

According to Cambridge City and South Cambridgeshire Primary Care Trusts'

Annual Report 2005-2006, during the first two years of integration:

> Through the integration of health and social care teams in this way, we have been able to significantly increase the number of complex rehabilitation packages provided in the community as an alternative to hospital based care. (C12)

> We have increased the amount of domiciliary care we purchase from the independent sector. This means that more people can remain in their own homes for longer, where previously they may have been admitted to residential or nursing homecare. (C12)

Through integrated working, the Vulnerable Patients' Programme and the increased

care provision, intermediate care has helped some older people to leave hospital

earlier. Some medically fit patients in hospital could be discharged promptly. One

policy document (C12), one set of meeting minutes (M27), one informal interview

with staff (II15) and two members of staff confirmed that the number of delayed

discharges had dropped:

> ... the number of people who are classed as 'delayed transfers' i.e. are medically fit to be discharged from hospital but are awaiting more appropriate care packages, either in the home or residential/nursing home setting drop significantly. Numbers of delayed transfers fell from 42 in June 2005 to just 11 at 1 June 2006. (C12)

When I asked a senior member of staff 'Do you think you have achieved these

intended outcomes or you haven't achieved them?' She replied confidently:

> Definitely, definitely achieved. Um, the statistics support that, um, the delayed discharges have plummeted. Um, we're very good at bringing people out of [hospital] at the right time. Um, I think there's less problem with delay, with poor discharges as well. (S6)

From his experience in hospital, a user also confirmed:

> In [name of hospital] they believe in keeping you at home. They'll give you all the help you need [to be discharged], you know, if they can. (U23)

Through the integration, the process of the homecare reconfiguration and care packages provision, emergency hospital admissions for people of 65 years and over had also decreased. According to two policy documents (C12 and CP2), two sets of meeting minutes (M31 and M56), one informal interview with staff (II 15) and five members of staff interviewed (S2, S3, S6, S7 and S8), more hospital admissions for older people were avoided than before the integration. The Integration Steering Group meeting minutes of September 2006 state: 'There is a trend downwards for emergency admissions for over 65s'. (M56). A member of senior staff told me quite proudly: 'We have achieved a lot with admission avoidance' (S8).

It appears that with the integration of services users were able to choose how and where to receive the care they needed. They could decide to stay at home instead of going to hospital. An increasing number of older people with complex problems and high level needs were being helped to live at home and avoid hospital admission (see inspection reports in Hanson et al., 2007; Commission for Social Care Inspection, 2008). Only one user told me that the availability of care services and support in the community made it possible for her to choose to be treated and cared for at her house and to avoid being admitted into hospital, as she wished:

> I'm very independent. When I had pneumonia earlier this year, doctor wanted to send me to hospital. But I didn't want to go. I wanted to stay in my house. My doctor arranged to have district nurses come in and carers come in three times a day. (Extract from notes of user survey NP9)

A member of the intermediate care team told me that the integration – the multidisciplinary care provisions – enabled more very unwell older people to get help at home instead of going into hospital:

> We've got people very very poorly, you know, yes: if we weren't going in or if we didn't have the different levels of people going in, they would end up in hospital. (S3)

According to Cambridgeshire Primary Care Trust and Cambridgeshire County

Council Joint Health Needs Assessment for Older People 2007:

> Cambridgeshire was amongst the highest performing Councils nationally in 2005/6 and is described as 'very good performance in providing intensive home-based care and maintaining low admissions to residential care'. (CP2)

In Cambridgeshire the number of older people being placed in residential care

dropped from 80 per 10,000 of the population aged 65 or over in 2005-06 to 74 per

10,000 in 2006-07:

> This placed Cambridgeshire in the CSCI top performance banding, and meant they were performing better than their comparator councils. (Hanson et al., 2007:15)

A comparatively high number of older people with complex needs (15 per 1,000 of

the population in 2005-06 and 16.5 per 1,000 in 2006-7) were being helped to live at

home. This is much higher than the average of 10 per 1,000 in similar councils

(Hanson et al., 2007:15).

As shown in a policy document (C12) and confirmed by three members of staff

interviewed (S3, S7 and S8), through the integrated care services, and in particular

the provision of intermediate care and palliative care services, more older people

were able to receive palliative care and to die at home rather than being admitted to

hospices or in hospitals. Talking about the intermediate care team, in the integrated

locality team, a senior member of staff said:

> They also care for lots of people who have chosen to die at home: the terminal care. And they're working very closely with district nurses in particular. (S7)

However, one intermediate care user with chronic lung disease who lived at home on

her own and used oxygen on continuously thought that her GP did not want to send

older people to hospital because they were not interested in older people's care. She told me about her experience of seeing her doctor:

> The GP wouldn't see me when I asked for it. She did not want to send me to hospital or visit me at home. She just prescribed antibiotics which I was already on. I had to put my foot down. When I went to the hospital the doctor said that I should've gone in earlier. Older people's care service is disgusting. Nobody is interested in it. (Extract from the notes of user survey NI 7)

She admitted that her case was an isolated one, and said that her GP surgery had a bad name. She was stuck with that surgery, as the next nearest surgery, a very good one, had a very long waiting list of people wanting to register there.

### *Ensuring personal safety and security*

Personal safety and security is particularly important for older people who live alone. Sheltered housing has become popular in recent years for older people who need a little more support than those staying independently at home. When I asked about the care needs of older people, a member of staff told me there had been changes in the warden-controlled housing or sheltered housing sector with the loss of the residential warden service:

> Then the warden controlled housing, the sheltered housing, they don't have the residential warden now, they have mobile [wardens], they're called independent facilitators now. Quite a few people felt that there wasn't enough support from having a residential warden, somebody that was there 24 hours and lived on site, but suddenly all gone. So they maybe just get a phone call once a day to say, 'Are you ok?' So we've lost a bit there. (S1)

During interviews with three sheltered housing residents (U17, U18 and U19) and one friend of a sheltered housing resident (U23) they told me that they were unhappy with the change. They said that the wardens were not around to talk to them and listen to their troubles, and the residents did not feel safe anymore.

> U19: Well, for people on their own, I think it's terrible, because they

sometimes don't see anybody all day.

Me: Uh-huh.

U19: Whereas when the warden used to go around, at least they had someone to talk to, to tell their troubles to and that sort of thing. But now, I mean all she does is just phone up, 'Are you all right?' and that's it. She just takes your word for it.

……

U19: Oh, you know, where the carer is living in, so that they feel more safe.

Me: Alright.

U19: It won't happen. They won't go back.

Some residents were particularly worried that nobody would be there if they fell ill in the night:

If you're ill, you couldn't get anybody in the night. (U23)

When visiting older people I found that a number of them had an emergency alarm system fitted in their houses and some were wearing a call bell around the neck. However, three users (two interviewed, U17 and U24, and one surveyed, SS4) told me that they did not feel safe with the change in the emergency alarm system operation because the calls were answered by a call centre run by North Hertfordshire District Council. A user said:

The call would go to somewhere I can't remember, very very far. (Extract from notes of user survey SS4)

A service user's mother, who lived in sheltered housing, had an emergency alarm system. She told me:

They said if an emergency happens she should call the call round her neck and next thing is contact me. Well I tried her call by mistake. It took them 20 minutes to answer the call from Hertfordshire. If my mother had an accident when they got there after 20 minutes and from Hertfordshire my mother would have been dead. (Extract from notes of user survey SO3)

This outcome of ensuring personal safety and security was not designed, nor was it intended by the integration programme. From the data I collected there was no

evidence that it had been achieved. On the contrary, the external changes in warden-controlled housing and the community emergency alarm system operation made integrated care service users living in sheltered housing and depending on the community emergency alarm system feel less safe than before the changes.

### 4.5.3 Service process outcomes

Service process outcomes of the integration programme included being treated as an individual and with respect, 'having a say' and control over services, and value for money.

#### *Being treated as an individual and with respect*

Being treated as an individual involves the service provider's recognition of and response to the individual needs and preferences of service users. It also involves the staff being warm and friendly to the service users. Being treated with respect involves having a legitimate right to the services, being a valued person, being able to maintain confidentiality and privacy despite their difficulties, illness, cultural and religious preferences and requirements (Qureshi et al., 1998).

Seventeen users (9 interviewed and 8 surveyed) felt that they were treated well as an individual and with respect by care staff who they described as very good (n9), very nice (n5), very kind (n4), marvellous (n2), lovely (n1), polite (n2), very caring (n1) and well-trained (n1).

Five users (4 interviewed and one surveyed) praised care staff for being hardworking and willing to help, to learn. A retired NHS hospital top manager and service user stated:

> But equally, I think there have been some very good successes in terms of community care. It does depend, you know, not on the boundaries that I was

talking about, not only on the organisations, but just on the good will of the people in the organisation, their willingness to learn and to constantly seek to improve. (U9)

One user surveyed (NO3) thought district nurses were responsive. When I asked the cancer patient who used intermediate care and occupational equipment if she had any comment about the care services in Cambridge, she said:

They are very good, very helpful. They are doing their job. Same as district nurses. They are out [to see you] if you want them. (Extract from notes of user survey NO3)

However, some services users reported that they had not been treated well. Of the 18 users, six who praised some of their care staff (NI 5, U4, U9, U12, U15 and U25) said that some carers were good and some bad:

Some carers are marvellous; some are very bad, horrible. (Extract from notes of user survey NI 5)

Three service users (NI 8, U5 and U26) thought that older people are not respected in this country. They had looked after older people themselves 50 years ago, but now they were old, young people did not think they should look after older people. When I asked what one user thought of care services for older people, she said:

It's disgraceful. There is nobody seems to care anymore. Nobody seems interested in old people at all. (Extract from notes of user survey NI 8)

One service user was very angry when a young neighbour had got a wet room before her:

The youngsters today, they get everything given to them on a plate, while we had to work. We get, we got nothing. (U26)

Of the social care users, 16 (10 surveyed and 6 interviewed) social care users, three of whom were both intermediate care and social care users, found one or some of

their carers disrespectful, that they did not do their job properly (n5), had low standards (n3), were too rough (n2), had a bad attitude towards older people (n2), were uncaring (n2), rude (n1), very bad (n1), horrible (n1), not helpful (n1), laid back (n1), cheated the user (n1). A user told me why she did not like one of her carers:

> U15: Well, she talked down to me, and I sort of resented it because I didn't need that.
>
> Me: Um. No.
>
> U15: I felt I was being, um, what the word I'm looking for, patronised.
>
> Me: I see.
>
> U5: I didn't like that.

One social care service user thought that carers were not caring and did not treat older people with respect or understand older people with memory difficulties. When I asked her how she thought the care services for older people in Cambridge could be improved, she said:

> I think they could be in a more caring manner, more than just ask you questions. I'm not [saying they should] use more time on you. I think they should treat you as older people. Sometimes they, you know, it's sort of 'what is this, what's that', it's sort of difficult, because, they think [older people] should remember everything. But you don't. Remembering back is very – well, I find I don't remember things in the last year. Yet I can remember back to the war, where I met my husband. (U4)

Most users who used both intermediate care and social care did not know that their carers were from different organisations and did not notice any difference between the care services provided. But one user thought the carers from a care agency were not as good as those from the in-house intermediate care team:

> SP6: I had six weeks care when I first came back from hospital. They were wonderful.
>
> Me: What's the difference?
>
> SP6: Agency carers don't get to know you. They didn't have the right attitude. They do the job for money. The other one [intermediate care] did it for care.

Seven social care service users (three surveyed SS1, NI 5, NI 8 and four interviewed U2, U4, U12, U14) complained that carers from care agencies had short time slots and were always in a rush. One (NI 5) told me that carers from a care agency refused to give her second cup of tea, which she always wanted, just because they didn't have time. Another user (U12) called the carers 'quicker' as they were always in a rush. Another user (U14) explained to me how her carers managed to provide personal care and prepared meals for her within a quarter of an hour three times a day:

> They come into your home. All they do is giving you a quarter of an hour to wash and dress you. Yes, and then make you a cup of tea and your breakfast or whatever you want. Yeah, dump it on the table. If you want toast, it's only bread just dried up. And they dump it on the table. And all the time they're doing that, they're putting their coat on and getting ready to go. Well, that's in the morning. (U14)

As a result of their short time slots, carers could not do their job properly:

> But you know they're in such a hurry. They want to get done and out. (U2)

One user felt the letter he had received from the physiotherapy team was not friendly. He said:

> What I didn't feel well was the letter. The letter should be more friendly. It was not one that encouraged you to go for physiotherapy. It said something like: 'If things get better do not bother. We have a long waiting list'. (Extract from notes of user survey NP7)

My finding shows that the outcome that a service user is treated as an individual with respect was achieved for some users but not for others. For some users this outcome was half achieved and half not. Thirty one users commented on this outcome. Fewer than two in five (n12, 38.7%) felt that they had achieved this outcome and more than two in five (n13, 41.9%) felt that they had not. About one in five users (n6, 19.4%)

felt that they were treated as an individual with respect by some care staff but not by others. The implementation processes of developing integrated health and social care services and reconfiguration of the homecare service had a close connection with the outcome. The care staff that were mentioned as treating service users as individuals and with respect were from different disciplines in the integrated locality team, while all the care staff that did not treat service users as an individual with respect were from the homecare service, including the intermediate care team and independent care agencies. As most service users did not know the difference between the intermediate care team and care agencies it was impossible to determine whether these two had any different outcomes.

### *Having a say and control over services*

Some service users were able to have a say and control over services, to decide when things were to be done, understand the care system, get help when needed, decide who would provide their care and to complain or change a carer if they were not satisfied with the care they gave.

One social care user (U25) was able to discuss with her social worker and decide at what time each day the carer would give her a shower, to suit her routine. Two service users interviewed (U25 and U27) found the care system easy to understand. One said:

> U21: I always felt that the, the, the supporting services were there, you know, that's, that's nice – That, you know, people who need help can find it
>
> Me: Um.
>
> U21: – without too much difficulty.

Four users (NI 5, U9, U12 and U14) were able to have a say in who gave them care.

When they were not happy with their carers they were able to ask for a change:

> U12: I only complained two times. ...
>
> Me: You complained twice?
>
> U12: Yeah, and necessary, some carers rushed him [father-in-law] before last year, but not now. Now he found a very good carer.

A user found it difficult to communicate with the care agency:

> It is complicated to communicate with the [name of care agency]. You have to press all the numbers before pressing five [care agency] and talking to the agency. It is too complicated for older people. (Extract from notes of user survey SS8)

One individual service user was afraid to complain. After complaining to me that her carers had low standards, always being late and lacking training, she reminded me twice:

> Don't tell them what I said. Probably I shouldn't complain. (Extract from notes of user survey SS4)

Lack of continuity of care was a barrier to service users' control over the services. One member of staff (S8) told me that staff of the old Social Services homecare teams used to have long-term one-to-one relationships with clients, working with their regular clients for years. Since the reconfiguration of the homecare service, users were cared for by the intermediate care team who worked shifts for short periods and the long-term social care users were looked after by independent care agencies. The long-term one-to-one staff-client relationship was lost. Although the intermediate care team and most care agencies tried to allocate regular staff to the same service users, 12 users (nine out of 46 social care users surveyed and three out of 21 social care users interviewed) told me that their carers from agencies were always changing due to staff illness, holidays and shortages:

> I had a good carer first. After she left I had 25 carers within nine months. It

There seemed to be no communication between the irregular carers. Service users found it difficult to cope with each day's new face:

> Don't get the same person [from the care agency] coming around twice. That's the trouble. You have got to explain everything each time. (Extract from notes of user survey NO8)

Delays in receiving services can hamper users' control over their services. The 100 service users surveyed were asked to recall how long they had waited for their assessment and to receive services. As some of them had been assessed more than a year before they were surveyed, their recall might not be exact. About one in four (25% regarding assessment and 31% regarding receiving services) either did not know or could not remember their waiting time and either did not have an assessment or had not received any services after assessment. These users were removed from the waiting time statistics to ensure that the statistics were as comparable as possible. Of the 75 users who did remember how long they had waited for their assessment, 54.6% had been assessed within two weeks and 70.6% within four weeks (see Table 4.13), compared to the national achievement of 59% within two weeks and 75% within four weeks, and the ministerial target of 70% within two weeks and 100% within four weeks to be achieved by December 2004 (National Statistics, 2006; Anderson et al., 2007).

Table 4.20 North or South City Integrated Locality Team: waiting time for the assessment

| Waiting time | North city team | | South city team | | Total | |
|---|---|---|---|---|---|---|
| 1 week | 15 | 27.8% | 13 | 28.3% | 28 | 28.0% |
| 2 weeks | 11 | 20.4% | 2 | 4.3% | 13 | 13.0% |
| 3 weeks | - | - | 4 | 8.7% | 4 | 4.0% |
| 4 weeks | 5 | 9.3% | 3 | 6.5% | 8 | 8.0% |
| 5-8 weeks | 5 | 9.3% | 8 | 17.4% | 13 | 13.0% |
| 9-12 weeks | 1 | 1.9% | - | - | 1 | 1.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13-16 weeks | 2 | 3.7% | - | - | 2 | 2.0% |
| 17-20 weeks | - | - | 2 | 4.3% | 2 | 2.0% |
| 21-24 weeks | 1 | 1.9% | 1 | 2.2% | 2 | 2.0% |
| Still waiting | 2 | 3.7% | - | - | 2 | 2.0% |
| Never had it | 1 | 1.9% | - | - | 1 | 1.0% |
| Don't know | 11 | 20.4% | 13 | 28.3% | 24 | 24.0% |
| Total | 54 | 100.0% | 46 | 100.0% | 100 | 100.0% |

Table 4.21 North or South City Integrated Locality Team: waiting time for the services

| Waiting time | North city team | | South city team | | Total | |
|---|---|---|---|---|---|---|
| 1 week | 12 | 22.2% | 17 | 37.0% | 29 | 29.0% |
| 2 weeks | 10 | 18.5% | 9 | 19.6% | 19 | 19.0% |
| 3 weeks | 2 | 3.7% | 3 | 6.5% | 5 | 5.0% |
| 4 weeks | 4 | 7.4% | 3 | 6.5% | 7 | 7.0% |
| 5-8 weeks | 3 | 5.6% | 1 | 2.2% | 4 | 4.0% |
| 13-16 weeks | - | - | 1 | 2.2% | 1 | 1.0% |
| 17-20 weeks | - | - | 1 | 2.2% | 1 | 1.0% |
| 25-28 weeks | - | - | 1 | 2.2% | 1 | 1.0% |
| Still waiting | 2 | 3.7% | - | - | 2 | 2.0% |
| Never had them | 3 | 5.6% | 1 | 2.2% | 4 | 4.0% |
| Don't know | 16 | 29.6% | 9 | 19.6% | 25 | 25.0% |
| Client declined | 2 | 3.7% | 0 | 0% | 2 | 2.0% |
| Total | 54 | 100.0% | 46 | 100.0% | 100 | 100.0% |

Of the 69 users who did remember how long they had waited to receive services, 69.5% had received services within two weeks and 86.9% within four weeks (see Table 4.14). This was below the national achievement of 75% within two weeks and 87% within four weeks and the ministerial target of 70% within two weeks and 100% within four weeks to be achieved by December 2004 (National Statistics, 2006, Anderson et al., 2007).

Six users (four of occupation health services and two of physiotherapy) were not happy about the considerable delay in receiving assessment or services. Two occupational health service users (U8 and U17) had to wait for 13 weeks and five months respectively before their assessment – the first step to getting the services. When I asked a user how she felt as she waited five months for the occupational assessment without having a bath, she attributed the delay to the high demand on and

cutting back of services:

> U17: Well, I'm not the only person in Cambridge what needs help. And they are few and far in between. And they keep cutting back, cutting back. And therefore the services are not there. They can't work miracles.
>
> Me: Uh-huh
>
> U17: And if you have to wait, you have to wait. I know you get bit desperate at times when you can't have a bath and things like that, but eventually it works out.

Two occupational health service users (U22 and SP4) had waited three or four months for a chair lift and six months for a ramp in the house respectively. The user who had waited for the chair lift was getting desperate because she had difficulty getting up or down the stairs. The user who had waited for the ramp could not wait any longer. To end her problem, her grandson bought her one for £400.

Two physiotherapy users (NI 16 and NP6) had to wait for 8-12 weeks and 24 weeks respectively for treatment. One user had a painful shoulder and her doctor referred her for community physiotherapy. She showed me a letter and said:

> Look at the letter they sent me. I have to wait for 24 weeks before getting treatment. I need physio now, not 24 weeks later. (Extract from notes of user survey NI 16)

Punctuality was important for some older people. Some of the carers from care agencies seemed poor at punctuality and caused many problems for service users because they never knew when they were coming. Two intermediate care users and eight social care users found their carers not punctual and frequently late. It was normal for early morning callers not to turn up until 9:30–10:30 and evening visits could be as late as after 22:00.

> SS4: They never got your breakfast, never came before 10 am. You were never sure when they came. They came at odd times.
>
> Me: What do you mean?

SS4: They came at 10 am. I got up at 8 am. They wouldn't ever prepare breakfast for me which was the social worker promised.

(Extract from notes of user survey SS4)

Two social care service users (U17 and U25) said the services they received were not flexible in response to their needs and preferences. They could not have a bath when they wanted and needed one:

... because they were so busy. This is the only one and only time they could come. (U25)

Three female social care users (NI 16, SS4, U24, two surveyed and one interviewed) told me that the social care services they received from care agencies did not respect their personal preferences, which was that they did not want to be bathed and dressed by a male carer as it made them uncomfortable and embarrassed. One of these three social care users needed carers' help to get up in the morning and go to bed in the evening. She told me that she wished the care agency would not send male carers to her because:

I don't like boys. It's scary waking up in the morning and seeing a strange strong man standing by your bed. (Extract from notes of user survey NI 16)

To be able to 'have a say' requires having information about the availability of and changes in services. However, of the 100 users surveyed, over a third of older people (n35) did not know who to contact if they had any problem with their care, which was especially important for the one in two (50%) of service users who lived alone and had nobody to contact professionals for them.

The Council's Contact and Advice Centre was designed as a main route for public self-referral to social care and occupational health services. It was open 6 days a week from 8 am to 8 pm. However, many older people and their carers appeared not to be well-informed about this service. Of the 100 service users surveyed, 97% of

service users did not know of the Cambridgeshire Direct Contact Centre. Of the tree who did, one had accessed the system through the Centre and the other two had only heard of it (they could not remember where from) rather than having personal experience of it.

Three service users found the care system difficult to understand:

> U16: Well, everything is complicated as you get older.
>
> Me:  You think it's complicated.
>
> U16: I think. I'm afraid we just don't want to know. [Laughs]... It's too complicated.

Most service users seemed not to notice or be aware of the big change that had occurred with the integration. Half of the eight members of staff I interviewed believed that older people were confused about the change. One member of staff was certain that service users did not know about the integration:

> I would be amazed if anybody other than somebody that perhaps knows somebody who's been working in the health services and knows what it's supposed to be about. I would be surprised if they knew what it would be about. (S4)

Another member of staff believed that the integration was too much for older people to take in:

> And for the service user, I think it's a bit of a change for them as well, you see. Some of them don't really know how our job's changed. They still think when we're the Home Help. We should be polishing the silver or what have we. So they need more information as well. Or some really don't understand, they don't change anymore. They're too old, you know. (S2)

One user interviewed (U2) did not know that her care agency was an independent agency and supposed they were all Social Services.

***Value for money***

Two service users (SS1 and SP6) thought the services they had received did not offer value for money. They contributed means-tested co-payments. One of the two users said:

> They never did what they're supposed to do. I expect proper help I've paid for. They didn't do anything, didn't wash up, they never put dishes in the machine. The bathroom was always messy. (Extract from notes of user survey SS1)

The above four sections have presented the findings of my study. In the next section, I will discuss the reasons why some intended aims were achieved while others were not.

**Contextual conditions**
1. Background of the integration
2. Enabling factors for the integration
3. Obstacles to the integration

**Intended outcomes**
1. To organise services around the needs of the older people
2. To unify care systems
3. To make it easier and simpler for service users to understand and access the services
4. To make the best use of the resources and to improve performance.

**Integration of social care and health services for older people**

**Implementation processes**
1. Setting up Cambridgeshire Direct Contact Centre
2. Establishing management structure of the integrated directorate
3. Reconfiguration of the homecare service
4. Vulnerable People's Programme

**Outcomes**

**Causal mechanisms**
1. Efficiency
2. Empowerment
3. Bringing down barriers
4. Synergy

**Actual outcomes**
1. Change outcomes:
e.g. Increased confidence & morale for most occupational health & physiotherapy users, and for only half social care users.
2. Maintenance and prevention outcomes:
e.g. More older people with complex problems and high level needs were helped to live or to die at home
3. Service process outcomes:
e.g. Two in five users were treated as an individual with respect, two in five were not, one in five were by some care staff and not by others.
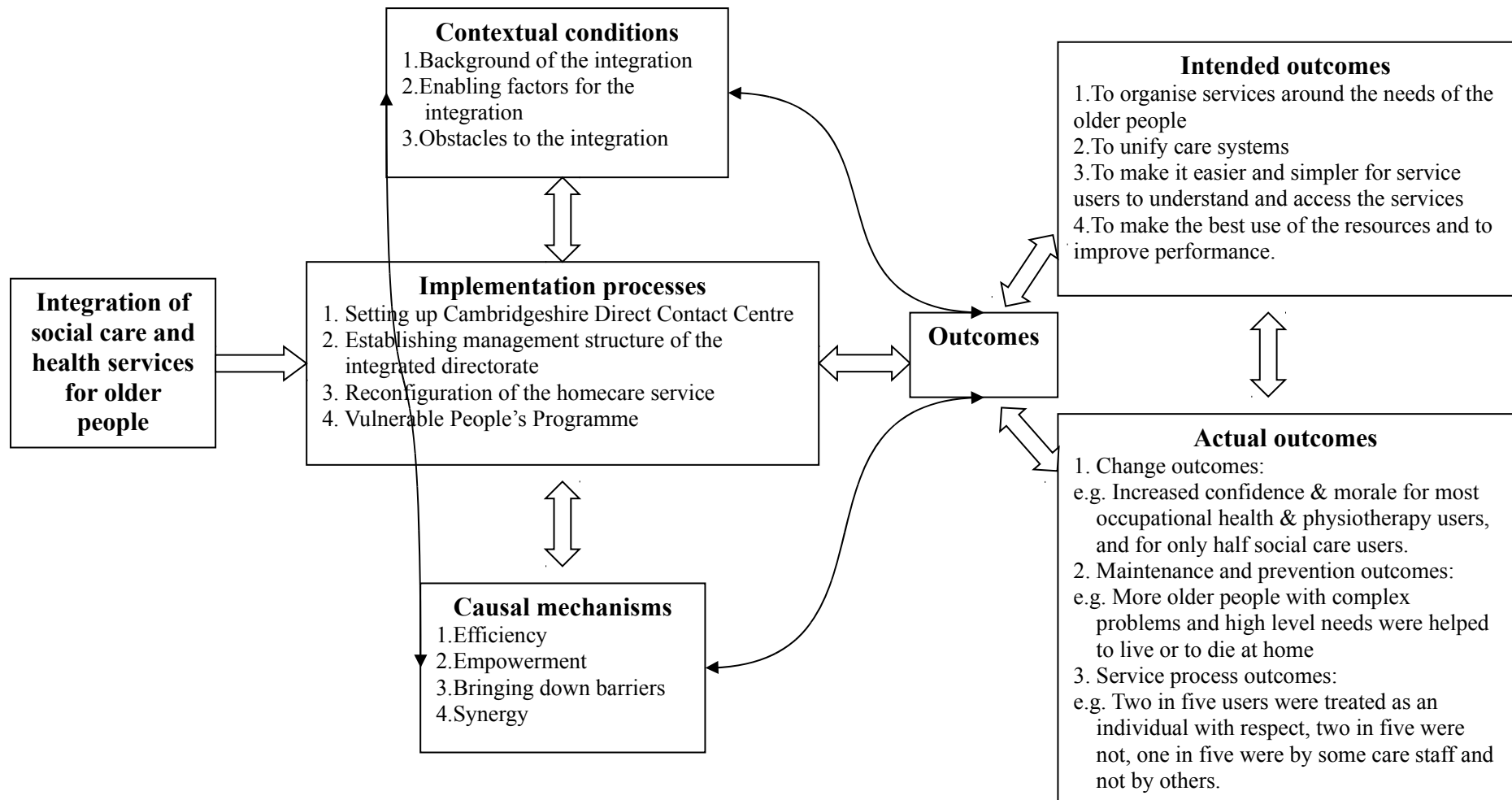
Figure 4.14 The causal model of the integration programme

## 4.6 Planned goals and achieved outcomes

The planned goals and intended and achieved outcomes of the integration

programme were studied by drawing on some of the strengths of the theories of

change approach (Weiss, 1998; Secker et al., 2005),. Below are the apparent reasons

why some of the planned goals and intended outcomes were not achieved.

### 4.6.1 Why did very few older people know of Cambridgeshire Direct and the integration?

Cambridgeshire Direct was developed in order to give the public simple, easy and

quick access to the care systems. According to *What Older People Want From*

*Community Health And Social Care Services* (Age Concern, 2006), older people and

their carers would like health and social care to join up at the point of service

delivery to offer 'one point of call' (Age Concern, 2006:3) to help them find their

way 'through the maze' of the health and social service system (Age Concern,

2006:8). Cambridgeshire Direct seems to be this 'one point of call'. A pre-integration

survey conducted by Age Concern Cambridgeshire showed that 76% of older people

thought it was a good idea for first contact to be made via a call centre (Age Concern

Cambridgeshire, 2004:4). However, the findings of my survey of integrated care

service users show that only 3% knew of Cambridgeshire Direct or had heard about

the integration. Only 1% had actually accessed the care system through the

Cambridgeshire Direct Contact Centre having been given the contact number by a

health professional. There appear to be three reasons for people's lack of awareness

of Cambridgeshire Direct and routes for accessing the integrated care system.

### *Lack of publicity*
The first reason is lack of publicity. A number of service users and their families read

local newspapers. How could they not have heard of the big change if it had been well publicised in the local papers? While I was shadowing I found that the old Social Services signboards were still up outside the building of North City Integrated Locality Team and on Arbury Road, Cambridge. There was no leaflet or brochure about the integrated team. The only thing I found was an old Social Services' booklet *Cambridge City Older People/Physical Disability Team* published in 2001. No information about the integrated team could be found in *The Phone Book: Cambridge 2006/07*, *Yellow Pages: Cambridge 2006/7* or *Thomson Local: Cambridge 2005-2006*.

A new booklet, *Adult Care Services in Cambridgeshire 2006* (Cambridgeshire County Council, 2006) about Cambridgeshire Direct and access to the integrated care system in Cambridgeshire had been published by Cambridgeshire County Council and staff had been asked to hand it to each user at their first appointment with the locality teams. Despite a big pile of the booklets in the offices of the locality teams, none of the service users I visited possessed or had seen a copy of the booklets. They seemed either to have accessed the care system before the publication of the booklet or had not been given the booklet by staff.

The result of a customer satisfaction survey conducted by Cambridgeshire Direct itself in 2006 supports my finding. The percentages of its customers, including both service users and professionals, finding Cambridgeshire Direct's telephone number from Cambridgeshire County Council's publication were 8% in the occupational health service (Cambridgeshire Direct, 2006a:3) and 6% in social care services (Cambridgeshire Direct, 2006b:2). The survey shows that Cambridgeshire Direct also recognised the 'need to make people aware of Contact Centre numbers' (Cambridgeshire Direct, 2006b:15).

During the interview, when I explained what the Cambridgeshire Direct Contact Centre was, some older people felt that they needed to have and keep the Centre's telephone number. Several of them asked me for the contact number and I rang back to give it to them. After that I always took the telephone number with me when I went to interview users. Two users even asked me to contact Cambridgeshire Direct Contact Centre for them because both had hearing and speech difficulties, lived alone and found it difficult to make telephone calls. For some service users, knowing the phone number of the Cambridgeshire Direct Contact Centre and how to access the care system would enable them to make self referrals whenever they needed to. This would give them a sense of security and control over their life.

### *Staff role in users' awareness*

Staff behaviour and attitudes seem to have contributed to users' low awareness of Cambridgeshire Direct and the integration. During my shadowing I observed that former Social Services staff still called themselves 'Social Services'. When the duty worker answered the phone, he would say 'Social Services'. But when he rang the other professionals, e.g. the district nurses, he would say, 'Integrated Locality Team' or 'Locality Team'. Nearly two years after the integration the staff were still calling themselves 'Social Services', raising the question of how service users could be expected to find out that social care for older people in Cambridgeshire was not organised by Social Services any more and had been integrated with health care.

Several members of staff I talked to and two members of staff I interviewed (S1 and S4) did not believe that service users would know what the integrated care services were and thought that the integration was quite confusing for them (S4 as shown in section 4.5.3).

During my shadowing, a member of staff told me that she described herself as from Social Services rather than the Cambridge City PCT locality team when she contacted or visited service users because service users would not know what the Cambridge City PCT locality team was. When staff knew that services users did not know about the integration, they did not tell them about the changes or take the trouble to explain it to them. Since the staff continued describing themselves as from Social Services after two years of integration, it was not difficult to understand why service users' awareness of Cambridgeshire Direct and the integrated care services was so low.

### *Service users' preference*

The third reason why service users had such low awareness of Cambridgeshire Direct and the integrated care services was their own preference. Some older people did not mind which organisation employed the staff as long as care staff delivered the service properly as they were supposed to do and met their needs. A member of staff I interviewed believed that service users cared that 'they get the care when they need it, and they get the advice whatever they need' (S4).

Some older people preferred their GP to be their first contact and problem solver. One in three service users in my survey accessed the care system while in hospital. One in six (15%) did not know or could not remember who they had contacted first. The majority (32%) of older people not in hospital would contact their GP first when they needed social care, physiotherapy or occupational health services. Community nurses (9%) were the next to be contacted and then social workers or care managers (7%). Only 1% would contact Cambridgeshire Direct. Again, when service users had any problem with their care, 30.8% would contact their GP first, as found in previous

studies (Age Concern, 2006; Barnes et al., 2007; Vestri, 2007). In the Evaluation of the Operation and Impact of Free Personal Care in Scotland (Vestri, 2007), NHS staff (GP, community nurses and staff of the hospitals when patients were discharged from there) were the major source of referrals for personal care assessments, rather than staff from Social Services departments, users themselves or third parties. Barnes et al. (2007) claim that most people:

> customarily come into contact with health professionals; it is predominantly members of stigmatised and marginalised groups who have contacted social workers. (Barnes et al. 2007:191)

**4.6.2 Why is a single process of assessment and recording not realised?**

Another planned goal that was not achieved was the single process by which all the user's health and social care needs would be assessed and recorded once users have made contact with the new integrated care system. The assessment should be made within 14 days. However, neither the electronic version of the assessment through a palm computer nor its paper version had been implemented by March 2008. Thirty-four percent of the service users that I surveyed had waited three weeks or more for their assessments.

The main reason the electronic Cambridgeshire Assessment Tool (CAT) had not been implemented was lack of funding. At the beginning of the integration programme the CAT was not available due to insufficient funding, so a paper version was piloted. After the pilot of the paper version, which was followed by a pilot of the electronic version in June 2006, the CAT was still not put into practice. Money was of course very tight. Cambridge City and South Cambridgeshire PCTs had a £40m deficit (M50). According to its Financial Recovery Plan: Turnaround, Cambridge City and South Cambridgeshire PCTs had identified £21.9 million in cost reductions in 2005/06 (P8). Implementation of the electronic CAT would be costly, and putting any

version into practice would require time for staff training.

Apart from lack of funding there seemed to be a lack of incentive, because other projects in Cambridgeshire had implemented CAT. When I asked about the single assessment one member of Cambridgeshire County Council's staff replied:

> II 12: Single Assessment? We are using the tool CAT. They haven't done the pilot yet after five years. There is no incentive for PCT to implement it.
>
> Me: City PCT was piloting the CAT.
>
> II 12: Yes, they piloted the electronic version of single assessment with the palm computer and it was too expensive. The physical disability project has already started using the CAT. The physical disability project started later has gone ahead of integrated older people's care services.
>
> (Extract from notes of informal interview II 12)

Not only was the single process of assessment not achieved but neither was the single process of recording. Service users were assessed by staff from different professional groups (social care, occupational therapy, physiotherapy, intermediate care and nursing) separately and their assessments recorded and case notes filed separately. Social care and occupational health used Social Services' computerised systems for referral, assessment and record keeping. Intermediate care used a countywide computerised record system with a handwritten case notes system. Physiotherapy and district nurses used their own handwritten referral record-keeping systems and handwritten case notes.

Incompatibility between the computer systems – a big obstacle to an integrated single process of assessment and recording – was another reason why assessment and record keeping systems were not integrated. In the locality teams former Social Services staff stuck to their old way of referral, assessment and record using Cambridgeshire County Council Social Services' computer system. Former health care staff retained their own way. Staff working in the former social services'

building were able to access Cambridgeshire County Council Social Services computer system, while staff working in health centres, GP surgeries or other premises which were not part of the former Social Services were not able to access the Social Services computer system. Without an integrated computer system for all professional groups the single process of assessment and recording could not be achieved.

Although all older people's care services staff were brought together, employed by one organisation on one payroll and working in the same office, the services could not be fully integrated until the single process of assessment and recording was implemented. When talking about the single assessment, every staff member I interviewed was full of enthusiasm. The single assessment was seen as a very important steppingstone to full integration. As one senior member of staff put it:

> We won't fully achieve [integration] until we've got the single assessment. (S7)

### 4.6.3 Was the new integrated programme easier for everyone to understand?

Another intended advantage of the integration that had not been fully achieved was a single system which was easier for everyone to understand (Cambridgeshire County Council et al., 2003). There were several reasons for this. First, the integration programme was not yet a fully unified system in terms of referrals, assessments, record keeping and the computer system. Cambridgeshire Direct, which was designed for simple and easy access to the integrated care system, was actually not the gateway to all care services but to social care and occupational health only. All the referrals of older people for social care and occupational health services from their families, their GPs or other professionals on their behalf had to go first to the Cambridgeshire Direct Contact Centre, then to the integrated locality teams through

the computer system. The situation was complicated by the fact that only former Social Services' care services could be accessed through Cambridgeshire Direct. It must be pointed out here that Cambridgeshire Direct was a Cambridgeshire County Council organisation. The staff there were employed by Cambridgeshire County Council, except the referral staff – the duty workers who had been moved to Cambridgeshire Direct from the PCTs but were still employed by the PCTs. Access to nursing care and physiotherapy was still, as before, at the GP surgeries.

As district nurses worked at GP surgeries it was easier for me to understand that people could contact GP surgeries if they needed nursing care. But physiotherapists had been integrated into the locality teams along with other professionals. Referrals for physiotherapy had to go from GPs to Chesterton Health Centre and then from Chesterton Health Centre via mail to integrated locality teams. These separate, awkward referral systems were not easy to understand, even for the staff of the locality teams, or for me, an external researcher. Needless to say it was not easy for older people to understand.

Because very few service users were aware of Cambridgeshire Direct and the integration because Cambridgeshire Direct was not yet the single point access for all care services because the referral, assessment, record keeping and computer systems of the integrated older people's care services were not yet fully unified, the intended goal that a single system would be easier for everyone to understand had not been achieved.

# 5 Discussion

## 5.1 Introduction

This chapter discusses the findings of my study as presented in the previous chapters and discusses why the integration programme worked for some service users in certain contextual conditions but not for others. It also discusses theories of effective integration, the drivers of the integration of health and social care and the structural change involved and its implications. In addition, I will discuss the contradictions uncovered through this study and lastly, the strengths and limitations of my study.

## 5.2 Why did the system work for some user groups but not for others?

From my findings, it appears that the integration programme worked better for users of occupational health services and physiotherapy than for the social care user group. There seem to be two main reasons for this: the difference between the change outcomes and the maintenance outcomes, and the impact of the privatisation of social care.

### 5.2.1 Change outcomes and maintenance outcomes vs. health care and social care

This study adopts the three clusters of social care outcomes identified by Qureshi et al. (1998) at step six of my data analysis to conceptualise the outcomes of the integrated health and social care services because, as Glendinning et al. (2006) argue, these outcomes are very similar to the factors that older people consider central to their independence and well-being. The fact that users of social care services

achieved fewer of the intended outcomes than users of occupational health and physiotherapy in my study reflects, to a certain degree, differences between the services' aims. There were differences between the aims of the majority of health care services and those of the majority of social care services. In Qureshi et al's study (1998:2), staff estimated that 85% of social care work was directed at maintaining an acceptable quality of life or preventing deterioration, and social care service users' conditions were expected to change only slightly for the better. In contrast, the majority of health care work was directed at achieving change outcomes, as it aims to treat, cure, rehabilitate, recover, and change older people's physical condition for the better. In this study, the occupational health and physiotherapy services provided therapy, treatments, rehabilitation and equipment. This was intended to achieve not only change outcomes such as improvement in physical functioning but also maintenance and prevention outcomes such as meeting physical needs. The fact that some of the social care users did not perceive themselves as having achieved some change outcomes meant not that the social care service did not do well in the integration programme, but that the majority of social care work is not intended to achieve these change outcomes.

**5.2.2 The negative effect of the privatisation of social care**

In the implementation process of the integration programme – the reconfiguration of homecare services – the transfer of long-term, in-house homecare packages to the independent sector in effect privatised long-term social care (P11). Due to environmental and resources constraints, private social care providers were unable to provide housework and domestic tasks as service users would have liked them to be provided. Thus the privatisation of social care services appears to have had some negative impacts on the delivery of social care services and on the process outcomes

of the social care reform.

### *The effect of environmental constraints*

The relationship between care staff and service users is crucial to social care service process outcomes. My interviews with staff and users indicate that the reconfiguration of homecare services had broken up the long term, one-to-one staff-client relationship that used to exist between service users and the staff of former Social Services homecare teams. The frequent changes of agency carers reported by one in five social care users surveyed and one in seven interviewed in this study were difficult for them to cope with. As a result they felt they had lost control over their services. Qureshi et al. (1998) observe that continuity is important to users with poor memories because they cannot remember frequently changing new faces and do not like explaining their personal care needs over and over again to strangers.

The reconfiguration of homecare services effectively privatised long-term social care. Previous researchers (Sinclair et al., 2000; Quinn et al., 2003; Ware et al., 2003; Glendenning et al. 2006) argue that environmental constraints hinder the continuity of care and impair the relationship between staff and user. As Glendenning et al. (2006) note, among the constraints on the environment within which independent care service providers operate is shortage and high turnover of staff. Private care service providers have more problems recruiting and retaining staff than in-house providers like Social Services and the NHS because many offer worse pay and conditions. With these shortages and high staff turnover the services private care agencies provide are inevitably performed often by new carers.

My study lent further evidence and support to the findings of previous studies with regard to maintaining continuity in providing social care services. For private care

agencies to achieve the kind of continuity achieved by Social Services or the NHS they must make more effort to recruit and retain care staff by improving pay and conditions.

### *The effect of resources constraints*

Resources constraints here refer to limited monetary or human resources. My findings suggest that resource constraints for private social care providers lead to four problems: (1) some care agencies are unable to provide service at individual users' favoured times; (2) they are unable to meet heavy demand for care early in the morning and late in the evening; (3) the punctuality of the care staff is poor; and (4) users feel that the social care they receive is 'rushed'. All these problems were associated with the privatisation of long-term social care and ensuing constraints to private care providers' resources, which have evidently impaired both the quality and the service process outcomes of social care.

The above problems are not new. Previous studies (Qureshi et al., 1998, Rapley, 2004) suggest that when service users do not have the right service at their favoured times, which fit in with their daily routine and give them a normal pattern of life, they or their families feel they have lost control of their daily life. Qureshi et al. (1998:6) suggest that providing 'intensive services with peaks of activity' in early mornings and late evenings is a widely recognised difficulty. According to a number of previous studies (Hardy and Wistow, 1997; Henwood et al., 1998; Patmore, 2003; Quinn et al., 2003; Ware et al., 2003), the private sector is especially vulnerable to the problem of dealing with uneven demand at different times of day due to problems of staff recruitment and retention and lack of availability of staff to work the hours that users prefer. Other studies (Gwyther, 1997; Patmore, 2003; Francis and Netten, 2002; Francis and Netten, 2004; Glendinning et al., 2006 ) point out that punctuality

is important to some older people, especially those with special medical needs. When social care providers cannot meet heavy demand at peak times service users feel they have lost control of their daily life and this compromises an important aspect of the maintenance outcome.

Patmore and McNulty (2005) observe that care staff from some private care agencies are always in a rush. Their explanation is that, unlike in-house homecare, independent sector providers make no allowance for time spent travelling between appointments, resulting in staff being tempted to curtail visits once essential tasks are completed (Patmore and McNulty, 2005) and to rush through their tasks. This appears to be the case in my study too.

As discussed in the previous section, for private care agencies to meet service users' needs at their favoured times and at peak periods, and to achieve the punctuality and the quality provided by social care services and the NHS, they must make more effort in recruiting and retaining care staff by improving pay and conditions. They also need to monitor the performance of their care staff. PCTs should closely audit the quality of social care services that they have commissioned from private care agencies and take action promptly if they find service quality jeopardised.

***Restrictions in providing housework and domestic tasks***

Older service users consider it important to be able to live in a clean and tidy environment. As my study shows, former Social Services in-house homecare teams used to provide domestic services, including cleaning. After the privatisation of long-term social care the duties of former Social Services in-house homecare teams changed from providing all social care services including some domestic tasks to providing short-term (fewer than six weeks) more health-rehabilitation-orientated intermediate care services. Because most private care agencies do not carry out

housework and domestic tasks, these changes leave social care users with no choice

except to purchase a cleaning service themselves from the private sector, or to leave

their home dusty or garden untidy. This made users in my sample feel they had lost

control over the standard of cleanliness in their home. The fact that some social care

users received no help with housework and other domestic tasks is not new (see

Clark et al., 1998; Ware et al., 2003; Francis and Netten, 2004). Qureshi et al. (1998)

point out that quite a number of Social Services departments nationally have

withdrawn from or substantially reduced the provision for cleaning, either because it

is considered a lower priority or because it is thought that it can be provided more

cheaply by the private sector; yet according to Glendinning et al. (2006), most

private care agencies are reluctant to provide low-skilled housework and social care

purchasers have restricted purchasing on the range of housework and domestic tasks.

Consequently the restrictions in providing housework and domestic tasks caused by

the privatisation of social care and the changes to duties of the in-house homecare

teams impedes the achievement of the important maintenance outcome – a clean and

orderly home environment.

One of the shared visions of the integration programme was 'designing and

delivering services around individual needs' (C2:13), and one of the visions in the

implementation process – the reconfiguration of homecare services – is to 'develop

community based services that anticipate and respond to older people's needs'

(P11:3). However, the changes the integration programme introduced not only do not

anticipate or respond to some users' needs for help with housework and other

domestic tasks; they have also taken away the help they used to receive under the

former Social Services homecare model. To guarantee that service users can achieve

a clean and orderly home environment, integrated care services for older people need

to recognise these needs and either commission domestic services for them or help them to purchase services themselves by providing information on such services.

## 5.3 Theory of integration of health and social care in Cambridgeshire

This section discusses my findings about the drivers of the integration of health and social care in Cambridgeshire, how the drivers and the form of the total integration in Cambridgeshire conform to or differ from these theories of integration and what, in theory, the integration programme should achieve.

### 5.3.1 Drivers of the integration programme

The findings of this study suggest that the health and social care services were integrated for a variety of reasons. The six backgrounds of the integration shown in Table 4.1 were all drivers of the programme in Cambridgeshire. 'Shared vision' appears frequently in early consultation documents of the integration programme, and developing a shared vision was a frequent topic in the discourse of the programme's policy makers and managers. This shared vision was to be achieved with regard to promoting the wellbeing of older people, improving preventive work, reducing reliance on institutional care and expanding community based care. As one of the six enabling factors for the integration programme, shared vision fits into the optimist perspective of integration in Sullivan and Skelcher's framework (2002) featuring shared vision and consensus among stakeholders.

Another driver was maximising resources which supported by Levine and White's (1962) exchange theory, which underpins the optimist perspective. My finding

suggested that the integration of health and social care in Cambridgeshire happened when organisations depended on each other for resources in order to realise their respective goals or objectives (Levine and White, 1962). My findings support the synergy concept implied by exchange theory of integration (Dickinson, 2008). Members of staff that I interviewed believed that synergy was one of the causal mechanisms of the integration programme.

My findings regarding the drivers of the integration of Cambridgeshire's health and social care services only partly fits Sullivan and Skelcher's (2002) optimist or pessimist perspectives (discussed in section 2.3), as I found six drivers altogether. However my findings match Alter and Hage's (1993) evolutionary theory, which sets out the realist position and suggests that integration takes place in response to the wider environmental changes. As evolutionary theory suggests, the integration of health and social care in Cambridgeshire was due to a number of reasons and took place in response to the internal and external environmental changes. It appeared to have functioned as a means for increasing power of resources over other agencies, for producing better services for users (Alter and Hage, 1993; Dickinson, 2008) and for achieving the targets government had set up.

Amongst a variety of reasons for the integration was the most important driver of the integration of health and social care in Cambridgeshire—meeting the government targets. Only one staff member (S7) believed that 'the integration is statistics driven by the Department of Health'. My finding suggests that the integration was standards or targets driven by the government. The integration programme took place in order to achieve government's targets and the performance targets set out in the Section 31 Partnership Agreements agreed to by Cambridgeshire County Council and the four

PCTs. To achieve the targets of reducing the number of delayed discharges from hospital and avoid delayed discharge fines introduced by Community Care (Delayed Discharges, etc.) Act 2003 (Her Majesty's Government, 2003) which came into force in 2004, the integration programme established the integrated locality teams, integrated discharge planning team and integrated STARTeam community, reformed the homecare service so as to provide integrated services in the community to help older people come home from hospital sooner. To achieve the target of helping older people live at home and reducing emergency admissions of people aged 75+ to hospital (set out in Section 31 Partnership Agreements), the integration programme established the integrated locality teams, integrated STARTeam community, integrated STARTeam A&E, the vulnerable people's project and reformed homecare service so as to provide integrated services in the community, keep older people in the community, avoid their admission to hospital or help them return home from hospital A&E. To achieve the targets of reducing waiting time for assessments and care packages (set out in the Section 31 Partnership Agreements), the integration programme set up the Cambridgeshire Direct Contact Centre, designed the service user journey, established the integrated locality teams in the hope of speeding up referral and assessment process and reducing waiting time.

A variety of the reasons for the integration of health and social care for older people in Cambridgeshire match both the optimist perspective and the realist perspective of Sullivan and Skelcher's framework (2002). The main or most important reason was meeting governments' targets. The form of full integration in Cambridgeshire was closest to the realist perspective – the formalised networks with the evolutionary theory.

**5.3.2 What the integration programme should achieve**

The findings of this study show that the integration of health and social care in Cambridgeshire achieved positive as well as negative outcomes for certain user groups and individual users. This is a rather complex picture and does not fit into any of the perspectives of Sullivan and Skelcher's framework (2002). Although the aims of the integration of health and social care in Cambridgeshire included achieving shared vision and maximising resources, which do fit into the optimist perspective in Sullivan and Skelcher's framework (2002), the fact that is has both positive and negative outcomes for certain user groups and individual users does not. The theories that underpin the optimist perspective suggest that integration mainly for altruistic purposes produces positive outcomes or improvements to the entire system. Yet the integration programme has not produced positive outcomes for the entire system. One reason for this could be that the programme is a unique form of total integration with many more drivers than Sullivan and Skelcher's optimist position assume and does not fully match their description. However, even in an integration programme whose drivers and form fully match the optimist perspective, and even if this was mainly for altruistic purposes, there could be no guarantee of positive outcomes or improvements for the entire system for two reasons.

First, the findings of this study indicate that drivers of integration or altruism are not the only ingredients necessary for the integration to produce outcomes. An effective integration programme not only needs clear, important drivers, but also generative mechanisms; contextual conditions, including enabling factors, a well-conceived design and sufficient financial resources; and short, medium and long term goals clearly stated at the outset. The role of technology should not be overlooked either. The importance of the compatibility of IT systems in multi-agency working is

pointed out by Townsley et al. (2004), who identify incompatible IT systems as one of the barriers to multi-agency working. The findings of my study demonstrate that without a well-conceived design, sufficient financial resources and compatible ICT systems, a single process of assessment and recording could not materialise even when the drivers, the generative mechanisms and the goals were all achieved.

Second, my findings indicated that an integration programme whose form and drivers match the optimist perspective would not produce positive outcomes or improvements for the entire system as implied by the optimist position, but would produce both positive and negative outcomes within certain contextual condition and through certain implementation processes for some user groups and individuals and not for others. My finding echoes Pawson and Tilley's realistic evaluation (1997). These authors believe that no individual-level intervention works for everybody and no institution-level intervention works everywhere. The realistic evaluator's job is to find out for whom the intervention works and for whom it does not, and why.

## 5.4 Contradictions

This section discusses the contradictions uncovered through this study, the contrasting evaluations of the drivers and the actual impact of the integration programme by managers, staff and service users.

### 5.4.1 Divergent drivers of the integration

I found that different staff members seemed to believe that the integration was driven by different drivers. This finding is supported by Yanow's (2000) interpretivist perspective, which suggests that each driver of integration might be held by different actors within a system (Yanow, 2000). It also suggests that staff members were not

sure what the most important drivers of the integration were. Dickinson (2008) claims that it is important to be clear about what the most important drivers of the partnership are at the outset of an integration programme. In its report *Inspection of Services for Older People, Cambridgeshire County Council 2007,* the Commission for Social Care Inspection points out that 'there was no whole systems agreement between the council and all health partners to ensure the best outcomes for older people' (see Hanson et al., 2007:7). The fact that staff were not clear about the drivers of the integration and that no clear short, medium and long term outcomes were set out for users at the onset of the integration could explain why this study found that staff did not know what the integration was meant to achieve for service users.

### 5.4.2 Contradictory impact of the integration programme on staff

The integration programme in Cambridgeshire caused significant structural changes and its present structure, with integrated locality teams and integrated interface teams were all associated with both positive and negative impact on staff members. My interviews with staff suggest that the structural change involved in the integration – the co-location of different professional teams in the same office – led to better communication, enhanced knowledge of the work cultures of other professionals and ensured closer collaborative working. This echoes Davey et al.'s (2005) finding that co-location of health and social care staff might lead to better communication.

My findings also suggest that the co-location of the different professional teams in the same office breaks down barriers between different professionals, promotes communication, builds trust, helps role sharing, promotes joint working and encourages team gelling, and consequently increases staff satisfaction and improves

services for users. This finding echoes that of Glendinning et al. (2003:205), who claim that if users are to experience 'seamless' services, relocation of staff to the same premises or into integrated teams, joint training and reallocating staff roles and responsibilities to reduce duplication and gaps in skills might be required.

Meanwhile, the structural change involved has had some negative impacts on social care staff. This study found that the transfer of 900 social care staff from Cambridgeshire County Council Social Services into the four PCTs caused some social workers to leave their jobs in order to avoid being transferred. Some staff members were not happy with or could not cope with these changes. Describing the impact of the integration programme on staff, one staff member said: 'Initially it's very stressful, like anything because is a big change.'(S4). Most of the staff members that moved into the integrated locality team office from their original offices did not really want to go.

In early 2004, I had a meeting with a director and a manager of the integration programme to discuss my research proposal. They wanted me to drop the part of my research on examining the impact of the integration programme on staff. I was told that one third of the 900 social care staff transferred from Cambridgeshire County Council Social Services into the four PCTs were happy about the transfer, one third were OK and one third were not happy at all. Two years later, when I discussed my revised research design with another assistant director of the integration programme before starting my study, she could not see the reason why I should not examine the impact of the integration programme on staff. She encouraged me to work with integration locality teams and to interview staff members, and was quite confident and positive about the integration's impact on staff members. My findings indicate

that the impact of the integration programme on staff members had changed as time passed. In the beginning of the integration programme, some of the staff members who were unhappy about the transfer and unable to cope with the changes had left. Most of those who stayed, coped with the stress, some slowly, others more quickly. After two years, much of their stress caused by the integration was gone. Most of them were happy with their working environment.

Some social services staff who were transferred from social services were concerned about losing their specialist role or their professional standing. This finding echoes those of studies by Townsley et al. (2004) and Abbott et al. (2005), who found that some social services staff were concerned about being marginalised in their social care role in a medical and health care dominated situation. My findings also indicate that the change to the structure and co-location of different disciplinary teams into one integrated team deprived the staff from occupational health of their professional managerial support and peer support and made some feel that their personal and professional development were compromised.

### 5.4.3 Contradictory impact of the integration programme on users

The integration programme in Cambridgeshire caused significant structural changes and its present structure, with integrated locality teams and integrated interface teams were all associated with both positive and negative outcomes for service users. My study finds that the integrated care services for older people in Cambridgeshire were associated with reduced use of acute hospital care, residential care and hospice palliative care and with greater use of community care. This echoes a number of previous evaluations in the USA, Italy and Canada (Kane et al., 1992; Bernabei et al., 1998; Zimmerman et al., 1998; Hébert et al., 2005), which demonstrate that

integrated health and social care teams working typically for older people can reduce health care costs by making greater use of intensive low-level community care in place of expensive inpatient acute or residential care. However, this finding differs from a number of previous studies in the UK (see Peck et al., 2002; Brown et al., 2002; Kharicha et al., 2004; Townsley et al., 2004; Davey et al., 2005) which conclude that integration does not necessarily produce better outcomes for service users. The integrated care services for older people in Cambridgeshire had a complex structure and process with multiple projects and interventions, involving multi-disciplinary teams in a complex environment. The positive outcome of reduced use of acute hospital care, residential care and hospice palliative care and with greater use of community care was produced not only by integrating multi-disciplinary professionals into one integrated locality team or by collocating them into one office. Without the reconfiguration of the homecare service to provide more flexible, responsive and integrated services, without the Vulnerable Peoples Project, which registers vulnerable people and gives them advice and support, without the services of integrated discharge planning team, integrated STARTeam community and A&E, and also without the additional resource that had been put in, this outcome would not have been achieved. Fewer older people with complex problems and high level needs would have been able to live at home; the number of delayed discharges would not have decreased; avoidance of hospital and residential care admission would not have been so successful; and many older people who wished to die at home would not have been able to do so. While all the members of integrated locality team I interviewed were telling me that they had achieved these outcomes, one staff member from the integrated discharge planning team disagreed. She believes that

without the additional resources put in, integration of health and social care staff alone would not be able to make the change.

Meanwhile, the integration programme appears to have had hardly any impact on service users, for the majority of the service users I interviewed were not aware of the integration or Cambridgeshire Direct, which had been developed in order to give the public simple, easy and quick access to the care systems. It was striking for me to discover this and to learn that front line staff members knew this. They told me that they would be surprised if service users knew what the integration was about. I had the experience of explaining what the integration programme, Cambridgeshire Direct, and even the Primary Care Trust were about to service users I visited. I also had the experience of being challenged by a social care service user, a retired professor, who showed me records of phone calls, visits and letters from staff members of an integrated locality team. Staff called themselves 'Social Services' and used Cambridgeshire County Council headed paper. As discussed in the previous chapter, service users' low awareness of Cambridgeshire Direct, the integration programme and the different routes to access the integrated care system were associated with low publicity, staff behaviour and attitudes and service users' preferences. Awareness could perhaps be raised by providing clear and unambiguous information about the community care services and access to it for people undergoing needs assessments by staff. Information about older people's care services could be disseminated to GP surgeries, day care centres, older people's clubs and other facilities used by older people and their carers. Staff should be trained on how to present themselves and be encouraged to explain the new integrated care services to service users.

The integration programme appears to have not had much impact on reducing waiting time, because the findings show that both waiting time for assessment and for services within two weeks and four weeks were below the national achievement and ministerial targets.

The findings of this study present a complex picture because the impact of the integration programme on users was complex. Positive outcomes were achieved for some user groups and individuals but not for others. The outcome of improvement in physical functioning was achieved for some occupational equipments users but not for other services users. The outcome of improvement in satisfaction was achieved for most occupational health and physiotherapy users but not for social care users. Basic physical needs were met for some social care users and individual occupational health service user, but not for other social care users. Twenty eight users did not have a say or control over the services they received, whereas six users had such rights. The outcome of being treated as an individual and with respect was achieved for less than 40% of users who used different care services, not achieved for more than 40% of users who used intermediate care and/or social care, and 20% of users felt that they were treated as an individual with respect by some care staff, but not by others.

Social care service user group appeared to have achieved fewer positive outcomes than occupational health and physiotherapy user groups. Only 54% of social care service users found the services they had received satisfactory, compared with 85% of occupational health service users and 82% of physiotherapy service users. The majority of social care work was not intended to achieve these change outcomes and privatised long-term social care appears to have had some impacts on it, which is discussed earlier in this chapter.

My findings show that some of the care needs were not met, including domestic care, cleaning, shopping and gardening, nail care, home hairdressing and access to social contact and company for older people living in the community on their own. Although the integration programme was not actually designed to provide services to meet those needs, one of its shared visions and intended goals was to organise services around the needs of the older people. My findings about these unmet needs could provide useful information for the designers and managers of this or other integration programmes about designing and organising their services.

The fact that the positive outcomes were not in the overwhelming majority might be because my study was carried out at a relatively early stage of the integration. The impacts of total integration may continue to be felt for up to three years (McClenahan and Howard, 1999). The Labour government changed its emphasis on policies regarding health and social care integration from no structural reorganisation to integrating front-line services, a new organisational structure and developing new ways of working. With the encouragement of the government, Cambridgeshire developed this new model of total integration of health and social care with major organisational structural changes and integrated front-line services. My findings indicate that this has achieved some positive outcomes for some user groups. However, there is no clear evidence that it has achieved more positive outcomes for service users than other models of integration, with or without structural changes. This integration programme might have achieved more positive outcomes if it had reached all of its intended goals: very few service users were aware of Cambridgeshire Direct and the integration; Cambridgeshire Direct is not the single access point for all care services; and the referral, assessment, record keeping and computer systems of the integrated older people's care services are not yet fully

unified. However, even an absence of clear demonstrable positive outcomes might not necessarily be problematic because, as Dickinson (2008:48) suggests, integration is not 'necessarily a simple answer that will overcome any number of challenges'.

## 5.5 Limitations and strengths of the study

### 5.5.1 Limitations

My study has a number of limitations. First, the impact of the integration on the staff, from top-level managers down to the members of the locality team, is treated as tangential to outcomes for service users rather than as a main focus. The changing context and organisational changes of the integration programme have had some impact on the staff, especially the top PCT managers. When Cambridgeshire PCT replaced the four former PCTs there were far fewer posts for executives, directors and assistant directors. All the top managers had to apply for a job, either in the new PCT or somewhere else. Staff told me that the integration of social and health care for older people in Cambridge City PCT was further advanced than in the other three PCTs in the county. Some of the managers and staff of the City PCT were worried about the future of the integration programme. During my fieldwork the Chief Executive of Cambridgeshire PCT was not appointed until late 2007 or early 2008. Nobody knew who the new Chief Executive would be or where s/he would come from. If this person held different opinions about the current development of the integration programme in Cambridge City PCT the programme might go in a different direction. I could sense the anxiety of the staff of the Integrated Locality Team where I was doing the shadowing and my fieldwork. These organisational changes posed a threat to managers' job security and caused uncertainty in staff of the integration programme at Cambridge City PCT which unavoidably affected the

integration programme and, most importantly, impacted on all staff from the top down to the bottom, affecting their work and their perceptions of the integration programme. Hanson et al. (2007), in their inspection of services for older people in Cambridgeshire County Council, observe that staff experienced too many changes, which sometimes drew their attention and energy away from the users. Although many direct or noticeable impacts on staff of the integration programme were observed in this study, they are explored only to a certain extent, as described in the section on obstacles to the integration. The main focus of this study is the impact of the integration programme on service users, not the impact of the changing context and the integration programme on staff.

The second limitation of this study is that for various reasons the views of top-level managers are not adequately reflected in the thesis. I was unable to interview three directors and manager of the integration programme because all three had left their posts not long after the introduction of the programme, and one of the research participants and the programme designers declined to be interviewed. If I had talked to the designers or decision makers of the integration programme I would have had a clearer picture of why the integration programme was introduced and why they had expected it to achieve the desired outcomes, or I would have known whether they had thought about it carefully or not.

The third limitation of this study is that I was not able to fully grasp the impact of the ongoing organisational or structural changes that took place in the process of the integration. During my study there were organisational changes in the PCTs in Cambridgeshire. In view of these changes the contextual conditions section of this thesis is limited in that I was unable to fully grasp the nature of the changing outer contexts –changes in national economic, political and social contexts – and the

changing inner contexts – the ongoing strategy, structure, culture, management and political process.

During my research I experienced a difficulty caused by frequent personnel changes with the integration programme. Not long after the integration programme was introduced in April 2004 the Integration Project Director in Cambridgeshire left, and this post has not been filled since. Just before the merger between Cambridge City PCT and South Cambridgeshire PCT's senior management teams, the director and the manager of Older People's and Adult Services for Cambridge City PCT and the director of the Research and Development Department of Cambridge City PCT left their posts. The director of Primary and Community Services for Cambridge City and South Cambridgeshire PCTs moved on just before the reorganisation of the Cambridgeshire PCTs. These frequent personnel changes forced me make new contacts in the PCT several times and to change the key informants to be interviewed. This caused certain delay to my research.

**5.5.2 Strengths of my study**

Although this study has the above limitations, it is the first to offer insight into how the total integration of social and health care services in Cambridgeshire has benefited service users from their own perspective. Besides this, it has the following strengths.

First, it is based on a relatively large and comprehensive data set, which has helped to map out the entire process of the integration programme. Using different methods of data collection and analysis, both qualitative and quantitative, this study has collected and analysed a relatively large amount of comprehensive data, covering relevant policy documents, minutes of Cambridge City and South Cambridgeshire

PCTs Integration Steering Group meeting and Integration Project Board meetings, the managers and staff of the different professional groups in the integration programme and service users from eight user groups of the two Integrated Locality Teams. With the analysis of these data I have been able to explore the whole process of the integration programme and uncover its contextual conditions, implementation processes, causal mechanisms, intended gaols and service users' perceived outcomes.

Second, using theory-led programmatic approach this study does not simply look at and make the conjunctions of input and output/outcomes of the integration programme without opening the 'black box' as method-led evaluations appear to do (Dickinson, 2006). With an overview of the whole process of the integration programme, it explores the causal links in more detail and is able to make more confident statements about when and how the integration programme works, for who and in what contextual condition(s).

Third, this research focuses on the outcomes. Previous research into health and social care integrations overwhelmingly centres on process issues – how health and social care professionals work together – with much less concern for outcome success (Dowling et al. 2004). As Challis et al. (1988) and Hardy et al. (1992) argue, the evaluation of an integration should focus instead on the outcomes. The main focus of this study is the outcomes of the integration programme for service users rather than on its processes. By mapping out the whole process of the integration programme, identifying and examining its contextual conditions, implementation processes, causal mechanisms, intended gaols and achieved outcomes, this study shows how and why some of the change outcomes, maintenance or prevention outcomes and service process outcomes of the total integration of social and health care services in Cambridgeshire are achieved for some users but not for others.

# 6 Conclusion

In England, a wide range of services for older people used to be provided by different agencies. The whole system for delivering care was difficult to understand and did not always work efficiently. After over 50 years working separately, social care and health services for older people in Cambridgeshire were integrated in a comprehensive reform programme introduced in April 2004, initiating a unique form of total integration in the UK. This study analyses the implementation process and causal links of the integration programme and its outcomes for service users.

The study has adopted a theory-led pragmatic approach for its evaluation framework. The main advantage of this approach is that it enabled me to open up the 'black box' and to make more confident statements about when and how the integration programme worked or did not work, for whom and in what contextual condition(s). It also enabled me to incorporate some strengths of individual theory-led approaches and to better deal with the evaluation difficulties encountered with individual theory-led approaches, like theories of change and realistic evaluation.

This study has discovered the causal links of the integration programme, including its 17 contextual conditions, four main mechanisms, four implementation processes, (see Chapter 4) and reveals that these are strongly associated with the following outcomes.

The physical functioning of some users of occupational equipment had been improved through improvements in both individual mobility and the provision of equipment and/or adaptations. A small number of multidisciplinary care users were

able to recover faster from their illnesses. There was an improvement in satisfaction for most occupational health and physiotherapy users, but not for social care users. There was an increase in the number of older people with complex problems and high level needs who were helped to live at home; who were able to receive palliative care and die at home as they wished. There was a decrease in hospital and residential care admissions, and fewer delayed discharges from hospital.

The findings show that three of the integration programme's intended goals were not fully reached. First, Cambridgeshire Direct was developed as one of the ways the new integrated care service would operate. However, 97% of the service users I surveyed did not know of the existence of Cambridgeshire Direct, nor of the integration, the suggested reason being a lack of publicity, staff inaction in disseminating information about it, and service users' preference for their GPs as their first contact for care services.

The second unachieved intended goal was a single process of assessment and recording. The findings suggest that lack of a well-conceived design and sufficient funding and the incompatibility between different services' computer systems were the reasons that the single process of assessment did not materialise and integrated recording and record keeping was not achieved.

The third unachieved goal was unification of the care system. Cambridgeshire Direct was not the single point of access to all care services and the referral, assessment, recording, record keeping and computer systems of the integrated older people's care services are not yet fully unified.

My findings also show that waiting time for both assessment and for services within two weeks and four weeks were below the national achievement and ministerial targets. They show that positive outcomes were achieved for some user groups and individuals but not for others. The outcome of improvement in physical functioning was achieved for some occupational equipments users but not for other services users. The outcome of improvement in satisfaction was achieved for most occupational health and physiotherapy users but not for social care users. Basic physical needs were met for some social care users and individual occupational health service user but not for other social care users. Twenty eight users did not feel they had a say or control over services they received, compared with six who say they had. The outcome of being treated as an individual and with respect was achieved for less than 40% of users who used different care services, not achieved for more than 40% of users who used intermediate care and/or social care, and 20% of users felt that they were treated as an individual with respect by some care staff, but not by others.

The privatisation of long term social care and the majority of social care services aiming to achieve maintenance and prevention outcomes appeared to be associated with social care users' low achievement in terms of change outcomes; low levels of satisfaction with their care services; and their perception of not being treated with respect as an individual by staff.

Findings indicate that the structural changes of the integration programme were also associated with both positive and negative impact on staff members. The structural change involved in the integration – the co-location of different professional teams in the same office – led to better communication, enhanced knowledge of the work

cultures of other professionals and ensured closer collaborative working. This change also broke down barriers between different professionals, promoted communication, built trust, helped role sharing, promoted joint working and encouraged team gelling, and consequently increased staff satisfaction and improved services for users. This study found that the transfer of 900 social care staff from Cambridgeshire County Council Social Services into the four PCTs initially made some social service staff unhappy. Those who could not cope with these changes left their jobs. Some social services staff who were transferred from social services were concerned about losing their specialist role or their professional standing. My findings also indicate that the change to the structure and co-location of different disciplinary teams into one integrated team deprived the staff from occupational health of their professional managerial support and peer support and made some feel that their personal and professional development were compromised.

My findings show that some of the care needs were not met, including domestic care, cleaning, shopping, gardening, nail care, home hairdressing and access to social contact and company for older people living on their own in the community. Although the integration programme was not actually designed to provide services to meet those care needs, organising services around the needs of the older people was one of its shared visions and intended goals. The knowledge of those unmet needs could provide useful information for designers and managers of this or other integration programmes.

The original contribution to knowledge that this study has made is knowledge about how far the total integration of health and social care services in Cambridgeshire benefits service users from their own perspectives. This study is original because it is

the first evaluation of this unique form of total integration in England for a whole user group – older people. This study fills the gap in assessing the effect of collaborative working in community and creates a new understanding of the issues in this important social and health care reform, which include the transfer of all social care staff from the County Council's Social Services into PCTs to be employed by the NHS; the co-location of different disciplinary teams into the same office; the privatisation of long term social care; and the reorientation of homecare services toward a more health-care orientated service.

This study emphasises the impact of the integration programme on service users. Its impact and the changes it has introduced for staff members are only included as tangential to outcomes for service users. The possible link between the impact of the integration programme on staff members and its impact on services users could be explored in further research.

# References

# List of appendices

## Appendix 1: Result of initial literature search

| Databases searched | Integration AND health care and social care | Partnership AND social care and health care | Collaborative working AND social care and health care | Joint-working AND social care and health care | Realistic evaluation | Theories of change AND social care and health care | Programme theory |
|---|---|---|---|---|---|---|---|
| **Journal Article Databases** | | | | | | | |
| Academic OneFile | 15 | 13 | 1 | 3 | 4 | 0 | 8 |
| ASSIA: Applied Social Sciences Index and Abstracts (CSA) | 28 | 34 | 6 | 32 | 6 | 1 | 12 |
| Care Knowledge | 62 | 196 | 19 | 95 | 0 | 0 | 1 |
| JSTOR | 0 | 0 | 0 | 0 | 0 | 0 | 20 |
| Social Care Online (SCIE) | 2 | 0 | 0 | 0 | 12 | 2 | 14 |
| Social Policy and Practice including ChildData (Ovid) | 93 | 113 | 16 | 268 | 0 | 0 | 21 |
| Social Services Abstracts (CSA) | 124 | 177 | 6 | 37 | 47 | 2 | 10 |
| Sociological Abstracts (CSA) | 75 | 97 | 2 | 9 | 72 | 1 | 7 |
| Web of Science via the Web of Knowledge (ISI) | 3 | 0 | 0 | 1 | 3 | 2 | 20 |
| Wiley InterScience Journals | 40 | 57 | 28 | 26 | 13 | 32 | 26 |
| **Research & Data Sources** | | | | | | | |
| Campbell Collaboration (C2) | 1 | 2 | 0 | 0 | 0 | 1 | 2 |
| Health Profiles - Association of Public Health Observatories (APHO) | 2 | 8 | 1 | 0 | 0 | 0 | 0 |
| UK National Statistics Publication Hub (Office of National Statistics) | 0 | 8 | 8 | 9 | 11 | 0 | 0 |
| **Internet Gateways** | | | | | | | |
| Intute: Social Sciences | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Intute: Statistics and Data | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| **Total 2069 hits** | 445 | 705 | 87 | 482 | 168 | 41 | 141 |

# Appendix 2: Models of Health and Social Care Integration

| Models | Programme | Definition | Stakeholders | Source |
|---|---|---|---|---|
| Integrated activities | A Midlands County | Co-locating social workers into fund-holding general practices or health centres within which three separate practices are located for adult services. | Primary care and social services. GP, district nurses and social workers. | Lymbery, 1998 |
| | Day centre rehabilitation in Huntingdon and St Neots | Augmenting visiting physiotherapists in social services day centres. | NHS hospital and social services | Burch et al., 1999 |
| | South Worcestershire | Base social workers in general practices | Primary health care and Social Services, GP and social workers. | Cumella et al., 1996 |
| | England and Wale | 34 of 109 (80 participated in a national survey) Social Services departments in England and Wales which existed before 1 April 1996 have practice-based social work schemes | Primary health care and Social Services, GP and social workers. | Cumella et al., 1996 |
| | Northern and Yorkshire NHS | Co-locating social services care managers in general practices | Primary health care and Social Services, GP, community nurses and social workers. | Callaghan and Hudson, 2000 |
| | A London borough | Locating a district nurse care manager in each social work team for the assessment of very complex health needs. | One health authority, one NHS Community Health Services Trust, social workers and district nurses | Levin et al., 2002; Davey et al., 2005 |
| | A London borough | Co-locating five social work teams for older people and adults with physical disabilities in health centres with some community nurses. Some centres have a GP in the building. | One health authority, one NHS Community Health Services Trust, and 99 general practices, social workers, community nurses and GP. | Levin et al., 2002; Davey et al., 2005 |
| | Support service for children with disabilities and complex needs | Health, social services and education staff contributing time and resources to improve liaison, minimise appointments and | On hundred staff from health, social services and education | See service A in Abbott et al., 2005 |

| | | | |
|---|---|---|---|
| | reviews for families and provide access to a named key worker for families | | |
| Support service for children with disabilities and complex needs | Health, social services and education staff working together to provide coordinated support and services by providing families with a named key worker | Project manger funded by NHS: fifty staff from NHS, social services and education work as part of the service as key workers. | See service E in Abbott et al., 2005 |
| On-Track | Floating support service includes helping young people with dual diagnosis to engage with relevant health and social care services | NHS Trust, Community Mental Health Services, Substance Misuse Service, Local Supporting People Team, Housing Associations and voluntary mental health group | Cameron et al., 2007 |
| SWAN NEST | Provision of supported housing and support to women wanting to exit the sex trade, including help to engage with relevant health and social care services | Primary Care Trust, Borough Council, Police, General Practice, voluntary sector Drug and Alcohol service | Cameron et al., 2007 |
| Place to Live | Provision of supported housing and supported living for people with learning disabilities. Promoting their health status. Support to move into independent living if appropriate | Primary Care Trusts, Borough Council, Social workers, learning disability nurses | Cameron et al., 2007 |
| Sure Footed | Integrated falls services | City Council Housing and Planning Services, Community, Health and Social Services, Primary Care Trust, Age Concern and Service User representatives | Cameron et al., 2007 |
| Housing support outreach and referral project | Floating support services for hard to reach individuals living with HIV, including help to engage with relevant health and social care services | London Boroughs' Supporting People Administering Authorities, Primary Care Trust and Terrence Higgins Trust/Lighthouse | Cameron et al., 2007 |
| Spiders | Raising older people's awareness of the local | Supporting People Administering | Cameron et al., 2007:3 |

| | | | | |
|---|---|---|---|---|
| | | Supporting People programme and its relevance to the 'health agenda' | Authority, Primary Care Trust, County Council Social Services | |
| Integrated teams | Care teams for older people living in the community in Wiltshire | Co-locating integrated health and social care teams for older people living in the community in large fund-holding general practices. | Social services and health authority. GPs, social workers, social work assistants, occupational therapists, occupational therapy assistants and district nurses | Tucker and Brown, 1997; Brown et al., 2003 |
| | Locality commissioning teams in Sandwell | Developing an integrated working model of locality commissioning and promoting health by addressing inequalities in health. | Sandwell Health Authority, Sandwell Metropolitan Borough Council, GP, Health Authority Commissioning Manager, Social Services Department Locality Manager and Senior Health Promotion Officer | Evans and Killoran, 2000 |
| | Rehabilitation teams in Northumberland | Creating integrated primary health and social care rehabilitation teams made up of a co-ordinator, occupational therapists and generic rehabilitation workers. | Care co-ordinator, occupation therapists and generic rehabilitation workers | Carrier, 2002 |
| | Care management teams in Leeds | Establishing integrated care management teams which track older people through their stay in hospital and make sure they return home as early as possible | Nurses, therapists, social welfare assistants and social workers | Audit Commission, 2002 |
| | Discharge planning team at St Mary's Hospital Paddington | Establishing integrated discharge planning team which tracks older people through their stay in hospital and makes sure they return home as early as possible | Nurses, therapists, social welfare assistants and social workers | Audit Commission, 2002 |
| | Children's Support Team | Creating integrated team for disabled children aged 0-19 to provide access to a | Sixteen staff from a range of professional disciplines | See service B in Abbott et al., 2005 |

| | | | | |
|---|---|---|---|---|
| | | named key worker | employed directly by the service | |
| Integrated residential rehabilitation unit | Residential rehabilitation unit in Devon | Short-term residential rehabilitation unit for older people discharged from hospital to improve mobility and regain the skills needed to live at home as independently as possible | Care and rehabilitation assistants, occupational therapists, physiotherapist | Trappes-Lomax et al., 2006 |
| Integrated care management system | Bedfordshire, Haringay, Hounslow and Leicester | Integrating the care programme approach (CPA) and social services care management into a single system | Health and social services | Edwards and Miller, 2003 |
| | Integrated Children's Support Service | Integrated care system for children with complex needs aged 0-5 years through a multi agency steering group; single assessment and care plan tool; access to named key worker. | Project manager and secretary employed by education[1]. Sixty health, social services and education staff[2] work together as part of the service. | See service D in Abbott et al., 2005 |
| Integrated organisation with joint management | Edith Summer Skill Unit managed by Harlow Primary Care Trust and Hertfordshire County Council and nine other such partnerships | Setting up strategic partnerships between councils and their NHS partners to develop community services for older people to reduce the number of emergency bed days for local people over 75 | Multidisciplinary team of nursing and care staff, social workers and therapists | Department of Health, 2005a |
| Partnership Health and Social Care NHS Trust | Somerset Partnerships Health and Social Care NHS Trust | Joint commissioning and creation of a combined mental health and social care provider. Transferring majority of Social Services' mental health staff to the Trust | Somerset Health Authority and County Council | Peck et al., 2001; Gulliver et al., 2002; Peck et al., 2002 |
| | Camden and Islington Mental Health Trust | Setting up Partnership Health and Social Care NHS Trust | | Department of Health, 2002a |
| Integrated care services for user group | Integrated Older People's Care Service in Cambridgeshire | Integrating health and social care service for a whole service user group – older people. Transferring all social | Primary Care NHS Trusts and Cambridgeshire | Cambridge City Primary Care Trust, 2004 |

[1] It was not clear whether "education" here means Ministry of Education or local educational authorities.
[2] Education staff includes educational psychologists, specialist teachers, senior educational officers, portage workers, operational managers, senior/strategic managers and nursery nurses.

| | | | |
|---|---|---|---|
| | services older people's social care staff into PCTs | County Council | |
| Witham, Braintree and Halstead Care Trust | Setting up a care trust responsible for local health services for everyone living in the area and for integrated health and social care services for local user group -- older people | NHS organisations, Essex County Council and Braintree District Council. | Department of Health, 2005a |

# Appendix 3: Abbreviated Mental Test Score

Code_____

Date_____

Abbreviated Mental Test Score

EACH QUESTION SCORES ONE POINT

1. What is your age? ☐
2. What is the time to the nearest hour? ☐
3. An address - for example 42 West Street - to be

repeated by the patient at the end of the test ☐
4. What is the year? ☐
5. What is the name of the care home/day centre or

number of the residence where the patient is situated? ☐
6. Can the patient recognise two persons (the nurse,

health care assistant, home help, etc.)? ☐
7. What is your date of birth? ☐
8. In which year did the First World War begin? ☐
9. What is the name of the present monarch or PM? ☐
10. Please count backwards from 20 to 1 ☐

Total score_____

# Appendix 4: Questionnaire

Anglia Ruskin University

20 November 2006                                    Code_____

Version 5                                            Date _____

                                                    AMT_____

## Users Survey

1. **Are you?**

Male□

Female□

2. **Which age group are you in?**

65-69□

70-79□

80-89□

90-99□

100 and over□

3. **Where do you live?**

In my own house □

In a private rented house □

In a social house □

In sheltered housing □

In very sheltered housing □

In a residential home □

In a nursing home □

Others (_____) □

**4. Who do you live with?**

With your spouse □

With your family □

With your relative(s) □

On your own with support of family or friends □

On your own without support of family or friends □

With carer □

**5. What care services did you ask for?**

To be visited by DN □

To be visited by HCA □

To be visited by CPN □

Personal care □

Medication □

Home Based Personal Support (day sit/night sit/living in) □

Mobility □

Meal prep □

Laundry □

Bed change □

Day care □

Choices Meals □

Respite care □

Permanent care □

Seen by a PT □

See by an OT (Assistive equipments) □

Others (_____) □

**6. Who did you contact first? (Referred by _____)**

'Cambridgeshire Direct Contact Centre' □

'NHS Direct' □

Your GP □

Community nurse □

Social worker/Care manager □

Hospital consultant □

Discharge planning □

Others (_____)□

Do not know □


**7. When did you first contact?**                    _____2004 □

_____2005 □

_____2006 □


**8. Who responded?**                    _____


**9. How satisfied you were with the first contact**


Very         Dissatisfied      Neither dissatisfied  Satisfied    Very

dissatisfied                          nor satisfied          satisfied

1        2         3          4       5      NA

□         □          □           □       □          □


**10.  How many days after the first contact were your health and social care needs assessed?**

1-7 days □

8-14 days □

15-21 days □

22-28 days □

_____ 5-8 weeks and over □

Do not know □

Never had □

_____ Waiting for □

**11. Please rate how satisfied you were with the assessment**

| Very dissatisfied | Dissatisfied | Neither dissatisfied nor satisfied | Satisfied | Very satisfied | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | NA |
| □ | □ | □ | □ | □ | □ |

**12. How long after the assessment did you get the services your were assessed for?**

1-7 days □

8-14 days □

15-21 days □

22-28 days □

_____29 days and over □

Do not know □

Waiting for □

NA □

**13. After the assessment have you got the appropriate services you needed?**

Yes □

No □

Not sure □

NA □

**14. Please rate how satisfied you are with the care services you received.**

| Very dissatisfied | Dissatisfied | Neither dissatisfied nor satisfied | Satisfied | Very satisfied | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | NA |
| □ | □ | □ | □ | □ | □ |

**15**. **If you have more than one services how satisfied you are with the other services?**

| Very | Dissatisfied | Neither dissatisfied | Satisfied | Very |
|---|---|---|---|---|
| dissatisfied | | nor satisfied | | satisfied |

| 1 | 2 | 3 | 4 | 5 | NA |
|---|---|---|---|---|---|
| □ | □ | □ | □ | □ | □ |

**16.** **If you have any problem with your care do you know whom to contact?**

Yes □ Who _____

No □

Not sure □

**17**. **Who is responsible to your care?**                    _____

**18**. **Please rate how satisfied you are with the person responsible to your care?**

| Very | Dissatisfied | Neither dissatisfied | Satisfied | Very |
|---|---|---|---|---|
| dissatisfied | | nor satisfied | | satisfied |

| 1 | 2 | 3 | 4 | 5 | NA |
|---|---|---|---|---|---|
| □ | □ | □ | □ | □ | □ |

**19.** **How would you rate the quality of your overall experience of using services?**

Very poor □

Poor □

Satisfactory □

Good □

Excellent □

Can't say □

20. **Did you know the Cambridgeshire Direct Contact Centre when you applied for the care service?**

Yes □

No □

Not sure □

21. **Did you use these care services before 4/2004?**

Yes □

(No □

Not sure □

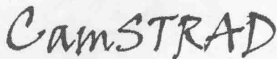22. **If yea in Q21, what do you think of the services?**

Better □

Worse □

Same □

Not sure □

NA □

23. **Do you have any comment you would like to make about the services?**

_____

_____

_____

_____

_____

_____

# Appendix 5: Research Governance Approval from Cambridge City and South Cambridgeshire PCTs

**CamSTRAD**

Cambridgeshire Support Team - Research and Development

Cambridgeshire Research Development and Support Group

Nightingale Court, Ida Darwin
Fulbourn, Cambridge CB1 5EE
Tel: 01223 884488; fax: 01223 884038
E-mail: camstrad@cambcity-pct.nhs.uk
www.camstrad.nhs.uk

Peterborough and Cambridgeshire
Primary Care Research Network

**NHS**

**Cambridge City and South Cambridgeshire
Primary Care Trusts**

15th May 2006

Camstrad
Nightingale Court
Ida Darwin
Fulbourn
Cambridge
CB1 5EE

Dear Mei Hu

**Re: Project Title What is the impact of the new older people's services in Cambridgeshire on service users**
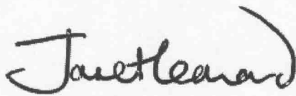
**Re: Project Number L00617**

The research project has been reviewed for Cambridge City and South Cambridgeshire Primary Care Trusts in accordance with the Department of Health Research Governance Framework and in compliance with Standards for Better Health.

Please accept this letter as confirmation of Primary Care Trust's positive governance review. This review is subject to the enclosed terms and conditions and unless we hear within a month from the date of this letter, we assume you are abiding by these conditions.

We would welcome feedback about your experience of this review process to help us improve our systems. May we take this opportunity to wish you well with your research and we look forward to hearing the outcomes.

Yours sincerely

Janet Leonard
Assistant Director of Quality Performance
Cambridge City and South Cambridgeshire Primary Care Trusts
cc Steve Young (R & D Team), Caroline Peet, David Vickers

# Appendix 6: Research Governance Approval from Cambridgeshire County Council

Your ref:

My ref:     JY/jl

Date:     6th September 2006

Contact:     Joseph Yow
Direct Dial:     01223 717165
E Mail:     Joseph.yow@cambridgeshire.gov.uk

**Office of Environment & Community Services**
Deputy Chief Executive, Brian Smith

**Adult Support Services**

Mei Hu
56 Wycliffe Road
Cambridge
CB1 3JE

Box No: SS1007
Castle Court
Shire Hall
CAMBRIDGE
CB3 0AP
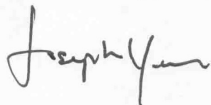
Dear Mei,

Re: **What is the impact of the new integrated older people care services in Cambridgeshire on service users?**

Please find enclosed the Research Governance Framework's approval checklist confirming that you have been given approval to conduct the above mentioned research project.

I would like to take this opportunity to wish you well with your research and we look forward to hearing your findings.

Yours sincerely,

Joseph Yow
RGF Co-ordinator for Adult Social Care

Enc.

Cc Sarah Lindsell

2006-2007
Delivery of Quality Services Through Procurement
Waste and Recycling
2005-2006
Asset Management
2004-2005
Better Local Public Transport

Beacon Council

INVESTOR IN PEOPLE

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**Appendix 7: Satisfaction level responses card**

**Very dissatisfied**


**Dissatisfied**


**Neither dissatisfied nor satisfied**


**Satisfied**


**Very satisfied**

**Appendix 8: Quality responses card**

**Very poor**


**Poor**


**Satisfactory**


**Good**


**Excellent**


**Can't say**