Chapter 1: Introduction

Background

This thesis explores the integration of care services for people living with chronic conditions. With recent demographic change seeing a major global growth in the numbers of people living with chronic conditions (World Health Organization [WHO], 2014), these are people whose care needs, many argue, are best met by integrated care (Goodwin et al., 2012). The latter's organising principle, it is widely agreed, should be the service user perspective and its fundamental objective the improvement of their care (Goodwin et al., 2012). Existing research, however, has largely failed to take account of the views of service users and of the outcomes they value (Cameron et al., 2012). I attempt to address this research-gap in this thesis, a qualitative case study of the introduction of a new integrated health and social care community Chronic Conditions Management (CCM) service in the Bro-y-Grug locality of the south Wales unitary authority of Armorshire. (For purposes of anonymity and confidentiality, Bro-y-Grug and Armorshire are pseudonyms, as are the names of all of the places and people directly involved in the introduction of this service, unless otherwise indicated). I do this by considering, from an interpretevist standpoint and drawing on multiple data-collection methods, the way in which integrated care for people living with chronic conditions developed during the implementation of the new service. The latter was inaugurated during Bro-y-Grug's participation – as part of the Armorshire demonstrator-site – in Wales' National CCM Demonstrator Programme.

In this opening chapter, I discuss the terminology and characteristics of chronic conditions, before exploring the rise in prevalence of chronic conditions worldwide amidst demographic change. I examine the impact these changes are having on global health and social care systems, describing how existing systems were not designed to manage the complex, multiple and long-term needs of people living with chronic conditions, but according to an acute and episodic model of care. I discuss the importance of self-management, empowerment and involvement to chronic conditions care. I describe how different countries have sought to address current pressures on health and social care systems by looking to disease management and,

in particular, to integration. I review the Welsh CCM Model and Framework, explaining that this, likewise, is premised on integration, self-management, service user involvement and empowerment. Subsequently, I outline the National CCM Demonstrator Programme and provide some background information about the Bro-y-Grug locality. I describe my own interest in integrated working and the care of people living with chronic conditions, prior to setting out the study's aim and objectives. I end the chapter with an overview of the remainder of the thesis.

Chronic conditions: terminology and characteristics

Alabaster (2006) suggests that an analysis of terminology is an essential starting point for any discussion related to the field of chronic conditions, but adds that its multifaceted nature militates against definitional precision. Indeed, this is reflected in the fact that in the Department of Health (DH) publication *Improving Chronic Disease Management* (DH, 2004, p. 1) it is noted that a number of terms – such as 'chronic condition', 'chronic disease', 'life-long disease/condition', 'long-term disease/condition' and 'non-communicable disease/condition' – are used interchangeably. Extending this list to include, 'chronic illness' and 'chronic illness and disability', Wellard (2010) likewise refers to the interchangeable use of terms, before adding that related literature is characterised by a frequent failure to acknowledge differences or define terms clearly. This, despite stressing that such a lack of clarity can, 'blur meanings and assumptions inherent in the arguments presented by authors' (2010, p. 2). (It is of note that a lack of clarity and consensus *vis-à-vis* terminology, definitions, meaning and conceptualisation[1] is a feature of many of the themes discussed in this thesis, as will become apparent in the course of this and subsequent chapters).

Whilst it is beyond the scope of this thesis to examine the differences between the many terms used within the field, it is perhaps helpful to clarify some basic concepts. Chronicity, first of all, relates to the temporality of a condition where changes in health are ongoing and cannot be cured by a short course of treatment or surgery (Miller, 2000). Disease, secondly, refers to the assignment of a diagnosis (Wikman et al., 2005) or the practitioner's view of pathophysiological alterations in a person's

[1] Conceptualisation, according to Brett et al. (2009, p. 31) is, 'the way a phenomenon is described, defined and understood'

condition associated with an objective medical view of a human ailment (Hofmann, 2002). Illness, thirdly, refers to the perceived human experience of living with and responding to disease (Taylor, 2005) and its subjective interpretation (Hofmann, 2002). Disability, finally, identifies any long-term or permanent loss or reduction in functional capacity (Alabaster, 2006).

As for the use of 'condition', Wellard (2010) notes that this has emerged as part of a recent movement to create, 'an umbrella term that will be inclusive of the different understandings of chronic ailments and link different audiences to look more at the overarching issues related to chronicity in the world'. In England, frequent reference is made to *long-term* conditions (LTCs) (see, for example, DH, 2008; 2010; 2012) whereas in Wales, frequent reference is made to *chronic* conditions (see, for example, Welsh Assembly Government [WAG][2], 2007; 2008; Wales Audit Office [WAO]; 2008; 2014). The definitions adopted in both countries, however, draw attention to the life-changing impact of living with a condition from which there is currently no hope of recovery:

> LTCs are those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal' (DH, 2008, p.10).

> Chronic conditions are those which in most cases cannot be cured, only controlled, and are often life-long and limiting in terms of quality of life. They can require differing levels of support due to disease progression or the fluctuating nature of the disease (WAG, 2007, p. 7).

Given the range of terminology used in this field, I make use of a variety of terms in this thesis, but for the most part employ the term chronic condition. Firstly, because the locality in which the new CCM community service that I researched was in Wales; secondly, because condition is a term which, Wellard (2010) points out, is used increasingly in health and social care projects – like the introduction of the new CCM service in Bro-y-Grug – that involve a number of different stakeholders[3]. According to O'Halloran et al. (2003, p. 100), 'Chronic conditions may be characterised by the following criteria: a duration that has lasted, or is expected to

[2] In keeping with current usage, I use the term'Welsh Government' throughout this case study.
[3] Stakeholders, according to Crosby and Bryson (2005, p. 22) are the, 'individuals, groups, or organisations that are affected by a public problem, have partial responsibility to act on it, or control important resources'.

last, 6 months; an insidious onset; an uncertain or poor prognosis; and the possibility of sequelae'. Alabaster (2006), likewise, notes that chronic conditions are generally associated with the presence of a protracted disease process – often considered as one which lasts for more than six months – which results in impairment or disability, and which is not amenable to treatment.

Carrier (2009), in turn, specifies that all chronic conditions continue indefinitely but that there is no single onset pattern, and adds that there can be long periods of remission with an absence of symptoms punctuated by episodic exacerbations. Carrier (2009) notes that the list of chronic conditions is long, including: diabetes, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease and musculoskeletal diseases such as arthritis and osteoporosis; neurological conditions such as epilepsy, multiple sclerosis, Parkinson's disease and motor neurone disease; skin conditions such as psoriasis and eczema; genetic conditions such as cystic fibrosis and muscular dystrophy; and mental conditions such as schizophrenia and dementia. Significant improvements in the diagnosis and treatment of cancer mean that this too can be understood as both an acute and chronic illness (Tritter, 2009). Similar advances have also rendered a number of communicable diseases chronic, such as HIV and AIDS (Richardson, 2009). Depression, too, is a long term condition and is considered by some to be more common than many of its physical counterparts (Mitchell et al., 2009).

Alongside the diversity of terms used to designate ailments characterised by their chronicity, it has been indicated that a diversity of terms are used to denote people who currently use health and social care services (which includes people living with chronic conditions) and members of the wider public who may need to do so at some future time (Hanley et al., 2004). Accordingly, reference is made, *inter alia*, to, 'the community', 'the public', 'clients', 'patients', '(service) users', 'survivors[4]' 'citizens[5]', 'taxpayers', 'consumers' and 'lay people[6]'. However, it is argued that –

[4] In the field of mental health services, 'survivor' is sometimes the preferred term in the UK, reflecting some service recipients' objections to the term 'service user' (Rogers and Pilgrim, 2010).
[5] Beresford and Croft (1993) indicate that notions of 'citizens' and of 'citizenship' are contested and explain that whereas the 'political right' often conceptualise citizenship in terms of obligations and responsibilities, the 'political left and centre' often do so in terms of a basis for people's rights.
[6] According to Hogg and Williamson (2001, p. 3), 'lay people' are, 'those who have not gone through the training or the socialisation into the particular profession under discussion'.

despite having divergent meanings and connotations – these designations are often unclearly defined and arbitrarily interchanged (see, for instance, Boote et al., 2002; Wait and Nolte, 2006; Conklin et al., 2010; 2012; Naidoo and Wills, 2011; Baggott, 2011; Mockford et al., 2012).

Focussing on people living with chronic conditions, it is widely recognised that their care needs are complex and span many different health and social care services (a subject to which I return later in this chapter). It is therefore of note that whilst Martin et al. (2010, p. 93) point out that 'patient' and 'client' are the favoured terms used in health care and social care respectively, they add that 'service user' is neutral; as for the lay-person who provides a significant amount of support to a person who is in need of both health and social care, Martin et al. (2010, p. 93) explain that she or he is often termed 'carer'. Given that in this thesis I explore the creation of a service that sought to integrate health and social care – and in keeping with their common usage in current Welsh Government (WG) documentation (see, for instance, WAG, 2007; 2008; WG, 2012; 2013) – for the most part I therefore employ the terms service user and carer.

Having discussed issues of language and characteristics pertaining to the field of chronic conditions, set out some of the different conditions that can be considered chronic and explored some of the terms used to describe the users (and potential users) of services, in the next section I discuss the growing prevalence of chronic conditions worldwide.

Demographic change: increasing numbers of people living with chronic conditions

In a joint-report on global ageing by the National Institute on Aging (NIA)/National Institutes of Health (NIH)/United States Department of Health and Human Services (USDHHS) and the WHO (2011, p. 2) it is noted that the world is on the brink of reaching a, 'demographic milestone'. The milestone, it is explained, is that for the first time in recorded history, the numbers of people aged sixty five or older in the world will soon outnumber children aged under five. It is further noted in the report that the 2010 global population of an estimated 524 million people aged sixty-five or older is projected to grow to nearly one and a half billion by the year 2050.

Focussing on Europe, in a WHO (2012) publication strategy and action plan on ageing, it is reported that the European Region has the world's highest median age and that residents of many European countries have some of the world's highest life expectancies. It is further noted that the population of Europe is ageing rapidly and that, according to current estimates, by the year 2050 around a quarter of people will be aged sixty-five or older. In an Office for National Statistics (ONS) report on population ageing across Europe and in the UK (ONS, 2012), it is indicated that the latter's population is ageing and that this trend is expected to continue over the coming decades. Of the UK's four constituent countries, moreover, attention is drawn in the same report to the fact that Wales was consistently the most aged between 1985 and 2010 and that it currently has the highest median age and highest proportion of people aged sixty-five or over. Indeed, with eighteen percent of the population of Wales already aged sixty-five and over (National Public Health Service for Wales [NPHSW], 2006), this figure is projected to increase to around thirty-two percent between 2010 and 2026 (WG, 2013).

Moreover, the ONS (2013) reports that women and men now aged sixty-five in England and Wales are expected, on average, to live for another twenty-one and nineteen years respectively. Indeed, according to the NIA/NIH/USDHHS/WHO (2011), the number of people aged eighty-five and older (whom, Glasby [2012, p. 47] notes, are often termed the 'oldest old') is burgeoning worldwide, and in many developed countries is the fastest growing part of the population. With the number of people aged eighty-five and over in England and Wales having doubled in the past three decades (ONS, 2013a), the highest proportion (five percent) of people aged eighty and over of any part of the UK lives in Wales (WG, 2013d). Furthermore, it is currently predicted that by the year 2020, the proportion of people aged eighty-five and over in Wales will increase by twenty-two percent (Daffodil, 2014).

Many of the reasons for these demographic changes can be traced back to advances in medical care, better public and preventive health measures and improvements in the socio-economic well-being of populations (ONS, 2009; Sadana et al., 2013). The NIA/NIH/USDHHS/WHO (2011) reports that greater longevity can, in part, be attributed to public health projects carried out in the course of the twentieth century that immunised millions of people against contagious diseases (such as smallpox,

polio and measles) as well as to improved living standards, more nutritious diets and cleaner drinking water, all of which have helped reduce serious infections and prevent deaths. But the significant fall in morbidity and mortality due to infectious and acute diseases, adds the NIA/NIH/USDHHS/WHO (2011, p. 9), has been accompanied by a marked rise in chronic and degenerative diseases, in a major shift which demographers and epidemiologists have labelled the, 'epidemiological transition' (see, for instance, WHO, 2002; 2014a).

With a significant growth in the incidence of chronic conditions witnessed in industrialised and affluent nations (Wellard, 2010) similar issues are also affecting parts of the developing world (WHO, 2011). Globally, the proportion of years of life lost (YLL)[7] resulting from non-communicable diseases (NCDs) increased from thirty-eight percent in 2000 to forty-seven percent in 2012 (WHO, 2014a). Chronic conditions currently account for sixty-three percent of all global fatalities (WHO, 2011) seventy-two percent of the global disease burden of people aged over thirty (Strong et al., 2005) and eighty-six percent of all fatalities and seventy-seven percent of the disease burden in Europe (WHO, 2007b). NCDs are currently the leading cause of death in all of the world's countries bar sub-Saharan Africa (Population Reference Bureau [PRB], 2012). In some parts of Europe, as many as forty percent of people aged fifteen or over report a long-standing health problem (European Commission, 2007). In the United Kingdom (UK), more than seventeen and a half million adults report living with a chronic health problem (DH, 2005). In Wales, one third of all adults (800,000 people) report having at least one chronic condition (National Public Health Service for Wales [NPHSW]/Welsh Assembly Government [WAG], 2006).

Furthermore, a growing number of people are living with more than one chronic condition, explain Jadad et al. (2010). Reporting that there is 'no accepted terminology for this phenomenon', Jadad et al. (2010, p. 21) note that the terms most commonly used are, 'comorbidity', 'polypathology', 'pluripathology', 'multimorbidity', 'multipathology' and 'complex chronic disease'. Irrespective of

[7] According to the WHO (2014a, p. 45), 'YLL due to premature mortality are calculated from the number of deaths at each age multiplied by a global standard life expectancy of the age at which death occurs'.

how the phenomenon is termed, however, data consistently shows that the numbers of people living with more than one chronic condition outnumber those living with one chronic condition (Jadad et al., 2010; Barnett et al., 2012; DH, 2012; WHO, 2014a). In Wales, for example, comorbidity is reported by a third of all people who report living with a chronic condition (NPHSW/WAG, 2006). The existence of multiple chronic conditions is associated with worse health outcomes such as poorer health-related quality of life and higher mortality, whilst people living with multimorbidity are higher users of care than those without (see, for instance, Gijsen et al., 2001; Wolff et al., 2002; Fortin et al., 2004; 2007; Kadam et al., 2007; Lee et al., 2007; Perruccio et al., 2007; Commonwealth Fund, 2010).

Arguably, the global scale of the issue of chronic conditions is nowhere more clearly illustrated than in the opening paragraph of the draft political resolution of the 2011 High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases:

> We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations from 19 to 20 September 2011, to address the prevention and control of non-communicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts, particularly for developing countries,
>
> 1. Acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century (United Nations General Assembly, 2011, p. 1).

There are correlations between long-term ill-health and socio-economic factors such as deprivation, income-disparity and lifestyle ,which mean that increasing numbers of people of all ages – including children and young people – are developing chronic conditions (see, for instance, Pomerleau et al., 2008; van Cleave et al., 2010; Global Alliance for Chronic Diseases [GACD], 2012; WHO, 2014). But it is widely recognised that a major contributory factor to the epidemiological transition is demographic change and increased longevity (see, for instance, Carrier, 2009; WHO, 2011; 2014a; Barnett et al., 2012; DH, 2012; Nolte et al., 2012; PRB, 2012; Goodwin et al., 2014). The reason for this is that physiological changes that occur as people grow older increase their risk of developing one or more chronic condition

(s) (see DH, 2010; 2012; Barnett et al., 2012; PRB, 2012; Coulter et al., 2013; Oliver et al., 2014; WHO, 2014a).

The NIA/NIH/USDHHS/WHO (2011) reports that among the world's population of people aged sixty and over, NCDs account for more than eighty-seven percent of the disease burden. Indeed, the WHO (2011) reports that a quarter of the global population of sixty-five to sixty-nine year-olds is living with more than one chronic condition, a figure that rises to half of people aged between eighty and eighty-four. Fifty-eight percent of people aged sixty and over report living with at least one chronic condition in England (DH, 2012), with two thirds of people aged over sixty-five reporting living with at least one chronic condition in Wales (National Public Health Service for Wales [NPHSW]/Welsh Assembly Government [WAG], 2006).

Moreover, there is a strong association between ageing and the existence of multimorbidity (see van den Akker et al., 1998; Vogeli et al., 2007; Walker, 2007; Marengoni et al., 2011; Salisbury et al., 2011; Barnett et al., 2012; Banerjee, 2015). Although exact figures are contested (Pomerleau et al., 2008), studies from across the world consistently show that more than fifty percent of older people are living with multimorbidity (Marengoni et al., 2011). In some parts of Europe, for instance, two thirds of people of pensionable age report living with at least two chronic conditions (van den Akker et al., 1998; Wolff et al., 2002) and in Wales, half of people aged between eighty and eighty-four and three-quarters of people aged over eighty-five report having a limiting long-term illness (NPHSW/WAG, 2006). In the next section I describe the impact these factors are having on the world's health and social care systems.

Health and social care systems under pressure: the need for change

In the previous section, I drew attention to the global impact of demographic change and the associated epidemiological transition and increase in the numbers of people living with chronic conditions. With thirty-eight million (sixty-eight percent) of the world's fifty-six million fatalities in 2012 attributable to NCDs (WHO, 2014) it is widely recognised that the burden of chronic conditions is assuming ever more magnitude, with chronic illness set to affect an increasing proportion of the world's

population in coming years (see, for instance, Mathers and Loncar, 2006; WHO, 2010; 2014; NIA/NIH/USDHHS/WHO, 2011; Global Burden of Disease Mortality and Causes of Death Collaborators, 2015).

Many commentators point out that the repercussions of these changes for the organisation of health and social care systems worldwide are far-reaching (see, for instance, Carrier, 2009; Wellard, 2010; Goodwin et al., 2014; Oliver et al., 2014). There are numerous reports, for instance, that the financial and human resources required to meet the complex needs of people living with chronic conditions are impacting on many aspects of service provision, with the growth in numbers of older people greatly increasing the burden on national economies worldwide (see, for instance, Suhrcke et al., 2006; 2008; Pomerleau et al., 2008; Busse et al., 2010; Nolte et al., 2012; Nolte and Pitchforth, 2014). According to Nolte et al. (2012) whilst these challenges require effective measures to prevent disease – for instance, by reducing risk factors and addressing the influences that drive exposure – they also call for the development of services that better meet the requirements of people living with chronic health problems.

With countries throughout the world facing analogous pressures (see Suhrcke et al. 2006; 2008; Carrier, 2009; Legido-Quigley et al., 2013; Nolte and Pitchforth, 2014) the UK has not escaped this trend (see Carrier, 2009; Coulter et al., 2013; Goodwin et al., 2014; Oliver et al., 2014). On the contrary, the DH (2012) reports that the increasing numbers of people living with chronic conditions are placing considerable and growing demands on numerous levels of care provision, from community services to emergency care and acute hospital services. The DH (2012, p. 3) reports that in England, for instance, people living with chronic conditions account for: half of all General Practitioner (GP) appointments; sixty-four percent of all outpatient appointments and seventy percent of all inpatient bed days. Moreover, with the DH (2012, p. 10) stressing that people living with LTCs are, 'the most intensive users of the most expensive services', it also notes that seventy percent of the entire health and care spend in England is given over to providing care for people living with chronic conditions, a disproportionately high level given that they constitute thirty percent of the population.

Moreover, the WAO (2014) warns that given the projected rise in the population of people aged sixty-five and over in Wales in coming years, the prevalence of chronic conditions is likely to place an ever-increasing burden on Welsh health and social care services. At the same time, however, the austerity measures of the Conservative/Liberal Democrat Coalition Government, whilst less far-reaching than some areas of the UK, have seen a real-term reduction in central government funding for Welsh councils (WAO, 2011).

But amidst growing pressures on health and social care systems around the globe, it is argued that many of these systems are ill-suited to meeting the care needs of people living with chronic conditions, with the need to develop a system-wide model of chronic conditions care remaining (see, for instance, WHO, 2011; 2014; Nolte and Pitchforth, 2014; 2014a). In order to understand why this is, it is first of all important to understand the all-pervasive impact of living with chronic illness (see, for instance, MacKay and Mensah, 2004; Nolte et al., 2008; Novotny, 2008; Busse et al., 2010; Coulter et al., 2013). Carrier (2009) notes that this affects not only physical health – resulting, for instance, in the need for increased visits to the hospital and GP and periods of rehabilitative care from allied health professionals (such as occupational therapists and physiotherapists) – but also has implications for countless other aspects of day-to-day life.

Hence, Carrier (2009) explains that chronic conditions are often associated with a range of complex psychological and psychosocial issues, affecting family relationships, everyday socialisation and the ability to go to work or school and to take care of one's daily physical needs. Moore (2008), however, reports that most health care systems in the world – including the UK's National Health Service (NHS) – are still based upon the biomedical model of health. According to the latter:

> Health is the absence of biological abnormality; diseases have specific causes; the human body is likened to a machine to be restored to health through personalised treatments that arrest, or reverse, the disease process; the health of a society is seen as largely dependent on the state of medical knowledge and the availability of medical resources (Taylor, S., 2003, pp. 21 – 22).

In Wales, demands on the NHS are also increasing, as the many indirect and direct resources associated with providing care for people living with chronic conditions impact on both the health and wellbeing of individuals and the primary, secondary and social care services that support them (NPHSW/WAG, 2006; WAO, 2014). But given the widespread recognition that people living with chronic conditions have complex care needs which span a range of health and social care services (see, for instance, WAG, 2007; Williams and Sullivan, 2009f; Carrier, 2009; Busse et al., 2010) it has been argued that it is critical to understand the social influences on health of those living with chronic conditions (Carrier, 2009) and that their care should instead be rooted in the *social* model of disability (Denny and Earle, 2009). According to the latter, the problems experienced by people living with disabilities result from their 'physical, social and attidudinal [*sic*] environments' (Locker, 2003, p. 84). Denny and Earle (2009) explain that the social model regards disability as a societal issue – with disabled people (including those living with chronic conditions) handicapped not by their impairments, but by societal structures – and recognises the need for self-determination and autonomy.

However, with Ellins and Coulter (2005) explaining that in the traditional biomedical model of healthcare delivery, the patient is viewed as a passive recipient of medical expertise, services and treatments, Brown and Piper (1995) add that the roles of expert health care professional and novice client are ill-suited to chronic conditions, with the latter's long-term and all-pervasive nature seeing the expertise of the health care professional often reduced compared to that of the person living with the chronic condition. Accordingly, note, Paterson and Sloan (1994) whilst the former tends to understand chronic conditions in general terms, the latter normally understands the vagaries of his or her circumstances in a far more sophisticated manner.

This is perhaps unsurprising, given that people living with chronic conditions do so for twenty-four hours a day, 365 days a year, and that during a year they may only interact with health care professionals for just a few hours (see, DH, 2004; Coulter, 2012). As a consequence, people living with chronic conditions are responsible for caring for themselves for most of the time (see, for instance, Holman and Lorig, 2000; Thorne et al., 2003; DH, 2004; Carrier, 2009; Coulter, 2011; Coulter et al.,

2013). Seminal to the day-to-day existence of people living with chronic conditions, therefore, are self-care and self-management (Alabaster, 2006; Long Term Alliance Scotland, 2008; Carrier, 2009; Coulter, 2011; Coulter et al., 2013). The former is defined by Orem (1991, p. 117) as, 'the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health and well-being'. The latter, according to the Long-Term Conditions Alliance Scotland (2008, p. 12) is,

> … a concept where the person takes ownership and is central. It is a process of becoming empowered to manage life with long term conditions. It is not an individual action, a specific treatment or service; neither can it be delivered by a single organisation. Self management is the successful outcome of the person and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long term condition.

Epping-Jordan et al. (2004, p. 304) draw attention to a growing body of evidence that shows that people living with chronic conditions benefit from receiving treatment, 'within an integrated system with self-management support'. In a similar vein, Greene and Hibbard (2012, p. 520) point out that people living with chronic conditions experience better outcomes when they are adequately 'informed and activated'; this means, the researchers explain, that they have the requisite, 'motivation, knowledge, skills, and confidence to make effective decisions to manage their health' (2012, p. 520).

Coulter (2007) explains that in England and Wales, the cornerstone of governmental efforts to promote self-management has been the Expert Patient Programme (EPP). The latter is a lay-led self-management programme designed for people living with LTCs with its foundations, in the United States (U.S.), in the Chronic Disease Self-Management Programme (Lorig et al., 1999). Carrier (2009) notes that the EPP was launched in Wales[8] in 2002, with the Welsh Government demonstrating a firm commitment to the programme's Wales-wide roll-out. In Chapter Four, 'Setting the context for the case study', I describe how the network of services in Armorshire for people living with chronic conditions that pre-dated the launch of the National CCM

[8] In Wales, the EPP is known as the Education Programme for Patients, see http://www.wales.nhs.uk/sites3/home.cfm?orgid=537

Demonstrator Programme included the EPP and the X-PERT Programme[9], the latter tailored to meet the needs of people living with type 2 diabetes.

Bandura (1995) notes that the development of the EPP drew upon self-efficacy theory – based on the premise that clients who feel confident in managing their condition will be able to exercise control in doing so (Williams and Bond, 2002) – and has sought to increase client empowerment. The latter, explains Laverack (2007, pp. 13 – 14), 'in the broadest sense is seen as a process by which people work together to increase control over events that influence their lives'. According to Means et al. (2008) empowerment concerns the direct involvement of clients in decisions affecting their welfare, with Barnes and Bowl (2001, p. 18) noting that in the context of social policy and health and social care practice, empowerment has often been conceptualised in terms of, 'a shift in the nature of the relationship between those who provide and those who receive services'.

According to Beresford and Branfield (2006), empowerment is based on involvement, respect, choice, equality and the valuing of diversity as part of broader issues of human and civil rights. Gibson (1991) notes that this has implications for the partnerships between health and social care professionals and their clients, drawing attention to the responsibility of health care professionals to facilitate empowerment by supporting clients in meeting their own needs, in problem solving, and in arranging the necessary resources to take control of their lives.

Arguing that empowerment is central to improving the management of care of people living with chronic conditions, Coulter et al. (2013) add that this care management should be proactive, holistic, preventive and patient-centred, with an active role for patients based on collaborative personalised care planning. Coulter et al. (2013) explain that this means that health care professionals need to abandon traditional ways of thinking and behaving – whereby they view themselves as the primary decision-makers – and to adopt a partnership model in which patients play an active part in determining their own care and support needs. Coulter et al. (2013) explain that this process of involvement sees people living with chronic conditions

[9] Information at: http://www.xperthealth.org.uk/people-with-diabetes/x-pert-diabetes

deciding on their own priorities by way of information-sharing and joint decision-making but supported to do so by health and social care professionals.

Indeed, with Holman and Lorig (2000, p. 526) indicating that the delivery of health care is more effective and efficient if service users are actively involved, they stress that people living with chronic conditions must therefore, 'become a partner in the process, contributing at almost every decision- or action-level'. In a similar vein, Bodenheimer et al. (2002a) note that self-management is premised upon collaboration, with clients viewed as experts in their own lives, and health care professionals as experts in diseases. Rees and Williams (2009) point out that it is therefore important that health care professionals recognise patient knowledge and expertise, with Bodenheimer et al. (2002) suggesting that optimum care for chronic illness occurs when a prepared, proactive practice team interacts with an informed, activated patient. However, Coulter et al. (2013) argue that despite widespread recognition of need for a radical re-design of services for people living with chronic conditions in the NHS whereby patients drive the care planning process by means of greater involvement, little improvement has thus far been achieved.

Once again, however, there is little consensus as to the precise meaning of the term 'involvement' (Baggott, 2005; Beresford, 2012). But this is perhaps in keeping with a phenomenon which, note Barnes and Wistow (1992), can take many different forms, including consulting, information-giving, establishing consumer satisfaction and participating in decision making. Barnes and Wistow (1992, p. 4) point out, however, that involvement activities usually fall under one of 'two broad categories of purpose', namely: 'those which seek to improve the quality of services by making them more sensitive or more responsive to the needs and preferences of those who use them' and, 'those which seek to extend the capacity of users to participate in decisions about the design, management and review of services'.

I revisit these issues in Chapter Two, 'Integration and the management of chronic conditions: a review of the literature', when I explore patient and public involvement (PPI) initiatives. But in addition to a change in the relationships between health and social care professionals and service users, the all-pervasive nature of living with chronic conditions has other implications in terms of the organisation of health and

social care systems. Alabaster (2006), for instance, draws attention to the wide range of services required by people living with chronic conditions and the considerable expense this can incur. Alabaster (2006) explains that these factors can be understood in terms of the long-term nature of support – with the need for ongoing and repeated contact with a range of agencies – and of the increase in intensity of this support should people's conditions deteriorate. Like Carrier (2009), Alabaster (2006) emphasises that people living with chronic conditions require support from a variety of (allied) health care and social care professionals, including therapists, nurses, doctors, social workers and social care professionals.

The need for the latter's involvement arises, explain Goodwin et al. (2014), because people living with chronic conditions (particularly those who are older) often require support with everyday activities such as dressing, bathing, shopping or preparing food. Indeed, with Twigg (1998) noting that the long-term nature of the care required by people living with chronic conditions means that it falls across care boundaries, Kodner (2006) adds that in both community and institutional settings, people living with chronic conditions often require services delivered by a range of health care *and* social care professionals. Billings et al. (2013, p. 7), moreover, point out that since they cannot be 'cured', people living with long term conditions fall outside the traditional medical binary-code of 'well versus ill'. Accordingly, Grumbach (2003) indicates that the goal of chronic care is to enhance functional status, minimise distressing symptoms and to prolong life and to enhance its quality.

With this in mind, Billings et al. (2013, p. 7) indicate that people living with chronic conditions require, 'care, assistance, social support and rehabilitation to accomplish instrumental activities of daily life'. Billings et al. (2013, p. 7) hasten to add, however, that these are functions for which health care systems are, 'poorly organised'. With these comments chiming with Nolte et al.'s (2008) indication that most countries' care systems are ill-equipped to meet the needs of people living with chronic conditions, Nolte et al. (2008) explain that one of the underlying reasons for this is that most were not designed for chronic conditions, but for acute diseases. In order to understand why this is, it is helpful to understand some of the key differences between acute disease and chronic illness. These are set out in Table 1 (see overleaf).

Table 1: Features of Acute Disease and Chronic Illness (source, DH, 2004b, p. 8).

	Acute disease	**Chronic illness**
Onset	Abrupt	Generally gradual and often insidious
Duration	Limited	Lengthy and indefinite
Cause	Usually single	Usually multiple and changes over time
Diagnosis and prognosis	Usually accurate	Often uncertain
Technological intervention	Usually effective	Often indecisive; adverse effects common
Outcome	Cure possible	No cure
Uncertainty	Minimal	Pervasive
Knowledge	Professionals knowledgeable, patients inexperienced	Professionals and patients have complementary knowledge and experiences

Nolte et al. (2008) explain that since most health care systems were designed with acute conditions in mind, most are based on an acute and episodic model of care. The latter, explains the WHO (2002), is characterised by testing, diagnosing, and relieving symptoms, is based on the expectation that a cure will be found, and frequently sees expert health care professionals providing specialist (and disease-specific) care to people who have little knowledge of their presenting disease (see also Holman and Lorig, 2000). Accordingly, adds the WHO (2002), it is a model that is not appropriate for the complex needs of people living with chronic

conditions. These are people who require holistic[10] care from a broad range of health *and* social care professionals, but who also – given that for most of the time they are responsible for meeting their own needs – have considerable expertise in their own condition(s) and therefore should be viewed as equal partners in care (see also DH, 2004b; Holman and Lorig, 2000; Goodwin et al., 2012; 2014; Coulter, 2011; Coulter et al., 2013).

But with the WHO (2002, p. 4) arguing that the rise in prevalence of chronic conditions has led to a, 'mismatch between health problems and health care', it attributes this discrepancy to the fact that most existing care systems in the world pre-date the epidemiological transition, when the burden of acute disease outweighed that of chronic conditions. Despite the subsequent reversal of this situation, the WHO (2002) states that most care systems have not, to any great extent, evolved beyond the conceptual approach used in diagnosing and treating acute conditions, with the acute care paradigm continuing to permeate all levels of care. But with the NHS likewise designed prior to the epidemiological transition, it too remains rooted in the acute and episodic model of care and, like much of the world, its health and social care systems have failed to keep up with demographic and epidemiological change (see National Voices, 2011; Coulter et al., 2013; Goodwin et al., 2014; Oliver et al., 2014; Naylor et al., 2015).

But alongside the pre-eminence of the acute and episodic model of care, other factors also militate against the effective care of people living with chronic conditions, such as the separate development of the organisation of health care and social care systems (Goodwin et al., 2012). Thus, Leichsenring (2003) points out that the majority of European countries, for example, have separate ministries for health affairs and social affairs and a marked difference in the handling of health care issues and social care issues. Whilst Leichsenring (2003) explains that the former are usually regulated by a national health system or national insurance system, he adds that the latter are often administered by regional or local social assistance systems.

[10] Holistic care, 'considers a person as a whole and respects their social, spiritual, mental and physical health needs rather than focusing on one or some aspect/s' (Williamson et al., 2006, p. 148).

Lloyd and Wait (2005) note, furthermore, that access to health care is often defined differently from access to social care, with healthcare coverage often universal or quasi-universal, and social care normally means-tested. Most of the UK, with the exception of Northern Ireland, shares this demarcation between the provision of health care services and social care services (see, for instance, Heenan, 2013; Longley, 2013; Steel, 2013; Goodwin et al., 2014). Accordingly, those considered sick are viewed as having health care needs to be met by the NHS (a national body) and given free at the point of delivery, but those considered frail or disabled are viewed as having social care needs that fall under the remit of the local authority and are means-tested (see, for example, Means et al., 2008; Ham, 2009a; Glasby, 2012). As a reflection of the disease-specific nature of the acute and episodic model of care and the separate development of health and social care systems, Nolte and McKee (2008) explain that many health and social care professionals have traditionally worked separately, with providers traditionally located in different settings. Nies (2009), in turn, describes the isolated development of different care systems in terms of funding, legislation, organisation, culture and working practices.

But Jelphs and Dickinson (2008) also point out that recent years have seen the progressive replacement of generalist health and social care posts with a diverse range of occupations and specialisms that are focused on a particular field of work, problem area or client group. Whilst Jelphs and Dickinson (2008) explain that such specialisation means that individual professionals have greater understanding of specific problems, they add that since it is unlikely that their knowledge of their own profession (or others) is exhaustive, it has also increased the need to work with a wider range of colleagues internal to their organisation. Hence, at the same time that the growing numbers of people living with chronic conditions – whose needs are multifarious – have increased the need for the involvement of a range of agencies, the agencies themselves have become more internally fragmented.

Indeed, with Glasby et al. (2006) also drawing attention to the structural and financial barriers which divide providers at the interfaces of primary and secondary care and of health and social care, to the barriers created by distinct organisational and professional cultures, and to differences in governance and accountability, they argue that the entire development of service delivery has resulted in the

fragmentation of care (both within and between sectors). But according to the Pan American Health Organization/World Health Organization (PAHO/WHO) (2011) such fragmentation has multiple repercussions in terms of the care of people living with chronic conditions. These include: a lack of co-ordination between different levels of care and care settings; duplication of services and infrastructure; unutilised productive capacity; care provision at the least appropriate location (especially hospitals); the use of emergency services (instead of outpatient services) for specialised care; unnecessary hospitalisation of patients; unnecessary extended hospital stays; lack of access to services; lack of continuity of care; and the failure of services to meet users' needs. Edwards (2014, p. 3) explains that in the NHS, fragmentation of care means that:

> A pattern of large numbers of small, narrowly defined and often poorly co-ordinated services (usually delivered by different providers) has arisen, making the system difficult to understand and navigate, even for professionals. This has mainly been the result of services being created for a particular purpose or client group without a clear plan for how they relate to the wider system. The fragmentation of services and tasks means that patients receive multiple visits from different professionals, incurring high costs of co-ordination, and leading to frustration for the referring clinicians, their patients and carers.

So, amidst widespread recognition that the care of people living with chronic conditions should be proactive, holistic, co-ordinated and consistent, there are numerous reports that throughout the world (including the UK) the delivery of care – still based on the acute and episodic model and with a distinct demarcation between health and social care systems – is often characterised by fragmentation and concomitant gaps in provision, duplication and a lack of care-continuity (see, for instance, McDonald et al., 2007; Nolte and McKee, 2008a; Minkman et al., 2009; Commonwealth Fund, 2010a; Nolte et al., 2012a; Coulter et al., 2013; Goodwin et al., 2014; Oliver et al., 2014; Naylor et al., 2015).

Accordingly, it is argued that health ministries and policy-makers worldwide need to develop and implement[11] specific policies and interventions so that the complex and multiple needs of the burgeoning numbers of (older) people living with chronic

[11] Implementation, according to Fixsen et al. (2005, p. 5) refers to a, 'specified set of activities designed to put into practice an activity or program of known dimensions'.

conditions are better met (see, for instance, Nolte et al., 2008; WHO, 2014). Indeed, the WHO (2002) stresses that patients, care professionals and decision-makers must recognise that effective chronic conditions care requires the development of an entirely different kind of health care system as a part of a 'paradigm shift'. In the words of Wellard (2010, p. 8): 'The global challenge is increasingly clear. There is a need for radical shifts in the way health is managed to address the impact of the epidemic of chronic illness.'

In the next section I discuss some of the efforts that have been made to improve systems of care for people living with chronic conditions. I consider one concept that has been widely used in the context of the care people living with chronic conditions, disease management, before introducing a second concept – and the one which underpinned the development of the new CCM service in the Welsh locality of Bro-y-Grug – integrated care.

Improving the care of people living with chronic conditions: the importance of integration

In the previous section, I explained that amidst mounting pressures on health and social care services worldwide, there is widespread recognition that existing care systems are ill-suited to meeting the complex needs of people living with chronic conditions. Accordingly, I added, the reorganisation of these care systems has become a matter of international concern. Whilst the WHO (2014, p. xii) notes that the need to address this issue is pressing in all nations, it points out that since each is at a different stage in its progress towards the 'prevention and control' of NCDs, there is, 'no single pathway' that should be followed to bring about change. On the contrary, recognising that the wide variety of care systems precludes a uniform response, Nolte et al. (2008, p. 2) suggest that in order to improve care services for people living with chronic conditions, different governments, 'must find their own solution'.

Nolte and Pitchforth (2014a), however, note that in seeking to identify effective approaches to improving systems of care for people living with chronic conditions, the absence of common definitions of underlying concepts is a significant issue. Indeed, there is widespread recognition that the field of chronic conditions care is

terminologically challenging, with regular use of a multitude of terms such as coordinated care, collaborative care, managed care, (chronic) disease management, case management, patient-centred care, chronic (illness) care, continuity of care, integration and integrated care (see, for instance, Nolte and McKee, 2008; McDonald et al., 2007).

Despite the fact that many of the terms that are regularly used may differ conceptually, a lack of definitional and semantic consensus means they are frequently used interchangeably, thereby leading to a blurring of the boundaries between them (Kodner and Spreeuwenberg, 2002). According to Nolte and McKee (2008), this multitude of terms (and of concepts) – and lack of agreement on definitions and meanings – is a reflection of the range of disciplines and professionals – and concomitant range in perspectives – typically called on in the care of people living with chronic conditions. But Nolte and Pitchforth (2014a) argue that this has significant implications for practice and learning, with the resultant lack of clarity as to what a term or concept consists of or entails militating against the comparison of empirical evidence, and in turn, against the drawing of conclusions *vis-à-vis* the relative value of different approaches.

Notwithstanding, Nolte and Pitchforth (2014a, p. 10) point out that two concepts that are frequently used in the context of systems of care for people living with chronic conditions are 'disease management' and 'integrated care'. Prior to turning my attention to integrated care – the concept upon which the new CCM service in Bro-y-Grug was built – I briefly discuss disease management, a concept that was first described in the United States of the 1980s in the context of educational programmes promoting medication adherence and behaviour change for people living with specific chronic conditions (see Bodenheimer, 1999). According to Faxon et al. (2004, p. 2652), disease management, 'typically refers to multidisciplinary efforts to improve the quality and cost effectiveness of care for selected patients suffering from chronic conditions'. Nolte and Hinrichs (2012, p. 4) note that disease management often includes the following components:

> (a) collaborative models of care among providers such as physicians,

> hospitals, laboratories and pharmacies; (b) patient education; and (c) monitoring/collection of patient outcomes data for the early detection of potential complications.

However, there is little agreement on the definition, meaning or conceptual basis of disease management, with a concomitant lack in terminological consistency (see Krumholz et al., 2006; Goodwin, 2007; McDonald et al., 2007; Peytremann-Bridevaux and Burnard, 2009; Schrijvers, 2009; Nolte et al., 2012). For instance, the term chronic disease management is also widely used, defined by the Royal College of Physicians/Royal College of General Practitioners/NHS Alliance ([RCP/RGP/NHS Alliance], 2004, p. 1) as, 'a system of co-ordinated health interventions and communications for populations with chronic conditions in which patient self care is significant'. (During my research, I was unable to find a definition of 'chronic conditions management'. However, it appears to be used interchangeably with [chronic] disease management). On the contrary – and incorporating a range of interventions and target populations – descriptions of disease management and approaches to its implementation are many and diverse (see Coleman et al., 2009; Goodwin, 2007; Lemmens et al., 2009; Pimouguet et al., 2011; Nolte and Hinrichs, 2012; Nolte and Pitchforth, 2014a). Hence, some fifty different strategies – in just twelve countries – are noted by Nolte and Pitchforth (2014a) in their overview of disease management in Europe.

Following widespread utilisation in U.S. care systems in the 1990s (Krumholz et al., 2006) disease management strategies have been adopted in other parts of the world, including Australia, Canada, as well as Europe (see, for instance, Glasgow et al., 2008; Jiwani and Dubois, 2008; Hewison and Cox, 2009; Nolte and Hinrichs, 2012; Nolte and Pitchforth, 2014a; Rijken et al., 2014). Despite its popularity, given that the focus of disease management in many settings is on single diseases (see Nolte et al., 2012), concerns have emerged regarding its suitability to address the complex needs of people living with multiple disease processes (Aspin et al., 2010; Nolte et al., 2012a; Rijken et al., 2014).

In addition to the implementation of different systems of disease management, many governments' efforts to improve the care of people living with chronic conditions have involved the integration of health and social care (Nolte and McKee, 2008;

Billings et al., 2013; Goodwin et al., 2014; Nolte and Knai, 2014a). Kodner and Spreeuwenberg (2002, p. 3) define integration in the context of health and social care as:

> … a coherent set of methods and models of the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors.

As with disease management, however, there is little agreement on the definition, meaning or conceptual basis of integration, with a concomitant lack of terminological consistency and sound conceptual framework by which it can be analysed (see, for instance, Goodwin et al., 2004; 2012; MacAdam, 2008; Curry and Ham, 2010; Ham and Curry, 2011; Nolte and Pitchforth, 2014; 2014a). I explore these issues in detail in Chapter Two, when I discuss how numerous terms – such as integration, integrated care, partnership (working), collaboration, joint-working, alliance, coalition, cooperative and merger – are employed in such a way that their meanings and the differences between them are unclear.

Nolte and McKee (2008, p. 65) point out, however, that the wide variety of terms used in the field of integration is a reflection of the 'polymorphous nature of a concept that is applied from several disciplinary and professional perspectives and is associated with diverse objectives', with Goodwin et al. (2014, p. 2) suggesting that this means that integrated care, 'can mean different things in different settings'. But just as I have referred to Nolte and Pitchforth's (2014a) contention that a lack of definitional and conceptual consensus across the entire field of chronic conditions care has militated against its overall development, so in Chapter Two I explore how a lack of common understanding of the meaning and purpose of integration has also adversely affected the development of this particular aspect of chronic conditions care.

Nevertheless, there is widespread belief that integration can help address the discrepancies between existing models and systems of service delivery and the needs of people living with chronic conditions (see, for instance, Goodwin et al., 2012; 2014; Nolte and Knai, 2014a; Naylor et al., 2015). As I explained in the previous section, the main problems that have been identified are: the pre-eminence of a

biomedical model in which people with chronic conditions are not adequately involved; the existence of health care systems that were, in the main, designed according to an acute and episodic model of care and which are ill-suited to meeting the needs of people living with chronic conditions; the divisions between health and social care systems and the separate and isolated development of different sectors of care and concomitant fragmentation of services.

Whilst in Chapter Two I explore why it is felt that these issues can be solved by integration, that this belief is widely shared is evidenced by the numerous reports of different countries' implementation of integrative measures in chronic conditions care (see, for instance, Conrad and Shortell, 1996; Ouwens et al., 2005; Hébert et al., 2008; Kodner, 2009a; Ham et al., 2011; Goodwin et al., 2012). Goodwin et al. (2014) point out that integrated health and social care programmes for older people living with complex needs are currently used, *inter alia*, in Australia, Canada, the Netherlands, New Zealand, the United States and the UK.

As regards the latter, it is argued that the growing interest in different forms of integrated working of recent years reflects the historic divisions between health and social care services to which I referred in the previous section (see Lymbery, 2005; Means et al., 2008; Baggott, 2013). Indeed, systematic incorporation of various forms of partnership-working into many areas of government policy began as long ago as 1997 with the UK general election victory of New Labour, with the latter's 'Third Way' proposing a system of governance to be accompanied by an explicit statement of partnership goals (Dowling et al., 2004). Whilst the years following New Labour's victory saw UK legislation and guidelines place an increasing emphasis on partnership, interest in different forms of joined-up working does not appear to have diminished since this time. On the contrary, Heenan (2013, p. 2) notes that integration, 'has been an explicit policy goal of successive UK governments over the last two decades'.

Although the UK, just like many other parts of the world, is looking to greater integration of health and social care to join up fragmented health and social care systems, there is limited, uncertain and inconclusive evidence to show that integrated

working is effective (Nolte and McKee, 2008). In terms of the outcomes[12] for people receiving health and social care (including those living with chronic conditions), the evidence-base that integration leads to improvements is far from conclusive, as is the evidence that service user involvement in the design and delivery of services has increased (see, for instance, Barnes and Coelho, 2009; Dickinson, 2009; Shaw et al., 2011; Cameron et al., 2012; Renedo and Marston, 2011; Mockford et al., 2012; Dalton et al., 2014). This, despite the fact that a number of commentators agree that the 'organising principle' of integrated working should be the service user perspective (Shaw et al., 2011; Goodwin et al., 2012) and that the 'common demoninator' of integration is the improvement of care of service users (Øvretveit, 1998; Billings et al., 2013; Coulter et al., 2013).

But with little evidence that integration improves care for people living with chronic conditions or that there has been significant involvement of service users in the design and delivery of services, in this thesis I attempt to address these issues by using a case study approach that incorporates multiple stakeholder perspectives – including those of people living with chronic conditions and their carers – from an interpretevist standpoint. I examine in more detail the lack of evidence that shows that integrated working benefits service users or that the latter have been involved in the design and delivery of new services in Chapter Two, and my use of the case study approach, methods of data collection (and analysis) and interpretevist stance in Chapter Three, 'Methodology and methods'. In the next section of this chapter, however, I describe how Wales has also looked to incorporate integrated working into a new model of care for people living with chronic conditions, the Welsh CCM Model.

The Welsh CCM Model: integration, self-management, involvement, empowerment

Sullivan (2004) notes that prior to devolution, Wales – along with the other devolved countries of the UK – had a distinct way of adapting (health) policy and delivering services, but that differentiations have sharpened since the formation of the Welsh Assembly. Indeed, according to Greer (2005, p. 508) Wales offers, 'the most

[12] Burke et al. (2012, p. 20) define 'outcome' as, 'the changes for service users, citizens, or other targets of change that happen as a result of an innovation being provided'.

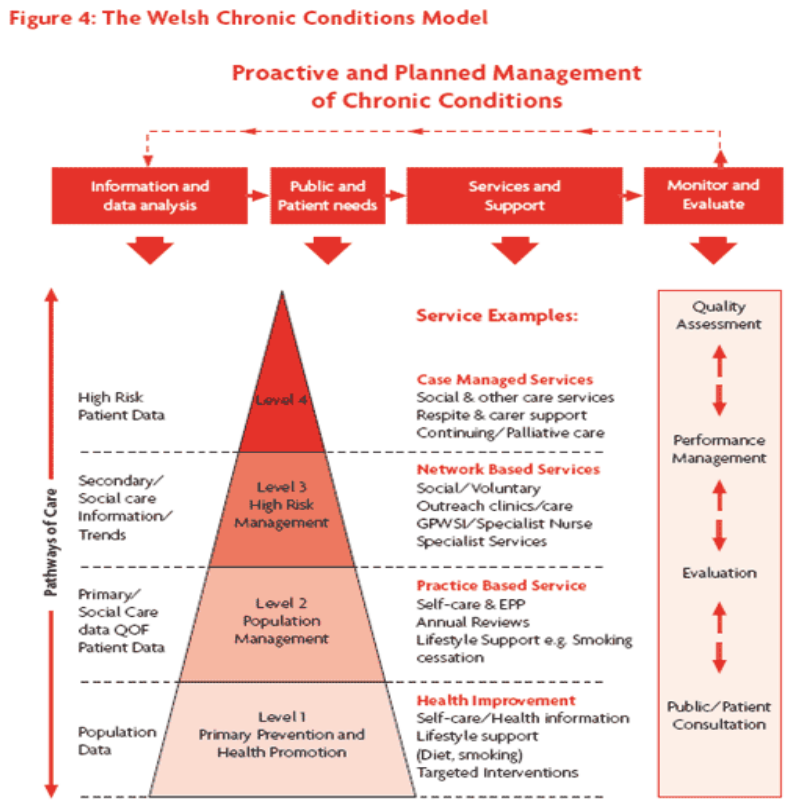
striking case of policy and political change since devolution', with health service reorganisation in Wales designed to shift the, 'centre of gravity of the health service downward and better integrate local government and health services' (2005, p. 509). According to Birrell (2009) the post-devolution era in Wales has been characterised by the principles of citizenship, public involvement, mutualism, localism and partnership-working, with Williams and Sullivan (2009, p. 6) likewise noting that 'partnership' is a 'key element' of Wales' prevailing model of public service. In a similar vein, Sullivan and Drakeford (2011) note that post-devolution, the NHS in Wales has entrenched an ethos of localism, with an emphasis on partnerships between health, local government and the voluntary/third sector.

Whilst indicating that there is no single Welsh Government document that is devoted to integrated care, Longley (2013, p. 63) points out that, 'aspects of the concept appear in many policy documents'. Alongside *Our Healthy Future* (WAG, 2009), Longley (2013) draws particular attention to two documents which were of central importance to this case study. These were: *Setting the Direction: Primary and Community Services Strategic Delivery Programme* (WAG, 2010; henceforth *Setting the Direction*) and *Designed to Improve Health and the Management of Chronic Conditions in Wales: An integrated model and framework* (WAG, 2007; henceforth *Designed to Improve Health and CCM in Wales*). As for the former, in Chapter Six, 'Flux, ambiguity and time-pressures: the impact on the Armorshire Collaboration', I explain how the belated introduction of one of its main features – the Community Resource Team (CRT) – resulted in a degree of ambiguity *vis-à-vis* the project's aims (and therefore adversely affected the delivery of an integrated CCM service in the Bro-y-Grug locality). As for the latter, this was of central importance to this case study, given that it was in this document that the Welsh Government set out its goals for the management of care of people living with chronic conditions by way of a new integrated model.

Originally called the 'Integrated Model and Framework' (WAG, 2007) the model has also been called, *inter alia*, the 'Welsh Chronic Conditions Model' (WAG, 2008), the 'CCM Model' (WAG, 2009a) and the 'Welsh CCM Model and Framework' (WAG, 2008b; I mostly use the term 'Welsh CCM Model' in this case study). It was indicated in *Designed to Improve Health and CCM in Wales* (WAG,

2007) that the Welsh CCM Model comprised three core themes: the recognition that chronic conditions impact on all areas of life; the promotion of strong partnerships between social and health care agencies, the voluntary/third sector and clients and carers; and the empowerment of clients and carers and their active participation in systems of care. It was also explained that the Welsh CCM Model would use population stratification and split care into four levels of ascending degrees of health and social care intervention according to need, as set out in Figure 1 (see under).

Figure 1: The Welsh CCM Model (as set out in *Designed to Improve Health and CCM in Wales* [WAG, 2007, p. 19])



In *Designed to Improve Health and CCM in Wales* (WAG, 2007) it was explained that the designers of the Welsh CCM Model had drawn on evidence and developments outlined in the earlier Welsh Government document, *International Overview of the Evidence on Effective Service Models in Chronic Disease Management* (WAG, 2006). One of the latter document's key messages was that the quality of care of people living with chronic conditions could be improved by CCM programmes based on the Chronic Care Model (see Wagner et al., 2001). The latter,

in turn, is premised on transforming health care for people with long-term conditions from a predominately reactive system (that responds when people are ill) to an increasingly proactive system that focuses on facilitating self-management (Wagner, 1998).

With the indication, in *Designed to Improve Health and CCM in Wales* (WAG, 2007) that a, 'large proportion of care for people living with chronic conditions is provided through self-care by individuals, their carers and local communities' (2007, p. 28) it was explained that one of the 'foundations for change' of the Welsh CCM Model would be 'independence and self-care' (2007, p. 28) and that it would incorporate EPPs for those identified as being at the 'population management level' (WAG, 2007, p. 19). In the *Service Improvement Plan* (WAG, 2008) it was further noted that self-management programmes would help to, 'maintain independence and ability to self-care' and that self-management training and education would be 'incorporated into interactions between the patient and health and social care staff' (WAG, 2008, p. 31).

It was also indicated in *Designed to Improve Health and CCM in Wales* (WAG, 2007) that a core principle of the Welsh CCM Model was that local people, people living with chronic conditions and their carers would have involvement in the design and delivery of CCM services. With the growth in recognition of the importance of integrated working accompanied by a repositioning of service users from passive recipients to active partners in care and in the design and delivery of services (see Thorne et al., 2000; Branfield and Beresford, 2006; WAG, 2007), the fundamental inter-dependency of involvement, integration, partnership working and CCM has been highlighted, *inter alia*, by Holman and Lorig (2000) Longley (2013) Baggott (2013) and Coulter et al. (2013). Davies et al. (2009) emphasise that this is particularly relevant to the management of chronic conditions, considering that clients and informal carers frequently monitor, coordinate and implement their own treatment plans.

Indeed, the Health and Social Care Act (2001) set out statutory requirements for all decision-making of care to involve patients and carers, with Parsons et al. (2010, p. 4) noting that this includes, 'involvement in the design, planning and delivery of

health services'. Newman (2001) notes that such involvement was a fundamental principle of the Health Action Zones, where consumers and communities were integral to the implementation of new policy. Just as Health Action Zones were designed to provide a framework within which the NHS, local government and a wide range of stakeholders could combine to address health issues in socially deprived areas (Cole, 2004), so current UK-wide and Welsh policy emphasises that partnerships should involve a three-way system of joint agreement between health care providers, social care providers and clients (Carnwell and Carson, 2009). Indeed, the last decade has seen a number of Welsh Government documents incorporate a socially inclusive philosophy promoting local community involvement, citizen-centred services and client and carer participation (see, for instance, WAG, 2006a; 2007; 2007a). These are themes that also underpin the Welsh CCM Model: hence, it was indicated in *Designed to Improve Health and CCM in Wales* (WAG, 2007) that it would incorporate integration and partnership at all levels of care and that it would, moreover, promote client and carer empowerment and involvement.

These are themes to which I return in Chapter Seven, 'Integrated working and community engagement: rhetoric and reality', when I explore the extent to which people living with chronic conditions in the Bro-y-Grug locality were involved in the reconfiguration of services during the creation of the new CCM service. In the next section of this chapter, however, I briefly describe the Welsh Government's plans for implementing and testing the Welsh CCM Model and provide some background information about the case study locality of Bro-y-Grug.

The National CCM Demonstrator Programme and the case study locality

Having introduced the Welsh CCM Model in *Designed to Improve Health and CCM in Wales* (WAG, 2007), the Welsh Government subsequently detailed plans for its three-year implementation in *Designed to Improve Health and the Management of Chronic Conditions in Wales: Service Improvement Plan 2008-2011* (WAG, 2008; henceforth *Service Improvement Plan*). Following the latter document's publication, the Welsh Government set up The National CCM Demonstrator Programme and launched three demonstrator-sites in three areas of Wales, with the aim being to:

> Provide and test a sustainable, affordable generic CCM service model that supports people's needs locally and promotes independent living within the community in order to communicate and inform service change across Wales (WAG, 2009a, p. 5).

One of the three demonstrator-sites was located in the south Wales unitary authority of Armorshire. The Armorshire demonstrator-site, known as the Armorshire Chronic Conditions Collaboration (henceforth Armorshire Collaboration) was launched in May, 2008 and ran until March 2011 (NHS Wales/CCM Demonstrators, 2009). In *The Chronicle: Newsletter Issue 2* (NHS Wales/CCM Demonstrators, 2009f) it was explained that the Armorshire Collaboration was split into the three localities of Tregwen, Aberwrach and Bro-y-Grug. The main points of focus of this case study were the implementation of the Welsh CCM Model and the launch of the new CCM service in the locality of Bro-y-Grug.

Bro-y-Grug has a mix of urban and rural areas, numerous small towns and villages and a main market town of Llannuon. Although Bro-y-Grug's economy was traditionally driven by coal-mining, the industry's demise in the last quarter of the twentieth century has had a significant impact on a locality that had hitherto enjoyed relative prosperity. Moreover, a high proportion of people aged sixty-five and over who spent their working lives in the mining industry are now living with chronic obstructive pulmonary disease (COPD). This was one of the main reasons why, in 2006, Armorshire Local Heath Board (LHB) launched a new nurse-led Chronic Disease Management (CDM) Team. The latter was one of a number of small services that helped pave the way for Armorshire's involvement in the National CCM Demonstrator Programme. In Chapter Four, 'Setting the context for the case study', I describe in detail the resource base of services for people living with chronic conditions in Armorshire prior to the launch of the Armorshire Collaboration.

In addition to a high prevalence of COPD, however, Bro-y-Grug has experienced major demographic and epidemiological changes in recent years, with the locality's population of older people living with all chronic conditions, in turn, growing significantly. (As regards ethnicity, over ninety-nine percent of the residents of Bro-y-Grug are White). Whilst I revisit the selection of Bro-y-Grug as the case study site

in Chapter Three and provide more background information about the locality in Chapter Four, in the next section of this chapter I describe my interest in integration and the care of people living with chronic conditions.

Researcher background

Having worked for a number of years as an English and French teacher, in my mid-thirties – after considering the change for some years – I applied to train to become a nurse, and was accepted at Swansea University. Beginning my studies in March, 2006, over the course of the subsequent three years I regularly observed – during my placements in both community- and ward-based settings – what I perceived to be a frequent lack of joined-up working in the care of older people (many of whom were living with chronic conditions). The result of this was that, despite the high-quality care that was invariably provided by individual health and social care practitioners, older people often struggled to navigate their way through the complexities of convoluted systems and, as a result, often did not receive the care they required where and when they needed it. Moreover, I also noticed that whilst some people were admitted to hospital who could, I felt – and with adequate support – have remained living independently in their own homes, others were unable to return home following secondary-care treatment due to factors which, to my inexperienced eyes, had little to do with health and wellbeing and more to do with systemic failures.

My interest in this area only grew during the latter part of my nurse-training, a three-month 'management-placement' on an oncology and haematology ward of a local hospital, where I was brought into regular contact with the difficulties in organising long-term care for people whose needs regularly crossed the health and social care boundary. Indeed, having graduated, I was preparing to apply for a position as a staff nurse on this ward when my personal tutor advised me that interviews would soon be taking place for a PhD scholarship on the subject of integrated working in the care of people living with chronic conditions. Given my burgeoning interest in this field, I applied. Whilst I was surprised even to gain an interview, I was even more so to be offered the scholarship, but did not hesitate in accepting. Within a matter of weeks my research had begun and I was able to try and discover for myself

what lay behind the apparent difficulties of securing joined-up care that I had so far observed. As will, I hope, become evident in the course of this case study, the answer is far from straightforward. In the next section I set out the study's aim and objectives.

Aim and objectives

Thus far in this chapter, I have explained that changing illness patterns and growing numbers of older people living with chronic conditions are placing increasing pressures on health and social care systems worldwide, systems which were designed for acute and episodic illness rather than chronic long-term care. I have indicated that many countries – including Wales and the rest of the UK – have looked to integration in order to address these challenges. I have noted, however, that the evidence base for integrated working in health and social care is questionable, particularly in terms of its influence on the care of people using health and social care services and their involvement in the design and delivery of services. This is despite widespread agreement that the goal of integration is to improve care delivery to service users, and that it is their and their carers' perspectives that should determine the organisation of integrated care.

In this thesis, I sought to address these issues by exploring the establishment of a new integrated CCM service, using a qualitative case study approach (underpinned by an interpretevist stance) that incorporates multiple perspectives, including those of the people living with chronic conditions (and their carers) for whom the new service was created. My aim in conducting the case study was to answer the research question: How has integrated care for people living with chronic conditions developed during the implementation of the new CCM service? My objectives, in turn, were to answer the following five sub-questions:

1. How have different stakeholders been involved in the establishment of the new CCM service?
2. What do the stakeholders involved in the establishment of the new CCM service say about integration?

3. What do people living with chronic conditions and their carers say about the new CCM service and the care they receive?
4. What do front-line health and social care professionals say about their work in the new CCM service compared to their work in their previous teams?
5. How has the development of the new CCM service been affected by pre-existing services, roles and relationships and concurrent developments in health and social care?

I will address the five objectives, not individually and consecutively, but by incorporating them into a narrative account of the development of the new CCM service and, in so doing, will address the study aim. The narrative account will involve description and analysis of various aspects of the establishment of the new CCM service, including: the resource-base of CCM services and network of relationships that existed prior to the project's launch; contextual issues, such as rising numbers of older people living with chronic conditions, financial constraints and the introduction of a new strategy; the project's original organisational structure and its subsequent replacement; the way in which changes were communicated to front-line health and social care professionals and the latter's engagement in the service reconfiguration; information-sharing, communication and engagement with service users and carers; and the involvement of voluntary/third sector representatives. In the next section, the last of this introductory chapter, I provide an overview of the thesis.

Overview of the thesis

This thesis comprises seven further chapters. In Chapter Two, 'Integration and the management of chronic conditions: a review of the literature', I explore the terminological and definitional issues that have hampered the development of integration and integrated care. I discuss why it is widely considered that integration is key to improving the care of people living with complex needs and chronic conditions. I then examine evidence-based practice and implementation research, before turning my attention to the evidence base for integration and issues of assessment, including the difficulties in measuring integration, especially in terms of service user outcomes. Subsequently, I explore some of the key determinants of integrated working, before ending the chapter with an examination of patient and

public involvement initiatives.

In Chapter Three, 'Methodology and methods', I describe my use of a qualitative case study approach and my interpretevist stance and why I felt that these choices were appropriate to meeting the study's aim and objectives. I consider issues of access, ethical approval and sampling, including my selection of the creation of the CCM service in the Bro-y-Grug locality as the 'case' of this case study. I discuss the four methods of data-collection that I used, namely non-participant observation, individual semi-structured interviews, focus groups, and documentary research. I also discuss my handling and analysis of data and issues of rigour.

Chapter Four is entitled 'Setting the context for the case study'. In this chapter, I briefly situate the Armorshire Collaboration within its socio-economic and political context by way of an introduction to the environment into which the project was launched. I explore some of the underlying principles of the Welsh CCM Model and the National CCM Demonstrator Programme. I set Bro-y-Grug within the county-wide context, outlining some of the locality's salient socio-economic features whilst drawing attention to the contribution of existing services to the care of people living with chronic conditions in the years preceding the launch of the Armorshire Collaboration. I end the chapter with a brief examination of issues of timing that affected the project's development.

Chapter Five is entitled 'The prioritisation of service users: project leaders' vision of integration' and is the first of the case study's three findings and discussions chapters. After briefly revisiting the pre-existing resource-base of services, I examine how lead agency representatives involved in managing and leading the project (henceforth 'project leaders') argued that prevailing health and social care structures were obsolete, ill-suited to existing needs and that services were correspondingly fragmented and duplication- and gap-ridden. I explain that a number of project leaders – who could be considered local 'champions of change' – believed that the solution to these problems lay in increased integration and that their conceptualisation thereof was one of service user-centred care. I end the chapter by noting that extraneous factors meant that the team that led the Armorshire

Collaboration in the Bro-y-Grug locality was only established when the project was over half-way through its three-year duration.

Chapter Six is entitled, 'Flux, ambiguity and time-pressures: the impact on the Armorshire Collaboration'. Following on from Chapter Five, in this chapter I contrast the significant time-delays in establishing key components of the Armorshire Collaboration with the contention that the project had served as a catalyst for change. I examine how project leaders discussed the complexities of providing care for people living with chronic conditions, and the pressures of demographic changes and financial constraints. I describe how the belated entrance of a new strategy created ambiguity *vis-à-vis* the project's aims and contrast the advocacy of linguistic clarity and consistency with the widespread use of nebulous language and the terminological flux that surrounded the project. I explore the project's original organisational structure (and its subsequent replacement) and contrast the considerable contextual (and time-consuming) challenges that confronted project leaders with the Welsh Government's desire for rapid change. I end the chapter by describing how a project originally premised on a local approach to change appeared to have been instead organised hierarchically.

Chapter Seven is entitled, 'Integrated working and community engagement: rhetoric and reality'. In this chapter, I describe the Welsh Government's vision of partnership working premised on service user participation, involvement and empowerment and explain that similar values – together with the promotion of self-care and self-management – underpinned the Welsh CCM Model, the National CCM Demonstrator Programme and the Armorshire Collaboration. On the one hand, I describe how project leaders suggested that the Armorshire Collaboration would involve all stakeholders and that this would be built on effective communication in the development of integrated working. On the other hand, however, I explain that front-line professionals, service users, carers and voluntary/third sector representatives alike reported having little (or no) involvement in or knowledge of the reconfiguration of services in the Bro-y-Grug locality. I conclude the chapter by briefly discussing the extent to which the Armorshire Collaboration – in the Bro-y-Grug locality – provided an integrated approach.

In Chapter Eight, 'Discussion, final conclusions and implications', I discuss the extent to which the study's aim and objectives were met. I explore the strengths and limitations of the case study, before describing its original contribution to the evidence base of integrated working and chronic conditions management. Subsequently I review the main findings of the case study. I end the chapter by discussing the implications of my research in terms of the future development of health and social care integration and the care of people living with chronic conditions and provide some recommendations for future policy, practice, research and education.

Summary

In this introductory chapter, I discussed the terminology and characteristics of chronic conditions, outlined the growth in prevalence of chronic conditions amidst demographic change and explained how this has placed health and social care systems worldwide under pressure. I considered the importance of self-management, empowerment and involvement to chronic conditions care. I described how different countries have sought to address current pressures on health and social care systems by looking to disease management and, in particular, to integration. I described the Welsh CCM Model and its core features of self-management, integration and empowerment. I discussed the National CCM Demonstrator Project and the case study locality. I provided information about my own interest in integrated working and the care of people living with chronic conditions, before ending with an overview of the thesis. In the following chapter, I discuss the literature of integrated working as it relates to the management of care of people living with chronic conditions.

Chapter 2: Integration and the management of chronic conditions: a review of the literature

Introduction

Having described the development of global interest in integration in health and social care in relation to chronic conditions management in Chapter One, in this chapter I examine how these subjects have been investigated by writers and researchers to date. I begin by describing my literature search strategy before examining the language of integration and the implications of the lack of consensus as to what integration means. I describe the widespread agreement that integration is a potential answer to fragmented health and social care provision and then explore evidence-based practice and implementation research. I then turn my attention to the evidence base for integration and issues of assessment, including the difficulties in measuring integration, especially in terms of service user outcomes. Subsequently, I explore some of the key determinants of integrated working, including structural and cultural issues, before ending the chapter with an examination of patient and public involvement initiatives.

Literature search strategy

In an effort to be as inclusive as possible of the range of perspectives inherent in integrated working, I reviewed a wide variety of literature. In so doing I adopted a systematic approach, thereby aiming to generate an understanding of the research field and to add to conceptual and theoretical developments (Aveyard, 2007). I only considered works in the English language. Publications came from a variety of sources and can be broadly divided into two categories: original empirical research incorporating accepted research methods to collect new data; and non-empirical work such as discussion papers, governmental and NHS policy reports, newspaper and magazine articles, expert opinion articles and press releases.

In reviewing the literature, I set out to identify research related to community integrated health and social care teams and the provision of services to adults and older people with chronic conditions. My initial searches of the literature

concentrated on the identification of published work up to ten years old or older works of seminal importance. However, given that in the wake of New Labour's 1997 general election victory Wales and the rest of the UK experienced an increased interest in joint-working (Dowling et al., 2004; Coyle, 2007), I extended this to examine research and legislation from the late 1990s and early 2000s.

I employed a number of techniques in conducting the literature review. I made electronic searches of databases including CINAHL, PUBMED, the Cochrane Library, ASSIA and PsycInfo. I manually searched health and social care journals. I retrieved relevant policy documents and guidelines from UK and Welsh governmental websites and other organisations with an interest in health and/or social care, such as the National Institute for Health and Care Excellence (NICE), the Social Care Institute for Excellence (SCIE), the King's Fund and the Nuffield Trust. I checked bibliographies of relevant studies and followed up references using a 'snowball technique' (Ridley, 2008).

During my initial searches it became apparent that a wide variety of terms that are broadly analogous both to integration and to chronic conditions are frequently used interchangeably. As a reflection of this terminological diversity, my searches of the databases incorporated a wide variety of keywords and combinations of terms, including: *chronic condition, long-term condition, chronic illness, long-term illness, partnership working, integrated working, collaboration* and *joint-working*. In order to appraise critically the articles that were identified, I consulted the Critical Appraisal Skills Programme (2006) and Polit and Beck (2005). Moreover, as an indication of the breadth of interest in integration in health and social care and chronic conditions management, I found that numerous associated themes have been – and continue to be – investigated by writers and researchers. However, given the restrictions of student research, it is impossible for me to review every area. Instead – and in keeping – with my inductive approach and my developing knowledge as research progressed, I focussed my attention on the following themes: the language of integration; integration and service fragmentation; evidence-based practice and implementation research; the evidence base for integration; assessment issues; the determinants of integration, including issues of structure and culture; and patient and public involvement initiatives. I begin by discussing issues of language.

The language of integration

Curry and Ham (2010) point out that there are many competing definitions of integration and integrated care. However, Nolte and Pitchforth (2014) argue that a key challenge to the development of this field is the lack of common definitions of underlying concepts, with commentators – such as Challis et al. (1998) and MacAdam (2008) – arguing that despite repeated calls for more clarity, integration has been dogged by a fundamental lack of understanding or agreement of what it means in practice. With Armitage et al.'s (2009) systematic literature review of health systems integration identifying seventy terms and phrases related to integration, in addition to one hundred and seventy-five associated definitions and concepts, it is perhaps little surprise that integration has been described as an, 'academic quagmire of definitions and concept analyses' (Howarth and Haigh, 2007, p. 1), or as a, 'rhetorical invocation of a vague ideal' (Powell and Glendinning, 2002, p. 3). Integration has been defined by the Care Services Improvement Partnership (CSIP)/Integrated Care Network (ICN) (2008, p. 17) as:

> ...a single system of needs assessment, service commissioning and/or service provision. These arrangements are managed together by partners from health and social care, who nonetheless remain legally independent. They will also need to work alongside service users, carers and the Third Sector to ensure viable and appropriate models of service provision.

Or by Gröne and Garcia-Barbero (2001, p. 7) as:

> ...a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user and efficiency.

Or by Leatt (2002, p. ii) as:

> ...the creation of a modernized, cost-effective system characterized by closer working relationships between hospitals, long-term care facilities, primary health care, home care, public health, social welfare agencies, schools, police and others whose services have implications for the determinants of health.

The CSIP/ICN (2008) suggests that in its most complete form, integration refers to a single system of service planning and/or provision put in place and managed together by partners from health and social care who nevertheless remain legally independent. Ham (2008) considers that integration is a single system of needs assessment,

commissioning and/or service provision that aims to promote alignment and collaboration between the cure and care sectors. Leutz (1999; 2005) suggests that integration is the search to connect health care systems (acute, primary medical and skilled) with other human service systems such as long-term care, education, and vocational and housing systems.

Just as integration appears to be a diverse and fluid term, it has been argued that terminological discussions have long been a feature of many other aspects of joint-working in health and social care (Banks, 2002). So much so that at the beginning of the new millennium – an age of burgeoning interest in integration between the NHS and local government (Baggott, 2011) – the literature of partnership-working was described as 'definitional chaos' (Ling 2000, p. 82). Huxham (2000), for example, explains that partnership, collaboration, co-ordination and integration are used interchangeably but describe different activities ranging from simple information exchange between separate agencies to full integration of service delivery. The analogous use of subtly different terms such as multidisciplinary and interdisciplinary[13] is referred to by Payne (2000) by Ouwens et al. (2005) and by Leathard (2003). Leathard (2003), for instance, lists more than fifty ways used to describe learning and working together in health and social care, and – foreshadowing Howarth and Haigh (2007) – likens the situation to 'a terminological quagmire' (2003, p. 5).

In a similar vein, Lazenbatt (2002, p. 84) explains that collaborative relationships existing in community health and social care have been variously termed networks, partnerships, collaborations, alliances, coalitions, cooperatives, affiliations, multi-disciplinary teams, joint ventures, mergers, and clinical teams. The language of joint-working in chronic conditions management is, it seems, characterised by a similar breadth of terminology, with Nolte and McKee (2008) explaining that it is variously termed: integrated care; co-ordinated care; collaborative care; managed care; disease management; case management; patient-centred care; chronic (illness) care; continuity of care; trans-mural care; and seamless care. Commentators have

[13] Multidisciplinary teams are made up of a group of individuals who work alongside each other to meet the needs of the patient. Their interventions are parallel but not necessarily made in close collaboration. Generic therapy teams within a district general hospital typically adopt this approach. Interdisciplinary teams take a more integrated approach. They work together towards a single set of agreed goals and often undertake joint sessions (for example, a specialist team working on a neuro-rehabilitation unit or a community neuro-rehabilitation team would typically adopt this approach) (see DH, 2005b).

also drawn a distinction between integration and integrated care. Shaw et al. (2011, p. 3), for instance, note that:

> ...integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seeks to bring this about.

This relationship between processes (integration), on the one hand, and outcomes (integrated care) on the other, is further described by Kodner and Spreeuwenberg (2002, p. 3):

> Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called 'integrated care'.

The Effective Interventions Unit (2002) reports that when efforts to improve integration are beneficial to the end users – specifically those people with complex needs – the result is integrated care. As with integration, however, it appears that there is little consensus as to the meaning of integrated care. Minkman (2012, p. 347), for instance, notes that, 'Integrated care appears in a variety of forms and there is no uniform and accepted definition; nor are there clear boundaries of the underlying concepts'. Berchtold and Peytremann-Bridevaux (2011, p. 2) suggest that integrated care is a, 'polymorphous concept viewed and understood very differently between national systems as well as between the various actors within the health systems'.

Walker et al. (2013) conducted a qualitative study of the perceptions of integrated care of people aged fifty and over living with one or more chronic condition(s) in San Francisco, California, including focus groups (n=7) with people living with chronic conditions (n=44). In each focus group, the researchers began by asking participants to write down their definitions of integrated care. During the subsequent discussions, participants were asked to describe: their health care experiences in multiple settings; their satisfaction with services; their views on how doctors and

other caregivers should share information and work together; and their views of co-ordinated and integrated care in different health care settings. Walker et al. (2013, p. 6) found that whilst participants did not understand the meaning of the term 'integrated care', they were 'relatively clear' on the concept. However, suggesting that the 'jargon-laden' (2013, p. 6) terms of integration and co-ordination are not 'patient-friendly', Walker et al. (2013) argue that they do little to help communication with people living with chronic conditions and the general public.

In an evaluation of the English Department of Health's Integrated Care Pilots (RAND Europe and Ernst and Young 2012), the researchers examined sixteen English integrated care initiatives. Although each initiative had a different focus, all involved complex areas, including structured care for dementia, end of life care, long-term conditions, falls in people aged over sixty, chronic obstructive pulmonary disease and cardiovascular disease. The researchers combined quantitative methods (Hospital Episode Statistics, surveys of patient/service user experience and staff) and qualitative methods ('structured free-form' questionnaires, non-participant observation and semi-structured face-to-face interviews with staff [n=213] and patients [n=82]). Across all of the sixteen sites it was found that staff described and interpreted integrated care in different ways. Recognising that integrated care is understood in different ways by different people, Goodwin et al. (2012, p. 3) nevertheless point out that:

> At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs.

In a similar vein, the House of Commons Health Committee (2012, p. 12) reports that integration is, 'not an end in itself. Rather, it is an essential tool to improve outcomes for individuals and communities'. Likewise, the National Collaboration for Integrated Care and Support ([NCICS], 2013, p.13) notes that integrated care is, 'a means to an end', the end being, it is stressed, an improvement in the experiences and outcomes of individuals and their communities. Just as the NCICS (2013) adds that integrated care involves people being partners in their own care and support, so the Integrated Care Network ([ICN], 2009) suggests that it encompasses: client and carer outcomes based on their needs and expectations; person-centred services drawing on the needs, preferences and lifestyles of individuals to determine how care

is provided; self-directed support including provision of service users with systems of increased control over how service budgets are used to purchase care; and the involvement of both service users and carers in the design and evaluation of integrated care services.

Mur-Veeman et al. (2003, p.11) likewise point out that, 'The essence of integrated care is that individuals receive the care services they are in need of when and where they need them'. With this in mind, Shaw et al. (2011, p.3) argue that those involved with planning and providing services must impose the service user's perspective as the 'organising principle'. Nevertheless, in a report on the measurement of people's experiences of integrated care produced by a multi-organisational team from the King's Fund, National Voices, the Nuffield Trust, and the Picker Institute Europe, Graham et al. (2013) noted that not only is there no consistent definition (or indeed model) of integrated care, but that the vast majority of definitions have been produced by policy makers from an organisational perspective and fail to take account of the perspectives of service users.

Whilst Kodner and Spreeuwenberg (2002) point out that a clear understanding of integrated care has been hampered by the lack of common definitions, Goodwin et al. (2004) note that there is also a general absence of a sound paradigm through which to examine the process. However, Kodner (2009) warns that when agencies are initiating integrated projects, the absence of commonly held understandings increases the likelihood of subsequent disagreement and imperils the chances of long-term success. In a similar vein, in their literature review of collaborative working in health and social care, Williams and Sullivan (2007) found that if terminology was not clearly demarcated at the initial stages of joint-projects, problems frequently ensued, with differing interpretations of its nature and purpose adversely effecting the chances of successful collaboration.

The CSIP/ICN (2008) reports that those involved in integrated projects need to use a common language to promote shared understanding and to avoid confusion in terminology that will otherwise hold back progress. In a similar vein, in her report into the foundation of an integrated health and social care team in south-west England, Hickey (2008) described the fundamental importance of the establishment – from the outset – of a shared language of integration for team members from

different professional backgrounds. This included decisions regarding the consistent use of terminology (such as whether to use the term 'client', 'service user', 'customer' or 'patient') and the clarification of specialist terms and acronyms that could otherwise militate against effective communication (Hickey, 2008, p. 23).

O'Hara (2006) argues that communication must remain an ongoing priority in joint-working, since even long-standing partnerships can be dismantled following perceived breakdowns in communication. The issue of language clarity emerged during Williams and Sullivan's (2009; 2009a-f) case study of five Welsh collaborative health and social care projects. The projects comprised: a health conditions management programme for people claiming incapacity benefit; an integrated primary, intermediate and community care and nursing service for adults; an integrated disability service for children; a co-ordinated health and social care service for people living with chronic conditions; and a multi-agency service for people living with long-term conditions and for older people. For each site, the researchers examined documentary material (including reports), held preliminary discussions with site leads/co-ordinators and conducted interviews (of an unspecified number) with managers and (allied) health and social care practitioners.

Williams and Sullivan (2009f) noted that one of the issues that emerged from the interviews was the relative importance of seeking absolute clarity of purpose (and intent) from all parties at the outset of the project, as opposed to the negotiation of sufficient consensus to promote collective action. On the one hand, Williams and Sullivan (2009f) indicated that this raised the issue of the extent to which insufficient clarity at project initiation may provoke conflict and dissent at a later point when potential divergences regarding purposes and modus operandi may emerge. On the other hand, however, Williams and Sullivan (2009f) posited that insistence on clarity could generate paralysis if partners were unable to reconcile their different values, motivations and views and that a degree of ambiguity might therefore be advantageous.

McLaughlin (2004), similarly, suggests that it is the very ambiguity of the concept of partnership which has allowed it to become so popular, arguing that it can provide the space for differing interpretations and allow room for manoeuvre. In a critical

examination of the conceptual basis of service user consultation with people from the deaf community, McLaughlin et al. (2004) term the absence of such precise definitions – in this instance, as it relates to consultation – as, 'useful ambiguity' (2004, p. 154). In a similarly pragmatic vein, rather than argue the primacy of a particular definition, Glasby and Dickinson (2008) and Williams and Sullivan (2010) suggest that it is important that stakeholders' agree on a shared understanding of joined-up working – irrespective of the particular term they adopt – and that this should be clearly set out at project initiation.

The setting out of a shared vision (Hudson et al., 1999) clarity and realism of purpose (Hardy et al., 2000) and agreement on a unified approach to partnerships (DH, 1999) have all been identified as key ingredients of successful joint-working. The importance of the establishment of a common purpose was emphasised in a report detailing the Lambeth Living Well Collaborative, a partnership platform for commissioning mental health services aimed at improving care for people living with long-term mental illness (Langford, 2013). The platform, Langford (2013) explains, included GPs, mental health commissioners, carers, peer supports, service users, information managers, clinical directors and representatives from the local authority, primary and secondary NHS providers, housing support and voluntary/third sector organisations. Langford (2013) reports that one of the key aims of partners was to work together to establish a 'ground-up' shared-vision towards which all partners could aspire.

Although Williams and Sullivan (2007) note that some have viewed a preoccupation with the language of joint-working as unhelpful, the recognition of the importance of terminological clarity to the developing field of integration that existed in the early 2000s (Ambrose, 2001) is still considered to be fundamental to its further development and to the application of research findings (CSIP/ICN, 2008). Conversely, in a literature review of the barriers and facilitators of inter-professional team-working in primary and community care, Xyrichis and Lowton (2008) reported that confusion over terminology has hindered its applicability as a variable in studies and that this may account for the lack of consistency reported in healthcare literature on the levels of collaboration in clinical settings.

But without clarity, suggest Armistead and Pettigrew (2004), the insistence of policy-makers on the benefits of integrated working risks colouring the language of integration with negative connotations. They caution that the word 'partnership', for instance, could become a byword for long unproductive meetings and legislation that forces unwilling partners into joint-working. The language of partnership, the ICN (2007) warns, could therefore become synonymous with a lack of motivation in the face of overwhelming bureaucracy. Indeed, whilst Alaszewski et al. (2003a) suggest that nebulous terminology often suits the purposes of the authors of policy documents – who present it, they argue, as a self-evident concept and thereby justify the avoidance of lengthy analysis – they emphasise that this does not help people on the ground who are trying to develop integrated services, or researchers who are trying to evaluate them. El Ansari (2011) argues that such a lack of conceptual consensus creates four main problems: there is little understanding of exactly what a given study is investigating; there are difficulties in comparing studies; there are issues in implementing the findings from studies in real life situations; and there are difficulties in generalising findings from one study to other situations.

Finally, it is perhaps worth noting that Goodwin et al. (2008) report that definitional issues were considered important enough to constitute a major theme in Professor Kodner's closing remarks of the 8th Annual Integrated Care Conference in 2008. Goodwin et al. (2008) note that Professor Kodner used the forum to remind the audience of the importance of precise and unambiguous terminology, stressing that this was essential for the establishment of an intellectual and theoretical basis of integration in health and social care that would allow development of future policy and practice. Having discussed the language of integration, in the next section I discuss why integration is considered so important in health and social care.

Integration and service fragmentation

Notwithstanding Professor Kodner's warning of the need for greater linguistic clarity in the development of integration, he has also noted (Kodner, 2009a) that integrated strategies in health and social care are becoming increasingly popular worldwide. The reason for this, explains Glasby (2012), is that irrespective of the structure of local and national health and social care services, they often work with people with

complex, cross-cutting needs who require a coherent and joined-up response from a range of agencies. The multi-faceted nature of complex societal issues led to Rittel and Webber's (1973, p. 160) coining of the phrase 'wicked problems' (often referred to as 'wicked issues') as a reflection of the variety of factors that makes each individual case unique and inherently intractable. Williams and Sullivan (2009, p. 5) note that:

> The metaphor of a 'wicked issue' is often used in relation to health and social care because the challenges presented are complex and difficult to resolve and require action across a range of different boundaries including geographic, administrative, professional and sectoral. It is generally considered that the management of such challenges cannot be undertaken by single organisations acting autonomously; rather, they require people and organisations to collaborate in various ways through networks, partnerships and alliances.

According to the Audit Commission (AC) (1998), one of the five main reasons that agencies develop partnerships is to tackle such 'wicked issues', with Glasby (2012) noting that this requires policy makers to adopt various forms of multi-agency response. According to Sullivan and Skelcher (2002), such a response draws on a range of actors who each have complementary perspectives, expertise and resources, with Kooiman (2000, p. 142) noting that:

> No single actor, public or private, has the knowledge and information required to solve complex, dynamic, and diversified problems; no actor has an overview sufficient to make the needed instruments effective; no single actor has sufficient action potential to dominate unilaterally.

Many experts have indicated that integration is the most suitable way of providing care to an identifiable group of people who have complex needs (Henwood and Hudson, 2009; ICN, 2009; Goodwin et al., 2012). This can be contrasted with people whose health and social care needs are less complex, easier to manage, and therefore better served by more basic systems of care (Leutz, 1999; 2005). On the contrary, Leutz (1999; 2005) notes that it would be inefficient and economically unsustainable to use an integrated approach for everyone requiring care. Instead, Leutz (1999; 2005) notes, it is important to target funding for integrated care at those who have more complex and hence more expensive needs, such as people living with chronic conditions.

Busse et al. (2010) indicate that whilst people living with chronic conditions may require different medical interventions, they frequently require care from different providers from both health and social care. Safford et al. (2007) note that aside from medical issues, chronic conditions management comprises wider socioeconomic, cultural and environmental factors and must also take into account individual behaviour. Alongside the physical implications of living with specific chronic conditions, Field and Kelly (2003) point out that sociologists have stressed that living with a chronic condition has social and psychological implications. Field and Kelly (2003, p. 118) note, for example, that people living with chronic conditions must cope with: changes in relationships with family and friends; reorganising life expectations; adjusting to the limitations caused by the conditions; and dealing with economic disadvantage and various degrees of discrimination. Over sixty years ago, Parsons (1951) argued that illness should be viewed as a social phenomenon and understood in terms of social functioning. Goffman (1963) subsequently sought to understand people's experiences of living with chronic conditions and their day-to-day coping mechanisms. Bury (1982, p. 169) developed the concept of the 'biographical disruption' of chronic conditions and the way in which the unpredictable and intractable nature of rheumatoid arthritis, for instance, affects people's lives.

According to Taylor and Bury (2007), the meanings and significance of chronic illnesses to the individuals and groups whose identities are affected by them have been well documented. Amongst the themes discussed in relation to the sociology of living with chronic conditions are the loss of identity, disguising symptoms, social exclusion, stigma, the impact of illness on relationships and life chances and the narratives that people use to explain and make sense of chronic illness within the context of their biographies (see, for instance, Charmaz, 1983; Williams, 1984; Frank, 1995; Kelly and Field, 1996; Kelly and Millward 2004). Just as Hydén (1997) points out that these narratives lie outside the domain of the biomedical sphere, so it has been argued that caring for people with chronic conditions involves a complex interplay between medical, psychological and social problems (Strauss et al., 1984), must strike a balance between treatment regimens and overall quality of life (Larsen, 2013) and therefore requires a co-ordinated response from a range of providers from the cure and care services (WHO, 2002; Bigby, 2004). This means, it

is argued, that systems of care should take into account people's socio-cultural milieux in addition to holistic, physical, and emotional factors (WHO, 2008). Indeed, this awareness of the wider factors that impact on wellbeing should, it is argued, be central to partnership working between health and social care (Improvement and Development Agency [IDeA]/Audit Commission [AC], 2006; Woodard, 2007).

Twigg (1998) notes that the long-term nature of the care of people living with chronic conditions means that it falls across the boundary of medical and social care, with Kodner (2006) reporting that the integration of health and social services is called for in the care management of people living with chronic conditions since their needs are part healthcare and part social care and involve all aspects of day-to-day life. Kodner (2006) adds that in both community and institutional settings, people living with chronic conditions require a variety of services delivered by a range of health care and social care professionals. In a similar vein, Billings et al. (2013, p. 7) note that, since they cannot be 'cured', people living with long term conditions fall outside the traditional medical binary-code of 'well versus ill'. Accordingly, Billings et al. (2013, p. 7) indicate that they require, 'care, assistance, social support and rehabilitation to accomplish instrumental activities of daily life', functions for which health care organisations are, they suggest, 'poorly organised'.

Instead, it is argued that the care of people living with chronic conditions calls on the involvement of many different professions, from medical and nursing teams to social work, domiciliary care, physiotherapy, occupational therapy, dietetics and podiatry (Alabaster, 2006). Whilst Davies et al. (2009) likewise note that a broad range of skills is required to meet the challenges of promoting and maintaining optimum health status for people living with chronic conditions, Coulter et al. (2013) nevertheless contend that the need to improve the treatment and management of long-term conditions is the most significant challenge facing the NHS. Coulter et al. (2013, p. 2) argue that this, 'must involve a shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive'.

In a similar vein, Goodwin et al. (2012) note that in view of the ageing population and increased prevalence of chronic diseases, it is necessary to move away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. Minkman et al. (2009), likewise, suggest that current care delivery for people living with chronic conditions is often fragmented and characterised by duplication, gaps in service and lack of continuity. In the words of the House of Commons Health Committee (2012, p. 7):

> The evidence is therefore clear: many older people and those with disabilities and long-term conditions need to access different health, social care, housing and other services, often simultaneously. Unfortunately the evidence is also clear that these services are fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them.

The Welsh Government notes that the situation has been mirrored across Wales, with people living with chronic conditions and care providers consistently describing service provision as, 'fragmented, inconsistent, wasteful of time and resources, difficult to navigate and frustrating' (WAG, 2008, p. 11). The Welsh Government also draws attention to the existence of, 'research and anecdotal evidence that services are fragmented, both within and across organisational and sectoral boundaries' (WG, 2013a, p. 3). According to Rand Europe and Ernst and Young (2012, p.11), the improvement of outcomes for people living with chronic health problems by solving the issues of fragmentation is the, 'overarching aim of integrated care'.

However, the recognition of the need for a holistic approach to the multi-factorial problems of people living with complex needs has also coincided with a growing specialisation in health and social care professions, explain Jelphs and Dickinson (2008). This, it is argued, has added to the fragmentation of health and care services, with each specialisation provided by different organisations, including governmental and non-governmental bodies, community groups and private enterprises (Andersson et al., 2011). But with Douglas (2009) noting that the more complex the problem, the greater the need to work together, Axellson and Axellson (2006) warn that a

growing differentiation of providers has seen a growing need to integrate to avoid fragmentation of services.

According to many commentators (for example, Nies, 2004; Mur-Veeman et al., 2008; Kodner, 2009; Curry and Ham, 2010) a host of countries face similar pressures to adapt their fractured health and social care systems to the shift in the global burden of disease from acute illness to chronic conditions. This situation reflects the fact that the traditional focus of health-care systems worldwide has been on acute and episodic models of care, with providers unaccustomed to working collaboratively (Nolte and McKee, 2008). Indeed, whilst contextually-specific issues relating to chronic conditions affect how different countries approach care management, they share broad similarities of care provision, given that most healthcare systems worldwide developed in order to respond to acute episodic illness (Glasby, 2012). In such systems, the people that require long-term care services are poorly served and faced with services that are missing, function in isolation or are poorly co-ordinated (Demers and Lavoie, 2008).

Indeed, a quarter of a century ago, Strauss and Corbin (1988) predicted that major health care changes would be necessary to cope with growing numbers of older people and frequency of chronic conditions. In order to co-ordinate effectively the different elements of care and to address the lack of joined-up working, many countries are therefore employing integrated approaches to the organisation of chronic conditions management (Antunes and Moreira, 2011). Goodwin et al. (2012) likewise note that most western developed nations are trying to shift the balance of care away from acute care by means of integration. Prior to examining the extent to which this approach is supported by existing evidence from research (see section, 'The evidence base for integration' below), in the next section I consider evidence-based practice and implementation research.

Evidence-based practice and implementation research

Following the UK general election victory of 1997, New Labour proposed a more pragmatic and evidence-driven approach to policy and guidelines in health care, as outlined in the Command Paper *The New NHS: Modern Dependable* (DH, 1997).

Not only was it stressed in the document that the NHS would be based on partnership working, but that the provision of health and social care would be built on evidence-based practice. With evidence-based practice central to a series of UK and Welsh policy documents published soon after the 1997 election victory, in addition to *The New NHS: Modern and Dependable* (DH, 1997) its importance was set out in, for instance, *Putting Patients First* (Welsh Office, 1998) and *Clinical Governance: Quality Care and Clinical Excellence* (Welsh Office, 1999). Moreover, these documents would be followed by the inauguration of NICE to develop evidence-based guidance around clinical- and cost-effectiveness (Glasby, 2012) and the launch of National Service Frameworks (NSFs), which set evidence-based national standards and service models for a defined service or care group (Chapman and Adam, 2001).

According to Long and Harrison (1996), evidence-based practice describes the use of contemporaneous research findings as the basis for clinical decision-making. Parahoo (2006) adds that evidence-based practice combines available evidence with clinical expertise and patients' wishes, with Melnyk and Fineout-Overholt (2005; 2005a) explaining that this enables clinicians to provide the highest quality care to meet the complex needs of patients and their families. Davies (2004, p. 3) notes that evidence-based practice, 'helps people make well-informed decisions about policies, programmes and projects by putting the best available evidence from research at the heart of policy development and implementation'.

A number of commentators have referred to a growing awareness of the importance of evidence-based practice in informing the development of practice and policy-making in health and social care and of growing pressure on policy-makers to ensure that policy is evidence-based (see, for instance, Murray and Lopez, 1996; Hanney et al., 2003; Muir Gray 2004; 2009; Ward et al., 2006; Nutley et al., 2007; Rycroft-Malone, 2008; Lavis et al., 2009). However, it has been argued that although research evidence itself has grown substantially, a concomitant translation into practice has not been forthcoming (Fixsen et al., 2005; Ward et al., 2006; Rycroft-Malone, 2008; Aarons et al., 2011; Nelson, 2011). On the contrary, a discrepancy between the numbers of people who could potentially benefit from evidence-based interventions and those who actually do so has been widely noted (see, for instance,

McGlynn et al., 2003; Glasgow et al., 2004; Nutley et al., 2007; Glasgow, 2008; Abildso et al., 2010).

Burke et al. (2012, p. 2) explain that the disparity between advances in knowledge and outcomes is commonly termed the, 'implementation gap' (analogous terms such as 'implementation failure' and 'implementation deficit' are also used [see Hill and Hupe, 2002]) and that this equates to the, 'difference between the evidence of what works in theory and what is delivered in practice'. The pervasiveness of the implementation gap in the field of health and social care has been widely acknowledged, with frequent reports that programmes designed to improve the quality of services and outcomes for service users have failed to reach their full potential due to issues related to implementation (Eccles et al., 2009; Aarons et al., 2010; Grimshaw et al., 2012; Colquhoun et al., 2014).

However, Guldbrandsson (2008) explains that, in order to achieve a successful outcome, not only the new intervention but also the process of implementation must be well-functioning, so that just as a poor intervention will have little effect if well implemented, a good intervention will have little effect if poorly implemented. Accordingly, a precondition of evaluating the success of the implementation of a new intervention is the ability to distinguish between the intervention and the process – or strategy – of implementation (see, for instance, Greenhalgh et al., 2004; Fixsen et al., 2005; Peters et al., 2013; 2103a). This distinction is illustrated by Peters et al. (2013), who explain that whilst the provision of a vaccine is an example of a health intervention, the outreach clinics and supervision checklists used to improve the coverage and quality of immunisation are examples of strategies of implementation.

Though the complexities of implementation mean that definitions of it are many and varied (see, for instance, Hill and Hupe, 2002; Gulbrandsson, 2008; Hill, 2009) in the context of evidence-based practice, it has been termed a, 'specified set of activities designed to put into practice an activity or program of known dimensions' (Fixsen et al., 2005, p. 5). But just as Peters et al. (2013) draw attention to the importance of distinguishing between an intervention and an implementation

strategy, so they note that it is important to distinguish between 'implementation' and 'implementation research'. The latter, explain Peters et al. (2013a, p. 1), is:

> …the scientific inquiry into questions concerning implementation – the act of carrying an intention into effect, which in health research can be policies, programmes, or individual practices (collectively called interventions).

A growing interest in such inquiry in the context of health and social care has seen the development of a plethora of competing terms. Inevitably, I use some of these terms in this section. For the most part, however, I refer to implementation research. The reasons for this are twofold: firstly, because Eccles et al. (2009, p. 2) note that in the UK, the latter term seems to be the, 'best recognised'; secondly, because implementation research also appears to be the favoured term of *Implementation Science*, considered the, 'leading international journal' of research into the implementation of evidence-based practice (Glasgow et al., 2012, p. 1275). Whilst the journal's introductory web-page *About Implementation Science* (Implementation Science, 2015) provides a definition of implementation research, it does not do so for, 'implementation science' (this despite the journal's name and the web-site's title). Elsewhere, however, the latter has been termed the, 'study of how evidence-based or evidence-informed practices and innovations are adopted, replicated, and scaled up in diverse practice settings' (Person et al., 2014, p. 8).

Peters et al. (2013a) note that implementation research considers the factors affecting implementation, the processes of implementation, and the results of implementation, including the introduction of potential solutions into health systems and the promotion of their large scale (sustainable) use. Peters et al. (2013a) point out that of central importance in implementation research is context, including social, cultural, economic, political, legal and physical environments, institutional settings, stakeholders (and their interactions) and demographic and epidemiological conditions, with particular interest paid to the structures of health systems and the role of governments, non-governmental organisations, providers and citizens. Schillinger (2010) indicates that implementation research has the following goals: the generation of new insights and generalisable knowledge *vis-à-vis* the processes

of dissemination[14]and implementation and related facilitators, barriers and strategies; the application and testing and refinement of models, theories, hypotheses, and principles; and the production of reliable strategies for improving health-related processes and outcomes for both local and other settings and groups.

Peters et al. (2013) point out that implementation research plays an essential role in ensuring the realisation of the benefits that accrue from the effective implementation of policies, programmes and services and the concomitant development of knowledge. In the absence of implementation research, argue Peters et al. (2013, p. 61), valuable resources are committed to new innovations in the 'naïve hope that things will work out'. This is an approach which can prove extremely costly, warn Peters et al. (2013), since programmes that fail because their designers had paid insufficient attention to context-specific factors can result in wasted resources and unnecessary human suffering. But despite its importance, stress Peters et al. (2013, p. 61), implementation research is a 'neglected field of study'.

With Eccles et al. (2009, p. 3) noting that this neglect extends to the UK, they explain that implementation research is not a recognised area of funding in the NHS and, as a consequence, 'lacks profile'; this is a situation that Eccles et al. (2009, p. 3) attribute – to some extent at least – to the fact that implementation research is a 'relatively young science'. But if implementation research is a young and emerging field of study in the context of evidence-based practice (see also Fixsen et al., 2005; Titler, 2008; Schillinger, 2010) in the context of public policy – where it is also frequently termed implementation research – it has a well-established heritage (see, for instance, Elmore, 1979/80; Hill and Hupe, 2002). O'Toole (2000, p. 266) explains that in the public policy context, implementation research, 'concerns the development of systematic knowledge regarding what emerges, or is induced, as actors deal with a policy problem'.

Given its long tradition, developments in implementation research in the field of public policy have influenced the more recent implementation research in the field of

[14] Dissemination, according to Schillinger (2010, p. 1), is, 'the targeted distribution of information and intervention materials to a specific public health or clinical practice audience'.

evidence-based practice (see, for instance, Bergen and While, 2005; Fixsen et al., 2005). Indeed, with Peters et al. (2013, p. 27) noting that a 'great strength' of implementation research in health and social services is its capacity to draw on multiple perspectives and multi-sectorial insights and to 'tap into different sources', Burke et al. (2012) argue that it is important to recognise the important insights – when researching the implementation of health and social care initiatives – that can be gained by examining the implementation of public policy.

The latter, notes Hill (2009), became the focus of intense interest in the 1970s – in the wake of Pressman and Wildavsky's (1973) seminal work on the shortfall between government policy and its execution at local level – with a series of studies in the U.S. and Europe. Hill (2009) explains that subsequent developments would see the emergence of debates between proponents of 'top-down' and 'bottom-up' approaches to implementation. Advocates of the top-down approach, explain Howlett et al. (2009), see a clear distinction between policy formation and policy implementation, viewing effectiveness in terms of adherence to original policy intent. From this perspective, explains Hill (2009), if there are clear and robust causal links between goals and actions and appropriate resources and distinct chains of command, failure to implement policy can be attributed to errors in strategy and machinery. This approach, however, has attracted a number of criticisms, including: a neglect of the contribution of the actors at various stages of implementation beyond central decision makers; an incompatibility with complex situations involving multiple policies and agencies; an over-estimation of the impact of government action; and a reliance on unrealistic preconditions (Buse et al., 2005).

The bottom-up approach, on the other hand, sees the focus of interest shift to the influence of local actors affected by and co-responsible for implementation (Sabatier, 1986). Rather than drawing a rigid distinction between policy and implementation, there is acknowledgement of the interaction between agencies and individuals in shaping policy (Howlett et al., 2009). There is recognition, moreover, that even when conditions for implementation are optimal, change can still occur in unforeseen ways (Buse et al., 2005). Instead of judging the effectiveness of a programme in terms of adherence to central directives, the bottom-up approach

therefore places greater importance on how it is re-shaped on the ground in order to achieve given objectives (Howlett et al., 2009).

A notable influence in the study of policy implementation from the bottom-up perspective has been the work of Lipsky (1980) and his examination of the adaptive behaviour of those at the front-line of service delivery, whom he terms 'street level bureaucrats'. This has been of particular relevance to health and social care, inasmuch as it has been argued that front-line professionals in these fields possess much of the intellectual, creative and social care capital in healthcare organisations (Walshe and Smith, 2006) and are active in an environment where negotiation and conflict are inevitable (Buse et al., 2005).

Later theorists have sought to synthesise top-down and bottom-up positions in a manner which can reconcile the roles of professionals, service users and other stakeholders in the implementation of policy with the authority of central policy-making bodies (Hill, 2009). Barrett and Fudge (1981), for instance, have incorporated differential power and the involvement of higher level actors in negotiations as policies are applied. Elmore (1978; 1979/80) has suggested that in the study of complex events, mixed research methods in combination with a variety of theoretical models can produce a multi-level analysis and that 'forward mapping' and 'backward mapping' approaches can help policy makers identify the incentives that affect the behaviour of implementers.

In addition, Sabatier (1986) has proposed an 'advocacy coalition' approach to examine the implementation role of actors at different levels, whilst 'third generation' implementation theory has seen attempts to move beyond a perceived reliance on descriptive and fragmented analyses of earlier writers to develop explanatory and predictive implementation studies (see Goggin et al., 1990). According to O'Toole (2000), implementation studies have reached a point where the general strengths of bottom-up and top-down approaches have been recognised, with complementary research now commonplace. Indeed, according to Peck and 6 (2006) elements of both top-down instruction (emphasising adoption) and bottom-up negotiation (emphasising adaptation) should be part of any effective approach to implementation.

With Fixsen et al. (2005) noting that such wider developments have influenced current understanding of the development and evaluation of implementation as it relates to evidence-based programmes and interventions, they explain that their review of the literature of implementation research produced a commonality of factors and processes across many different domains. One such commonality, Fixsen et al. (2005, p. vi) emphasise, is that the use of systematic implementation practices, 'are essential to any national attempt to use the products of science – such as evidence-based programs – to improve the lives of its citizens'.

Attempts to ensure a systematic approach to the implementation of evidence-based practice in the UK saw the 2006 creation – at the request of the then Chief Medical Officer of England/UK Government Chief Medical Advisor Sir Liam Donaldson – of a High Level Group on Clinical Effectiveness[15] (Eccles et al., 2009). The request was made following Sir Liam Donaldson's report of the departure of clinical decisions from research evidence within the NHS and of unnecessary, 'clinical practice variation' (DH, 2005a, p. 16). The group – convened by Professor Martin Eccles at the request of chair Professor Sir John Tooke – was subsequently named the Clinical Effectiveness Research Agenda Group (CERAG: see Eccles et al., 2009). That it was considered necessary to convene such a group would seem to reflect the recognition of the necessity of employing a systematic approach to implementation and the acknowledgement that implementation is a challenging and complex process (see, for instance, Greenhalgh et al., 2004; Dopson and Fitzgerald, 2005; Australian Government/Australian National Audit Office, 2006; Institute of Medicine, 2007; Bond et al., 2009).

Indeed, the literature of the implementation of evidence-based practice frequently includes lists of potential barriers to this process. Barriers that have been identified include: an absence of personal contact between researchers, policy makers and practitioners; a lack of time, resources and encouragement; obstructive organisational structures and decision-making processes; inopportune timing of research; poor quality or limited availability of research; poor reporting of research;

[15] Clinical effectiveness, according to the Royal College of Nursing (1996, p. 3), 'provides a framework for linking research, implementation and evaluation in clinical practice' and is concerned with, 'doing the right thing in the right way for the right patient at the right time'.

lack of authority for clinicians to make changes; negative attitudes about knowledge and use of evidence-based practice; political influence; professional and cultural factors; resistance to change; and vested interests (see, for instance, Elliott and Popay, 2000; Innvær et al., 2002; Petticrew et al., 2004; Cooksey, 2006; Mitton et al., 2007; Nutley et al., 2007; Armstrong et al., 2008; Bowen et al., 2009; Houser, 2011; Burke et al., 2012).

Alongside the barriers to the effective implementation of evidence-based practice, the literature contains numerous examinations of the factors that can facilitate this process. For instance, researchers have identified: global-level facilitators, such as the creation of international collaborations and associations and the use of scientific journals to circulate high quality research (Oliveri et al., 2004; Poolman et al., 2007); national-level facilitators, including governmental requirements to introduce the study of evidence-based practice in healthcare educational establishments or the creation and financing of regulatory professional bodies to assure quality and the use of guidelines (Al-Almaie and Al-Baghli, 2004; Melnyk et al., 2004; Ubbink et al., 2011).

Researchers have identified hospital board-level facilitators, such as the creation of research councils and the allocation of budgets to promote high-quality research (Mehrdad et al., 2008; Brown et al., 2009; Ubbink et al., 2011); management-level facilitators, including the evaluation of ward-level evidence-based practice activities, the building of an infrastructure and environment that support the use of evidence-based practice and the provision of non-patient hours for staff (Palfreyman et al., 2003; Gale and Schaffer, 2009; Brown et al., 2010; Ubbink et al., 2011); and educator-level facilitators, such as the formulation of curricula and educational programmes in collaboration with healthcare professionals and the use of interactive face-to-face education (Al-Almaie and Al-Baghli, 2004; Al-Omari and Al-Asmary, 2006; Poolman et al., 2007; Gerrish et al., 2008; Gale and Schaffer, 2009).

Researchers have also identified faculty and researcher-level facilitators, including the documentation, analysis and interpretation of the effectiveness of actions and the support of professionals in clinical settings (Mehrdad et al., 2008; Brown et al., 2009); service-level facilitators, including the provision of medical library facilities

and computer and internet facilities (Al-Almaie and Al-Baghli, 2004; Melnyk et al., 2004; Ubbink et al., 2011); workplace-level facilitators, including the provision of access to evidence-based practice mentors and time and personnel dedicated to evidence-based practice activities and regular research meetings (Andersson et al., 2007; Poolman et al., 2007). Finally, researchers have identified cultural-level facilitators, such as regular emphasis on the importance of evidence-based practice to daily practice and patient-care, the empowerment of nurses to influence change and the demonstration of willingness to facilitate the process of implementation (Parahoo and McCaughan, 2001; Amin et al., 2007; Gerrish et al., 2008; Brown et al., 2009).

There is some agreement, furthermore, that implementation is more effective when a variety of strategies is utilised (Fine et al., 2003; Schechtman et al., 2003; Gotham, 2004; Rohrbach et al., 2006). Guldbrandsson (2008), for instance, explains that the chances of successful implementation are enhanced by combining the distribution of guidelines for new routines with education, practical training, coaching, feedback and consultation. There is also some consensus that implementation strategies need to address the perspective of both the individual practitioner and that of the organisation (Katz et al., 2004; Greenhalgh et al., 2004; Murtaugh et al., 2005; Nieva et al., 2005). Jones et al. (2004) note that when, conversely, practitioners decide individually what evidence to use in practice, considerable variation in practice patterns results; such variation, warns Titler (2008), can lead to adverse patient outcomes.

A number of experts also note that implementation is not an event but a process that occurs in discernible and incremental stages (see, for instance, Fixsen et al., 2005; Guldbrandsson, 2008; Walshe, 2009; Saldana, 2014). Whilst Burke et al. (2012, pp. 6 – 8) indicate that the latter's exact number – and the labels and meanings assigned to them – may vary, they add that it is possible, in broad terms, to discern the four consecutive stages of 'exploring and preparing', 'planning and resourcing', 'implementing and operationalising' and 'business as usual'. It is also argued that in order to facilitate successful implementation, research evidence needs to be conceptualised, conducted and communicated in a manner that is meaningful to decision-makers (Davies and Nutley, 2002; 2008; Petticrew et al., 2004); that it needs to be accessed, assessed and properly applied (Bowen et al., 2009); and that

researchers and decision-makers need to work in partnership to fund and conduct research that addresses key policy questions (Nutley et al., 2007).

Another important factor that can facilitate the implementation of evidence-based practice, suggest Rycroft-Malone and Burton (2010), is the application of theoretical models or frameworks to the development and evaluation of interventions. Rycroft-Malone and Burton (2010) argue that this can help to identify appropriate outcomes, measures and variables – thereby paving the way for the development of further theory and focused and appropriate evaluation – as well as enhancing the understanding of what influences and mediates success. According to May (2013) the goal of the development of implementation theory is the production of a robust set of conceptual tools that can enable researchers and practitioners to identify, describe and explain important elements of implementation processes and their outcomes.

Rycroft-Malone and Bucknall (2010) explain, however, that there is no single theoretical model that represents all of the complexities of the implementation of evidence-based practice. On the contrary, Titler (2008) draws attention to the existence of multiple models that are used across a variety of clinical settings. But Titler (2008) adds that these models often include a number of common elements, such as: the selection of a practice topic (such as discharge instructions for individuals with heart failure); the critiquing and synthesis of evidence; the implementation and evaluation of the impact on patient care and provider performance; and the consideration of the context/setting in which the practice is implemented.

Peters et al. (2013) explain that many theoretical models of implementation of evidence-based practice attempt to explain individual or group behaviours around implementation issues. Peters et al. (2013) draw attention, for instance, to: the RE-AIM (reach, efficacy, adoption, implementation, and maintenance) framework, commonly used in health promotion interventions where it is used to provide a practical approach to evaluating the effects of health interventions through changes in individuals, organisations and communities; the Diffusion of Innovations Theory, which seeks to explain how innovations spread; and the Consolidated Framework for

Implementation Research (CFIR), developed as a way of consolidating the various theories and terms used to support further development of theory and testing *vis-à-vis* the translation into practice of effective health interventions.

In a review of 'knowledge translation' – defined by Grimshaw et al. (2012, p. 2) as the process of, 'ensuring that stakeholders are aware of and use research evidence to inform their health and healthcare decisionmaking' – Estabrooks et al. (2006) also draw attention to the existence of numerous models of research utilisation. In the field of the implementation of evidence-based practice in nursing, for instance, Estabrooks et al. (2006) list: the Conduct and Utilization of Research in Nursing (CURN) model, based on a problem-solving approach that sees knowledge transferred through linkages when a practice problem is encountered and which relies on a reciprocal relationship between the users and producers of knowledge; the Western Interstate Commission on Higher Education in Nursing (WICHEN) model, again based on a problem-solving approach, and which draws on concepts of diffusion of innovation and planned change and relies on nurses acting as organisational change agents; and the Iowa Model of Research Use in Practice, which sees triggers in practice acting as catalysts for knowledge-seeking and relies on clinicians incorporating research into practice when a trigger is encountered (and when traditional knowledge cannot be used to solve a problem).

However, just as Estabrooks et al. (2006, p. 25) report that there is, 'no satisfactory overarching knowledge-translation theory', they also note that the study of research into the implementation of evidence-based practice lacks terminological and definitional clarity. Indeed, in McKibbon et al.'s (2010) literature review of the language of knowledge translation, the researchers draw attention to the use of approximately one hundred terms – and lack of standardised definitions – to refer to related research; this is a situation which, the researchers suggest, is tantamount to a modern-day 'Tower of Babel' (2010, p. 1). Similar findings were recorded by Tetroe et al. (2008) in their study of knowledge translation in thirty-three research-funding agencies across Australia, Canada, France, the Netherlands, Denmark, Norway, Sweden, the UK and the U.S. Using semi-structured interviews with agency key informants and web-site information, Tetroe et al. (2008) identified twenty-nine definitions of knowledge translation to refer to various aspects of clinically effective practice. Noting that the lack of terminological and conceptual

clarity and consistency militated against an understanding of how and by whom knowledge translation should be operationalised, Tetroe et al. (2008, p. 152) stress that these factors constitute the 'largest looming barrier' to advancing the knowledge translation agenda.

But alongside McKibbon et al.'s (2010) reference to knowledge translation's 'Tower of Babel', Peters et al. (2013a, p. 1) draw attention to the 'confusion' surrounding the 'terminology and scope' of implementation research, just as Eccles et al. (2009, p. 2) note the analogous 'confusion' surrounding the terminology of clinically effective practice. Indeed, with the burgeoning interest in research into the implementation of evidence-based practice having witnessed the emergence of a host of related terms – such as 'quality improvement', 'dissemination', 'uptake', 'knowledge transfer', 'delivery science', 'research use', 'translational research', 'dissemination research', 'diffusion research' and 'knowledge translation' – there is widespread recognition that the field lacks terminological, definitional and conceptual cohesion (see, for instance, CERAG, n.d.; Fixsen et al., 2005; Tetroe et al., 2008; Damschroder et al., 2009; Eccles et al., 2009; Woolf, 2008; McKibbon et al., 2010; Schillinger, 2010; Makic and Fink, 2011; Glasgow et al., 2012; Colquhoun et al., 2014).

Fixsen et al. (2005) argue, however, that this lack of cohesion reflects the field's relative novelty. Indeed, it is this very novelty that, suggest McKibbon et al. (2010, p. 8), may account for the terminological flexibility of knowledge translation. But McKibbon et al. (2010) hasten to add that in order to facilitate the assessment of the application of evidence to practice, the creation of a standardised vocabulary for writing, collaborating, communicating and retrieving information is essential. In the continued absence of such a standardised vocabulary, however, it is argued that the plethora of terms – and concomitant variety of conceptualisations – continues to present a significant challenge to the effective promotion and support of the use of evidence in health and healthcare policy and practice (Lokker et al., 2015).

Indeed, acknowledging that implementation research is beset with 'taxonomic challenges', 'confusion regarding nomenclature' as well as 'significant debate' as to scope, Peters et al. (2013, p. 27) argue that the concomitant lack of understanding as to what implementation research is and the key role it plays in maximising the

benefit accrued from new interventions are amongst the principal reasons why it continues to be a neglected field of study that is beset – in the UK at least – by inadequate funding. But Peters et al. (2013) point out that it is possible to argue that, with many of the interventions and technologies that can reduce morbidity and mortality already in place, greater attention should now be paid to developing the implementation research agenda.

According to Peters et al. (2013), this development requires the following seven actions: recognition of implementation research as a core part of programme implementation; encouragement of researchers to become more engaged in programme activities; facilitation of increased accessibility to/participation in new programmes for researchers; increased funding for implementation research; increased training opportunities for implementation research; increased guidance and opportunities for mentorship to researchers and implementers; and incentives for researchers to become more engaged in making changes in policies and programmes and in academic publication and teaching.

It remains to be seen, however, what notice will be taken of those who call for greater interest in implementation research and the extent to which their arguments will lead to greater funding in this reportedly neglected field. Having explored evidence-based practice and implementation research, in the next section I consider the evidence base for integration.

The evidence base for integration

UK governmental support for the integration of services for the care of specific sub-sections of the population was set out as long ago as 1998 in the discussion document *Partnership in Action* (DH, 1998). In the document, the value of integration for the care of society's vulnerable groups was indicated, with the suggestion that this was an appropriate approach to meet the complex and changing nature of the needs of frail older people, adults or children with mental health problems and/or learning or physical disabilities. Similarly to Kodner (2006), it was noted that because these specific groups of people required input from a number of different agencies, optimum service delivery was achieved through integration of

services. Like the ICN (2004) and Leutz (1999; 2005) it was indicated that single agency working was inappropriate for the care of vulnerable people with complex needs. These people, it was noted, had suffered from an historic lack of co-ordination and fragmentation in service provision, caused by 'sterile arguments about boundaries' that left the most vulnerable in the, 'no man's land between health and social services' (DH,1998, p. 3).

The response was a period of heavy investment in local partnerships in the UK, with moderate estimates of total annual spending of £15 – 20 billion from the early 2000s (Sullivan and Skelcher, 2002). These partnerships, Sullivan and Skelcher (2002) explain, involved 75,000 people in 5,500 local projects relating to economic regeneration, rural transport, child development and health and social care. Contemporary commentators such as Miller and Ahmad (2000) underlined the extent to which partnership working was embedded in policy at this time. Moreover, not only did a series of government documents provide guidelines, but Section 31 Flexibilities of the Health Act (1999) were introduced to facilitate joint-working between health and social services and the NHS. Glendinning (2003) explains that this new legislation was not centrally defined and prescriptive but instead facilitated adaptation to local circumstances through a number of flexibilities, thereby allowing for: the pooling of health and social care budgets for specific services; the delegation of responsibilities and service planning and commissioning to one lead organisation working on behalf of all the partners; and the integration of health and social services within a single organisational, managerial and employment framework.

Just as the years following New Labour's 1997 UK general election victory were characterised by an increased interest in evidence-based practice, they also saw an increased emphasis on partnerships (see, for example, DH, 1997; 1998; 1999). In a similar vein, joint-working ran through a number of key policy documents in Wales (see, for, instance, Welsh Office, 1998; 1998a; NHS Wales/National Assembly for Wales [NAW], 2001; WAG, 2003). A similar insistence on the importance of integration also characterises more recent Welsh strategies relating to: the care of older people (WAG, 2007a; 2008c); to people living with chronic conditions (WAG, 2007; 2008); to people living in rural communities (WAG, 2009c); to primary and

community services (WAG, 2010); to health and social care staff (WG, 2012a); to older people (WG, 2013); and to older people with complex needs (WG, 2013a).

However, many commentators have argued that categorical proof of the effectiveness of integrated working is weakly supported by empirical research (El Ansari et al., 2001; Dowling et al., 2004; Glasby and Dickinson, 2008; Nolte and McKee, 2008; Carnwell and Carson, 2009; Dickinson, 2009; Perkins et al., 2009; Graham et al., 2013; Skills for Care, 2013). Evidence that supports the use of a variety of collaborative designs relating specifically to the care of people living with chronic conditions is also inconclusive (Ouwens et al., 2005). Perhaps most problematic of all have been reports of a dearth of evidence that integrated working benefits service users (El Ansari et al., 2001; Brown et al., 2003; Cameron and Lart, 2003; Glendinning, 2003; Kharicha et al., 2004; Townsley et al., 2004; Dowling et al., 2004; Davey et al., 2005; Dickinson, 2009; Shaw et al., 2011; Cameron et al., 2012). Armitage et al.'s (2009) systematic literature review of health systems integration, for example, draws attention to the dearth of empirical evidence of the impact of integration on outcomes; Powell and Dowling (2006) consider proof of effectiveness to be uncertain; and Williams and Sullivan (2007) note that there is little to show that partnerships have produced any changes (positive or negative) in health status or service provision.

In a literature review of research into the impact of partnership-working in the UK, Dowling et al. (2004) assessed the evidence concerning its effects and investigated the conceptualisation of 'success' in this field. The researchers identified thirty-six peer-reviewed research papers published after 1997 which made an explicit link between partnership working and success. On the one hand, the researchers noted that thirty-one papers focused on factors of process, examining, for instance, how individuals and partners worked together, to what extent there was agreement as to purpose, and the levels of reciprocity and trust. On the other hand, the researchers identified just four studies that specifically considered whether partnership-working had made a difference to the people using services and on the outcomes (see next section for discussion of outcomes) for individuals, with one study focusing on both processes and outcomes. Moreover, Dowling et al. (2004, p. 312) noted that even in

the studies that explicitly investigated whether partnerships had produced successful outcomes, 'the results were ambiguous'.

One such study was Brown et al.'s (2003) evaluation of two integrated co-located[16] health and social care teams in a rural county of south-west England. Brown et al. (2003) used a non-randomised comparative design to compare outcomes for a user group served by two new integrated health and social care teams with those for a group of patients served by more 'traditional' arrangements over a period of eighteen months. The researchers noted that the co-located integrated teams – of primary care and social care staff – were based in a GP practice and in a health centre (attached to a GP practice), with the comparison site consisting of a Social Services Department (SSD) team and a separate team of district nurses attached to a GP practice.

Brown et al. (2003) explain that the study sample comprised people aged sixty-four and over (registered with one of the GP practices taking part in the research) who were referred to the SSD for a community care assessment between July 1999 and June 2000, with the study only including those people who subsequently received an assessment for community care services. Noting that the integrated teams claimed that joint-working could facilitate earlier intervention (and thereby prevent emergency admissions to a residential/nursing home) the researchers explained that the main outcome-measure used was the proportion of people who remained living independently at eighteen months from the initial referral date. This, alongside speed of response from the referral to assessment, was used with the whole sample (n= 393). Additionally, the researchers used secondary outcome measures with a sub-sample of service users who agreed to be interviewed. Semi-structured qualitative interviews (n=207) were carried out with people using the new integrated teams (n=109) and the traditional teams (n=98) during which issues relating to the secondary outcome measures were covered in addition to more general discussion regarding service users' experiences and satisfaction with the process of asking for and receiving help.

[16] According to the British Medical Association (BMA, 2012, p. 6), co-location is a process of, 'professionals from different organisations being located in and potentially working together from the same place to offer a common service'.

Contrary to expectations, Brown et al. (2003) reported that less (rather than more) of the group of people using the integrated teams remained living independently after eighteen months compared to the group using traditional teams. The researchers pointed out that there were no discernible differences between the two groups as regards systems and outcomes measures pertaining to: contact with social services, visits made by a district nurse, functional ability and mental functioning. The researchers also noted that whilst the speed of response from referral to assessment was faster for the group served by the integrated teams, people from this group more often reported depression as well as scoring lower for Quality of Life. Moreover, Brown et al. (2003, p. 92) reported that:

> The qualitative part of the interviews did not reveal any major differences between the groups in relation to their experience of asking for help or their satisfaction with the services which they received.

A number of subsequent UK studies have reported similarly mixed findings in terms of the effectiveness of integrated working (for instance, Kharicha et al., 2004; Townsley et al., 2004; Davey et al., 2005). In a similar vein, in the evaluation of the English Department of Health's Integrated Care Pilots (RAND Europe and Ernst and Young 2012) the researchers noted that fifty-six per cent of staff who completed a questionnaire felt that care for their patients had improved as a result of the pilot, with staff interviewees also reporting that they believed that their patients were receiving better care. However, whilst the researchers noted that service users reported better co-ordination of care following discharge from hospital and the increased use of care-plans, fewer reported that their doctors or nurses involved them in decisions about care, that their views were taken into account or that they were able to see their preferred nurse.

Nevertheless, researchers of a number of local projects across the UK claim that these have made important steps towards integrated working. These include projects in Torbay (Thistlethwaite, 2011); Barking and Dagenham (Wistow and Waddington, 2006); Sedgefield (Hudson, 2006a; 2006b); Castlefield (Lyon et al., 2006); South Devon and Torbay (Sonola et al., 2013a); Bexley, Bromley and Greenwich (Sonola, et al., 2013); and Pembrokeshire (Thiel et al., 2013). Furthermore, a number of international studies are frequently cited as having provided evidence to support the integration of health and social care (Curry and Ham, 2010). Some of these I

referred to in Chapter One (see section, 'Improving the care of people living with chronic conditions: the importance of integration'). Additionally, Kodner (2009a) refers to the success of the *Program of All-inclusive Intensive Care for the Elderly* (PACE) and *Social Health Maintenance Organisations* (SHMOs) in the U.S., whilst notable projects in Francophone Canada are the *Système de Services Intégrées pour les Personnes Âgées en Perte d'Autonomie* (SIPA; see Béland et al., 2006) and the *Program on/of Research for Integrating Services for the Maintenance of Autonomy* (PRISMA; see Hébert et al., 2005; 2008).

Rosen et al. (2011) conducted case studies of four organisations integrating health and/or social care across different providers, comprising: a government-funded network to improve access to/quality of Medicaid services in North Carolina, U.S.; an independent practice association in New York, U.S.; an organisation providing support to GPs to deliver integrated care for people living with diabetes and other chronic conditions in Maastricht, the Netherlands; and a health and social care partnership in North Lanarkshire, Scotland. Rosen et al. (2011) explain that data were collected through document analysis and semi-structured interviews with senior executives, clinicians and managers from each organisation. The researchers reported that between nine and fifteen interviews were conducted at each site (no site-specific details were provided).

Rosen et al. (2011) explain that the interview-guide used open questions regarding: how interviewees understood integration; the goals that the organisation was pursuing through integration; and the factors that supported or hindered integration. The researchers included specific prompts regarding: the influence of factors internal to the site; data and information systems; financial and non-financial incentives; governance arrangements; leadership; the characteristics of teams and individuals; and the characteristics of the wider health system. Rosen et al. (2011, p. 22) note that their research identified six, 'key ingredients for progress with information'. However, no information was provided *vis-à-vis* the impact on service users' care or their views on integration.

Referring to the greater interest shown in integrative processes than in outcomes (as with Rosen et al.'s [2011] study), Glasby and Dickinson (2008, p. 28) contest that

many claims made by health and social care partnerships regarding potential improvements for service users are, 'more faith than evidence-based'. With Cameron et al. (2012, p. 1) likewise reporting that, 'The evidence base underpinning joint and integrated working remains less than compelling', Perkins et al. (2009, p. 113) go a step further in suggesting that:

> …in the case of tackling health inequalities and improving public health, partnerships hitherto have had only a marginal impact and, on the basis of the admittedly poor evidence available, the cure could be said to have failed.

Reflecting on fifty years of NHS and Local Government integration, Wistow (2012) draws attention to the limited evidence that shows its effectiveness. In a similar vein, Cameron and Lart (2012) note that whilst successive UK governments have set out an agenda of increased structural integration, there remains little evidence as to whether they have been successful in removing the barriers to joint-working. Indeed, whilst in the section 'Integration and service fragmentation' (see above in this chapter) I noted that evidence of care fragmentation was referred to in a report by the House of Commons Health Committee (2012), in the subsequent Government Response (Her Majesty's Government, 2012, p. 2) it was indicated that, 'Integration can deliver real benefits to service users but progress achieved over the years has been limited and continues to be disappointing'.

At the same time, there is limited high-quality evidence of the impact of any model of integrated care for people living with chronic conditions (Singh and Ham, 2006; Nolte and McKee, 2008) just as Ouwens et al. (2005) and Bodenheimer (2008) argue that evidence supporting the use of a variety of collaborative designs relating specifically to the care of people living with chronic conditions is inconclusive. Moreover, it has been argued that service user involvement in the design, commissioning and planning of services has been weak and variable (Wistow, 2005) or has been overlooked completely (Beresford and Branfield, 2006). Indeed, Beresford et al. (2005) note that in projects aimed at incorporating joint-working and client and carer involvement into service-delivery, there is evidence of departmentalism and widespread fear of dominance of a biomedical over a social model of care.

So, whilst McCray and Ward (2003) suggest that the future of integration is positive – especially since issues of hierarchy and interpersonal conflict have to some extent been addressed – they also concede that despite team leaders' faith and positive views of their teams, quality and fragmentation of services remain an issue. However, those who question the validity of partnerships have been seen as confrontational, divisive and lacking common sense (Clarke and Glendinning, 2002). Moreover, it is suggested that there is a tendency for researchers to focus on the *perceived* benefits of integration (Armitage et al., 2009). In a similar vein, Perkins et al. (2009, p. 101) contend that, 'partnerships tend to be viewed a priori as "a good thing"', just as Nolte and McKee (2008, p. 64) argue that collaborative practice has a, 'logical appeal'. Davies (2002) suggests that this popularity has been enhanced by a widespread belief in partnership working that began to establish itself in the UK's political consciousness following New Labour's 1997 general election victory, arguing that, 'It is easy to assume partnership generates added value in a political-ideological culture that assumes it will' (2002, p. 176). Having described how the belief in the benefits of integrated working contrasts with a lack of robust evidence, in the next section I explore the difficulties in assessing how integration can be measured.

Assessment issues

In the first section of this chapter, I explained that the case for integration appears to have been hindered by language issues. However, in their literature review examining the impact of partnership working in the UK, Dowling et al. (2004) note that the situation has been exacerbated by an under-developed approach to assessment and, 'the rudimentary state of the art of conceptualising, measuring and demonstrating the success of partnerships' (2004, p. 315). In a similar vein, Billings and Leichsenring (2014) suggest that, notwithstanding increased international research into integrated health and social care for people living with long-term conditions, challenges remain *vis-à-vis* the acquisition of robust comparative information that can enable judgements to be made regarding the best approaches to adopt.

Others note that collaborative initiatives are inherently long-term and ill-suited to experimental research methods (Houston, 2008). The situation is not helped, it is

argued, by the frequent involvement of many partners and different interventions amidst broader initiatives, where attribution of change to a specific element can be particularly challenging (Kreuter et al., 2000). Indeed, in a report into health inequalities by the House of Commons Health Committee (2009), attention was drawn to the inherent difficulties of isolating and establishing causal links amidst the many variables of complex collaborative interventions and the length of time needed to detect the effects of policy change. Accordingly, it has been argued that the lack of evidence is perhaps a reflection of the complexity of evaluation rather than failings *vis-à-vis* the impact of health and social partnerships, with Dickinson (2009, p. 157) positing that:

> One possibility, therefore, is that the lack of unequivocal evidence linking partnerships to service user outcomes might be an expression of this complexity, rather than a lack of impact *per se*.

Indeed, Dowling et al. (2004) point out that successful integration is conceptualised in different ways by different people, with Thomas and Palfrey (1996) suggesting that this mirrors the way in which an integrated service, by definition, involves multiple stakeholders with differing conceptualisations of success. This is reflected in the wide variety of methodologies and measurements – even for similar indicators and outcomes – that are used to measure integrated programmes (Kodner, 2009a). Whilst Kodner (2009a, p. 73) adds that this renders consistency in evaluation of integrated projects problematic, he also suggests that it is difficult to compare like with like when the best integrated care for older people involves 'finding specific solutions to local problems'. In a similar vein, Leutz (2005) contends that all integration is local, later adding (Leutz, 2009) that joint-working should be tailored to the objectives and mechanisms of the specific initiative.

However, in their literature review of joint-working in health and social care, Cameron and Lart (2003) found that evidence has largely failed to take the multiple perspectives of all of the people typically involved in integrated projects into account. For instance, whilst the researchers identified many studies that examined service-provider viewpoints, they found few that examined improvement in outcomes from the clients' perspective. Similar comments were made in Cameron et al.'s (2012) update of the 2003 review, with the newer version including fifty-eight

UK-based peer-reviewed evaluations of different models of joint-working across the health and social care interface published since 2000. According to Cameron et al. (2012, p. 16), one of the main problems of the research evidence of integrated working to date has been that:

> The voice of service users and carers remains largely absent. Their views are not routinely collected in evaluations, which makes it almost impossible to comment on the outcomes that matter to the people who use services.

This is despite the fact that Cameron et al. (2012) emphasise that the priorities of service-providers and national policy-makers may differ from those of service users, with the latter less interested in the configuration of services than in how their own needs are addressed. A failure to take such factors into account has been seen as a fundamental weakness in UK policy, with Petch et al. (2005) arguing that central government has frequently neglected to frame partnership policy in terms of the outcomes desired by service users. Indeed, rather than focussing on outcomes, it has been argued that there are many more studies of partnership and integration in health and social care that concentrate on assessing process (ICN, 2004; Glasby and Peck, 2005; Kodner, 2006; Dickinson, 2008; Glasby and Dickinson, 2008). In a literature review of partnership-working carried out by the National Primary Care Research and Development Centre ([NPCRDC], 2007, p. 2), for instance, it was noted that:

> Research focussing on 'outcomes' is very limited. Hence there is little to show, one way or the other, that partnerships have produced changes in health, services and carers' experiences.

In the review, it is explained that 'process' is how a partnership functions and 'outcome' is its impact on services, carers and health status. It is further explained that issues of process include partners' commitment, shared aims and inter-dependency, levels of reciprocity, trust and respect, financial and legal implications, accountability, leadership and management arrangements and that issues of outcome include service accessibility for clients, equitability of service distribution, efficiency, effectiveness or quality of services and improvements in the experience of staff who provide care (NPCRDC, 2007). Whilst outcomes-measurement does not relate exclusively to the experiences of clients and carers, it is nonetheless this

measurement that has been frequently neglected in research to date (Petch et al., 2007; Coulter 2006; 2012).

This is a curious situation, arguably, given the centrality of client perspectives in UK policy and guidelines relating to integration and the importance attached to the use of evidence-based practice (Rummery, 2002; Muir Gray, 2009). But debates concerning validity tend to focus on selective understandings of what constitutes sound evidence (Humphries, 2003). For example, Glasby (2011b) notes the traditional dominance of a healthcare model that is quantitative in approach and that favours experimental design. However, Glasby and Beresford (2006) suggest that research designs should be determined by the questions that need answering and argue, for instance, that the experience of those admitted to a mental health hospital is best investigated by qualitative interviews. Indeed, Cook et al. (2007) argue that this 'lived experience' must be considered in order to assess how clients and carers feel about services. The quantitative randomised controlled trial – long seen as the 'gold standard' of health care research – is therefore, it is argued, an inadequate measurement tool in the complex field of integrated care (Woodard, 2007).

Instead, Gilbert (2006) considers that in terms of measurement of outcomes, the 'gold standard' is only attainable by taking into account the perspective of clients, with Nies (2009) noting that the effectiveness of partnership working should be assessed against the extent to which it delivers quality of life. Nocon and Qureshi (1996) concur, adding that any other approaches are likely to be inappropriate. Telford et al. (2006) explain the central role of 'patient stories' in the delivery of appropriate care of people living with chronic conditions, with the individual experience of clients the starting point for developing sensitive, client-focussed systems of care. This, according to the CSIP/ICN (2006), is an integral component of the implementation of key drivers for change and improvement in services.

The development of a set of questions that could be used to measure service users' experiences of integrated care was the goal of King et al.'s (2013) five-phase study. The first phase was an evidence review focussing on literature describing key domains of integrated care. The second phase comprised four qualitative focus groups (conducted in Oxfordshire, England), two with people living with long-term

physical/mental health conditions (n=6 and n=7) one with people living with long-term mental conditions (n=3) and one with informal carers (n=9). King et al. (2013, p. 19) explain that participants were invited to describe their experiences of health and social care with specific reference to 'integrated care' or 'care co-ordination', and encouraged to elaborate on components of care that were important to them based on good or bad experiences. The third phase, King et al. (2013) explain, was a desk review of existing surveys and drafting of questions for testing, with the aim of identifying additional considerations to inform question development. The fourth phase was an 'owners' workshop' attended by representatives from national survey owners, with the aim of highlighting issues with the developed questions before cognitive testing. The fifth phase, finally, consisted of cognitive testing, with three rounds of testing carried out with patients, service users and carers. King et al. (2013, p. 6) explain that the study produced a set of eighteen recommended questions that could be used in national surveys to help providers and commissioners to, 'identify, explore, and challenge poorly integrated care locally'.

Despite such developments, Glasby (2011) contends that evaluative research in health and social care has been strongly influenced by method-led approaches derived from effectiveness studies carried out by organisations such as the Cochrane Collaboration and NICE. This is also true, it has been argued, for evidence-based policy making, where there has been a tendency for measurement based on a positivist worldview (Bate and Robert, 2003). Nevertheless, the position of primacy enjoyed by such long-standing approaches to programme evaluation has been challenged as ill-suited to real world research, with Pawson (2006) considering such methods to be purgative of context. Glasby and Beresford (2006) therefore argue for a more inclusive conceptualisation of evidence-based practice that takes account of the socio-cultural complexities and multiple perspectives involved in health and social care research.

This, Glasby and Beresford (2006) argue, should be based on the following four core assumptions: the best method for answering any research question is by using the most appropriate methods (rather than a pre-defined hierarchy); some questions necessitate proximity to the research subject (rather than the distance and objectivity associated, for example, with randomised controlled trials); the need to incorporate

as broad a range of material and voices as possible; the need to examine the experience of service users and carers and the knowledge-base of practitioners. Furthermore, alongside a limited number of controlled studies that identify which specific elements are effective in integration and long-term care (Nies, 2009), there has been a recognition that the study of integration is ill-served by current approaches to the measurement of the quality of processes and outcomes (El Ansari and Weiss, 2005; Dickinson, 2008).

Outcomes have been defined as the, 'impact, effect or consequence of help received' (Nicholas et al., 2003, p. 2). Viewed in these terms, they are the net result of all the actions of an organisation on a service user's experience. However, there is widespread recognition that measuring outcomes and examining the effects of health and social care interventions on those outcomes are complex tasks (Cheetham et al., 1992; Qureshi and Nicholas, 2001; Nicholas et al., 2003; Davey et al., 2005; Netten, 2011; Cameron et al., 2012). Moreover, Netten (2011) notes that what is meant by an outcome inevitably varies on the context and scope of what is under consideration. This is perhaps not surprising given that most services are characterised by: intangibility – they can be neither stored nor tested in advance; heterogeneity – consumers often have different priorities; inseparability – it is only in the interaction with clients that services are produced (Lewis and Hartley, 2001).

Some sociologists have argued that it is not necessarily possible to obtain objective measures in a research environment that is both dynamic in nature and subject to many extraneous influences (Guba and Lincoln, 1981; Strauss and Corbin, 1990). This perhaps explains how writers have interpreted quite differently the same integrated schemes. For example, the Command Paper *A Plan for Investment a Plan for Reform* (DH, 2000) included a case study of a partnership between Somerset Health Authority and Somerset County Council that created a combined Trust, the Somerset Partnership Trust (believed to be the first integrated health and social care organisation in England ([Glasby et al., 2010]). The partnership utilised a Joint Commissioning Board (JCB) to organise the care of people living with mental health problems. In the case study included in the government document, attention was drawn to the inclusive nature of the project and to the fact that all major stakeholders – including service users and carers – were represented on the JCB. As regards the

partnership structure itself, moreover, it was indicated in the government document that:

> The benefit for clients is that they have a single care plan, a single key or link worker and a unified multi-disciplinary team to deal with whatever health or social care need they have (DH, 2000, p.71).

However, Peck et al.'s (2002b) evaluation of the Trust's creation was more guarded in its conclusions. The study, carried out over a 30-month period, combined non-participant observation of JCB meetings; analysis of documentation (including meeting minutes); structured interviews with service users; focus groups with service users and their carers; a self-administered survey of all staff members involved with adult mental health provision; semi-structured interviews with senior managers of health and social services; and exploratory workshops with self-selected members of staff.

Peck et al. (2002b) reported that service users' and carers' initial hopes of full involvement in the JCB were replaced by a degree of disillusionment. Whilst one service user reported, for instance, that the agendas of JCB meetings were decided without prior service user/carer consultation – thereby restricting their input into the decision-making process – carers suggested that they were ill-informed and unrecognised as co-members of the care team. Although some service users recognised improved co-ordination within the multi-disciplinary team, this was felt to be compromised by a loss of therapeutic and support groups and the closure of buildings. Finally, whereas there was a general improvement in mental health status, the lack of control study made it impossible to conclude with certainty that this was as a result of integration. In a later appraisal of the research, Peck et al. (2004, p. 47) noted that:

> The establishment of the combined Trust did not appear, by the conclusion of the evaluation period in 2001, to have delivered any significant benefits that had not been delivered elsewhere in England without the transfer of social care staff to NHS employment. This is not to say that it did not achieve change (e.g. improved care co-ordination within co-located teams). However, there is no way of knowing whether comparable change would not have been achieved without the novelty of that application.

Arguably, the episode highlighted two important issues of research into integration in health and social care: the first was whether or not changes were due to the application of integrative practice or to outside factors that have been overlooked:

the issue of attribution; the second was whether or not specific changes were set out as a pre-defined goal at the outset of the project or were unforeseen: the issue of unintended outcomes. According to Petch et al. (2005) problems of attribution are frequently encountered because it is difficult to rule out extraneous factors. Safford et al. (2007) argue that this is particularly true in the care of people living with chronic conditions, especially in the community. The latter, Safford et al. (2007) point out, is an environment characterised by changing power relations and intricate social processes that easily confuse the link between cause and effect and in which, moreover, outcomes may not be obvious for many years. As for unintended outcomes, the difficulty of untangling potential contributory elements has been noted by Levin et al. (2002).

Levin et al.'s (2002) prospective study assessed the feasibility of comparing alternative approaches to integrated working between health and social care in the community setting, with the researchers comparing two mainstream health and social care collaborations for the care of people aged over seventy-five in two London boroughs. The researchers added an extra dimension by attempting to replicate the challenges of inter-agency working by making the research project itself a collaboration between two teams based at separate sites. Levin et al.'s (2002) study included several different methods of data collection: interviews with health and social care managers and practitioners (n=69) to assess joint-working arrangements and the training and support required for its development; systematic data collection of people (n=224) aged seventy-five or over (previously referred to the locality teams) with complex long-term care needs; baseline assessments of older people (n=79) divided across both areas in the community setting; interviews with main carers (n=47) to assess their physical and mental state and satisfaction with services; follow-up interviews with carers and clients after six months to evaluate satisfaction with services and outcomes; and analysis of methods to log and assess the health and social care input into care packages.

Whilst Levin et al. (2002) noted that there were challenges in comparing and measuring integrated health and social care services in the community setting at each stage of the research project, two examples provide an indication of the difficulties they faced. Firstly, the participation of health and social care professionals was not

consistent and frequently relied on individual goodwill. Social workers' participation, for example, was influenced by the enthusiasm and backing of senior or team managers. This was not the same for the managerially and professionally autonomous GPs. The absence of accountability to senior managers meant the latter alone decided whether or not to co-operate (both in the research project and in the integrated project itself). This varied according to interest-levels in and knowledge of older people's health issues, the support staff available in each practice, work-load, and the importance attached to closer working with social services. Secondly, existing computerised systems could not always provide necessary research information, Levin et al. (2002) reported. This reinforced the importance of co-operation at individual practitioner-level; it made the tracking of clients very time consuming, due to procedural differences in recording client-contact of GPs and social workers; it complicated collection and comparison of client information due to inconsistency in data collection and storage, plus differences in quality and content of logs across the various GP practices.

The researchers found the comparison of different strategies for integration to be complex, labour-intensive and time-consuming. Whilst Levin et al. (2002) reported that some information gained from the research was useful in its own right, they noted that service users' experience and the outcomes of services could only be explained partially without an in-depth and multi-faceted approach. Moreover, the varying degrees of health and social care professional participation had implications as to the extent to which structural change alone could improve services without an accompanying cultural change (a subject to which I return in the next section).

Comparing Levin et al.'s (2002) research with the development of the Somerset JCB, arguably, helps elucidate how outcomes depend on the interplay of many factors within a very complex setting. On the one hand, therefore, the Somerset partnership was deemed to have had limited success, without showing a categorical link between cause and effect (Peck et al. 2002b). On the other, it was held up as an example of good practice of partnership working leading to an improvement in outcomes (DH, 2000). But on closer inspection, arguably, what was praised in the government evaluation were those elements that related to the *process* of service delivery rather than the *outcomes* for service users.

In the last two sections I have discussed, on the one hand, the lack of robust evidence to show that integrated working improves outcomes for people using services and on the other, the inherent difficulties in assessing such outcomes. Whilst these discussions appear to be ongoing and unresolved, in the next section I explore some of those factors that are considered to help promote and develop integration.

The determinants of integration: structure or culture?

According to Goodwin and Shapiro (2001), integration is often considered in terms of the development of techniques and models to establish formal and informal collaboration between the health and social care sector, occurring at a number of different levels, including planning and policy making, funding, administration, and the provision and delivery of care itself. Glendinning (2003) refers to the existence of structural frameworks to facilitate integration, the Organisation for Economic Co-operation and Development (OECD)/European Commission (EC) (2013) to the use of multidisciplinary teams supported by case or care management and Leutz (1999) to the connection of health care systems with other human service systems. MacAdam (2008) notes that integration is frequently viewed as a way of reducing the fragmentation and duplication of care, inefficient services and wasted resources that result in poor outcomes for service users. In a similar vein, the literature from the last decade has witnessed a growing recognition that the ultimate goal of integration is to deliver quality of life to service users (Gröne and Garcia-Barbero, 2002; Nies, 2009; Goodwin et al., 2012) and to improve outcomes and people's experience of care (Goodwin et al., 2012; Coulter et al., 2013).

Accordingly, instead of organisations, services, budgets or professions, it is argued that the focus of attention of integration should be on the needs of service users (Humphries and Curry, 2011; Coulter, 2011). Alongside their informal carers, the need to increase service users' involvement in the process of integration has been highlighted by a number of commentators (Hiscock and Pearson, 1999; Nies, 2004; Curry and Ham, 2010; Barnes and Cotterrell, 2012; Coulter et al. 2013) and has been noted in numerous policy documents in Wales and UK-wide (WAG, 2009; 2010; WG, 2012; DH, 2004; 2007). According to Lewis et al. (2010), this places the service user firmly at the centre of the wider framework of integrated care. It is

therefore argued that the level, type and combination of strategies used to integrate services should correspond to the particular needs and challenges of those individuals receiving care (Veil and Hébert, 2008) with an awareness of the wider socio-economic factors that impact on wellbeing considered essential (Improvement and Development Agency/Audit Commission [IDeA/AC], 2006; Woodard, 2007).

However, despite many governmental exhortations for health and social care agencies to work together to improve service provision, the way in which this should be done remains unclear (Powell et al., 2001). On the contrary, just as Goodwin et al. (2012, p. 3) note that there is no 'best practice' model of integration, so Ham and Walsh (2013, p. 2) indicate that there is no 'best way' of integrating care. Notwithstanding, integration is often considered in terms of the development of specific techniques and models to establish formal and informal collaboration between the health and social care sectors (Goodwin and Shapiro, 2001). This can occur at a number of different levels, including planning and policy making, funding, administration, and the provision and delivery of care itself (Curry and Ham, 2010).

Rosen and Ham (2008, p. 2), for instance, explain that integration can be 'real' or 'formalised' using organisational mergers or 'virtual' using networks between different organisations with contracts or informal agreements. Alaszewski et al. (2003) explain that organisational integration can be considered in terms of vertical and horizontal levels. These are, respectively, integration between different components of a supply chain or integration between similar levels of care (Shaw et al., 2011). Alongside a number of other commentators (such as Curry and Ham, 2010, and Petch, 2014) Glendinning (2003) refers to three horizontal levels at which integration can take place, namely macro-, meso- and micro-level. Macro-level integration takes place within national or state ministries or county-level strategic-planning bodies, involving decisions that relate to resource allocation and investment; meso-level integration refers to the operational management of local service units or frontline teams; and micro-level integration is the integration of diverse elements of different services at the individual service user level (Glendinning, 2003).

Glasby (2003) considers integration of services in terms of the relationships that exist within and between different levels. He draws on his review of research studies focussing on hospital discharge to provide evidence of a number of recurrent problems. These include: a failure of health and social care professionals to work effectively together; a failure to involve clients and carers in ongoing care arrangements; the incompatibility of health and social care systems due to different professional cultures; and the existence of structural, organisational and professional barriers. According to Glasby (2003), these problems can be positioned in three separate but related categories, each requiring a different policy response. At the outermost level is the structural level integration existing between central and local government; following this is the organisational relationship between the local authority and the NHS; and at the innermost level is that between the client, carer and practitioner. Glasby (2003) considers that each of these levels depends on and is influenced by the others in a two-way movement. According to Poxton (2004) this makes management across these boundaries a fundamental issue in the drive for 'joined up' health and social care. This is reflected in the way in which researchers have examined integration in terms of individual, operational and structural levels or by focussing on horizontal and vertical integration, either within the same agency or between different ones (Edwards and Miller, 2003; Glasby and Lester, 2004; ICN, 2004; Komp et al., 2004; Fletcher, 2006; Glasby and Peck, 2006).

A number of commentators have used frameworks that categorise partnerships in terms of matrices or continuums of integration. Poxton (2004), for instance, refers to a sliding scale that moves from informal links through to full integration via increments of increasing collaboration. Poxton (2004) points out that there is a growing emphasis on partnership working which concentrates on users' pathways or journeys through the various care systems, the aim being to enable older people to stay in their own homes as long as possible, to make their hospital stays as brief as possible, and to help them remain as independent as possible. Poxton (2004) divides integration into four levels: informal communication between partners relating to their individual outcomes; more formal co-ordination, incorporating a recognised system of information exchange; collaboration, comprising joint-working but maintenance of separate identities; and full integration, with partners working together as one agency.

The AC (1998, pp. 17 – 19), similarly, provides specific details of the functioning of different degrees of collaborative initiative. At the least formalised level, prospective partners can initiate a 'steering group' that has neither specific staff nor budget allocated to the partnership, with service delivery made using each partner's mainstream programme and resources. At the next level, staff from partner organisations are co-located and work to a common agenda, albeit under separate management. Subsequently, there are 'virtual partnerships', in which a partnership adopts a new and separate identity, but lacks legal formalisation. It therefore has all the traits of a partnership, for example, co-located staff who are answerable to the partnership (which has a unique name and logo) but is formally managed by only one of the partners, who also employs all staff. Finally, there is the creation of a 'separate organisation' that has its own legal identity.

Peck (2002) describes a continuum for partnerships in graph-form, allowing potential partners to consider the balance they wish to strike between depth and breadth of relationship. The depth of relationship runs from information-sharing to formal merger (by way of consultation, co-ordination, joint-management and partnership). The breadth relationship runs from two partners (from health and social care) to health and local authority, and health, local authority and wider community. Peck (2002) specifies that this framework highlights the dynamic nature of partnership, with the possibility of repositioning partners (according to breadth or depth) as circumstances change and develop.

Nolte and McKee (2008) draw attention to a series of typologies, laws, classifications and dimensions that have been used to classify integration and to analyse different approaches. Wales' Health and Wellbeing Best Practice and Innovation Board ([HWBPIB] 2013, pp 5 – 6), for instance, notes that the 'key determinants of effective integration of health and social care' are: clarity of strength and purpose; collaborative leadership; a culture of learning and knowledge management; a supportive legislative/policy environment; integrated management structures; trust based interpersonal and interprofessional multidisciplinary relationships; appropriate resource environments and financial models; comparable IT and information-sharing systems; unified performance management systems; and collaborative capabilities and capacities.

In an overview of integrated care in the NHS, Shaw et al. (2011, p. 8), explain that 'five main types' of integration are frequently described in the literature of integrated working, namely: systemic, normative, organisational, administrative and clinical integration. Alongside each type of integration, Shaw et al. (2011, p. 7) describe their accompanying 'allied integrative processes'. Table 2 (below) sets out this relationship.

Table 2: Description of the five main types of integration and allied integrative processes (Source: Shaw et al., 2011, p. 8)

1. Systemic	**Co-ordinating and aligning policies, rules and regulatory frameworks** for example, policy levers emphasising better co-ordinated care outside of hospitals, central impetus for diversity of providers, development of national incentive schemes (for example, the Quality and Outcomes Framework) or financial incentives to promote downward substitution).
2. Normative	**Developing shared values, culture and vision across organisations, professional groups and individuals** for example, developing common integration goals, identifying and addressing communication gaps, building clinical relationships and trust through local events, or involving service users and the wider community.
3. Organisational	**Co-ordinating structures, governance systems and relationships across organisations** for example, developing formal and informal contractual or cooperative arrangements such as pooled budgets or practice-based commissioning; or developing umbrella organisational structures such as primary care federations or local clinical partnerships. (Continued overleaf)

4. Administrative	**Aligning back-office functions, budgets and financial systems across integrating units** for example, shared accountability mechanisms, funding processes or information systems.
5. Clinical	**Co-ordinating information and services and integrating patient care within a single process** for example, developing extended clinical roles, guidelines and inter-professional education, or facilitating the role of patients in shared decision-making.

Similar typologies are described, *inter alia*, by Fulop et al. (2005), Demers and Lavoie (2008), Lewis et al. (2010) and Valentijn et al. (2013). In addition to the five 'types' identified by Shaw et al. (2011) Ramsay and Fulop (2008, p. 11) add 'functional integration'. The latter, Ramsay and Fulop (2008, p. 11) explain, occurs when, 'non-clinical support and back-office functions are integrated'. Whilst Ramsay and Fulop (2008, p. 1) note that these six elements have been considered 'key requirements' for effective integration, they add that this does not mean that every sort of integration will be relevant to every sort of integrated project. Likewise, Shaw et al. (2011) report that the incorporation of specific elements reflects the stakeholders who are involved in a specific project and its goals and resources.

As illustrated in Table 2, one of the 'types' of integration described by Shaw et al. (2011, p. 8) is normative, or the development of 'shared values, culture and vision'. The relative importance of structural and normative features of integration has been widely discussed in the literature of integrated working (Robertson, 2011; Petch, 2014). Peck and Dickinson (2009) and Petch (2014) note that in discussions of partnership working between health and social care organisations, culture is a recurrent theme. Although Mullins (2013) points out that (organisational) culture has many different meanings, Schein (2004, p. 17) suggests that the culture of a social group (in which he includes organisations) can be defined as:

> ... a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.

Hudson has consistently argued that a key factor in achieving successful integration relates to the relationships between those who deliver and use care (see, for instance, Hudson, 2011; 2012). Hudson (2011) contends that despite repeated reorganisations of health and social care systems and the proliferation of policies to encourage partnerships, little progress in achieving health and social care integration has been made since the turn of the millennium in England. In order to address 'wicked issues', Hudson and Henwood (2002, p. 164) have argued for 'new partnerships' which, they contend, should be premised on: *understanding*, a recognition of the need to take account of a variety of viewpoints; *thinking*, based on holism, interactions and relationships; *working*, acceptance of different perspectives, approaches and styles; *involving*, a mentality of inclusion that draws on a wide variety of organisations and interests and is open to public involvement; and *learning*, the promotion of experimentation, diversity and reflection.

Many commentators argue that integration should be viewed as a combination of factors, with structural factors alone insufficient to ensure such success (Goodwin et al., 2012; Petch, 2013). Minkman (2012, p. 348), for instance, explains that the process of integration is often described as 'multifaceted in nature, requiring the integration of structures, processes, cultures and social relationships'. Kharicha et al. (2004, p. 135) note that: 'It appears that good working arrangements derive from the culture, skills and attitudes of the professions involved and are less likely to be the result of structural changes'. In order to examine the relative importance of structural and normative factors, it would seem useful to compare systems that have different levels of structural integration.

Helpfully, this can be done within the context of the UK, given that Northern Ireland has a more structurally integrated system than the rest of the UK (Timmins, 2013). Heenan (2013) reports that since 2007, Northern Ireland has had five fully integrated and fully comprehensive health and social care trusts. Each provider trust covers all primary acute and community health and social care provision, with one central

integrated commissioning body, the Regional Health and Social Care Board. Heenan (2013) notes that each unified trust has a number of key integrated features: it delivers all health and social care; it has 'employing body' status; it has a single financial system; and it has a single strategic approach with an agreed set of aims and objectives. Although the current structure in Northern Ireland dates from 2007, in 1993 it was already considered to possess one of the most structurally integrated systems of health and social care in Europe, having had highly integrated arrangements in place since 1973 (McCoy, 1993).

Heenan and Birrel (2006) conducted a qualitative study of structural and operational factors on the delivery of integrated care in Northern Ireland. At the time of the study (pre-2007), Northern Ireland had eleven Community Health and Social Services Trusts sharing a structure of nine integrated 'programmes of care' (Heenan and Birrell, 2006). These included mental health, physical and sensory disability and care services for older people, all delivered on an interdisciplinary basis. All professionals across the Trusts were employed by the same organisation, had the same source of funding, were co-located, and shared the same goals. Heenan and Birrell's (2006) study consisted of semi-structured interviews (n=24) and three focus groups (participants n=16). The interviewees comprised directors of social services from the boards (n=4), chief executives from the trusts (n=3), and directors and assistant directors from the trusts (n=17). Following the interviews, the focus groups were used to capture the views and opinions of those involved in the management of the delivery of care, including nurses, community nurses and social worker leads involved in integrated programmes of care.

Heenan and Birrell (2006) reported widespread conviction amongst health and social care professionals that integration at an organisational level was an appropriate way of providing care for clients with complex needs, with the perceived benefits of the system including a 'one-stop shop' (2006, p. 50) of co-ordinated health and social care by way of a single point of entry and key worker. The researchers also reported consensus that the co-ordinated approach helped avoid duplication, fragmentation and disorganisation in service delivery, whilst ensuring that vulnerable people did not have to navigate their way around the systems of different care organisations. Interviewees emphasised the client-focussed nature of the service, indicating that this

was facilitated by key structural features, including: a single care manager working across health and social care, thereby providing an overview of co-ordination and monitoring of service delivery and allowing the service to remain client-focussed; a single assessment system, with the co-ordination of assessments involving multiple agencies and professionals, thereby facilitating transfers from hospital to community and the sharing of information; a single budget, facilitating the move from institutional to community care and helping avoid arguments regarding payments and transferral of people across different budgetary systems.

Northern Ireland's integrated system has also been researched using quantitative methods, with Challis et al. (2006) using a cross sectional survey to make a direct comparison with England's care system. Two postal questionnaires were distributed to all English local authority social services departments (n=131) and Northern Irish Trusts (n=11), with response rates of 77% and 100% respectively. The first questionnaire considered care management arrangements for all adult service user groups, the second focussed on people aged over sixty-five. The questionnaires were completed by staff with responsibility for policy formulation or management of community based services in the respective agencies. The researchers used questions related to five 'core' management tasks to reflect the levels of integration within each system: case finding; assessment; care planning; monitoring; and review.

Challis et al.'s (2006) initial proposition was that England's division of health and social care provision should display significant differences from the structurally integrated Northern Irish system. The researchers posited that differences would be most apparent across the following three areas: the process of care (including multi-disciplinary working) and assessment/care planning; care management; and specialist services. By drawing on broad hypotheses regarding integrated services gained by way of a literature review, the researchers sought to test five propositions. The hypotheses were that, in comparison to the English system, health and care services in Northern Ireland should be characterised by: greater involvement of health care staff; a more integrated approach to assessment; a more differentiated approach to care management; a closer link between care management and specialist provision; and a more expansive specialist dementia service. Following data analysis, Challis et al. (2006) reported that across all five indicators there was

evidence supporting greater integration in Northern Ireland compared to England. The researchers concluded that the delivery of health and social care by a single organisation was a significant factor in enabling a more integrated approach to meeting the needs of vulnerable older people through assessment and care management arrangements.

Returning to Heenan and Birrell's (2006) study, however, the researchers also found that negative legacies of inter-professional and cultural differences persisted. For example, the researchers reported ongoing difficulties *vis-à-vis* the dominance of the medical model of care and the frequent diversion of funding away from social care to meet acute care needs. The researchers therefore considered that whilst structural changes had improved services, for integration to become reality involved the adoption of a shared vision, noting that, 'This culture must permeate all levels of service planning and provision in order to provide an integrated mindset' (2006, p. 63).

Similar findings were made in Øvretveit et al.'s (2010) case study of the creation of an integrated health and social care system in Norrtalje, a Swedish local authority area. The researchers examined documents (including the new organisation's administrative plans, and legal/procedural frameworks) and conducted two rounds of individual interviews with: the project's implementation officers (n=2); the project's Chief Executive Officer (CEO) and senior administrative officer; the administrative head of the 'political board'; politicians from the latter (n=2); one private care provider; and heads of health and social services operational units (number unspecified). Whilst the new organisation was launched in 2006, interviews were conducted in the spring of 2008 and the autumn of 2009, with questions related to: how the new structure differed from the old; what preparations were made to implement the change and what factors helped/hindered it; the new structure's impact on working procedures and service-provision and its impact on patient experience and outcomes.

Reporting that changes were hampered by inter-professional cultural differences and professionally protective practices (with regard to boundaries and autonomy), Øvretveit et al. (2010) noted that there were weak incentives to develop co-ordinated

care in the public health and social service system and that management underestimated the need for and lacked the time and resources to develop clinical level integration until after the first phase of macro-level integration. The researchers added that whilst the latter facilitated the development of integration, this could only develop further by way of working closely with clinicians to make changes at micro-level, with actions required to modify the specialised systems and cultures which the new organisation had inherited. This, the researchers stressed, required a significant investment in time. Øvretveit et al (2010) noted (as with so many studies) that it was not possible to ascertain if integration had improved client-outcomes or experiences. Whilst the researchers suggested that the likelihood that this would be achieved had been increased by the structural and procedural changes, they noted that in view of the time-investment required to develop micro-level integration, the expectation was that only after five years would improvements be discernible. Alongside the time-investment necessary to develop integration, one of the study's main messages for managers and policy makers, Øvretveit et al (2010, p. 119) stressed, was that 'both macro- and micro-integration are needed for better care coordination and outcomes'.

According to Ham and Oldham (2009), the importance of different determinants in integrated working was indicated by the experiences of the so-called 'early adopters' of the three flexibilities of the 1999 Health Act (introduced under Section 31) and Care Trust status. Glendinning (2003) explains that the Health Act (1999) flexibilities were introduced to facilitate joint-working between health and social services and the NHS, noting that this legislation was not a centrally defined prescriptive template, but facilitated adaptation to local circumstances through a number of flexibilities. These flexibilities, Glendinning (2003) explains, allowed for: the pooling of health and social care budgets for specific services; the delegation of responsibilities and service planning and commissioning to one lead organisation working on behalf of all the partners; and the integration of health and social services within a single organisational, managerial and employment framework. As for Care Trusts, Ham (2009) notes that these were first announced in the NHS Plan in 2000, with powers to create them included in the Health and Social Care Act in 2001. Ham (2009) points out that Care Trusts combined NHS and local authority

responsibilities within a single statutory NHS body, with local authority councillors on their boards.

The 'early adopters', explain Ham and Oldham (2009), were areas of England that were amongst the first to make use of the Health Act flexibilities and the opportunity to adopt Care Trust status. Ham and Oldham (2009) note that three early adopter areas were Knowsley, North East Lincolnshire and Torbay. Developments in the first two areas have been documented by Wistow and Waddington (2006) and in the latter area by Thistlethwaite (2011). Other areas that were early adopters were Barking and Dagenham (also documented by Wistow and Waddington, 2006), Somerset (documented by Peck et al., 2002a; 2002b; 2004) and Sedgefield (documented by Hudson, 2006a; 2006b).

According to Ham and Oldham (2009), the principal lessons learned from the experiences gained in Knowsley, North East Lincolnshire and Torbay were fivefold. Firstly, local history and context are important factors in developing integration, with different approaches required in different areas. Secondly, integration needs to begin with a focus on service users and the creation of a shared vision across different agencies for future development. Thirdly, integration requires leadership from the top. Fourthly, integration at the front-line of care delivery is key, for instance by bringing together community health and social care teams and aligning them with GP practices. As regards this fourth point, the researchers also referred to the importance of the co-location of teams, a single point of access and a single assessment process. The fifth lesson, the researchers note, is the importance of evaluation, with the value of the work of each area corroborated by external recognition.

Like Øvretveit et al. (2010), Ham and Oldham (2009) stress that structural factors alone are not sufficient to achieve integration, but that this also requires a considerable investment in time. Moreover, a number of the lessons identified by Ham and Oldham (2009) appear to tally with the principles identified by the NHS Confederation (2010, p. 10), namely that integration should be based on: outcomes not targets; cultures not structures; place not organisation; delegation not transfer of functions; and clinical and professional engagement. Having discussed some of the

determinants of integration, in the next – and final – section of this chapter, I consider patient and public involvement initiatives.

Patient and public involvement initiatives

Recent years have witnessed a marked increase in interest across the world in the involvement of service users and citizens in the design and delivery of health and social care (see, for example, Martin, 2008a; Coulter, 2012; Baggott, 2013). With this interest mirrored in the UK, Coulter and Ellins (2006) report that here, 'the term patient and public involvement (PPI) is often used as *shorthand* [my emphasis] to describe the processes by which members of the public can shape service development'. Andersson et al. (2006, p. 9), likewise, report that in the NHS, 'the term PPI is used *loosely* [my emphasis] to refer to a range of initiatives and a number of ways of working that all share a commitment to involving the public'. Before providing a definition of PPI, I begin this section by discussing how this, once again, is a field that has been dogged by terminological issues.

Whilst the fundamental inter-dependency of involvement, integration and partnership working has been highlighted, *inter alia*, by Longley (2013) and by Baggott (2013), as with integration and partnership working – and as the above use of 'shorthand' and 'loosely' seems to suggest – PPI has been criticised for its lack of precision and clarity (see, for instance, Conklin et al., 2010; Renedo and Marston, 2011; Barnes and Cotterell, 2012; Beresford and Carr, 2012; Beresford, 2012; 2013; Carr, 2012; Mockford et al., 2012; Peckham and Willmott, 2012; Baggott, 2013; Dalton et al., 2014). Indeed, Albert and Passmore (2008, p. 11) note that the field is, 'littered with jargon', Forster and Gabe (2008, p. 334) indicate that there is, 'no consensus on terminology' amidst a, 'bewildering diversity of definitions' and Beresford (2012, p. 21) stresses that, 'terms tend to be poorly defined and carelessly used'. Hence, there are numerous reports that terms such as involvement, participation, engagement, empowerment and consultation are used inconsistently: sometimes synonymously, sometimes to denote fundamentally different phenomena (see, for instance, Anderson et al., 2006; Wait and Nolte, 2006; Moriarty et al., 2007; Robson et al., 2008; Mockford et al., 2012; Purtell et al., 2012).

Amidst the different definitions and perspectives, however, Adams (2008, p. xvi) considers involvement to be, 'the entire continuum of taking part, from one-off consultation through equal partnership to taking control' and participation to be that part of involvement, 'in which people play a more active part, have greater choice, exercise more power and contribute significantly to decision-making and management'. As for engagement, according to the King's Fund (2012, p. 4), this is the degree to which people are, 'empowered to be fully involved in their care, share in decision-making, and work with clinicians in meeting their needs'. As for consultation, this is defined by Participation Cymru (2011, p. 6) as a, 'formal process by which policy makers and service providers ask for the view of interested groups and individuals'. According to some (see Cook, 2002; Rowe and Frewer, 2005; National Voices, 2014) consultation is a weakened and passive form of participation in which professionals and statutory agencies retain control of (and power over) processes and outcomes and therefore often leads to little change.

When considering involvement in the provision of health and social care, Ong and Wood (2005, p. 250) point out that it is important to distinguish between the role of patients and that of citizens, explaining that the former is concerned with, 'personal rights and services' and the latter with, '"common good", collective provision and pooling risks'. In a similar vein, Coulter and Ellins (2006, p. 249) note that, 'patient involvement', on the one hand, 'is concerned with the contributions that people can make to decisions about their own treatment and care', and that 'public involvement', on the other, 'refers to the ways in which lay individuals can participate in decisions about the development, planning and provision of services'. Although Coulter and Ellins (2006, p. 249) recognise that there is 'considerable overlap' between patient involvement and public involvement – just as Florin and Dixon (2004, p. 159) point out that a 'spectrum of possible involvement' exists between them – they argue that a clear understanding of PPI has been muddied by a blurring of the distinction between the two.

Likewise drawing attention to the blurring of this distinction, Conklin et al. (2012) – in their systematic review of empirical research into public involvement in healthcare policy – suggest that this has led to confusion and lack of consistency in the way that involvement is theorised and conceptualised. Returning to Coulter and

Ellins (2006, p. 250), they argue that the frequently understood 'shorthand' meaning of PPI – one that is, they suggest, *inclusive* of public involvement in shaping service development but *exclusive* of patient involvement in the delivery of their own care – has only compounded the situation. But this has not stopped PPI from becoming, in the words of Coulter (2006a, p. 29), 'part of the everyday rhetoric of the NHS'.

Glasby (2012) explains that in the UK, widespread use of the term PPI followed the 1997 general election victory of New Labour. With many experts noting that from this time, ever growing interest was shown in PPI (see, for instance, Barnes, 1997a; Forster and Gabe, 2008; Renedo and Marston, 2011; Ocloo and Fulop., 2012; Armstrong et al., 2013), it has been called a, 'central component' (Vincent-Jones et al., 2009, p. 248) a 'central plank' (Andersson et al., 2006a, p. 3) and the 'cornerstone' (Hogg, 2007, p. 129) of the NHS under New Labour. Moreover, the subsequent election of the Conservative/Liberal Democrat coalition has seen no decline in this interest, argue Gibson et al. (2012, p. 531), who assert that PPI is now, 'firmly embedded in the policies of the Department of Health'. A comprehensive definition of PPI is provided by the Nottingham University Hospitals NHS Trust (2014, p. 5):

> PPI defines the way in which patients and the public have a voice in decisions about how healthcare services and research are planned, designed, delivered and evaluated. PPI must therefore operate on three levels: involving individual patients and their carers as partners in decisions about their treatment and care and empowering them to make informed decisions about their healthcare wherever practicable; enabling patients and the public to be involved and consulted on planning, monitoring, evaluating and developing services, proposals to change services and decisions about the way services operate; involving and engaging patients and the public in planning, development, delivery and evaluation of relevant research and research related activities to the benefit of patients and public.

As indicated in the last part of this definition, attention can be drawn to the use of PPI to denote involvement in healthcare research (see INVOLVE, 2014). Although my main focus of interest in this section is PPI as it relates to the design and delivery of healthcare services, my understanding of this field was enriched by a number of articles that I read on PPI in healthcare research. This was particularly helpful with regard to an issue that has been identified as a significant barrier to the development of PPI in both healthcare design and delivery and in healthcare research, namely the

lack of discussion – in empirical research – of the conceptualisation and theorisation of PPI.

Whilst I return to the conceptualisation and theorisation of PPI later in this section, even when used in the specific context of the design and delivery of healthcare services, Renedo and Marston (2011) draw attention to the failure of policy makers, healthcare professionals and lay participants to agree on an overarching definition, rationale or *modus operandi* for PPI. On the contrary, PPI has been described – by both Andersson et al. (2006a, p. 3) and the Joint Health and Social Care Regulators' Patient and Public Involvement Group (2010, p. 5) – as a, 'catchall term' and, in a House of Commons Health Committee (2007) report into PPI within the NHS, as a, 'nebulous and ill-defined concept, used as an umbrella term to cover a multiplicity of interactions that patients and the public have with the NHS' (2007, p. 10).

Commentators have referred to a lack of clarity, consistency and consensus – and concomitant ambiguity – pertaining to numerous facets of PPI. These include: the rationale, ideologies, philosophies, theories and concepts that underpin PPI (Fudge et al., 2008; Vincent-Jones et al., 2009; Staniszewska et al., 2011a; Foot et al., 2014); the aims and objectives of PPI initiatives (Anderson et al., 2002; House of Commons Health Committee, 2007; Dalton et al., 2014); the decision-making processes, strategies and methods used during the implementation of PPI initiatives (Crawford et al., 2002; Anderson et al., 2006; Walsh et al., 2012); the contribution of service users to PPI initiatives (Attree et al., 2008); the links between participatory initiatives and democratic representative structures (Beresford, 2012); the identify/role of those involved in PPI initiatives (Andersson et al., 2006; Coulter, 2011; Barnes and Cotterell, 2012; Beresford, 2013); the link between the context and processes of PPI (Anderson et al., 2002; Staniszewska et al., 2011a); feedback mechanisms used in PPI initiatives (Healthwatch England, 2013); and (measurement of) the impact and outcome of PPI initiatives (Staniszewska et al., 2011a; Mockford et al., 2012; Dalton et al., 2014).

Anderson et al. (2002, p. 20) contrast the prevailing lack of clarity that surrounds PPI with the 'rational ideal' of PPI initiatives, namely that these should begin with a clear definition of aims and objectives, proceed to the refinement of a clear approach

and thence to the implementation of an agreed plan using clear methods: the whole within a framework of careful monitoring and evaluation. But the researchers stress that the reality of most PPI initiatives, conversely, is that they are set against a backdrop of pre-existing initiatives, partnerships and networks that are populated by stakeholders with differing viewpoints, values, degrees of power and commitment. According to Anderson et al. (2002, p. 20), these factors render PPI, 'a messy business': so messy, they add, that the rational ideal of neat progression from aims through methods to outcome, 'almost never happens'.

On the contrary, Anderson et al. (2002) stress that those who try to adhere to the rational planning ideal are often frustrated by PPI's inherent contextual complexities. Drawing attention, instead, to the gulf that often separates planning from practice, Anderson et al. (2002) emphasise that organisers of PPI initiatives instead need to recognise that PPI equates to the accommodation of a diversity of interests, ideas and values, to the identification of common ground and to the negotiation of mutually acceptable solutions. Accordingly, the researchers advocate the adoption of an open-ended and exploratory stance to the design and delivery of PPI initiatives in which dialogue is ongoing and implementation – and its measurement – are subject to constant reconsideration. With this in mind, the researchers contend that the lack of clarity – and concomitant ambiguity – that surrounds PPI can, in fact, be seen as a positive attribute; positive, inasmuch as by allowing multiple interpretations of PPI, it fosters the accommodation and promotion of a range of perspectives. Others, however, maintain that such imprecision is a major barrier to the development of PPI (see, for instance, Brett et al., 2009; Staniszewska et al., 2011; 2011a).

The reported nebulousness, confusion and ambiguity that surround the field appear to have done little to dampen governmental interest in PPI across the UK. On the contrary, Tritter and Koivusalo (2013) argue that commitment to empowering individuals and communities to play a greater role in shaping health and social care services has assumed an increasingly prominent position in public policy discourse over the last two decades. Commentators stress that the growth in interest in PPI has been triggered by many different factors (Wait and Nolte, 2006; Naidoo and Wills, 2011; Conklin et al., 2010; 2012). For instance, it has been linked to: the influence of service user and patient rights movements (Barnes and Cotterell, 2012a; Brown et

al., 2012); a recognition that current methods of policy-making are no longer in tune with a public that is more educated and sophisticated but less deferential than in the past (Coulter, 2011; Baggott, 2013); an awareness that public participation can foster social capital[17] (Abelson et al., 2003); and a belief that encouraging people and communities to participate can improve their health and wellbeing or encourage them to assume greater responsibility for their own health or to develop their own initiatives (Wanless, 2004; Naidoo and Wills, 2011; Baggott, 2013).

In Chapter One (see sections, 'Health and social care systems under pressure: the need for change' and 'The Welsh CCM Model: integration, self-management, involvement, empowerment') I discussed the importance of involvement as it relates to the care management of people living with chronic conditions and its central position within the Welsh CCM Model. But it is perhaps worth reiterating that self-care and self-management render involvement particularly relevant (see also Davies et al., 2009; Battersby et al., 2010; Wellard, 2010; Coulter 2011; Coulter et al., 2013). According to Kralik (2010, p. 200) the major mechanism of policy change that will positively impact on people living with chronic conditions is therefore, 'the emergence and escalation of the agendas, priorities and values of consumers shaping policy'. The need to empower people living with chronic conditions to make decisions about their treatment has been highlighted by the Department of Health (2013) and by the Welsh Government (2014b).

Indeed, it is indicated in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 34) that a key element in the establishment of the Welsh CCM Model is, 'the involvement and views of local people and of those living with chronic conditions'. But just as Coulter (2006a) draws a distinction between the concerns, interests and aspirations of patients and of the public, so she differentiates between the potential benefits of encouraging patient involvement, on the one hand, and of encouraging public involvement, on the other. Hence, Coulter (2006a) suggests that the former can help ensure appropriate treatment and care, improve health outcomes and safety, and reduce risk-factors ill-health, complaints and litigation; and that the

[17] Putnam (1993, pp. 35 – 36) defines social capital as, 'features of social organisations, such as networks, norms and trust, that facilitate action and co-operation for mutual benefit'.

latter can help improve service-design, determine priorities for commissioning, manage demand, meet expectations and strengthen accountability.

Commentators have put forward a number of fundamental justifications for the use of PPI (Abelson et al., 2003; Martin, 2008; Baggott, 2013). It has, for instance, been linked to the need to render decision-making accessible to those previously excluded (Milliband, 2006) or the need to show the public value for money in spending decisions (Andersson et al., 2006). However, two basic rationales to justify PPI are frequently cited: from an ideological perspective, that it can increase the legitimacy of decision-making processes; and from a pragmatic perspective, that it can contribute to improvements in the quality of service provision (see Anderson et al., 2006; Barnes et al., 2007; Coulter, 2009; Heritage and Dooris, 2009; Martin, 2008; 2009; Vincent-Jones et al., 2009; Tenbensel, 2010; Baggott, 2011; Armstrong et al., 2013).

In terms of the legitimacy of decision-making, firstly, Tenbensel (2010) argues that when conducted in a democratic context, policy processes must be participatory in order to ensure transparency and accountability. In a similar vein, Ellins (2012, p. 189) refers to a, 'rights-based perspective' that advocates giving people a say in the services they use. Martin (2009, p. 310) suggests that participatory initiatives affirm the integrity of the connection between the public and public services, thereby contributing to the democratic renewal of society and addressing the issue of, 'democratic deficit'. The latter, according to Levinson (2007, p. 860) occurs when, 'ostensibly democratic organizations or institutions in fact fall short of fulfilling what are believed to be the principles of democracy'. This is of some note, arguably, given Glasby's (2012) assertion that a perceived democratic deficit within the NHS is a longstanding area of concern.

In terms of improvements in the quality of service provision, secondly, Tenbensel (2010) explains that this relates to the way in which public involvement can inform the development of policy. Martin (2009) argues that by engaging with communities on more equal terms, organisers of public services can draw on people's knowledge. Taylor (2007, p. 99), for instance, suggests that capturing the 'lay experience' of daily living with health or ill-health can help: identify behaviour and lifestyle

patterns (highlighting new areas for investigation); identify those factors that lead to health inequalities and influence health (enabling the adaptation of existing resources); identify ways in which people live and manage their lives; encourage interest and promote active involvement; and create mechanisms to allow dialogue/debate and to promote health-improvement programmes that are owned by the people. Ellins (2012) suggests that when seen in such 'instrumentalist' terms – as a means to better ends – involvement can be considered an important mechanism for ensuring the provision of health and social care services that are more accessible, targeted and responsive.

Ellins (2012) adds that the way in which PPI is justified has significant implications in terms of the criteria against which success is subsequently judged. Hence, she notes that when justified in 'rights-based' terms, on the one hand, the availability of opportunities for people to discuss issues and to share views and experiences is of paramount importance. But when justified in 'instrumentalist terms', on the other, she notes that the effectiveness will be measured against the outcomes that those opportunities produce. In the latter context, Ellins (2012) therefore stresses that the main issue of concern will be the extent to which involvement impacts on the quality and availability of services.

But the quality of the evidence-base for PPI – both in terms of the levels of service-user/public involvement and in terms of the subsequent effect on service-delivery – has been called into question by many experts (see Barnes and Coelho, 2009; Renedo and Marston, 2011; Mockford et al., 2012; Dalton et al., 2014). These include: Merrell (2009, p. 38), who notes that, 'there has been little research to date on how services are influenced by patient and public involvement'; Conklin et al. (2012, p. 1), who stress that, 'despite the growing body of work on public involvement in health-care policy, evidence of its impact remains scarce'; Tritter and Koivusalo (2013, p. 115), who contrast an extensive literature-base with, 'far less evidence of PPI on prioritization or commissioning of services'; Forster and Gabe (2008, p. 348), who note that PPI is characterised by a, 'striking lack of published evaluative research'; and Foot et al. (2014, p. 6), who report that although PPI is an established priority in UK health and social care policy, 'the evidence is clear:

overall, people are not as involved as they want to be in decisions about health and care'.

Similar remarks were made by Nilsen et al. (2007) in their systematic review of health care and 'consumer involvement' for the Cochrane Collaboration. Whilst at the time of writing of this thesis, the Cochrane Library contained no systematic reviews of PPI, Hunt (2004, p. 4) argues that there is 'little of note' to distinguish the latter term from the term 'consumer involvement' and that – alongside a number of other similar terms – the two are used interchangeably. In their systematic review, Nilsen et al. (2007) sought to assess and compare consumer involvement as it related to the following four areas: healthcare policy and planning (such as health technology assessment, consumer pay-back systems and inequalities in health care); clinical policies (such as clinical practice guidelines); patient information materials (specifically, those informing patients about personal healthcare decisions); and healthcare research (such as the design of clinical/epidemiological studies, identification of relevant outcomes or priority-setting).

Nilsen et al. (2007, p. 10) explain that their selection criteria was met by just five studies, comprising: two 'moderate quality' randomised controlled trials (RCTs) that showed that consumer involvement in the development of patient information material can improve clarity and knowledge; a further two 'moderate quality' RCTs that showed that the use of consumer interviewers rather than staff interviewers in healthcare research can result in (small) differences in satisfaction surveys; and one 'low quality' RCT that showed that the use of telephone discussions and face-to-face group meetings in priority-setting for community health can better engage consumers than mailed surveys.

Conversely, Nilsen et al. (2007) report that they were unable to identify any comparative studies of consumer involvement in the development of clinical practice guidelines. Moreover, whilst they explain that all of the studies included in their review evaluated involvement with consumers to assist in the development of healthcare policy, research or patient information, they add that none evaluated the involvement of consumers in the decision-making process. Accordingly, Nilsen et al. (2007, p. 10) conclude that this area remains largely unevaluated and that there is:

> … a huge gap in the evidence from comparative studies about desirable and adverse effects of consumer involvement in healthcare decisions at the population level, or how to achieve effective consumer involvement.

Similar conclusions were reached by Mockford et al. (2012) in their systematic review of empirical research into the impact of PPI on UK NHS healthcare services. The researchers reviewed twenty-eight studies involving patients, carers or the public working either collaboratively with health care front-line professionals or managers (for instance, as lay members of NHS committees or in condition-specific groups) or as activity-leaders. The studies examined services in the fields of cancer, stroke, learning disability, community and mental health, as well as Primary Care Groups/Trusts and Primary Care PPI Forums. Methodologies comprised: case studies/reports (n=20); evaluations (n=5); secondary data analyses (n=2); and surveys (n=1). Methods of data collection included semi-structured questionnaires and telephone interviews, semi-structured and in-depth interviews, focus groups, non-participant observation of meetings and postal surveys.

On the one hand, Mockford et al. (2012) report that the reviewed studies contained numerous accounts of the positive impact of PPI on healthcare services across the three areas of service planning and development, information development and dissemination and attitudes of service users and providers. As regards service planning and development, firstly, Mockford et al (2012) note that improvements were reported in fifteen studies covering the following seven domains: the design of new healthcare buildings and their environment; the location of/access to services; the provision of additional services; the reorganisation of existing services; the organisation of acute trusts; systems of communication between health professionals and patients; and systems of communication between patients. As regards information development and dissemination, secondly, the researchers note that improvements were reported in ten studies covering the following three domains: the production of public and patient information; awareness-raising; and the development (or contribution to the development of) existing services. As for the attitudes of service users and providers, finally, the researchers note that, ‘many studies’ (2012, p. 35) reported the positive impact of service user involvement on attitudes, values and beliefs.

On the other hand, however, Mockford et al. (2012) indicate that the data collection methods used in the studies meant that these effects were captured, in the main, by way of descriptive reports and personal opinion, rather than by way of valid and reliable measurement tools. Moreover, the researchers point out that whilst the studies showed a marked variance in their levels of detail, they were uniform in their lack of description of service users (for instance, in terms of their age, ethnicity, work-situation or involvement in healthcare services), of how the latter were recruited or of the extent of their involvement in each PPI initiative. The researchers suggest that such inconsistent reporting, allied with the lack of valid and reliable measurement tools, militated against their ability to make objective assessments of the impact of the initiatives and to conduct cross-study comparisons.

However, Mockford et al. (2012) argue that this does not necessarily mean that the PPI initiatives had no effect, but instead denotes the difficulties of defining precisely what is meant by 'impact' in such a contextually challenging field. At a more fundamental level, the researchers suggest that this is a reflection of the fact that none of the studies provided an explicit definition of PPI and that all bar two failed to use theoretical arguments to elucidate their findings. As a consequence, the researchers point out that most studies lacked the necessary, 'conceptual and theoretical underpinning' (2012, p. 35) to develop a clear understanding of the impact of specific components or dimensions of PPI and to assess levels of conceptual equivalence across studies. This, despite the fact that the researchers stress that such detailed understanding is key to the development of a robust evidence-base that can, in turn, help policy makers and researchers further develop PPI initiatives.

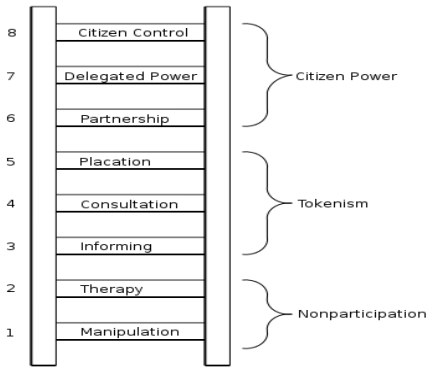
Indeed, in their systematic review of the conceptualisation, measurement, impact and outcomes of PPI, Brett et al. (2009) point out that clear concepts and conceptualisations constitute the building blocks of theoretical models which can, in turn, provide a blueprint – once empirically tested – for the development of tools to evaluate specific concepts. However, Brett et al. (2009) note that formal conceptualising and theorising or the use of models or tools is uncommon in empirical research of PPI initiatives. In a similar vein, Staniszewska et al. (2011, p. 394) state – in a study that sought to develop a quality 'checklist' for PPI reporting –

that whilst there have been, ‘some attempts to develop conceptual or theoretical frameworks’, there is, ‘no overall conceptual model of PPI impact that captures the essence of the concept and has been empirically tested’.

Accordingly, as regards the current landscape of empirical research, there appears to be some consensus that although there are numerous studies of PPI initiatives that claim to show increased levels of service user/public involvement and/or a concomitant rise in standards of service delivery, the majority comprise descriptive reports based on personal perspectives, with little use of valid and reliable measurement tools or theoretical models. As a consequence, it is argued that the way in which people have been involved or improvements achieved is difficult to understand and the contribution of specific elements difficult to isolate. In turn, it is argued that this lack of clarity militates against the accurate evaluation of impact, cross-study comparisons and the transferability of findings. In the words of Abelson et al. (2010, p. 18) the literature of participation is dominated by ‘practice stories’ that are ‘heavy on contextual learning but light on causal mechanism’, with much related empirical research conducted in a, ‘theoretical vacuum’.

But that does not mean that the entire field of PPI operates within a theoretical vacuum. Quite the contrary, many theoretical models have been developed to help shed light on those factors which can inform participatory initiatives and provide the field with the necessary conceptual underpinning to promote further development (as noted, for instance, by Beresford, 2012; Glasby, 2012; and Baggott, 2013). Glasby (2012, p. 145) points out that these models are often portrayed in terms of a continuum that begins from a position in which the user/patient is a, ‘passive recipient of services’ and moves progressively to one in which services are, ‘user-led’. Glasby (2012) adds that one of the best known and most influential of these models is Arnstein’s (1969) ‘Ladder of Citizen Participation’. The latter (henceforth Arnstein’s Ladder) is, as Figure 2 (see overleaf) displays, set out as a hierarchical structure that moves from citizen ‘manipulation’ (at the bottom rung) to ‘citizen control’ (at the top rung) in increasingly participatory (and empowering) increments.

Figure 2: Eight Rungs on a Ladder of Citizen Participation. (Source: Arnstein, 1969, p. 217).



Anderson et al. (2002, p. 18), on the one hand, consider that Arnstein's Ladder can be seen as, 'a useful tool', arguing that even though its terminology is somewhat nebulous – the authors note, for instance, that 'partnership', is a, 'vague word which is used in many ways' (2002, p. 18) – it serves both to foster discussion and to encourage stakeholders to be, 'upfront about their expectations' (2002, p. 18). Tritter and McCallum (2006), on the other hand, question the continued relevance of Arnstein's Ladder, claiming that it has a linear and uni-dimensional format that is restrictive, that it conflates the means and ends of involvement and favours certain approaches over others (irrespective of context) and that it does not capture the dynamic and changing forces that impact on user involvement or the 'agency' of service users. Beresford (2012), in turn, contends that Arnstein's Ladder fails to take account of the complex, interactive and political aspects of public participation and of its susceptibility to manipulation (including that of citizens). With Beresford (2012, p. 24) adding that the same can be said of the 'derivatives' of Arnstein's Ladder, his remarks appear to be an allusion to those models that have conceptualised public participation by way of similarly hierarchical structures. These include Brager and Specht's (1973) 'Ladder of Community Participation', Connor's (1998) 'New Ladder of Citizen Participation' and, more recently, NHS England's (2013) 'Ladder of Engagement and Participation'.

Other models of public participation, whilst expanded to pay greater heed to contextual factors, have retained hierarchical structures. Examples include Charles and DeMaio's (1993) 'Dimensions of Lay Participation in Health Care Decision Making' and Wilcox's (1994) 'Framework for Participation'. Still other models contain no hierarchical structures at all. Examples include: South Lanarkshire

Council's 'Wheel of Participation' (Davidson, 1998) and its participation techniques which, it is argued, are 'transparent, inclusive and empowering' (1998, p. 14); Health Canada's (2000) 'Public Involvement Continuum', a model of involvement that purports to be cumulative and inter-dependent; Fung's (2006) 'Democracy Cube', which, it is suggested, represents the evolutionary and dynamic nature of participation and the diversity of citizens and their various roles and contexts; Tritter and McCallum's (2006, p. 165) 'mosaic analogy' which, it is indicated, captures the, 'interactions between individual users, their communities, voluntary organisations and the healthcare system on which successful user involvement depends'; and NHS England's 'Engagement Cycle' (NHS Institute for Innovation and Improvement, 2012) that comprises five-stages of patient and public involvement in commissioning decisions, from the identification of needs and aspirations to patient and carer engagement in monitoring services.

Despite these developments, it is widely reported that Arnstein's Ladder remains an important point of reference for those involved in participatory practice in health and social care (see Tritter and McCallum, 2006; Beresford, 2012; Glasby, 2012). This is evidenced by the inclusion of an Arnstein Ladder-influenced, 'Ladder of Engagement and Participation' in a recent guide to PPI and the English NHS (NHS England, 2013). Merrell (2009, p. 36) claims that nowhere is the continued relevance of Arnstein's Ladder better illustrated than in the UK's 'questionable' history of power-sharing between service providers and service users, particularly with regard to society's most disadvantaged people – like those living with chronic conditions – whose multiple and complex needs render them particularly reliant on many different health and social care services. In its 'PPI Good Practice Handbook', the Joint Health and Social Care Regulators' Patient and Public Involvement Group (2010, p. 33) notes that it is the very absence of disadvantaged people from many discussions pertaining to the development of services that makes them one of society's, 'seldom-heard groups'. The latter, Morrow et al. (2012, p. 107) explain, are made up of, 'under-represented people who use or might potentially use health services and who are less likely to be heard by service professionals and decision-makers'.

In a research project undertaken to inform the development of a practical guide to service user involvement for the Shaping Our Lives National User Network[18], Beresford (2013) sought to identify why it is that the voices of some service users are seldom heard and how the situation might be improved. The project comprised: the establishment of a steering group of service users to help guide the research; a collaboration between the report's research team and four local service user organisations that work with disadvantaged groups[19] (to identify which service users were missing from these groups, what the barriers to their involvement were and how these could be overcome); a national survey of service users' experiences of involvement in the development of health and social care services using a semi-structured interview questionnaire (respondent n=130); two group discussions with service users who face particular problems of exclusion (approximate n=100); and a comparison of findings with the views of other experienced service users from the Shaping Our Lives National User Group.

In the report, Beresford (2013) points out that a wide range of people are routinely under-represented during the development of health and social care services, including older people and those living with chronic conditions. Beresford (2013) explains that those people living with chronic conditions and older people who participated in the project, moreover, listed a number of structural and physical access barriers to their involvement in the development of health and social care services. These barriers included: a lack of accessible transport; inaccessible signage; lack of 'flat access'; inappropriate seating; unsupportive and hostile receptionists; inappropriate timing/unsuitable length of meetings; buildings that were difficult to access and inappropriate seating.

Beresford (2013) notes that one of the messages that emerged from the research project was that participants felt that such barriers reflected the low worth and low value attached to their perspectives. But he argues that little has been done to improve the situation and that there has instead been a, 'widespread failure to

[18] An independent user-controlled organisation, think tank and network. See http://www.shapingourlives.org.uk/

[19] The four groups comprised: a black and ethnic minority mental health service users group; a self-advocacy group of people with learning difficulties; a support group of women with alcohol problems; and a mixed service user group of people who use a variety of health and social care services.

encourage and support their [i.e. older people's] involvement' (2013, p. 21). He adds, moreover, that the voices of those with complex and multiple needs often remain unheard because of, 'unevidenced assumptions that they are not able or interested in being involved' or because they have been labelled, 'difficult' or 'awkward' (2013, p. 8). This is despite the fact that Beresford (2013) notes that access is a human and civil rights issue, inasmuch as any failure to meet the access needs of service users is tantamount to a denial of their right to full and equal participation in society.

Furthermore, participants referred to the negative impact of many other factors, not only on their ability, but also their willingness to participate. These included: the limited opportunities, multiple difficulties and lack of support that characterise their day-to-day lives and the concomitant low levels of confidence, self-esteem and expectations; the stigma associated with their specific service user identify and the perception that this would be reinforced by coming forward to participate; a devaluing of the service user perspective compared to that of people considered 'conventional "experts"' such as health and social care professionals and academics (2013, p. 34); and the reluctance of service providers to cede power amidst a 'tokenistic' approach to involvement that amounted to little more than, 'ticking boxes' or a, 'publicity-exercise' (2013, p. 34). Collectively, Beresford (2013, p. 35) explains, these barriers and issues had left many participants feeling, 'disempowered, disillusioned and disappointed'.

But similar barriers and issues have been listed in many reports that have examined the experience of service users/patients and/or the public during the development of health and social care services (see, for instance SCIE, 2007; Joint Health and Social Care Regulators' Patient and Public Involvement Group, 2010; Williamson, 2012). This, despite the longstanding awareness – which significantly pre-dates the appearance of the term PPI – of the key role these people can and should play in this process (see, for instance, Coulter, 2011; Baggott, 2013). Indeed, frequent reference has been made to the emergence – during the 1960s and 1970s – of independent service user and patient organisations and of statutory initiatives that were premised on increasing levels of participation (see Wait and Nolte, 2005; Greener, 2009; Beresford et al., 2011; Coulter, 2011; Tritter, 2011; Barnes and Cotterell, 2012;

Tritter and Koivusalo, 2013; Foot et al., 2014). Since it is beyond the scope of this thesis to examine both areas, I instead focus on statutory initiatives and, more, specifically, Community Health Councils (CHCs).

Established in 1974, Hogg (2009) explains that CHCs were established – alongside similar statutory bodies in Scotland and Northern Ireland – as the patients' watchdog for the NHS in England and Wales. According to Greener (2009), CHCs constituted the first concerted attempt organisationally to improve services to patients, created as they were in the wake of mounting censure of the NHS for its doctor-centred, paternalistic, over-medicalised and impersonal care. With Forster and Gabe (2008, p. 335) likewise drawing attention to an NHS culture characterised by a, 'paternalistic approach' in which little heed was paid to, 'the interests of users and citizens', they add that by creating CHCs, the objective was to give patients a voice in the NHS both individually and collectively: at the individual level, to assist patients who wished to complain about their care; and at the collective level, to monitor local health services, to inform the public and to consult on local health reorganisations.

But describing the introduction of CHCs as a, 'first tentative attempt' to develop involvement, Forster and Gabe (2008, p. 235) note that amidst criticisms of their lack of statutory powers, limited financial and staffing resources and inconsistent standards, many felt that their impact on the prevailing NHS culture was limited. With Barnes and Cotterell (2012, p. xv) drawing attention to the CHCs', 'ambiguous position *vis-à-vis* their insider/outsider position within the National Health Service', Baggott (2013, p. 99) adds that whilst CHCs made 'great efforts' to involve local communities, their democratic legitimacy was called into question. The House of Commons Health Committee (2007), moreover, drew attention to reports of CHCs' limited responsibility to primary care, insufficient independence and of a membership lacking in diversity (in terms of both age-range and ethnicity).

As a result of these and other issues (in particular, the advent of the internal market) Baggott (2013) explains that the 1980s and 1990s witnessed a growing tendency for NHS bodies to bypass CHCs altogether, with public opinion instead gauged and policies legitimised by way of surveys, focus groups, patients' and citizens' forums

and consultation exercises. Furthermore, Coulter (2011, p. 167) argues that in the absence of formal procedures for election to CHC boards, CHCs were heavily reliant on the energy and commitment of unpaid volunteers and a, 'very small number' of paid staff and that their roles were effectively, 'undermined by successive waves of policy innovation' (2011, p. 167). Consequently, Coulter (2011) explains that CHCs were abolished in England in 2003.

In England, the abandonment of CHCs was followed by the launch of a number of new initiatives, some of which, in turn, have been abandoned. As for the Welsh NHS, conversely, CHCs have remained in place since their 1974 inauguration. Vincent-Jones et al. (2009) explain that this was one of a number of significant differences between Welsh and English PPI policy to emerge in the post-devolution era (in contrast, the researchers add, with the broadly analogous approaches during the 1990s). With Hughes et al. (2009) indicating that these differences have crystallised around issues of 'choice' and 'voice', Le Grand (2007) explains that in the choice model, first of all, services are selected from competing providers, with choices including where, how and by whom treatment is provided and how relevant information is communicated. Andersson et al. (2006) explain that patient choice has been justified on the grounds that it promotes patient-focused care, is the logical extension of informed consent and is a mechanism for redressing the power inequality between health professionals and patients.

But Andersson et al. (2006) add that PPI has also been viewed as a means of promoting collective patient voice. Hughes (2009) explains that voice equates to the right to be informed, express views and be understood, Thompson (2007) that it involves collective freedom to achieve inclusiveness through a developmental process of engagement and Le Grand (2007) that it is a communicational process in which public service users transmit their views to public service providers. Hirschman and the American Council of Learned Societies (1970, p. 30) define voice as, 'any attempt at all to change, rather than to escape from, an objectionable state of affairs'. According to Greener (2007), implicit in the notion of voice is the right of citizens to participate in public services and change them by way of the political process or through direct involvement in their running.

Vincent-Jones et al. (2009) explain that post-devolution Wales has rejected market reforms and economic regulation and instead opted for PPI policies that promote public representation and provide opportunities to air the collective voice. With Hughes et al. (2009) suggesting that this trend has been consistent with Wales' post-devolution focus on citizenship, public engagement, mutualism, localism and partnership-working, these comments are, in turn, consistent with Birrell's (2009) indication that citizen-involvement in decision-making was central to the Welsh Assembly's new direction in health and social policy (see Chapter One, section 'The Welsh CCM Model: integration, self-management, involvement, empowerment'). With the importance of PPI emphasised in numerous Welsh policy documents published during the 2000s (see, for instance, Wanless, 2003; WAG/NHS Wales, 2005; WAG, 2006a) as well as in more recent strategies related to both health care and social care (WG, 2014b) Hughes et al. (2009, p. 245) assert that the Welsh Government has put a, 'distinctive stamp on PPI policies by developing a focus on citizen voice and engagement, while rejecting the consumerist market model'. Instead, note Longley et al. (2012a), the *views* of patients in Wales have been prioritised by way of the internal mechanisms of Local Health Boards and CHCs.

However, the transparency and understanding of a number of elements pertaining to the organisation and functions of Welsh CHCs have been questioned in recent reports. These include: a Welsh Government (2014c) review of governance and delivery in the devolved public sector in Wales, in which it is indicated that there is a need for CHCs, LHBs and Trusts to, 'clarify their respective roles and actions in public engagement' (2014c, p. 141); Lloyd's (2014) review of NHS Wales service-change engagement/consultation exercises, in which she notes that there is 'confusion about the role and responsibility of the Board of CHCs' (2014, p. 29) and that, 'the accountability of CHCs needs clarification' (2014, p. 34); and Evans' (2014) review of the handling of concerns/complaints by NHS Wales, in which he reports that, 'for the public, the role of CHCs in respect of complaints support is not properly understood' (2014, p. 52). In Longley et al.'s (2012) Welsh Government-commissioned review of the impact of the 2010 CHC reforms, moreover, the authors draw particular attention to the lack of consistency and clarity in the conceptualisation of the purpose and function of CHCs, emphasising that, 'doubt

remains in some areas about what is *really* [original emphasis] required of CHCs, and therefore about how they should perform their role' (2012, p. 19).

In addition to noting the uncertainty *vis-à-vis* CHC roles and functions, Longley et al. (2012) draw attention to a number of additional problems pertaining to the organisation and performance of Welsh CHCs. These include: inconsistency of performance (with substantial variations in how CHCs discharge responsibility); lack of diversity and representativeness (with membership described as, 'disproportionately white, older and middle-class' [2012, p. 6]); low levels of public knowledge/understanding of CHCs; sub-optimal discharge of the National Board of CHCs' leadership of the internal development of CHCs/representation of the collective voice of patients and the public; and unsystematic involvement in the NHS-funded services provided by registered nursing homes. With Longley et al. (2012, p. 6) describing these as, 'persistent weaknesses', they point out that amidst longstanding concerns about many aspects of Welsh CHCs' organisation and performance, these had already been areas of priority at the time of the 2010 reforms of CHCs.

In their recommendations to the Welsh Government to improve the organisation and performance of CHCs, Longley et al. (2012, p. 102) put forward a number of measures to address these 'persistent weaknesses'. However, in view of the prevailing lack of terminological/conceptual transparency to which I have referred throughout this section – and, indeed, throughout this chapter – it is of particular note that a number of these so-called 'weaknesses' relate directly to the lack of clarity and consistency *vis-à-vis* respondents' understanding of the role and function of CHCs and of the low-levels of public knowledge/understanding of CHCs. At the time of writing of this thesis, the Welsh Government had accepted the majority of Longley et al.'s (2012) recommendations and set out its response in the Consultation Document *Community Health Councils in Wales: Proposed Changes* (WG, 2014d). It therefore remains to be seen to what extent the many proposed actions that have been set out to increase clarity and understanding surrounding CHCs will be taken forward. Having discussed PPI initiatives, I end this chapter with a brief summary of the themes discussed.

Summary

I began this chapter by setting out my literature search strategy. I then examined the language of integration, explaining that despite a lack of clarity as to its meaning, there is some consensus that its organising principle should be the service user's perspective and that its ultimate aim should be to improve client care. Subsequently, I described the widespread agreement that integration is a potential answer to fragmented health and social care provision, before exploring evidence-based practice and implementation research. Whilst I subsequently discussed the lack of evidence that integration leads to improvements in care, I explained that researchers have encountered difficulties in assessing integration amidst discussions as to what precisely should be measured in order to gauge its effectiveness. I then reviewed some of the frequently identified determinants of integration and explored the relative importance that researchers have attached to structural and cultural elements of integration. I concluded the chapter by exploring PPI initiatives. In the next chapter, I discuss the methodology and methods I used in the case study of the development of the new CCM service.

Chapter 3: Methodology and methods

Introduction

Having conducted a review of the literature of integrated working in the previous chapter, in this chapter I discuss my chosen research methodology of case study and the methods I used to collect data. I begin by restating the aim and objectives of the case study, before describing my research approach and linking this design choice with my interpretevist stance. Subsequently, I discuss the research design, examine issues of access and sampling (including ethical approval) and the selection of the 'case' of the case study. I discuss the four methods of data collection I used (and whose I chose them), describe my subsequent handling and analysis of data and conclude by setting out the measures I took to ensure rigour.

Aim and objectives

My aim in conducting the research was to answer the question: How has integrated care for people living with chronic conditions developed during the implementation of the new CCM service? My objectives, in turn, were to answer the following five sub-questions:

1. How have different stakeholders been involved in the establishment of the new CCM service?
2. What do the stakeholders involved in the establishment of the new CCM service say about integration?
3. What do people living with chronic conditions and their carers say about the new CCM service and the care they receive?
4. What do front-line health and social care professionals say about their work in the new CCM service compared to their work in their previous teams?
5. How has the development of the new CCM service been affected by pre-existing services, roles and relationships and concurrent developments in health and social care?

Research approach

Commentators indicate that there is no commonly agreed definition of the term 'case study' (Hammersley and Gomm, 2000), that it is not used in a standard way (Hammersley, 2012) and that it has undergone changes in meaning over time (Ragin, 1992). The case study has been called, 'the study of the particularity and complexity of a single case' (Stake, 1995, p. xi), 'a study of a particular social unit or system' (Richards and Morse, 2013, p. 76), 'in-depth description and analysis' (Merriam, 2009, p. 4) and 'an empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context' (Yin, 2009, p. 18). Whilst Richards and Morse (2013, p. 76) describe the case study as a 'method', it has also been described as, 'a way of organising social data' (Goode and Hatt, 1952, p. 331) and 'more a strategy than a method' (Punch, 2014, p. 120). There is, however, broad agreement that it is a way of providing an in-depth analysis of a naturally occurring single entity, or a small number thereof (Miles and Huberman, 1994; Stake, 2005; Denscombe, 2007; Silverman, 2010; Punch, 2014).

Just as there is no standard use of the term case study, so the case study is not the preserve of one methodology (Hancock and Algozinne, 2006) nor does it belong to a clearly defined methodological 'school' (Richards and Morse, 2013). On the contrary, Luck et al. (2006, p. 107) explain that the case study has been termed a 'paradigmatic bridge' between methodologies, with van Wynsberghe and Khan (2007) indicating that case study researchers have adopted a range of methodological approaches from post-positivism to critical theory. However, with its focus on a natural phenomenon over which the researcher has no influence (Yin, 2009) the focus of the case study is, it has been argued, social interaction (Hamel, 1993). Indeed, the case study is considered to be particularly well-suited to grappling with real life's intricacies and nuances (Denscombe, 2007) with Yin (2009, p.9) stressing that it aims to provide the answers to 'how' and 'why' questions of process, questions which are explanatory in nature and investigate operational links examined over time. Hence, Denscombe (2007) notes that whilst the case study is interested in outcomes, it is how these outcomes come about that is of primary importance.

Accordingly, note Richards and Morse (2013, p. 77), in case studies there is, 'almost always a commitment to qualitative techniques', with Hammersley and Gomm (2000) pointing out they often utilise qualitative data and analysis alone. Simons (2009) likewise notes that case studies often utilise qualitative methods only, with the aim of providing a detailed examination (and understanding) of the case in question. In a similar vein, my exclusive use of qualitative methods to chart the development of the new CCM service reflected my desire to focus on meanings, description, context and process (see, for instance, Becker and Bryman, 2004). Indeed, a number of commentators have made reference to the complexities of partnership-working in the care of people living with multi-factorial needs (Williams and Sullivan, 2009f; Glasby, 2012) just as others have noted that people living with chronic conditions face a complex combination of physical, social and psychological factors that impact on their lives (Field and Kelly, 2003). The impact of this combination of factors was recognised in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 7), where it was stressed that amongst the concerns of people diagnosed with a chronic condition are:

> ...coping with fear, anger, frustration and denial, and also the effect the chronic condition is going to have on their job, relationships and perhaps other caring responsibilities.

Just as Charmaz (1983, p. 168) notes that the altered biographical trajectory of people living with chronic illness causes a, 'loss of self', she also indicates that this is best understood by way of a qualitative approach. According to Topping (2010), the philosophical tradition that underpins this qualitative approach is interpretevism. Topping (2010) explains that interpretevism is based on the assumption that in order to make sense of the world, human behaviours should be interpreted by taking account of interactions between people. This means, Topping (2010) adds, that research that seeks to understand human behaviour must employ approaches and techniques that allow interpretation in natural settings.

According to Bryman (2012), interpretevism subsumes a number of approaches to research which reject the application of the scientific model and positivist tradition to the field of social sciences including its *a priori* approach and theory-testing methods. The interpretive approach, notes Ransome (2013, pp. 63 – 64), aims to

generate theory from data, so that by starting out from the observation of individual cases, 'Theory is *induced* from the evidence rather than evidence being *deduced* from the theory [original emphases]'. Williams and May (1996) indicate that this inductive approach starts with a collection of data and moves to a general conclusion, involving the derivation of general principles from a set of specific observations. Accordingly, notes Rapport, (2005), interpretevism allows participants to give their own account of the world without the use of predefined measures, with Schwandt (1994) explaining that this provides an insight into the complex world of lived experience from the point of view of those who live it. Interpretevists consider that all knowledge – and therefore meaningful reality – is contingent upon human practices and is constructed in and out of interaction between human beings and their world and developed and transmitted within a social context (Golafshani, 2003).

Klenke (2008) notes that, according to interpretevism: human beings are not mechanistic and embrace multiple realities which need to be understood in context; the social world cannot be described without investigating how people use language, symbols and meanings to construct social practice; and no social explanation is complete unless it adequately describes the role of meaning in human actions. Moreover, Jones (1993) notes that interpretevism seeks to understand human social action by taking account of structural situations, motivation, and the element of choice in human behaviour, factors that are absent in natural science research. Accordingly, an underlying concept of interpretevism is *Verstehen*, an attempt to understand the social world from the perspective of the person being studied (Weber, 1949), a stance reflected in Liebow's endeavour to describe 'the life of ordinary people, on their grounds and on their terms' (1967, p. 10). Given my interest in examining how a wide a variety of stakeholders were involved in and experienced the implementation of the new CCM service, I felt that the natural epistemological stance to adopt was interpretevism, inasmuch as it is an approach that respects the differences between people and seeks to grasp the subjective meaning of social action (Bryman, 2012). In the next section, I provide further details regarding the decision to use a case study approach.

Research design

Flick (2009) explains that the 'case' of a case study is the focus of a process of precise description or reconstruction, with Creswell (1994, p. 12) noting that it is investigated within its natural environment and is, 'bounded by time and activity', so that it is self-contained with clear spatial and temporal margins. According to Merriam (2009), it is this concentration on the unit of analysis, not the topic of investigation, that characterises a case study (and therefore sets it apart from other types of qualitative research). Whilst I return to temporal margins overleaf, in terms of spatial margins, the case study restricts itself to the study of one naturally occurring entity (or a small number thereof) such as a person, village or firm (Gomm, 2009). There have been case studies of communities (Whyte, 1981), families (Brannen and Nilsen, 2006), organisations (Pettigrew, 1985) and events (Asmussen and Creswell, 1995). This concentration of the case study on the development of one natural phenomenon seemed to make this type of research suitable for my exploration of a new CCM service within in its 'natural environment' – a Welsh locality – and self-contained (or bounded) within the Armorshire Collaboration (itself contained with the National CCM Demonstrator Programme).

Hakim (1987) also suggests that case studies are well-placed to investigate organisational cultures, processes of change and the implementation and evaluation of policy. Simons (2009) adds that case studies examine the intricate and singular aspects of a particular project through close description, documentation and interpretation of events. This in-depth and multi-faceted approach seeks to capture how different stakeholders experience project implementation (Simons, 2009) and is essential in gauging service users' understanding of new services (Levin et al., 2002). Again, these features seemed to make the case study approach suitable for my aim, as I sought to explore the introduction of new CCM policy (by way of the implementation of the Welsh CCM Model), how the concomitant process of change impacted on a wide variety of stakeholders, and to gauge the extent to which the latter – in particular, service users and carers – were involved in the creation of the new CCM service. Moreover, given that it is widely agreed that organisational culture is a key factor in integrated working (Fulop et al., 2005; Shaw et al., 2011), the creation of the CCM service seemed to provide an ideal opportunity to examine

how front-line professionals had experienced leaving existing teams (and colleagues) to join a new team (and new colleagues) and how levels of partnership-working were affected by cultural and other factors.

In terms of temporal margins, case studies cover a specific time period, with data-collection often occurring simultaneous to events (Yin, 2009). Such 'real time' analysis is considered a particular strength of the case study, providing the immediacy and intimacy of a direct window onto contemporary events (Yin, 2009). These factors, arguably, made the case study approach a suitable match for my exploration of the creation of the new CCM service, as I set out to chart its development over the final two years of the Armorshire Collaboration's three-year existence and to research multiple stakeholders' experience of this process as it happened. Moreover, just as Fitzgerald and Dopson (2009) suggest that the flexibility of case study research allows it to cope with dynamic settings and thereby makes it well-suited for researching organisational change, so these characteristics seemed to make it all the more appropriate for researching the creation of an integrated service in the field of health and social care, given that the latter is considered especially 'context heavy' (Hartley and Benington, 2010, p. 4).

Indeed, issues of context are considered an integral part of case study research, which assumes that context is of great significance in understanding the phenomenon in question (Clarke and Reed, 2010). Stake (2005) notes that the qualitative approach to the case study concentrates on the detailed description of a complex entity (the case) as it is located in a particular social milieu and paying particular attention to its economic, political and cultural context. Contextual issues – and the flexibility of the case study approach in accommodating them – turned out to be of particular importance in my research. This was because the Armorshire Collaboration coincided with the 2009 NHS Wales Reforms, the 2010 UK general election victory of the Conservative/Liberal Democrat Coalition Government (and with it, the launch of a series of austerity measures) and the Wales-wide introduction of a new strategy, *Setting the Direction* (WAG, 2010). As I explain in the findings and discussions chapters, all three factors had a considerable impact on the Armorshire Collaboration's integrated agenda and the extent to which different stakeholders were able to become involved in the process of reconfiguring services.

In fact, Yin (2009) explains that case study research sees no clear demarcation between the phenomenon and its context, with Clarke and Reed (2010) arguing that this complementary relationship makes a study of both essential if the researcher is to gain a comprehensive picture of events. In a similar vein, The United States General Accounting Office Program Evaluation and Methodology Division ([USGAO/PEMD] 2000, p. 15) explains that:

> A case study is a method for learning about a complex instance, based on a comprehensive understanding of that instance obtained by extensive description and analysis of that instance taken as a whole and in its context.

According to the USGAO/PEMD (2000), a case study of the Three Mile Island nuclear disaster would therefore be expected to provide an in-depth examination of the events leading up to it as well as the disaster itself. The inherent flexibility of the case study approach was especially valuable in my research, not only because it allowed me to take account of extraneous contextual factors, but also because it allowed me to chart the development of the CCM service in Bro-y-Grug within the broader context of Wales' post-devolution era, characterised as it has been by a particular interest in partnerships and citizen-centred care, and a growing awareness of the impact of major demographic shifts and changes in disease patterns (Williams, 2011). Moreover, it also meant that I could compare stakeholders' views (in particular, those of front-line professionals, service users and carers) of the new CCM service with the services it replaced. In this way, I attempted to examine the CCM service in the light of a host of pre-existing and contemporaneous factors and, through a process of 'precise description' (Flick, 2009, p. 134), to be able to, 'understand this case in its complexity and its entirety, as well as in its context' (Punch, 2014, p. 122).

There is a variety of case study designs and classifications that can be adopted depending on the goals of the research. For example, case studies can be theory-testing, theory-seeking, story-telling, or picture-drawing (Bassey, 1999) or descriptive, interpretive or evaluative (Merriam, 1988). Yin (2009) identifies four basic case study designs: single-case holistic and single-case embedded, and multiple-case holistic and multiple-case embedded. The designation single or multiple refers to the number of cases to be studied; the terms holistic and embedded

refer to analysis of the case as a whole or of a sub-section thereof. Yin (2009) also describes the critical case, used to test out an existing hypothesis; the extreme/unique case, considered a 'one-off' and of intrinsic interest; the representative/typical case, exemplifying a broader category of a phenomenon; the revelatory case, previously inaccessible to social science inquiry; and the longitudinal case, examined at different points in time. Furthermore, Yin (2009) makes reference to the negative/deviant case, a phenomenon that is divergent from the general pattern. According to Silverman (2005), the study of the negative case can help to understand why the case is different and the others similar, an approach familiar to medical researchers who study diseases to learn about health.

Stake (1994) classifies three types of case study: intrinsic, aiming for a better understanding of the case in question; instrumental, seeking a better understanding of an issue or to reconfigure a generalisation; and collective, where the instrumental case study is extended to cover several cases. Stake (1994) explains that intrinsic and instrumental case studies have different goals regarding their wider application. Hence, Stake (1994, p. 237) explains, the former is undertaken to gain a better understanding of the case in question (because it is itself of interest) so that it can 'reveal its story', whilst the latter is undertaken to, 'provide insight into an issue or refinement of a theory'.

However, whilst indicating that the application of specific designs or categorisations may help to demarcate the case, Simons (2009) cautions that global understanding should not be hampered by an over-emphasis on classification. Simons (2009) adds that the use of categorisations is in any event flexible and that these are likely to develop and change as research continues, due to the real time and dynamic nature of case study research. Indeed, it is widely recognised that one of the main strengths of case study research is its flexibility (see, for instance Stake, 1995; Merriam, 2009; Bryman, 2012). Robson (1993) explains that this can be contrasted with the rigidity of experimental research, in which any failure to adhere to the pre-specified design often has serious implications.

But Robson (1993, pp. 148 – 149) points out that given that case studies are defined solely in terms of their concentration on a specific case in a specific context, their

design can instead be as loosely 'emergent' or as tightly 'pre-structured' as the case study researcher wishes, adding that this choice depends on the specific purposes of the case study in question. Indeed, Taylor (2013) notes that as long as the choice of approach can be justified – by showing that the sequence of methods and processes relates directly to the research aims and questions – case study researchers have the freedom to choose their own specific approach. Robson (1993) notes that in practice, however, most case study work falls between the extremes of loosely emergent and tightly pre-structured. Indeed, Miles and Huberman (1994) explain that even researchers whose stance is inductive and who favour a loose and emergent design invariably have conceptual knowledge about the phenomenon in question in addition to some initial ideas regarding how to gather information and where to look for those parts of the phenomenon – in which settings and among which actors – that are less well understood and which they hope to elucidate.

Reflecting the inherent flexibility of case studies and the freedom of the researcher to choose the most suitable design for the case in question, I combined a less formalised (emergent and inductive) stance with a defined – albeit adaptable – plan. My adoption of an emergent approach, on the one hand, was in keeping with my exploratory stance and my conviction that if I began with too strong a conceptual framework, it could blind me to the important features of the case or cause me to misinterpret evidence. This approach also allowed a potential shift in response to a growing understanding of the case, to unanticipated events or a change in emphasis of stakeholders (see Simons, 2009). This was especially important in allowing me, as the study progressed, to identify and interview several new key informants.

The defined but adaptable plan, on the other hand, was a reflection of my initial orienting ideas that had first arisen during my nursing placements, when I had witnessed at first-hand a lack of joined-up working in the care of older people. These ideas had then developed further as I read about the specific issues related to integration and the management of care of people living with chronic conditions. Recognising that these were issues that touched upon numerous stakeholders with many – and often contrasting – opinions, I believed that the best way of capturing the diversity of perspectives and relationships of those involved in developing a new integrated health and social care service for people living with chronic conditions

would be by way of a qualitative case study approach using multiple methods of data collection.

The pre-structured approach was also influenced by my awareness that case studies tend to produce large volumes of data which, without some guiding parameters, can become unmanageable (see, for instance, Miles and Huberman, 1994; Merriam, 2009; Yin, 2009). Indeed, Robson (1993) points out that in case study research, practical issues – such as tight time-scales – may dictate a more pre-structured approach, with Miles and Huberman (1994) likewise noting that this is an appropriate choice for researchers who – as I was – are new to qualitative studies. I therefore sought to realise the 'trade-off' between clarity, purpose and data management and receptivity to local circumstances that has been identified by Miles and Huberman (1994).

Appendix 11 provides a timeline for the project. Beginning with my acceptance of the offer of the scholarship for the PhD in March 2009, this charts the development of my research and of the case study until my submission of the thesis at the end of September, 2014. The timeline includes details of dates pertaining to: academic supervision, training and conference attendance; my long period of illness (and that of my mother) and concomitant time-extensions; my teaching to students within the College of Human and Health Sciences at Swansea University; submission of progress reports to the Wales Office of Research and Development for Health and Social Care; the process of ethical review; fieldwork, including dates of preparatory site-visits, meetings observed and interviews and focus groups conducted; and thematic analysis and the writing-up of the thesis.

Having discussed my reasons for choosing the case study approach and the rationale for my use of a flexible design, in the next section I discuss issues of access and sampling.

Access and sampling

Research must adhere to specific guidance, codes of practice and regulations (Gelling, 2010). In practical terms, this means that researchers need to gain

admittance to the field. This is normally a closed or private setting accessed via gatekeepers – defined by Gomm (2009, p. 146) as, 'those who control access to the subjects or site of research or repository of documents' – or an open or public setting in which data is freely available (Gobo, 2008). Given that most of my research was conducted in the former setting, my involvement was largely dependent on the co-operation and facilitation of the study's two main gatekeepers, Armorshire Collaboration Project Manager Jo Marshall and Armorshire CDM Nurse Lead Anne Richards[20]. This is a reflection of the requirement of gatekeeper approval typical of case study research (Creswell, 1998) and of the increasingly 'closed' settings of health and social care (Sharkey and Larsen, 2005). Given that my involvement in the research began after the proposal had been written, I had no involvement in establishing initial contact with Jo Marshall or Anne Richards. Nevertheless, we met several times during the first months of my study to discuss the development of the Armorshire Collaboration and my involvement in studying it. Prior to proceeding with my research, however, I needed to secure ethical approval.

My research could be seen from different perspectives with associated ethical risks, such as case study research with the potential abuse of trust gained through a long (and increasingly familiar) association with research participants (Simons, 2009) and as organisational research with the potential favouring of one stakeholder standpoint at the expense of another (Bell and Wray-Bliss, 2009). However, as I carried out the research as a qualified nurse guided by the Nursing and Midwifery Council (NMC) Code of Conduct (NMC, 2008), my brief review of ethics will be from a nursing perspective.

The branch of ethics often applied to nursing is normative and considers the way nurses ought to behave (Holloway and Wheeler, 2002). Normative ethics help to assess values and assist in the making of informed, thoughtful choices (Thompson, 2000). Although nurses have long been viewed as possessing professional integrity and as advocates of patients' rights, early nursing researchers paid little attention to ethics *per se* (Johnson and Long, 2010). Today, however, the Royal College of Nursing (RCN) has its own guidelines for researchers (RCN, 2009). There is also an

[20] As I explained on p. 1 (Chapter One) the names of all of the places and people directly involved in the introduction of the new CCM service, unless otherwise indicated, are pseudonyms.

expectation that biomedical research (including nursing research) should adhere to the principles of the World Medical Association (WMA) Declaration of Helsinki (WMA, 2013). However, the RCN guidelines and the Declaration of Helsinki are neither mandatory nor enforceable by law. Nevertheless, in the light of a variety of high-profile incidences of unethical and potentially harmful research, procedures to ensure ethical probity have become increasingly stringent (Howarth and Kneafsey, 2003; 2005). It is beyond the scope of this thesis to chart these developments. However, it is important to point out that all research involving NHS patients is required to undergo ethical review by an appropriate NHS Research Ethics Committee (REC) and Research and Development (R&D) department. Together, these play an important role in ensuring that researchers comply with the law, act in an ethical manner and do not put research participants (or themselves) at risk while undertaking research (Gelling, 2010).

In order to proceed with my research, I therefore required approval from the relevant Local Research Ethics Committee (LREC) and NHS R&D approval from the All Wales Primary Research Management and Governance Office. In order to do this, I completed a joint-online application, by way of the then newly launched Integrated Research Application System (IRAS). This was a challenging process that included, for example, the submission of copies of bilingual Welsh/English introductory letters, participant information sheets and consent forms for all of the many stakeholders whom I hoped to speak to during my research. It also required the submission of Site Specific Interest forms providing evidence of approval from an officially designated Local Collaborator (CDM Nurse Lead Anne Richards) and evidence of approval by the Armorshire Clinical Governance Committee.

The IRAS application took up much of the first three months of my study. Having submitted my application, however, I was invited to attend an LREC meeting in August 2009 to discuss the research proposal and to address any areas of concern on the part of the committee. Following the meeting, ethical approval was granted subject to some minor alterations to the participant information sheets.[21] In turn, approval was also granted by the All Wales Primary Research Management and

[21] See Appendices 1 - 4 for copies of consent forms, cover/introductory letters, information sheets and letter confirming ethical approval.

Governance Office and by the Owain Glyndŵr LHB R&D Office. With all necessary approvals granted, I was therefore able to commence fieldwork proper. Before doing so, however, I still had to identify the precise 'case' of my proposed case study. I discuss this in the next section, when I consider my use of purposive sampling.

Purposive sampling

The selection of the case of the case study – the phenomenon in its context – was the first instance of the purposive sampling that I used throughout my research (which also included the choice of meetings to attend and documents to analyse and the selection of participants for individual semi-structured interviews and focus groups). According to Patton (1990, p. 169) purposive (or, as he calls it, 'purposeful') sampling is typical of qualitative research, with its 'logic and power' lying in its selection of, '*information-rich cases* [original emphasis] for study in depth'. According to Parahoo (2006) purposive sampling is a strategic process of selection that attempts to ensure that what is researched is relevant to the research questions, with Hood (2006) noting that it involves the selection of a sample with known characteristics from a known population.

Denzin and Lincoln (1994) point out that purposive sampling allows the researcher to choose a case because it illustrates a feature of the process which is of interest. It is an approach that is frequently used in organisational research (Drabek et al.,1982) and is seen as enabling researchers to choose the most appropriate cases for review in the case study approach (Seawright and Gerring, 2008). However, as Silverman (2013) indicates, purposive sampling does not mean that the researcher is free to choose any case, but requires critical analysis of the study population. The possible case of my case study was discussed at some length during a meeting between myself, my principal academic supervisor Professor Joy Merrell, and gatekeepers Jo Marshall and Anne Richards. As I explained in Chapter One (see section, 'The National CCM Demonstrator Programme and the case study locality'), whilst the Armorshire Collaboration was one of three demonstrator-sites in Wales, it was also sub-divided into the three localities of Tregwen, Aberwrach and Bro-y-Grug, each of which was to launch its own CCM service. During the meeting with the study

gatekeepers, initial discussions focussed on specifying which particular locality might be suitable for the case study, or indeed whether I could carry out a comparative case-study of all three. First of all, we agreed that the latter was beyond the scope of a lone researcher, just as we agreed that Aberwrach would not be a suitable choice for a single-case study, given that its size (more than three-quarters of Armorshire's total area), predominately rural nature and low population-density meant that its CCM service would comprise a central hub and small satellite offices. This, we all felt, was ill-suited to one of the central themes of the case study, namely the study of integration in a diverse multi-disciplinary environment.

Moving on to Tregwen, Anne Richards explained that given that it was a predominately urban locality characterised by high levels of social deprivation and drug- and alcohol-use, its existing services for the care of people living with chronic conditions had developed in a specific way to deal with these issues and its new CCM service would develop accordingly. I felt that this did not provide an adequately broad cross-section of issues related to chronic conditions management, and in particular those related to an ageing population. We therefore turned our attention to Bro-y-Grug. Bro-y-Grug, Jo and Anne explained, had an urban/rural split and high levels of chronic conditions that are typical of an ageing population, such as coronary heart disease, chronic obstructive pulmonary disease, but also significant numbers of people living with asthma and diabetes. I felt that these factors made it an appropriate choice for study, and reflected the national demographic and health issues that lay at the heart of my study. Moreover, given that the plans for the new CCM service involved the creation of a co-located team of some forty (allied) health and social care professionals, I felt that this presented a potentially interesting instance of joint-working. Hence, it was agreed that the creation of the Bro-y-Grug CCM service would be the focus of my case study, which could be broadly categorised as single case holistic case study with both intrinsic and instrumental aims.

However, my use of purposive sampling extended to all aspects of my research, not just the selection of the case. Hence, I chose documents to analyse and meetings to attend that, I felt, would give me a wider understanding of the Welsh CCM Model, the National CCM Demonstrator Programme, the Armorshire Collaboration and the

development of the CCM service in the Bro-y-Grug locality. Whilst many of the documents (such as Welsh Government strategies and guidance and National CCM Demonstrator newsletters) were in the public domain, others (such as meeting-minutes and project initiation documents) were made available to me in negotiation with the gatekeepers. Although the same logic of wider understanding underpinned my selection of meetings to attend, with the exception of reviews of the National CCM Demonstrator Programme and Armorshire Collaboration, none were open to the public. Accordingly, my attendance was usually arranged in negotiation with the gatekeepers, after which the Armorshire Collaboration Project Support Officer emailed details to me and requested permission for me to attend from respective chairs. As regards the meetings of the Bro-y-Grug Locality Leadership Team (LLT), my attendance was arranged in negotiation with Locality Care Co-ordinator Christine Thompson.

As regards individual semi-structured interviewees and focus groups participants, just as Patton (1990) notes that purposive sampling allows the researcher to identify respondents with knowledge of questions that are central to a study, so I sought to select stakeholders who were involved in or affected by the creation of the new CCM service during the Armorshire Collaboration. In order to ensure that a wide range of perspectives was taken into account, at the beginning of my research I envisaged that participants would encompass the following: six lead agency representatives (from, for example, Owain Glyndŵr NHS Trust, Armorshire LHB and Armorshire Social Services Department and including the Armorshire Collaboration Project Manager and Armorshire CDM Lead Nurse); six referrers to the service (for example GPs and practice nurses); twenty-four front-line professionals who delivered the service (including community nurses, social workers, [allied] health professionals and support workers); and twenty service users and ten carers. By the end of my research, I had interviewed: twelve lead agency representatives; three referrers; twenty-five front-line professionals; twelve service users; five carers; and three voluntary/third sector representatives.

Whilst I conducted more interviews with lead agency representatives than I had originally anticipated (and with three other people whom I identified as research progressed) Bryman (2012) notes that the flexibility of purposive sampling allows

the sample to be increased during research as new factors emerge that may be of interest. This was an important feature in my research for three main reasons: firstly, because the 2009 NHS Wales Reforms meant that the organisation of health services in Armorshire changed during the Armorshire Collaboration, with concomitant changes in positions in some of the lead agencies; secondly, because the Armorshire Collaboration changed structurally during its three-year existence, with the result that new stakeholders became involved in the project who were not involved from the outset; and thirdly, because as my research progressed, new key informants emerged whose views I felt were important to include. As regards the voluntary/third sector stakeholders, for instance, I felt that their inclusion in the study could provide me with an insight into voluntary/third sector involvement during the reconfiguration of services, an insight which had hitherto been missing.

As regards recruitment of potential participants, my non-participant observation of meetings meant that all of the lead agency representatives whom I hoped to interview were familiar with my research. In addition, of course, they were familiar with the Armorshire Collaboration. In view of the fact that Rubin and Rubin (1995) note that one of the key areas of recruitment is finding a knowledgeable informant, this seemed to provide me with a useful opportunity to approach people with the necessary knowledge and ask if they would be interested in being interviewed (which, in turn, seemed to tally with Rapley's [2004] observation that interview recruitment routinely happens on an *ad hoc* basis). In negotiation with the gatekeepers, I therefore often approached lead agency representatives directly (before or after meetings) so that I could further detail my research, and provide them with introductory/cover letters and participant information sheets. These explained issues of confidentiality, anonymity and informed consent. When prospective lead agency interviewees agreed to be interviewed, I either arranged the time and location immediately or later by phone or email. I conducted twelve interviews with lead agency representatives (including Jo Marshall and Anne Richards) with all interviews taking place on NHS or local authority premises.

Regarding the referrers to the service (whom I also wished to interview individually), I hand-delivered introductory letters and participant information sheets to ten GP practices in the Bro-y-Grug locality. The documentation included my

contact details as well as reply slips and FREEPOST envelopes. I received three reply slips (from two GPs and one practice nurse) expressing an interest to participate in the study. I subsequently telephoned the three prospective participants to answer any possible questions and to organise a suitable time and place for the interview if they were still willing to participate. This was the case with all three prospective participants, whom I subsequently interviewed at their own GP surgeries. Concerning the three members of voluntary/third sector organisations – whom I contacted with gatekeeper approval – all were provided with the same documentation. I interviewed the first person in his own home, the second in her organisation's head-office, and the third at the College of Human and Health Sciences at Swansea University.

In terms of service users and carers, it was decided that it was beyond the scope of the study to include the views of children and young people living with chronic conditions. In order to be eligible, service users and their carers had to be aged eighteen or over and able to give informed consent. I sought to include the views of men and women – from both rural and urban areas – living with a range of chronic conditions. As regards recruitment, I was reliant on the help of front-line professionals. Hence, in negotiation with the gatekeepers, I identified three CDM nurses, one Physiotherapist and one Occupational Therapist who agreed (during home-visits) to inform service users/carers about my research and to distribute, on my behalf, introductory letters and participant information sheets (again, with reply slips and FREEPOST envelopes). I provided each front-line professional with twenty sets of documentation, one of which was made available to anyone who expressed an interest in participating. I received twelve reply slips from service users and five from carers. When I received reply slips, I telephoned respondents to arrange a date, place and time for the interview, at the same time answering any questions related to my research. I interviewed all seventeen respondents in their own homes.

The front-line practitioners who participated in the focus groups were recruited in negotiation with Locality Care Co-ordinator Christine Thompson who, following my decision to carry out a case study of the CCM service in the Bro-y-Grug locality, was appointed third gatekeeper to the study. Whilst I initially proposed a group

presentation to introduce the study, Christine advised that given their busy schedules, an opportunistic approach would be better advised. Accordingly, whenever I visited the new CCM service's offices – in Ty'r Felin, the Social Services Business Support Centre in Llannuon – I spoke individually to prospective participants and provided them with introductory letters and information sheets (which I also left in all front-line professionals' pigeon-holes). Again, the documentation included my contact details, reply slips and FREEPOST envelopes (plus a short questionnaire about professional roles and experience). During the first focus group, I also learned that there were members of the new CCM service who were not based in Ty'r Felin but at other locations in Bro-y-Grug. Subsequently, I therefore arranged for introductory letters and participant information sheets to be distributed to these externally-based CRT-members on my behalf by their line-managers.

Krueger and Casey (2000) suggest that focus groups should include those people most likely to yield the required data. However, Bowling (2009) notes that focus groups are as interested in what is said as in how collective meaning is reached, with Merton et al. (1956) indicating that selection should reflect a shared experience of a particular situation. I therefore considered that most members of the new CCM service in the Bro-y-Grug locality were suitable potential candidates, given that most had extensive experience of working in health and social care (and to varying degrees in integrated environments) and that they also had shared experience of working in the new service. The one exclusion criterion for front-line professionals that I used related to professional experience (anyone who had been in their role for less than six months) as I considered that they would have an inadequate breadth of experience to compare the 'integrated' CCM service with more traditional services. A total of twenty-five front-line practitioners agreed to participate in the focus groups (n=4) comprising: Occupational Therapists (n=3); Occupational Therapy Assistants (n=2); CDM Nurses (n=2); Social Workers (n=3); Care Management Assistants (n=3); Senior Enablement Practitioners (n=2); Enablement Workers (n=2); Domiciliary Care Practitioners (n=3); and one Physiotherapist, Assessor Care Manager, Care Manager and Senior Domiciliary Care Practitioner[22].

[22] Appendix 8 provides details of all focus groups.

At the beginning of each individual interview and focus group I discussed the issues of confidentiality, informed consent and withdrawal from the study that were set out in the participant information sheets. I asked all participants to sign a consent form agreeing to take part in the research, whilst stressing that participants were under no obligation to take part and could withdraw at any time. I reminded participants that all information would be confidential to the researcher, that all reports would be fully anonymised and that all recordings would be stored securely. Bearing in mind that informed consent is an ongoing process (RCN, 2011), I revisited these issues at the end of each interview and focus group. All people who attended meetings which I observed were provided with introductory letters and information sheets detailing the purpose of the research project. Verbal consent was requested from all attendees to record each meeting. Having discussed issues of access and sampling, in the next section I move on to the data collection methods I used.

Data collection methods

Merriam (2009, p. 43) explains that the qualitative case study can be considered: 'particularistic', inasmuch as it focuses on a specific situation, event, programme or phenomenon; 'heuristic', inasmuch as it illuminates the reader's understanding of the phenomenon under study; and 'descriptive', inasmuch as it provides a rich and detailed representation. Focussing on the descriptive element, Merriam (2009, p. 43) explains that the 'end product' of a qualitative case study is a, 'rich, "thick" description of the phenomenon under study'. Merriam (2009, p. 43) defines 'thick description' as the, 'complete, literal description of the incident or entity being investigated' and notes that it is a term derived from the field of anthropology. Indeed, it was employed by American anthropologist Clifford Geertz[23] (1973, p. 10) to describe the data collection of a researcher who is faced with:

> ... a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and inexplicit, and which he must contrive somehow first to grasp and then to render.

Dawson (2010) points out that the term thick description has come to be employed extensively in social disciplines which make use of qualitative research, where it is

[23] Geertz (1973, p. 6) acknowledged that he borrowed the 'notion' of thick description from Gilbert Ryle. See Ryle's (2009) *Collected Papers Volume 2: Collected Essays 1929 – 1968.*

used to highlight the need to pay attention to significant detail in the process of conducting field work and as part of the interpretation of social meaning. Arguing that in the social sciences, there is '*only* [my emphasis] interpretation', Denzin (2009, p. 85) goes on to assert that:

> Nothing speaks for itself. Confronted with a mountain of impressions, documents and fieldnotes, the qualitative researcher faces the difficult task of making sense of what has been learned. I call making sense of what has been learned the art of interpretation.

Denzin (1989, p. 33) explains that thick description, 'presents the action as a text that can then be interpreted' and enables, 'thick interpretation'. The latter, Denzin (1991, p. 162) explains, 'Builds on thick description; attempts to take the reader to the heart of the experience being studied'. Patton (2002, p. 504), likewise, explains that thick description facilitates thick interpretation, adding that in order for a report to be readable and interesting, it should provide 'sufficient description to allow the reader to understand the basis for an interpretation and sufficient interpretation to allow the reader to appreciate the description'.

According to Dawson (2010), the concept of thick description – with its emphasis on detail, context, thoughts, feelings and relationships – has particular relevance for case study researchers, given that their goal is to illuminate the characteristics and particularities of the case in question. In a similar vein, Stake (1994) notes that qualitative case study researchers seek to report as much as possible through interaction and observation and by giving voice to the views and stories of the various research participants. Stake notes that this process of, 'telling the story' (1994, p. 239) is mediated by the researcher's interpretive lens and the circumstances in which the case study is conducted. Simons (2009, p. 23) likewise refers to the case study researcher's part in, 'telling a story'. Simons (2009) explains that the story can be used to explain how and why things happened during the development of programmes or policies, enabling their complexity to be studied in depth and interpreted against their precise socio-economic backdrop by way of multiple perspectives, contested viewpoints and a demonstration of the influence of key actors and interactions.

In order to convey the detail and complexity of the case study whilst reflecting the multiplicity of perspectives and viewpoints, Simons (2009) notes that case study

researchers have a wide range of data collection methods at their disposal. May (2011, p. 234), likewise, notes that commentators agree that multiple methods of data collection are 'essential' in providing the requisite richness of detail of the case in question, thereby providing, 'maximum confrontation' between the researcher and the field of study. Indeed, Punch (2014, p. 120) points out that the case study makes use of, 'whatever methods and means seem appropriate' to achieve these ends, just as Richards and Morse (2013, p.77) report that, 'most case study texts offer the full palette of qualitative data-making methods'. According to Hamel (1993) a commonly used combination of data collection methods in qualitative case study research is: non-participant observation, semi-structured individual interviews, focus groups and documentary analysis.

In the section on research design, I indicated that in planning the case study, I sought to mix emergent and pre-structured approaches. I also explained that my approach was influenced by my awareness that case studies tend to produce large volumes of data which, without some guiding parameters, can become unmanageable, and that I therefore sought to realise a pragmatic 'trade-off' between clarity, purpose, data management and receptivity to local circumstances. As regards my plan for the collection of data, I therefore used those methods which I felt would best allow me to meet the aim and objectives of the case study – by capturing the dynamic and changing nature of local circumstances and providing adequate detail to ensure thick description and adequate breadth to ensure the capture of as many perspectives as possible – but that would be realistically achievable given that I was a lone researcher with limited time and no previous experience of conducting qualitative research. With these elements in mind – and with my knowledge of the scope of methods available to case researchers – I therefore chose a combination of methods which, as I have explained, is commonly used in case study research, namely: non-participant observation, semi-structured individual interviews, focus groups and documentary analysis. In the next four sections I describe each of these four methods in detail, my rationale for choosing them, and their roles in helping me meet the aim and objectives of this case study.

Before doing so, however, it is important to emphasise that, whilst having some bearing on my overall approach to the process of research, the practical constraints I

knew I would face played little part in my specific choice of methods. In order to illustrate this point, it is perhaps helpful to use the example of focus groups. On the one hand, therefore, my background reading had alerted me to the latter's practical advantages, such as the collection of a volume of data on a given topic in the same place and at the same time (see, for instance, Bloor et al., 2001; Flick, 2009). In the event, it was certainly true that in addition to the thirty-five individual interviews with representatives from lead agencies, clients, carers, referrers to the new service and voluntary sector representatives, it would have been beyond my scope to record the views of twenty-five front-line professionals from the new Community Resource Team using the same data-collection method.

On the other hand, however, my decision to use focus groups with front-line professionals was not made with the intention of boosting the numbers of participants in the study and volume of data whilst avoiding the significant work that the arrangement of more individual interviews would have entailed. In any case, as well as alerting me to the practical advantages of conducting focus groups, my background reading had also drawn my attention to the numerous challenges which the organisation of focus groups pose, such as the arrangement of times and locations that are convenient to a number of people, the transcription – and subsequent analysis – of recordings with multiple voices and viewpoints, not to mention the specific skills that are required on the part of the researcher to moderate focus groups (see, for instance, Bowling, 2009; Bryman, 2012). On the contrary, the decision to use focus groups was based on my awareness of what they could bring to the study by way of providing a forum for discussion between a variety of health and social care professionals (see section, 'Focus groups' below for details) and my conviction that, in combination with the three other methods of data collection I used, focus groups would enhance my depiction of the development of the new integrated service. In the next section, I describe the first method of data collection I employed – and my reasons for choosing it – namely non-participant observation.

Non-participant observation

Observational research, explains McKechnie (2008, p. 573), is one of the oldest and most fundamental of research methods, and involves collecting impressions of the world, 'using all of one's senses, especially looking and listening, in a systematic

and purposeful way to learn about a phenomenon of interest'. A way of discovering how something factually occurs in a direct way (Flick, 2009), observational research is used to view events, behaviour and objects in the social setting which are often recorded in the form of field notes[24] (Marshall and Rossman, 2006). As for non-participant observation, Liu and Maitlis (2010), explain that this is used extensively in case study research and describes a situation in which the researcher enters a social system to observe events, activities, and interactions with the aim of gaining a direct understanding of a phenomenon in its natural context but without participating directly in the activities being observed.

As regards the rationale for choosing non-participant observation as a data collection method, this was in large part attributable to my wish to witness first-hand the development of the Armorshire Collaboration and of Bro-y-Grug's new integrated health and social care service for people living with chronic conditions, given the opportunity I had of charting these 'real world' developments in 'real time'. Hence, by attempting to capture the dynamics of stakeholders' interactions with each other, within the natural setting of their work environment and as events unfolded, I believed that non-participant observation would provide me with a unique and unfiltered view – over a period of approximately two years – of the creation of a community health and social service premised on providing an innovative integrated approach to the care of people living with chronic conditions. Indeed, it is argued that observation is an 'essential part' of gaining 'an understanding of naturalistic settings' (Robert Wood Johnson Foundation, 2008b, p. 1), just as McKechnie (2008) notes that it is particularly well-suited to exploring topics about which little is known and to the study of social processes over time, with the resultant rich descriptions generating deep and full understanding of phenomena.

With Flick (2009) explaining that a non-participant observer refrains from interventions in the field, Adler and Adler (1998, p. 81) point out that this means that, 'behavior and interaction continue as they would without the presence of a researcher, uninterrupted by intrusion'. It was the chance of discovering how something occurred in a direct way and without the contrivance, manipulation or

[24] Field notes, according to Becker et al. (2012, p. 398), are, 'A record of field observation. Usually divided into three types: mental "notes", jotted notes (prepared in the field) and full notes (a detailed description of the round of observation)'.

stimulation of behaviour associated with other data-collection methods which, acknowledged as being one of the main strengths of observational techniques (see, for instance, Robson, 1993; Flick, 2009; Punch, 2014), prompted me to incorporate non-participant observation into the case study. Indeed, some consider that observational techniques provide the most credible form of qualitative data collection, given that they are the subject of only one transformation, namely the rendering of reality into material for analysis (Murphy and Dingwall, 2003). This directness can be contrasted with interviews, notes Robson (1993), who explains that the latter have been criticised for the potential discrepancies that exist between what people say and do. It was this production of a different kind and quality of data – and one which I believed would complement the other three data-collection methods I used – that underpinned my choice of non-participant observation.

Simons (2009) suggests that from the moment the case study researcher enters the field until completion of data collection, there are opportunities to observe. Heeding this advice, during the spring and summer of 2009 – and in negotiation with CDM Nurse Lead Anne Richards – I sought to familiarise myself with the existing Armorshire CDM service (which continued to provide care for people living with chronic conditions until the launch of the new CCM service in September, 2010). I did this by visiting the existing CDM offices, by attending CDM nurse-led COPD and oxygen clinics at a local hospital and by making home visits with a CDM diabetes specialist nurse. These early observations allowed me to gain an initial overview and a 'sense of the setting' (Simons, 2009, p. 55) into which the new CCM service would be launched.

From August 2009 I began non-participant observation of meetings, and during the remaining nineteen months of the Armorshire Collaboration, I attended a total of thirty-five meetings[25]. These included: National CCM Demonstrator Programme meetings, which provided me with an overall view of the development of the three demonstrator-sites across Wales; Armorshire Collaboration meetings, which gave me an understanding of the project's development across Armorshire; Joint LLT meetings, which showed me how the approach of the three Armorshire localities compared; Bro-y-Grug LLT meetings, which allowed me to follow closely the local

[25] Appendix 6 provides a list of all meetings observed.

implementation of the new CCM service; and a number of consultation meetings, which gave me some insight into the process of engagement with line-managers, front-line health and social care professionals and the voluntary/third sector.

Given my inductive and interpretive stance, I initially adopted a broadly unstructured approach to observation in an attempt to give as complete a picture as possible of events (Erlandson et al., 1993) whilst maintaining openness (Glaser, 1978). However, I sought to balance this open stance against an orientation of observations to the aim and objectives of the research. Gold's (1958) classification of fieldwork considers observation as a continuum that moves between complete participation, participation-as-observer, observation-as-participant and complete observation. However, such distinctions between participation and non-participation have been considered problematic: Sharkey and Larsen (2005) point out, for example, that the very concept of non-participation contradicts wider understandings of social interaction. They consider that irrespective of how detached researchers may wish to be, their very presence in the field will influence participants and the wider social and cultural dynamic. Moreover, the researcher's role may change and develop, so that a participant-as-observer may become an observer-as-participant (Melnyk and Fineout-Overholt, 2005).

Observation can therefore become modified as the relationship between researcher and participants alters. For example, Millard et al. (2006) report that although their community nursing research ostensibly adopted a stance of observer-as-participant, participants sought practical advice in the knowledge that the researcher herself was a practising community nurse. Rather than considering observation in terms of researchers' activities, Adler and Adler (1994) therefore suggest viewing it as a function of social identity. In this way a continuum of participation is replaced with a system of membership roles, whereby the researcher is a peripheral, active or complete member of the social setting. My observation of national, regional and county-level meetings remained static as a peripheral observer, reflecting the meetings' higher level strategic goals, full agendas, relative infrequency and formal structures. In view of the sense of urgency that characterised these meetings – due to the many concurrent organisational developments and the volume of subjects that needed to be discussed – I felt that my presence had a negligible impact.

The same could not be said of the LLT meetings, given the lengthy and more intimate relationship I had with the LLT's three members and Locality Care Co-ordinator Christine Thompson, which seemed to result in a gradual (if nuanced) move from peripheral observation towards a more active stance. On more than one occasion, for example, I was asked to volunteer my views on certain aspects of the new CCM service. Whilst I was aware that answering risked compromising my position as a non-participant observer, I nevertheless felt that a refusal to do so ran the greater risk of alienation from the four participants. The fact that I did answer (though attempting to do so in non-specific terms) appeared to validate Flick's (2009) contention that fulfilling the researcher's aim of observing events but having no impact on them is doubtful.

During all meetings, I collected data both by making digital audio recordings and by taking detailed field notes. Gomm (2004) considers that audio-recording allows data to be reviewed carefully subsequent to the instance of observation. I also felt that cross-referencing digital recordings with field notes helped accuracy and, as indicated by Silverman (2006), provided a complement to field notes whilst assuring that a minimum of oral data would be lost. By also taking copious field notes, I aimed to provide rich, detailed and contextual information through, 'thick description' (Geertz, 1973, p. 3). Drawing on Burgess' (1984) work, I therefore included detailed descriptive accounts of, for example, seating plans and made diagrams to indicate how attendees communicated with those around them.

I was also influenced by Spradley's (1979) systematic four-stage approach, so that I took notes during observation (first stage) and then expanded them as soon as possible following observation (second stage); this in an effort to maintain legibility and salience (Green and Thorogood, 2004). Just as Lofland and Lofland (1995) explain that this expansion of notes is a process of careful consideration that can take as long as the observation itself, I frequently spent my lunch-times (most meetings were held in the morning) and longer completing these 'write ups' (Miles and Huberman, 1994). As further advocated by Spradley (1979), I kept a fieldwork journal (or study journal), including ideas, experiences and problems from observation (third stage) and an outline of initial analysis and interpretations (fourth stage). Again, I updated my study journal as soon as possible after meetings had

ended. Having discussed non-participant observation, in the next section I describe my use of interviews.

Semi-structured individual interviews

Interviewing, explains Brinkmann (2008), is a conversational practice where knowledge is produced through the interaction between an interviewer and an interviewee or a group of interviewees. Adding that unlike everyday conversations, the research interview is most often carried out to serve the researcher's ends (which are external to the conversation) Brinkmann (2008) explains that many different forms and structures of interviewing exist. However, he adds that most qualitative research interviews are semi-structured, with the agenda being set by the researcher's interests yet with room for the respondent's more spontaneous descriptions and narratives.

As regards the rationale for the decision to include a form of qualitative interview as a data collection method, this was based on my interpretevist stance, with one of my objectives being to learn about the perceptions of developments from the perspective of all of the different stakeholders. This was something that I felt that I could only achieve by talking to people and providing them with the opportunity to tell me of their experiences. Indeed, noting that, from a philosophical and epistemological perspective, qualitative interviews are appropriate for researchers seeking to access participants' understanding of the world, Clare Taylor (2005) points out that these provide participants with the opportunity to describe both their experiences and their interpretations of them. Moreover, Clare Taylor (2005) adds that in qualitative interviews, the interviewer also has the opportunity to discuss and explore issues with participants and to probe more deeply into their accounts of events.

Within the broadly qualitative framework, however, there are different types of interview (Patton, 1990). In order to capture individual experiences, explains Holloway (2008), qualitative researchers can therefore choose between a range of unstructured or semi-structured approaches. The former tend to be very similar to conversation (Burgess, 1984) allowing the interviewer to build a partnership with the interviewee (Rubin and Rubin, 1995). The interviewee is given room to respond

freely with the interviewer and the interview becomes an active process of collaborative creation (Holstein and Gubrium, 1997). The latter, on the other hand, include lists of predetermined topics with some questions (normally in the form of an interview schedule) allowing similar data to be gathered from a range of informants (Bryman, 2012).

At the same time, however, the semi-structured format's tighter structure does not mean that the interviewer is bound by the order of the questions, and the interviewee is likewise given considerable freedom in responding (Tod, 2010). By adopting a semi-structured framework, I therefore sought a balance between direction and flexibility, by addressing the central questions to the study and further exploring particular issues as necessary (May, 2011). On the one hand, I felt that a semi-structured approach was important if I was to gain some uniformity across the interviews and to be able to focus on my primary concerns of integration and involvement. On the other hand, I felt that this would give interviewees the space to explain, in their own words, their experiences of the establishment of the new CCM service, allowing me to gain an understanding of the social world from their perspective (see Weber, 1949).

In order to help guide my interviews, I used interview schedules.[26] The use of guides, outlines or schedules that contain key ideas or lists of questions in qualitative interviewing is referred to by a number of experts, including Warren (2002) and Mason (1996). Whilst noting that their format can differ – from formally typed schedules to handwritten keywords – Rapley (2004) suggests that it is useful to have a list of questions in order to provide structure to an interview. The list of questions, Rapley (2004, p. 17) adds, is initially generated in light of relevant literature but also by the researcher's own 'thoughts and hunches'. Given my relative inexperience of integrated working or CCM prior to beginning my research, I was initially more influenced by the knowledge I had gained in carrying out my literature review than by any particular hunches. However by the time I began conducting interviews, I had attended numerous meetings and read a considerable amount of documentation

[26] See Appendix 5 for all interview schedules.

that related to the National CCM Demonstrator Programme and the Armorshire Collaboration, and this too shaped my approach.

Whilst the schedules for the four stakeholder groups who were involved in semi-structured interviews differed, there were common points. On the one hand, therefore, I was interested in ascertaining why lead agency representatives felt that integration of health and social care was important and how this related to the aims of the Armorshire Collaboration; I was interested in learning about service users' and carers' experience of care and the impact the new CCM service was having on their lives; and I was interested in knowing to what extent referrers used the new CCM service and its potential role in improving the lives of service users. On the other hand, however, given that it was indicated in the Armorshire Collaboration Project Initiation Document (PID)[27] that service users would help co-design the new CCM service, I was also interested in ascertaining how different stakeholders – including the service users themselves – felt they had been involved in this process.

Bearing in mind that another of my objectives was to ascertain how different stakeholders had experienced the launch of the new CCM service, before beginning each interview I explained that my primary goal was to explore the participant's perspective, but that I was ready to engage in further discussion if the opportunity arose. I therefore attempted to combine my questions with the development of a rapport (Noaks and Wincup, 2004), my approach influenced by feminist perspectives on interviewing and the emphasis they place on openness and development of trust rather than objective detachment (Oakley, 1981). It has been suggested that the development of such a rapport can help the researcher gain access to the world of the interviewee (Payne and Payne, 2004). I felt that this approach created an ambiance of openness and honesty that allowed people to talk freely of their particular issues and concerns that would have been impossible in a more tightly structured interview format.

[27] See Appendix 9 for Armorshire Collaboration PID.

I commenced the semi-structured individual interviews[28] with lead agency representatives in June 2010, when I interviewed Bro-y-Grug LLT Social Care Lead Gwyn Evans. Over the course of the following three months I interviewed Armorshire Collaboration Project Manager Jo Marshall, CDM Nurse Lead Anne Richards, Locality Care Co-ordinator Christine Thompson and the remaining two members of the Bro-y-Grug LLT (with each interview lasting between sixty and ninety minutes). When the new CCM service in Bro-y-Grug was launched in September 2010 – by which time it had been renamed the Bro-y-Grug Community Resource Team (CRT, see Chapter Four, section: 'Two key services') – however, I felt that it was important to allow it time to become established before seeking to interview service users and carers. At the same time, it was difficult to arrange further interviews with lead agency representatives given that the other two Armorshire localities were also launching their own CRTs, thereby making it an extremely busy time for all those involved in the Armorshire Collaboration. As a consequence, I did not recommence the semi-structured interviews until April 2011.

Having sought consent to do so, I recorded all interviews using a digital recorder, bearing in mind Henn et al.'s (2006) indication that the verbatim report offered by audio-recording offers a more complete representation of interviews than taking notes alone. Heritage (1984) suggests that the recording and subsequent transcription of interviews: helps to correct the natural limitations of memories; allows a more thorough examination of what people say; permits repeated examination of answers; opens up the data to public scrutiny (thereby countering accusations of researcher bias); and allows the data to be reused by others. However, Simons (2009) notes that the process of transcription is time-consuming, adding that for each hour of recording five more need to be added for transcribing. In order to facilitate the process – and to help in my subsequent analysis – I endeavoured to transcribe in the days immediately after interviews, when the nuances, meaning and tone of what people told me were still fresh. Having described my use of individual interviews, in the next section I discuss my use of focus groups.

[28] See Appendix 7 for a list of all individual interviewees.

Focus groups

Many experts refer to case study researchers' use of focus groups (Stake, 1995; Yin; 2009; Simons, 2009). The latter, explain Green and Thorogood (2004), are discussions with small groups of people brought together by a facilitator to explore a specific topic. Morgan (2008) points out that focus groups are a popular method of data collection because they are flexible and can be modified to suit a range of purposes, such as exploratory research or as part of more structured approaches. Krueger (1998) explains that focus groups are characterised by interactions between participants, thereby differentiating them from other forms of group interview. Indeed, it is this collective element and the way that participants discuss subjects of joint-interest together – rather than individually responding to the moderator's questions – that is one of the hallmarks and strengths of the focus group, explain Kitzinger and Barbour (1999). By affording the researcher an opportunity to see participants considering topics or experiences of shared interest, the focus group therefore allows an examination of group interaction (Denscombe, 2007).

It was this interaction between participants that underpinned the rationale for the inclusion of focus groups as a data collection method in the case study. Hence, I felt that by providing front-line health and social care professionals with an opportunity to discuss, with each other, issues related to the development of the CRT in a conversational manner – rather than by answering, separately and independently, questions that I had put to them – I could gain insight into the processes of joint-working and the forging of group identities in a co-located health and social care team. This was an especially important factor, given my interest in the cultural dynamics of integration and my awareness of the belief that integration can foster the development of a joint ethos of health and social care – premised on client-centred integration – that supersedes professional distinctions and allegiances.

I also felt that by providing participants with themes to discuss collectively, the focus group format would facilitate understanding of the development of new relationships amongst participants from different (allied) health and social care professions, of the interaction of people in an inter-disciplinary environment, of the ways in which joint-decisions were made and hence of aspects of the development of integration within the CRT. These were all areas which, in accordance, with my

background reading, I felt would be made possible in the focus-group setting. Hence, it has been indicated that focus groups can: provide an example of the formation of group identities (Wilkinson, 1999); permit an examination of collective decision making processes and professional practice (Barbour, 2007); and are a useful way of studying organisational change (Barbour, 1999).

Membership of focus groups is usually determined by a shared attribute, such as a known opinion-position, socio-demographic position, experience or other variable (Henn et al., 2006). Indeed, it has been argued that keeping people with similar backgrounds together lowers the risk of inhibition in interaction and communication in the focus group setting (Foster-Turner, 2009) and that too much heterogeneity can render focus groups unmanageable and unwieldy (Henn et al., 2006). Given that I wanted to garner views on integrated working in a team that included (allied) health and social care professionals, however, I felt that it was important to mix different professions in the same focus groups. But I felt that even across the different professional groupings, a degree of homogeneity would be guaranteed by the participants' shared attribute of being part of the same co-located team. By setting out to foster the supportive environment which, explains Gomm (2009), can encourage participants to express themselves freely, and aware of Kamberelis and Dimitriadis' (2005) suggestion that focus groups allow a detailed examination of how a subject has been constituted out of particular intersections of forces and systems of forces, I felt that a professionally heterogeneous focus group – but one in which issues of common interest were discussed – might help shed light on how the 'intersection' of health and social care professionals working within the same team had contributed to the development of integration.

I also felt that it was important that the members of the CRT had gained some familiarity with their new roles before exploring their views on moving to a new team of health and social-care professionals who were co-located. After consulting with my academic supervisors, I considered that between five and six months would be adequate, and began making preliminary plans for the first of the focus groups in January 2011. Before arranging any specific dates, I considered the possible size and composition of each focus group. Regarding the former, there is general agreement that focus groups should contain between six and twelve members

(Morgan, 1998; Barbour, 2007). I therefore decided to aim for six participants per focus group, believing that this number would combine breadth of viewpoints with manageability (Stewart et al., 2007).

It is important to stress, however, that the front-line professionals who agreed to participate in the focus groups had limited availability due to their heavy work-schedules. Indeed, Bryman (2012) notes that focus groups are difficult to organise and that it is common for people not to turn up at the appointed time. But just as Bryman (2012) notes that payments (such as book tokens) may be used to induce participation, so I hoped that my offer of home-made chocolate brownies and a selection of fresh fruit and juices would encourage attendance. Of great benefit was the availability of a large interview room at Ty'r Felin – where most of the team was based – to conduct the focus groups. Nevertheless, the identification of lengthy time-slots that were convenient to a cross-section of busy front-line professionals was a challenging process. Nowhere is this better illustrated, arguably, than the time it took me to organise each focus group, as indicated by the minimum gap of a month between each. So, whilst the first focus group took place in early February, 2011, the last – including seven of the CRT's peripherally-based members – was held some seven months later in September, 2011.

Given that they worked from different locations across Bro-y-Grug, these peripherally-based members found it more difficult to attend focus groups than the Ty'r Felin-based practitioners. Locality Care Co-ordinator Christine Thompson therefore advised that optimum attendance would be achieved by organising a focus group specifically for them. As a result, the first three focus groups comprised a mix of (allied) health and social care professionals who worked in the centrally co-located office, but the fourth included social care professionals dispersed across the locality. Accordingly, whereas participants in the first three focus groups discussed at length the advantages and disadvantages of sharing office-space with a variety of health and social care professionals, this topic was conspicuous by its absence from the fourth focus group. Conversely, their relative isolation led the participants in the fourth focus group to discuss at some length the issues related to being what they called 'lone workers in the community'. Nevertheless, one of the themes common to all four focus groups was the impact on communication and information-sharing that

this central/peripheral split in CRT membership had engendered. As a consequence, I felt that the different levels of homogeneity/heterogeneity of focus groups had strengths and weaknesses (but that arranging them in any other way was not a valid option).

Focus groups can be used to explore a specific set of issues, with a collective activity used as a means of focussing group discussion (Kitzinger and Barbour, 1999). Punch (2014) refers to the use of unstructured, semi-structured or highly structured frameworks depending on context and research purposes. As with the semi-structured individual interviews, whilst adopting a relatively free framework, I also used the aim and objectives of the study as a guide to try to ensure some consistency. As I sought to generate discussion on a given subject without restricting freedom of expression or flexibility in format, these goals again seemed to ally themselves with a semi-structured approach using a topic guide (Goodman and Evans, 2010). In drawing up a schedule[29], I again used the knowledge that I had acquired through conducting the literature review. However, reflecting my growing interest in ascertaining the extent to which different stakeholders had been involved in the reconfiguration of services, some of my questions related directly to these issues, whilst others related to participants' understanding of their roles within the CRT and of integrated working, and the opportunities integration would offer service users.

Before commencing the focus groups, I explained the semi-structured approach, and the importance of ground-rules, including respect for different opinions and non-interruption of other participants. I revisited issues of anonymity and confidentiality explained in the introductory letters and information sheets, whilst stressing that I could not ensure that participants would respect confidentiality following the session. I provided an opportunity for questions, sought written consent and asked permission to record the session. As with the interviews, I felt that recording and transcription was the best way of collecting data. However, Bryman (2012) notes that there are specific reasons for recording in focus groups (many of them linked to the difficulties of simultaneously writing and observing a group). Bryman (2012) suggests that it is advisable to record: due to the difficulties in writing down not only

[29] See Appendix 5.

what is said but who said it; because it can help trace where the range of opinions in a group originate; because it can help in the study of the processes whereby meaning is collectively constructed and to capture group dynamics; and because it can help to capture the nuances of language (not just *what* people say but *how* they say it).

I began each focus group with a brief round the table introduction as an 'ice-breaker' to initiate proceedings (Krueger and Casey, 2000), before asking the first question from my schedule, namely what the focus group participants' views had been on the establishment of the CRT. Discussions then developed, with my topic guide framing the discussion. At the same time I bore in mind Gomm's (2004) contention that the focus group facilitator's principal task is to *focus* group-discussion – not just to ask questions – with the expectation that what participants know and believe will be developed through this process. This allows the examination of group interaction in the discussion of a subject that is of interest to the researcher (Morgan, 1998) but with the emphasis on shedding light on the shared experience of the participants (Bryman, 2012). In order to allow the participants adequate opportunity to discuss their own priorities, I drew on Bryman's (2012) advice to relinquish a certain amount of control to the group. Indeed, when the goal is to engage participants in analysing their own practice, a predominately listening stance is essential, argues Simons (2009). With this in mind, having asked a question from my schedule, I endeavoured to let the discussion develop. At the same time, however – and mindful of the informality that encourages discussion but the need to manage closely proceedings (Puchta and Potter, 2004) – I sought to move proceedings on whenever I felt this was necessary. When I felt that all of my main questions had been adequately covered, I summarised the key points to check for accuracy and asked if any important issues had been missed. Having described my use of focus groups, in the next section I discuss my use of documentary evidence.

Documentary sources

Although my use of documentary sources is the last method of data collection that I discuss, this is not a reflection of its chronological positioning in my data collection, nor an indication that it was any less important than the other three methods. On the contrary, documentary research was fundamental to my research at the outset and remained so throughout. Indeed, Robson (1993) notes that in the social sciences, particular interest has been shown in documents. The latter, he explains, primarily refers to materials that are written, such as books, newspapers, magazines, notices and letters, but adds that they can also refer to films, television programmes, pictures, drawings and photographs. As regards the analysis of documents, Prior (2008) refers to the possibility of adopting sophisticated approaches using strategies derived from the analysis of speech transcripts (involving, for example, notions of grounded theory or thematic coding schemes) or at another level still, discourse analysis. However, Prior (2008, p. 230) adds that the 'standard approach' to documentary analysis focuses primarily on what is contained within documents, with the latter viewed as 'conduits of communication' containing meaningful messages.

As regards the rationale for the decision to include documentary sources as a data collection method, this was driven by my desire to compare people's experience of the establishment of the CCM service with the Welsh Government's stated aims in implementing the Welsh CCM Model and launching the National CCM Demonstrator Programme and the Armorshire Collaboration's stated aims in establishing the individual CCM services. This approach was in keeping with Yin's (2009, p. 103) assertion that the most important use of documents in case study research is to, 'corroborate and augment evidence from other sources'. I was, for instance, especially interested in exploring how the Welsh Government's stated aim of establishing a model of care premised on service user involvement in its design and delivery played out in practice. In such a way, I sought to compare how the 'rhetoric' of integrated working as indicated in policy documents produced prior to the programme's launch compared with local stakeholders' experience of the 'reality' of integrated working as reported during meetings I observed and interviews and focus groups I conducted as the programme developed.

Commentators have indicated that documentary evidence can be a rich source of data for social research, particularly in a society characterised by extensive use of documentary records (Punch, 2014). Silverman (2006) suggests that the utility of textual data is displayed in four areas: its richness in revealing presentational subtleties and skills; its relevance to how society and people are viewed; its naturally occurring documentation of participant activities (without researcher intervention); and its rapid availability to researchers and relative freedom of access and ethical issues.

Whilst some commentators consider that documents should be treated as informants or interviewees (Glaser and Strauss, 1967) others (including Lee, 2000; Plummer, 2001, and May, 2011) consider them as neutral repositories of information, or what Prior (2008, p. 823) terms, 'inert carriers of content'. Indeed, Bryman (2012, p. 543) notes that documents – as sources of data in qualitative research – are, '"out there" waiting to be analysed', before explaining that by such documents, he means materials that:

> ... have not been produced specifically for the purpose of social research; are preserved so that they become available for analysis; and are relevant to the concerns of the social researcher.

Simons (2009) notes that using documentary evidence in case studies can provide a better understanding of an organisation's self-image or development of a specific programme. Simons (2009) explains that such documentation can include: formal literature, such as policy documentation, public records and organisational documentation (prospectuses, annual reports, audit reports, equal opportunity statements, vision statements and rules and regulations); and informal records, such as newspaper articles, bulletins, and memos. My use of documentary evidence in the development of a specific programme – the Armorshire Collaboration in the Bro-y-Grug locality – spanned many of these different types of documentary evidence.

For instance, I examined Welsh Government policy documentation that discussed integrated working in health and social care, including the two key documents – *Designed to Improve Health and CCM in Wales* (WAG, 2007) and the *Service Improvement Plan* (WAG, 2008) – that set out the Welsh CCM Model and plans for

its Wales-wide implementation. I read National CCM Demonstrator Programme documentation – including yearly reports, briefing sheets, bulletins and newsletters – that related to the three demonstrator-sites and their trialling and testing of the new model and sharing of learning with the rest of the country. I examined Armorshire Collaboration documentation – such as the Project Initiation Document (PID) – that detailed the organisational structure that would be used to facilitate the model's local implementation and the project's vision statements. I read minutes and PowerPoint® presentations from: National CCM Demonstrator Programme meetings at national and regional level; from Armorshire Collaboration meetings at county-level; and from Bro-y-Grug LLT meetings at local level. I also read emails that were sent to front-line professionals describing plans for the CRT's launch.

In view of the importance of setting and context in case study research, I also examined: documentation relating to the services that the Bro-y-Grug CRT replaced, such as the Armorshire CDM Team and the Llawfon Reablement Service; and documentation related to chronic conditions management and integrated working in Armorshire in the years leading up launch of the Amorshire Collaboration. Bearing in mind that documents for use in qualitative research, according to Bryman (2012), can include mass-media/virtual outputs and visual materials, I also watched National CCM Demonstrator Programme and Armorshire Collaboration DVDs, consulted the National CCM Demonstrator Programme website, and examined floor-plans of Ty'r Felin and seating arrangements of its CRT members (the latter in order to try and gauge the extent to which the physical layout of the building was conducive to integrated working).

I frequently used documentation to cross-reference, check and verify (by way of triangulation) data that I collected during non-participant observation, interviews and focus groups. This was of particular relevance in terms of the (lack of) definitional clarity pertaining to many elements of the CCM Model and Framework, the National CCM Demonstrator Programme and the Armorshire Collaboration. Hence, by comparing how, for example, a specific role (such as the Locality Care Co-ordinator) was referred to/defined in interviews, focus groups and meetings and then comparing this with how it was referred to/defined in documentation, I was able (arguably) to identify the sources of some of instances of 'role ambiguity' (Handy, 1993).

Sometimes I used documentary evidence as a starting point against which to chart the development of a particular theme during the Armorshire Collaboration. For instance, beginning with the Welsh Government's recognition – set out in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 4) – of the need to 'design and operate services around the needs of the users, not the provider', I used other sources of data to try and gauge how the vision-statement tallied with what I observed, what respondents told me and what was reported in other documents. As my research progressed and I found no evidence of the involvement of clients and carers in the creation of the new CCM service – despite the claims made in numerous documents to the contrary – I became increasingly aware that, in the words of Atkinson and Coffey (2011, p. 79), 'we cannot treat records – however "official" – as firm evidence of what they report'.

Indeed, Atkinson and Coffey (2011) note that documents should be approached with an awareness of what they are being used to accomplish, of their place in organisational settings and of the cultural values attached to them. Hence, even something as ostensibly straightforward as, for instance, the minutes of a meeting can, according to Bryman (2012), reveal a great deal about an organisation's culture and preoccupations. However, Bryman (2012, p. 555) warns that when reading minutes, one should remember that they are written not only for the meeting's participants but also with, 'prospective scrutiny by others in mind'.

In this respect, the fact that I was able to observe many of the meetings of which I also read the minutes provided me with a point of comparison. For instance it allowed me to note that a major difference in opinion *vis-à-vis* the role within the project of Locality Care Co-ordinator Christine Thompson – between the latter and GP Lead Dr David Lewis – that emerged during an LLT meeting that I observed was not subsequently referred to in the meeting's minutes. Just as this discrepancy was, I felt, perhaps connected with its lack of concordance with the cultural values of partnership working – values which were fundamental to the CCM Model and Framework, National CCM Demonstrator Programme and Armorshire Collaboration – Prior (2008) notes that documentation is subject to writer and editor manipulation that is context driven.

Also, I was able to compare the minutes of meetings that I had not attended with what I subsequently learned during interviews or focus groups. For instance, this allowed me to contrast the indication – in the minutes of several LLT meetings – that front-line professionals were to be/had been consulted with regard to the creation of the new CCM service with the many reports – during focus group interviews – that participants had little prior knowledge about the changes. Again, I felt that this was a reflection of the cultural values of the Armorshire Collaboration and the indication, as set out in the Armorshire PID (see Appendix [App.] 9) that one of the project's 'success factors' was 'clinicians leading change', just as May (2011, p. 199) notes that what people decide to record is informed by decisions which relate to the 'social, political and economic environment of which they are a part'. Hence, heeding Flick's (2009) advice, during my analysis of documents I attempted not only to focus on the contents of the documents, but also to take into account their context, use and function and the way that they are used to construct 'a specific version of an event or process' (2009, p. 261). Having discussed how I collected data, I now move on to describe data handling and analysis.

Data handling and analysis

Reflecting Merriam's (2009) emphasis that the mass of data typically produced by case studies requires careful management, I stored the data I collected in one file on my computer in the postgraduate student-office of the College of Human and Health Sciences at Swansea University. Such a 'case study database' is, according to Yin (2009), a priority of case study researchers. In a similar vein, Patton (2002, p 449) refers to the importance of maintaining a 'case record', which, he notes, 'includes all the major information that will be used in doing the case analysis and case study'. On returning to the postgraduate office following fieldwork I immediately set about transferring everything to my own case study database. This involved typing up my handwritten field notes and my study and reflexive journal entries and filing audio-recordings ready for transcription which, as I noted in the previous section, I carried out in the days immediately following fieldwork.

Alongside my own case study database I also used the qualitative software package NVivo to store all of my documentation – which effectively became a database

within a database – reflecting the recognition that such programmes can help in the challenges of maintaining and handling large amounts of qualitative data (Silverman, 2006; Punch, 2014). Learning to use NVivo, however, was time-consuming, and in not seeking to go beyond a fairly basic level of understanding, my main use of it was to support data management. Nevertheless, the programme served as a useful back-up, particularly inasmuch as it became a central reference point – or overview – which allowed me to orientate myself around my data.

Merriam (2009, p. 204) notes that the existence of a case study database facilitates data analysis, but adds that in case studies there are, 'various procedures for deriving meaning from qualitative data'. In a similar vein, Richards and Morse (2013, p. 207) indicate that across case studies, the 'analysis technique differs widely'. However, Merriam (2009) and Richards and Morse (2013) also emphasise that such diversity is true of many different approaches to qualitative research, with Tesch (1990, p. 4) likewise alluding to the 'fluid' nature of qualitative analysis. In a similar vein, Punch (2014, p. 168) explains that there are, 'multiple perspectives and practices in the analysis of qualitative data', before stressing that whichever method of analysis is chosen, it should be integrated – from the outset – with other parts of the research.

Indeed, many experts stress the importance of handling, analysing and interpreting qualitative data as soon as they are collected (Glaser and Strauss, 1967; Wolcott, 1990; Silverman, 2013). In a similar vein, Stake (1995, p. 9) explains that data analysis in case studies is an ongoing process that begins as soon as data are collected and that lasts throughout, with the researcher always maintaining, 'vigorous interpretation'. Merriam (2009, p. 171) notes that analysis should be ongoing, and warns that without it the data can be:

> ... unfocused, repetitious, and overwhelming in the sheer volume of material that needs to be processed. Data that have been analyzed while being collected are both parsimonious and illuminating.

I combined early analysis with data collection by writing down ideas about the meaning of text (and how this might relate to other ideas) next to my field notes and transcripts. In my study journal I also recorded theoretical insights that emerged from my reading of the data in the form of 'memos'. Used as an aid to the generation of concepts (Bryman, 2012), the latter are, according to Bluff (2005, p.

156), 'the written records of abstract thinking about the data'. As I developed propositions and hypotheses, I then paid greater attention to particular elements of subsequent fieldwork, before attempting to refine my initial hypotheses on returning to my desk.

These initial thoughts helped provide me with the early focus which is, according to Eisendhart (1989), an important factor in managing the large volume of data typically produced by case studies. Eisendhart (1989) nevertheless adds that unlike hypothesis-testing research, this early focus can be viewed as a provisional measure that is open to change as research develops, so that it does not impose strict categories on the emergent data. Indeed, Silverman (2010) adds that one of the strengths of qualitative research lies in its flexibility to change focus as analysis progresses, as part of a dynamic interaction between theory, concepts and data. Hence, although the aim and objectives of the research proposal and the findings of the literature review also served as an initial point of reference, in keeping with my interpretevist stance, I attempted to incorporate this into a process that is often – but not exclusively – inductive in nature, namely thematic analysis.

According to Braun and Clarke (2006, p. 79), the latter involves, 'identifying, analysing and reporting patterns (themes) within data'. At the same time it is perhaps important to note that although Bryman (2012, p. 580) notes that thematic analysis is widely used by qualitative researchers, he adds that it is a, 'remarkably undeveloped procedure, in that there are few specifications of its steps or ingredients'. Gomm (2009, p. 360) explains, however, that thematic analysis involves the search for semantic features that are either pre-established or – more usually – inductively 'discovered' and begins with thematic coding.

Codes, Miles and Huberman (1994, p. 56) explain, are, 'tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study'. As for the relationship between codes and themes, Bryman (2012) notes that some writers discern little difference between the two, but that others believe that themes transcend a single code and are instead built-up out of groups of codes. However, Bryman (2012, p. 580) notes that a theme can be considered:

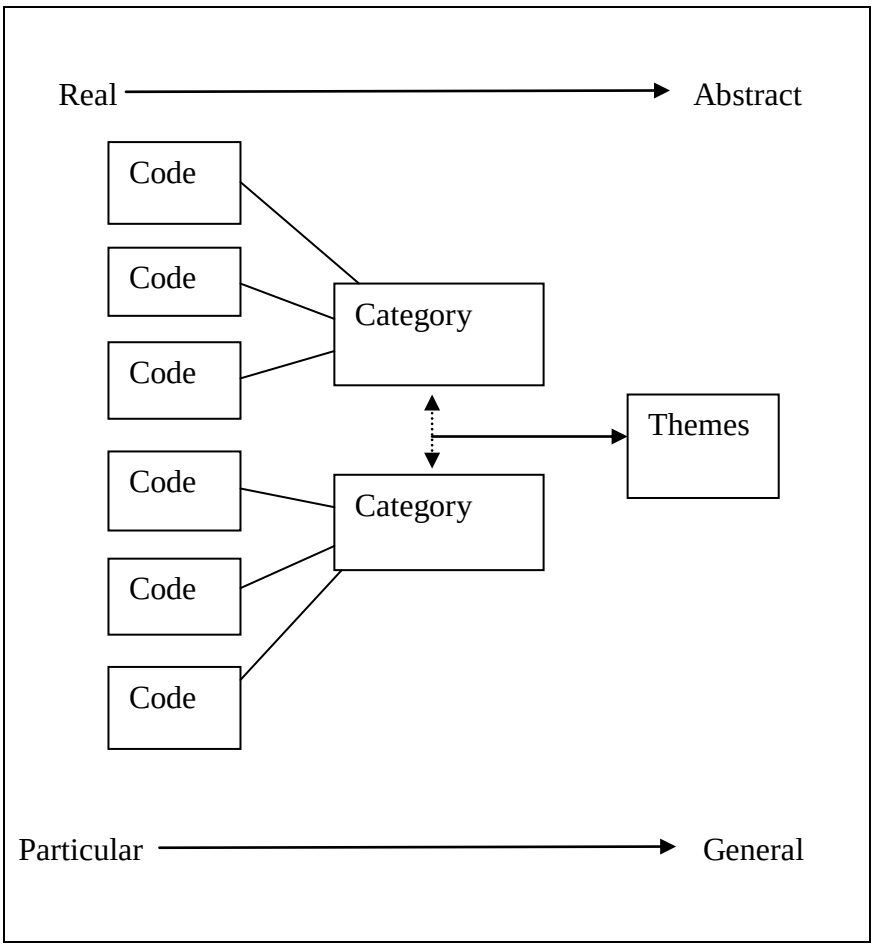
> ...a category identified by the analyst through his/her data; that relates to his/her research focus (and quite possibly the research questions); that builds on codes identified in transcripts and/or field notes; and that provides the researcher with the basis for a theoretical understanding of his or her data that can make a theoretical contribution to the literature relating to the research focus.

As my empirical data grew, alongside noting the development of theoretical concepts, I also printed out transcripts and field notes and read through them line by line to identify and isolate phenomena. Heeding Merriam's (2009) observation that during the opening stages of analysis the researcher should be as expansive as possible, initially I did this in very general terms, taking sections of text and assigning to them codes (equivalent to broad categories) that described the piece of data itself; these initial categories can perhaps be seen as analogous with Miles and Huberman's (1994, p. 57) 'descriptive' or with Richards' (2005, p. 92) 'topic' codes. To do so I used capitalised abbreviations such as CHA for change, INT for integration, STR for strategy and so on. After reading through the texts and assigning them descriptive/topic codes, I returned to the original transcripts and field notes in my case study database and proceeded to disassemble (by copying) them, and reassemble (by pasting) them – according to their codes – in one document. I repeated the exercise in NVivo. However – and bearing in mind the limitations of my knowledge of the programme – I felt that this process could not replace (or replicate) my interpretive analysis and that NVivo's main benefit lay in the fact that it served to provide a central overview of the data.

Having assigned initial categories to all of the data and copied and pasted everything into one document, I returned to my original printouts and recommenced coding in a more analytical way. According to Richards (2005, p. 94) such, 'analytical coding' is coding that, 'comes from reflection and interpretation on meaning'. In a similar vein, Miles and Huberman (1994, p. 57) refer to the more abstract 'pattern codes' that pull together the less abstract 'descriptive codes'. Miles and Huberman (1994, p. 58) stress that by pulling together data – by means of the 'astringent' nature of codes – this makes them '... intelligible, suggests thematic links, and functions like a statistical "factor", grouping disparate pieces into a more inclusive and meaningful whole'. Perhaps unsurprisingly, given the 'fluid' nature of qualitative research to

which I referred at the beginning of this section, Punch (2014) notes that different writers – as exemplified by the different names used by Richards (2005) and Miles and Huberman (1994) – employ different terminology to describe the different levels and types of coding. Whilst Punch (2014, p. 176) notes that this can engender confusion, he nevertheless notes that whatever the terms employed, codes are generally divisible into two main types, namely, 'low inference descriptive codes and higher inference pattern or conceptual codes'. In fact, through ongoing thematic analysis, I finished with three divisions that I named: codes, categories and themes that represented a movement from particular to general and from real to abstract (as set out in Figure 3 below).

Figure 3: From codes to themes. (Source: Saldaña, 2009, p. 12).



Appendix 12 sets out the various codes, categories and themes that resulted from my analysis and Table 3 (overleaf) provides some examples of this process. The left-hand column of the table consists of four extracts from the empirical data I collected, one from each data collection method. The first extract is from a documentary

source; the second from an individual interview with a representative from a lead agency; the third from a focus group with members of the Bro-y-Grug Community Resource Team (CRT); and the last from a Locality Leadership Team meeting. The three subsequent columns show, respectively, the codes categories and themes that I ascribed to the empirical data.

Table 3: The process of coding: codes, categories, themes.

Empirical data	**Code**	**Category**	**Theme**
The following key principles underpin the basis for an Integrated Model and Framework for Action for Chronic Conditions in Wales…Proactive and planned population management across all 4 levels of the model to ensure that the right care and support is identified and services delivered at the right place and in the right way and by the right people, with the active engagement of carers and patients (WAG, 2007, p. 15).	Engagement	Active/passive/ tokenism	Involvement
When we're talking about independence with service users, that's what we're talking about: giving people the opportunity to make their own decisions, choices about their own lives, having control over their own lives, over their own destiny (LARI1: 7).	Control	Self-determination	Empowerment
I wasn't being obstructive. As a team of occupational therapists, we just had genuine concerns with regard to our service provision. This is how we were trained, we were trained to challenge practice and we were educated on challenging and engaging in debate, engaging in that.	Consultation	Active/passive/ tokenism	Involvement

(Continued overleaf)

And the consultation process sort of allowed that. Well, on the surface it allowed people to voice their opinions, but really, it wasn't allowed (FPFG1: 8).			
There's an organisation called Llawfon, and they were fantastic, they really were. They'd come in and they'd say: 'Move your finger!' and: 'I can't move my finger!' and: 'Yes you can! Yes, there's a flicker there! Brilliant!' Then they'd come back later that day: 'We got a flicker earlier, so let's see what we can get this time!' And then, progressively, you know, we worked particularly on my arm, so that my hands began to work, and my arm began to work. They were quite wonderful (CLI1: 3).	Pre-existing services	Facilitators	Integration
When you get to that place where all feel that that's my working home, things will happen on behalf of clients. This is the received wisdom in this building, within our departments. We've now got to demonstrate that it works, and that having a Housing Officer of significant seniority in the team is vitally important. And stuff will happen which the review won't be able to anticipate. It is a leap of faith, I say that as someone with faith only in what we have evidence for. But we may have to practise for a while before we get the evidence that this is pretty strong stuff (LLTM06: 7)	Co-location	Facilitators	Integration

Returning to Richards' (2005), 'analytical coding', she notes that this is the hardest type of coding, since meanings are considered in context and categories are created that express new ideas about the data. Whilst this type of coding was undoubtedly

more intellectually challenging than the assignation of simple descriptive labels, given that this was concurrent with data collection, it was informed by my burgeoning knowledge of integration, chronic conditions management, the National CCM Demonstrator Programme, the Armorshire Collaboration and local developments in Bro-y-Grug. It is therefore perhaps important to emphasise that the thematic coding – and, indeed, the whole process of analysis – was an ongoing process of re-examination, re-conceptualisation and narrowing down.

Indeed, given its lack of recognised 'identifiable approach' (Bryman, 2012, p.578) my approach to thematic analysis was influenced by the importance of, 'immersion in the data' (Marshall and Rossman, 2006, p. 158). According to Denscombe (2007) this is something that can only be achieved through a process that includes repeated readings, cross-referencing for contextual understanding, and a search for implicit meanings. Hence, my analysis consisted of a sustained effort to develop further categories and links within the context from which they were derived – the development of the CCM service within the Bro-y-Grug locality – and to develop relationships within the framework of integration and the management of chronic conditions in which the case study was set.

Reflecting the growing recognition that qualitative researchers need to be explicit about the analytic procedures used during research (Silverman, 2006), in this section, I have attempted to give an overview of the analytic procedures that I used during my research. At the same time, however, Woods (2006) notes that qualitative researchers face a special challenge in depicting how they analyse their data, with Marshall and Rossman (1999, p. 150) noting that qualitative data analysis is:

> ...the process of bringing order, structure and interpretation to the mass of collected data. It is a messy, ambiguous, time-consuming, creative and fascinating process. It does not proceed in a linear fashion: it is not neat.

Indeed, Denscombe (2010, p. 303) notes that given the, 'complicated and messy process of data analysis' and, 'relatively large amount of data based on words or images', qualitative researchers need to be selective in what they present, limiting themselves to identifying key parts of the analysis. In a similar vein – and bearing in mind the limitations of this thesis – I have therefore limited myself to presenting the

salient features of my analysis. In the next section, I move on to discuss the issue of rigour in this case study.

Rigour

Although quantitative researchers have developed a clearly understood set of criteria regarding how research is executed and written about, the same cannot be said of qualitative research (Seale and Silverman, 1997; Long and Johnson, 2000; Bryman and Becker, 2012). Accordingly, the qualitative research community is often engaged in discussions about the contested issue of methodological rigour (Clare Taylor, 2005). Traditionally, social research has looked to originally quantitative concepts such as reliability and validity (Guba and Lincoln, 1994). Some writers have assimilated these criteria into qualitative research with little change in meaning (Mason, 1996). Some have adapted the meaning of these terms to make them more compatible with qualitative research (LeCompte and Goetz, 1982). Others have viewed the application of such criteria as ill-suited to social science's radically different guiding ideals (Seale, 1999) and as poorly equipped to deal with paradigms which view the world as a constructed product of human interaction (Denzin, 1988). This has seen the emergence of alternative principles to measure quality, including reflexivity, transparency and examination of evidence in light of relevant theory (Avis, 2005).

The same lack of universally recognised criteria *vis-à-vis* methodological rigour that is characteristic of all qualitative research is also true of case study research. This is perhaps unsurprising, given that, as I indicated at the beginning of this chapter, the case study does not belong to any specific methodological 'school'. Yin (2009), for example, uses the following four criteria for judging the quality of research design: construct validity, internal validity, external validity and reliability, with Simons (2009) referring to the use of validity (internal and external), credibility, trustworthiness and authenticity, as well as intrinsically qualitative measures that relate to the personal feelings of the researcher. I have incorporated elements of the work of various experts on case study research – including Yin (2009), Simons (2009) and Stake (1995) – in order to try and ensure rigour in my research.

However, I have also looked to the four 'trustworthiness' criteria proposed – by way of a 'replacement position' to internal validity, external validity, reliability and objectivity (Bryman and Becker, 2012, p. 276) – by Lincoln and Guba (1985). These four criteria are: credibility, transferability, dependability and confirmability. Credibility refers to having confidence in the 'truth' of the findings, in their value and believability (Lincoln and Guba, 1985; Leininger, 1994; Miles and Huberman, 1994; Bryman and Becker, 2012). Transferability refers to whether or not particular findings could be transferred to another similar context or situation (Leininger, 1994; Bryman and Becker, 2012). Dependability refers to whether findings are consistent and could be repeated, and the extent to which findings can be relied upon (Tobin and Begley 2004; Rolfe 2006; Bryman and Becker, 2012). Confirmability, finally, refers to the degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Tobin and Begley 2004; Bryman and Becker, 2012).

I incorporated various strategies to try and meet the four criteria. As far as assuring credibility was concerned, the first of these strategies was 'prolonged engagement'. The latter, according to the Robert Wood Johnson Foundation (2008, p. 1), is 'Spending sufficient time in the field to learn or understand the culture, social setting, or phenomenon of interest'. From the spring of 2009 when I commenced preparatory fieldwork until the end of March 2011 when I attended the final Joint LLT meeting at the end of the National CCM Demonstrator Programme, I spent one or two days of most weeks in the Bro-y-Grug locality observing meetings, interviewing stakeholders, discussing my research with the study gatekeepers, or planning future fieldwork. Over the nearly two years that I charted the development of the CCM service, I spoke regularly with a wide range of stakeholders – in both formal and informal situations – from the project leaders who were responsible for overseeing and coordinating implementation of the Welsh CCM Model across Armorshire and in the Bro-y-Grug locality to the local people living with chronic conditions – and their carers – for whom the new service was created.

On the one hand, this extended contact helped me gain a contextual understanding of the development of the Armorshire Collaboration in the Bro-y-Grug locality and allowed me to compare – on an ongoing basis – my theories about integrated

working with the development of the CCM service in the field. According to Creswell and Miller (2000, p. 128) extended engagement in the field, 'solidifies evidence because researchers can check out the data and their hunches and compare interview data with observational data'. On the other hand, this prolonged engagement helped me develop rapport and trust with local stakeholders, a development which, Creswell and Miller (2000, p. 128) suggest, means that participants are comfortable disclosing information and helps gain a 'credible account by building a tight and holistic case'.

Through a process of constant self-scrutiny, however, I attempted to render a fair and unbiased representation of the perspectives of the multiple stakeholders. By careful pre-planning, I sought not to abuse the trust that I had gained during interviews or focus groups by asking questions that might be intrusive, indiscreet or engender emotional anguish. I sought informed consent throughout, kept information disclosed to me confidential and did not discuss with any third party any aspects of my research using the real names of places or participants, and – as I noted in Chapter One (see p. 1) – have used pseudonyms throughout the case study. Indeed, whilst Simons (2009) notes that good field relations during case study research depend on the development of trust, she warns that this needs to be set against a constant and ongoing awareness of ethical judgements.

By combining four data-collection methods to study one phenomenon, I also attempted to enhance both credibility (and dependability) by way of triangulation. Whilst Gomm (2009) lists a number of different types of triangulation – from meta-analysis to theoretical triangulation – I utilised only data-source triangulation. Yin (2009, p. 116) notes that the latter involves the collection of information from multiple sources but aimed at, 'corroborating the same fact or phenomena'. Hence, rather than asking, for instance, project leaders alone about the extent to which people living with chronic conditions had been involved in the reconfiguration of services, I put the question to all stakeholders (during interviews and focus groups) in addition to recording how the same subject was discussed in meetings and in official documentation. Just as Yin (2009, p. 117) notes that triangulation in case studies can lead to a, 'convergence of evidence', its usefulness in cross-checking the relevance and significance of issues in case studies has been noted by Simons (2009)

and Stake (1995). Patton (1999, p. 1192) notes that triangulation enhances credibility by providing ‚'cross-data validity checks' and that studies using multiple methods are less vulnerable to the potential errors – such as loaded interview questions or biased or untrue responses – of single-method studies.

Throughout my study, I also met regularly with my academic supervisors to discuss data collection methods, analysis, emergent findings and the development of my research. Some commentators have questioned the value of discussing analysis, arguing that no two researchers interpret data in the same way (Cutcliffe and McKenna 1999; McBrien 2008) and that qualitative analysis is an individual and unique process contingent on the creative processes between researcher and data (Munhall and Boyd 1993; Schutz 1994). However, just as a number of other authors –such as Burnard (2002) and Casey (2007) – advise consulting with colleagues to support the credibility of findings, so I felt that my research study was enhanced by such 'peer debriefing', the latter defined by Lincoln and Guba (1985, p. 308) as:

> … a process of exposing oneself to a disinterested peer in a manner paralleling an analytical session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind.

One way in which I sought to increase credibility through consultation with others was by asking my academic supervisors independently to code sections of my interview and focus group transcripts (that I had also coded) in order to assess 'inter-rater reliability'. The latter, Gomm (2009, p. 179) explains, refers to 'the extent of agreement between two or more judges', before adding that it is commonly used in coding data to see how far different judges agree on coding classifications. However, my intent was not primarily to verify that data were analysed in the same way or that the codes matched, but to determine whether or not there was agreement on the logical paths taken. Indeed, whilst Graneheim and Lundman (2004) point out that agreement amongst co-researchers improves credibility, they also add that – bearing in mind the multiple and subjective nature of reality – credibility is enhanced by the discussion-process itself.

Reflecting the importance of context-rich and meaningful descriptions to the transferability of qualitative research (Miles and Huberman, 1994), in my four

findings and discussion chapters I have tried to depict the development of the CCM service in the Bro-y-Grug within the rapidly evolving and highly pressured 'context heavy' world of health and social care. This I have attempted to do by way of 'thick description' (Geertz, 1973, p. 3). Indeed, Chapter Four, 'Setting the context for the case study' is specifically devoted to an account of the wider socio-economic and political backdrop into which the Armorshire Collaboration was launched, with the aim of providing the reader with an understanding of some of its many contextual complexities. Creswell and Miller (2000, pp. 128 – 129) suggest that:

> The purpose of a thick description is that it creates verisimilitude, statements that produce for the readers the feeling that they have experienced, or could experience, the events being described.

A number of commentators have referred to the responsibility of the researcher to provide such detailed descriptions, so that the reader is able, in turn, to make informed decisions about the transferability of the findings to their own specific contexts (Lincoln and Guba 1985; Firestone 1993; Stake 1995; Bogdan and Biklen 2003; McKee 2004). As part of my contextual accounts in the findings and discussion chapters, I also include numerous examples of empirical data – including excerpts from documents and from my transcriptions of meetings, interviews and focus groups – to allow the reader to consider my interpretations of them (Stake 1995; Popay et al., 1998). In this way, readers can decide for themselves to what extent findings are transferable to another context (Graneheim and Lundman 2004).

Indeed, my approach has been influenced by the interpretevist case study researcher Robert Stake and his, 'naturalistic generalisation' (1980). Stake (1980, p. 69) explains that the latter develops within a person as a result of experience, and is formed from the tacit knowledge of, 'how things are, why they are, how people feel about them and how these things are likely to be later or in other places with which this person is familiar'. Stake (1980) therefore notes that given sufficient detail, a reader can discern which aspects of the case they can generalise to their own context and which they cannot. In order to assist the reader in making naturalistic generalisations, Stake (1995, p. 86) notes that, 'case study researchers need to provide opportunity for vicarious experience'.

Lincoln and Guba (1985) point out that there are close ties between credibility and dependability, so that a demonstration of the former may go some way to ensuring the latter. Dependability, may be achieved, Lincoln and Guba (1985) note, by the use of 'overlapping methods' (or triangulation) such as the focus group and individual interview. Lincoln and Guba (1985) also propose that researchers adopt an auditing approach by leaving an 'audit trail' – defined by the Robert Wood Johnson Foundation (2008a, p. 1) as, 'a transparent description of the research steps taken from the start of a research project to the development and reporting of findings'. Lincoln and Guba (1985) note that such an approach involves keeping records of all phases of the research process, with peers then acting as auditors to establish to what extent proper procedures have been followed. Such an approach was, however, beyond the scope of my research. Indeed, Bryman and Becker (2012) note that this is likely to be a very demanding process for the peer-auditors, who would need to examine in detail the transcripts of all interviews, field notes, meeting-minutes, draft reports and so on. In reality, notes Bryman (2012), auditing has therefore not become a popular approach amongst qualitative researchers.

Nevertheless, throughout my research I kept a study journal. I used the latter to record my developing theories and to chart the different stages of the study, including initial background reading, the process of ethical review, decisions *vis-à-vis* data collection and analysis, and how my chosen methodology related to the data collection methods I used. Indeed, Koch (1998, p. 1188) notes that what is meant by dependability is the recording of a 'decision trail' and that, 'Leaving a decision trail entails discussing explicitly decisions taken about the theoretical, methodological and analytic choices throughout the study'. Gadamer (1975/1996) also recommends that to encourage dependability, the researcher maintains a study diary. Rapport (2005) suggests that this helps the researcher note aspects of the research design integral to findings and conclusions and additional information about the participants themselves, such as their reactions to events and comments. Rapport (2005) suggests that the diary is at its most valid during the writing-up stage, when the researcher makes public the private workings of the research and further contextualises personal actions and behaviours.

As regards confirmability, finally, Lincoln and Guba (1985) advocate the use of an audit trail approach as well as triangulation (both of which I have already discussed). However, Lincoln and Guba (1985) suggest that another technique that can be used to achieve confirmability is reflexivity. In research terms, Gomm (2009, p. 290) explains that the latter, 'refers to self-aware and self-critical attitude and practice where the researcher, as far as possible, monitors his or her own activities'. According to Mantzoukas (2005) reflexivity is a system of critical self-reflection that includes the researcher's experiences, preconceptions, presuppositions and theoretical standpoint, with Cutcliffe (2003) noting that this implies that the researcher think deliberately about how the research process shapes its outcomes.

From the beginning of the study, alongside my study journal I maintained a reflexive journal, in which I recorded my own feelings regarding the process of research and reflections upon my methodological decisions, my reasons for making them, the logistics of the study, and reflections upon what was happening in terms of my own values and interests. The thoughts and ideas that I documented during data collection also helped in the development of the themes that I examine in the findings and discussions chapters. Etherington (2004) notes that reflexive journals are commonly maintained in qualitative research, with Aherne (1999) explaining that this can help in the examination of personal assumptions and goals and the clarification of individual belief systems and subjectivities. As far as case studies are concerned, Stake (1994) notes that the case study researcher, whilst seeking to provide a vicarious experience to readers, is inevitably influenced by his or her individual preferences. Flyvbjerg (2006) explains that the context-dependent nature of case studies has led to accusations of subjectivity and arbitrary judgement compared to other research methods. However, Stake (2005) points out that a reflexive process of continual reinterpretation allows the researcher to relate local contexts and experiences to local meanings, with Simons (2009) arguing that if issues of reflexivity are made transparent, the case study researcher can illuminate how personal actions, values, beliefs, preferences and biases influenced the process and outcome of research. Having discussed issues of rigour, I conclude with a brief summary of this chapter.

Summary

I began this chapter by setting out the aim and objectives of this thesis, before describing my interpretevist stance and providing a detailed exploration of the case study approach and its applicability to my research. In particular, I noted how the case study approach can provide a contextually-rich account of a 'bounded' phenomenon. I discussed issues of access and sampling (and the process of gaining ethical approval), described the four methods of data collection I used (and explained why I chose them) and how I handled and analysed data. I ended the chapter by detailing the measures I used to ensure rigour, including my use of the four 'trustworthiness' criteria of credibility, transferability, dependability and confirmability. Having discussed the methodology and methods of this case study, in the next chapter, 'Setting the context for the case study', I set out the contextual backdrop to the Armorshire Collaboration, including the pre-existing resource-base of services prior to the project's launch.

Chapter 4: Setting the context for the case study

Introduction

In this chapter, I provide some contextual background information by way of an introduction to the Armorshire Collaboration and the Bro-y-Grug locality. I set out the Welsh Government's objectives in introducing the Welsh CCM Model and National CCM Demonstrator Programme. I explain how the launch of the Armorshire Collaboration – one of the three Welsh CCM demonstrator-sites – coincided with a number of significant changes in the delivery of health and social care services across Wales. I review some of the socio-economic features of the Bro-y-Grug locality. I then discuss Armorshire's resource-base of CCM services prior to the Armorshire Collaboration's launch, including two key statutory health and social care services as well as voluntary/third sector provision and self-care programmes. I conclude the chapter with a discussion of issues of timing that impacted on the Armorshire Collaboration.

The Welsh CCM Model: local, integrated, participatory

In 2007, the Welsh Government set out its long-term goals for the management of care of people living with chronic conditions:

> In Wales we know what we want. We want to have world class health supported by a world class health and social care system for all. We want where possible, to prevent or delay chronic conditions arising and, where they do arise, ensure that they are managed in an *integrated* way with *patient and carer involvement* …We want to give individuals the skills and support to help manage their conditions within their *local* communities [my emphases] (WAG, 2007, p. 13).

This statement of intent to create a new system of CCM based on integration, patient- and carer-involvement and support within local communities appeared in *Designed to Improve Health and CCM in Wales* (WAG, 2007). In the document, attention was drawn to the changing patterns of disease from communicable to chronic conditions – largely due to an ageing population – and the extra demands that this was placing on existing health and social care systems. It was stressed that, because of a predicted further population growth in people aged sixty five and over, these demands would only increase in ensuing years.

Not only was it reported in the document that a large proportion of healthcare resources were used by just a small proportion of the total number of people living with chronic conditions, it was also noted that many of the people admitted to hospital (planned and emergency) were living with one or more chronic condition (s). At the same time, it was stressed that these admissions were frequently unwarranted and avoidable and were attributable to, 'inappropriate care and an inadequate general support infrastructure for people with chronic conditions and their carers in the community' (WAG, 2007, p. 9). Whilst reference was made to the many services, agencies and practitioners available to people living with chronic conditions, it was suggested that these frequently operated in relative isolation and were not mainstreamed within core services. As a result, it was stressed that care-provision was often piecemeal, often overlapped – thereby leading to duplication and inefficiency – and was sometimes absent altogether. All too often, it was indicated, systems of care reacted to emergencies instead of preventing them from occurring in the first place.

However, it was noted in the document that the potential answer to these problems lay in a new model of care: the Welsh CCM Model. Rooted in the social model of disability (see Chapter One, section, 'Health and social care systems under pressure: the need for change') the Welsh CCM Model, it was explained, would take account of the social, psychological or emotional consequences of living with a chronic condition. In contrast with the prevailing reactive system, the Welsh CCM Model would entrench a proactive approach that would encourage independence and self-care and would focus on partnership-working between statutory health and social care services, the independent sector, the voluntary/third sector and service users and carers (WAG, 2007).

The Welsh CCM Model would not be predicated on the investment of new resources but on the more appropriate remodelling of those that already existed (WAG, 2007). This process of remodelling would incorporate the views of all stakeholders, foster independence, take account of holism and an understanding of the wider determinants of health and consider the issues facing people living with chronic conditions in the, 'wider context of the social and community settings of their everyday life' (WAG, 2007, p.3). By dismantling the barriers between services and

addressing issues of fragmentation, the introduction of the Welsh CCM Model would, it was envisaged, deliver a co-ordinated, consistent, engaged and contextually relevant approach to health and social care, so that service-provision would progress from, 'fragmentation to integration' (WAG, 2007, p. 11).

Subsequently, the aspirations set out in *Designed to Improve Health and CCM in Wales* (WAG, 2007) were taken forward into the three-year implementation programme outlined in the *Service Improvement Plan* (WAG, 2008). The complementary document reiterated that the Welsh CCM Model would be a partnership between all stakeholders, including people living with chronic conditions and their informal carers. It was indicated that through a collaborative effort, Wales would undergo a 'transition' from a system of secondary-based care to one of local community-based care that would, 'integrate and more effectively plan, manage and where appropriate reconfigure existing services and support' (WAG, 2008, p. 5). This would be based on, 'local vision, priorities and partnerships' and local, 'resources for delivery' (WAG, 2008, p. 25).

By way of these two policy documents, the Welsh Government set out plans to deliver a remodelled system of care for people living with chronic conditions that would centre on: community-based systems of care operating at a local level and taking into account local context; the reconfiguration and increased integration of existing services; and the participation of all stakeholders in the process of change. In the next section I examine the support that the demonstrator-sites would receive in implementing the Welsh CCM Model and the utilisation of existing resources during this process.

The National CCM Demonstrator Programme: transition and reconfiguration

Having introduced the Welsh CCM Model and set out an implementation programme, the Welsh Government made available £15 million of transitional funding in order to facilitate nationwide roll-out (WAO, 2008). In *The Management of Chronic Conditions by NHS Wales* (WAO, 2008, p. 11) it was noted that the Welsh Government's allocation of transitional funding was part of a three-year programme that would, 'assist health communities improve the planning and integration of services and enable change to happen'. It was further specified that

£4.5 million of the allocation had been set aside to aid the establishment of three regional demonstrator-sites as part of the National CCM Demonstrator Programme (WAO, 2008). These resources, it was noted in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008) would support, 'project management, transitional service change, Information Technology (IT) infrastructural needs and research and evaluation'.

In his preliminary assessment of the costs and benefits of the Welsh CCM demonstrator-sites, Phillips (2011) specified that transitional funding had supported the development of initiatives and schemes that enabled the transition of services and resources from secondary- to community-based settings. Additionally, Phillips (2011, p. 3) described the relationship between what he identified as the three, 'main aims' of the National CCM Demonstrator Programme and the saving of resources. The core features of these 'main aims' were: the provision and testing of a sustainable and affordable generic CCM service model; the focussing of support and resources in localities; the application of the model, the development of the business case for change and the support of further mainstreaming (see also NHS Wales/CCM Demonstrators [2009], p. 1). In Phillips' (2011, p. 3) opinion:

> It is clearly evident that these aims do not explicitly reflect a desire or intent to secure resource-savings *per se*, but the underlying ethos of the Welsh CCM Model is to prepare the health and social care systems in Wales to deal with the ever increasing demand on service provision and a severe constraint on resource availability with which to address these demands.

Just as Phillips (2011) drew attention to the apparent need to prepare the system for growing pressures and constraints, this need had already been deemed imperative in both *Designed to Improve Health and the Management of CCM in Wales* (WAG, 2007) and in the *Service Improvement Plan* (WAG, 2008). This was not lost on Armorshire Collaboration Project Manager Jo Marshall, one of the three Project Managers seconded to the three CCM demonstrator-sites from the National Leadership and Innovation Agency for Health care (NLIAH). Accordingly, when I interviewed Jo, she informed me that:

> We are inefficient at the moment because we've got all these people doing different things. There's duplication, people are falling within the gaps, we're not coordinating people with chronic conditions. It isn't episodic, we're not efficient in what we are doing. But we've got to use all the resources and expertise, skills, knowledge that we've got amongst our work-

> force. Because the demographics are going to mean that whatever is in place now will just completely and utterly fall apart unless we do things differently (LARI2: 5 – 6)[30].

Suggesting that if change was not forthcoming existing systems would 'fall apart', Jo stressed that this scenario could only be avoided by drawing on all resources, expertise, skills and knowledge. Just as Jo's indication of the need to become more efficient and to use all resources was noted in *Designed to Improve Health and CCM in Wales* (WAG, 2007), it was also indicated in the document that in view of the rising numbers of (older) people living with chronic conditions and the drive to improve systems of care management, Wales could draw on, 'many existing schemes, initiatives, services and programmes' (WAG, 2007, p. 10).

Indeed, reference was made in both *Designed to Improve Health and CCM in Wales* (2007) and in the *Service Improvement Plan* (WAG, 2008) to: the statutory health and social care sectors, including community nursing, therapy and social care services; primary care services; the independent sector; housing services; the voluntary/third sector; people living with chronic conditions and their informal carers; and neighbours and others in the community. Attention was also drawn to: the Unified Assessment; National Service Frameworks; specialist nurse services; the Expert Patient Programme; social services care management and care pathways; Health, Social Care and Wellbeing Partnerships; Informing Healthcare; the Workforce Development Education and Contracting Unit; NHS Direct; the Social Services Improvement Agency; the National Public Health Service; Health Challenge Wales; the Wales Centre for Health; Want 2 Work; Care and Repair; and the National Leadership and Innovation Agency for Healthcare (WAG, 2007; WAG, 2008).

The sheer number and variety of resources listed in the two documents perhaps served to indicate the extent to which society's 'wicked problems' – like the management of care of people living with chronic conditions – are inherently complex and difficult to resolve (Glasby, 2012). Such issues, note Williams and Sullivan (2009f, p. 8), cannot be managed by single organisations acting

[30] See p. xi for explanation of data identifiers.

autonomously and instead call for a multi-faceted response which spans jurisdictional, administrative, professional and 'sectoral' boundaries. Amongst the many agencies listed in the two documents, it is perhaps worth singling out the contribution of NLIAH to the Welsh demonstrator-sites. Although now discontinued, NLIAH was an NHS Wales agency that worked in partnership with NHS Trusts and Local Health Boards in a number of areas, including: service improvement; workforce development; leadership and organisational development; and partnership development (NLIAH, 2012).

Not only was NLIAH tasked by the Welsh Government with assisting health communities across Wales during their implementation and development of CCM action plans (NLIAH, 2008), it also had a specific remit to support the three Welsh CCM demonstrator-sites locally in the three fields of communication, research and management (NHS Wales/CCM Demonstrators 2009c). These three fields, in turn, comprised the development of: local action plans; advice related to service-improvement tools, CCM policy, strategy, current thinking and models; advice related to Integrated Care Pathways development and the integrated workforce planning process; and support with collaborative working and training for leadership, change and development (NLIAH, 2008, p. 1). Furthermore, the National CCM Demonstrator Programme Manager, the National CCM Demonstrator Principal Researcher and the three Project Managers were seconded from NLIAH for the duration of the project.

Whilst I have explained that £4.5 million of governmental transitional funding had been made available to the National CCM Demonstrator Programme, the respective responsibilities of the Welsh Government and the individual demonstrator-sites *vis-à-vis* the specific use of resources were set out in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008). In the document, it was stressed that the National CCM Demonstrator Programme was a joint programme of work between the Welsh Government and the three demonstrator-sites. On the one hand, it was indicated that the Welsh Government's Head of Community Health Strategy would provide national leadership for the programme and that additional resources would be made available to support: project management; transitional service change; Information Technology (IT) infrastructural needs; and research and evaluation. On the other

hand, it was specified that: '*Local* partners will be expected to actively engage with and support the programme from within *existing* resources [my emphases]' (WAG/NHS Wales, 2008, p. 3). Whilst I turn my attention to this local resource-base of existing services below (see section, 'Pre-existing service-provision for local people living with chronic conditions'), in the next section I discuss some of the wider developments which coincided with the launch of the Armorshire Collaboration. My reason for doing so is that these developments had a significant impact on the project's development, both within the Bro-y-Grug locality and across the rest of the county.

The Armorshire Collaboration in the Wales-wide context

I begin this section by drawing attention to the comments of Emma Fletcher, Assistant Director of Primary and Community Services of the then recently inaugurated Owain Glyndŵr LHB:

> Since we met fifteen months ago we are now in a very different environment in NHS Wales across health and social care. We've got new Health Boards, we've got a whole different range of strategies, such as *Setting the Direction*, we've got a new care framework, we've got further developments around chronic conditions. It's important that we understand the context in which we're delivering this, the critical role that chronic conditions has in terms of delivering services (RMO1: 2).

Speaking at the *Armorshire CCM Demonstrator Review Visit* in August, 2010, Emma Fletcher noted the 'different' health and social care environment in Wales in comparison with fifteen months earlier (when the Armorshire Collaboration had begun). Hence, by referring to new Health Boards, new strategies, a new care framework and to further developments pertaining to chronic conditions, Emma drew attention to the fluctuating backdrop to the Armorshire Collaboration. Indeed, Emma felt that an understanding of the 'critical role' of chronic conditions lay in an understanding of the programme's context. The latter, Cappelli and Sherer (1991, p. 56) explain, refers to, 'the surroundings associated with phenomena which help to illuminate that phenomena, typically factors associated with units of analysis above those expressly under investigation'. Just as Bryman (1988) suggests that it is only when they are viewed within their social context that a fuller understanding of social phenomena can be gained, so Hartley and Benington (2010, p.4) contend that this is

of particular importance to health and social care, since political and economic pressures render this field especially, 'context heavy'.

But in a field that is typically 'context heavy' one could argue that its 'complex multisectorial and multi-agency environment' (WAG, 2009a, p. 7) made the National CCM Demonstrator Programme particularly so. Hence, not only was it run alongside the range of Welsh-specific developments referred to by Emma, it also coincided with a period of extensive cuts to public expenditure that were part of the 'austerity measures' proposed by the UK's then newly elected Conservative/Liberal Democrat Coalition Government. In this and subsequent chapters I will consider in some detail the two factors which – as indicated, perhaps, by the fact that they were the only two to which Emma referred by name – were of particular significance to the Armorshire Collaboration: the creation of the new Health Boards and the publication of *Setting the Direction* (WAG, 2010).

The seven new (Local) Health Boards, firstly, were the result of the restructuring of the existing seven NHS Trusts and twenty-two Local Health Boards (LHBs) as part of the 2009 NHS Wales Reforms. During this process, Armorshire LHB joined the new Owain Glyndŵr (Local) Health Board. Just as the Welsh CCM Model was built on integration, independence, self-care and transformation within local communities, the Welsh Government's then Minister for Health and Social Services Edwina Hart[31] (WAG, 2009b, p. 2) stressed in a Written Cabinet Statement that the 2009 NHS Wales Reforms were driven by the need to:

> … provide more care closer to people's homes and more self-care programmes to help people live more independent lives, provide more joined up services between health and social care, and increasingly focus on public health, creating a wellness service rather than a sickness service. This is about developing a service which is based on co-operation, collaboration and partnership working.

Whilst Holland (2010) echoes Hart's descriptions of the aims to create a wellness rather than a sickness service, he also points out that the NHS Wales Reforms of 2009 had provided the opportunity to bring collaborative working and public health to the forefront of, 'a truly integrated healthcare system' (2010, p. 431). Moreover,

[31] Real name.

Longley (2013) notes that the NHS Wales Reforms also signalled an end to the purchaser-provider split whilst unifying the planning and delivery functions of primary, secondary and tertiary care on a geographical basis. Viewed in this light, the reforms also appeared congruent with what Williams and Sullivan (2009, p. 6) term the Welsh Government's 'distinctive approach' to the design and delivery of public services. This approach, they explain, is predicated on partnership-working and on ensuring that services are grounded within the needs of local people and local communities. In the same vein, Greer (2004) has drawn attention to a desire in Wales both to shift the centre of gravity of the health service downward and to integrate more effectively health services with local government. Accordingly, Greer (2004, p. 147) stresses that:

> The dominant thrust in post-devolution Welsh health services organisation is localism: the creation of a locally responsible health service that formulates its understanding of needs in local communities and in partnership with local government.

Stoker (2004), similarly, explains that localism expresses the value of devolving power and resources away from central control to local decision-making structures and local communities. Greer (2004, p. 151) adds that post-devolution Wales has also shown a marked interest in the wider determinants of health outcomes, the reduction of health inequalities and in the development of public health strategies that 'cut across government borders and integrate multiple public policies to defeat complex causes of ill health'. Although Greer (2004) indicates – as do Coyle (2007), Drakeford (2006) and Michael and Tanner (2007) – that a sharper focus on the economic and social context of health predated devolution, like Longley (2013) he stresses that it is in the post-devolution era that Wales has been able to prioritise public health, the tackling of health inequalities and collaboration between public services.

Given that Longley (2013) also suggests that health and social care policy in Wales has been dominated by the desire to move Wales away from England's quasi-market approach, one could argue that it was somewhat paradoxical that during the previous NHS Wales reorganisation (in 2003), the country had witnessed the creation of a commissioner-provider split through the establishment of separate LHBs and NHS

Trusts. Notwithstanding, Sullivan and Drakeford (2011) argue that these changes were premised on ensuring that services provided by NHS Trusts reflected the health needs of their local population. But in the event, they add, the large provider organisations (the NHS Trusts) retained power, the 'market' generated huge volumes of transaction costs, whilst on the ground little changed. The response of the 2007 administration, Sullivan and Drakeford (2011) report, was to replace this structure with the seven combined organisations that were subsequently inaugurated as part of the NHS Wales Reforms of 2009.

Just as the creation of the new LHBs appeared to have been predicated on fostering a more integrated and locally-appropriate approach to the delivery of healthcare, the same appeared to hold for the second feature of the 'different environment' to which Emma Fletcher referred by name. This was the new Primary and Community Strategy as described in *Setting the Direction* (WAG, 2010). The document set out, 'a framework aimed at assisting LHBs in the development and delivery of improved primary care and community-based services for their local populations' (WAG, 2010, p. 6). At its heart sat 'Locality Working' premised on the 'co-ordination of services within localities' (WAG, 2010, p. 14). However, the document provided no clear definition of either 'Locality Working' or 'localities'; following the document's introduction of the former, moreover, it was subsequently referred to as the (also undefined) 'Locality Model'. Definitional opacity apart, it was indicated in the document that Locality Working would incorporate a number of so-called 'crucial concepts' (WAG, 2010, p. 14). These included: a focus on patients/service users; agreed health and social care boundaries that were 'meaningful' in terms of 'natural communities'; multi-sectoral joint-leadership; and utilisation of the full community based resource, including integrated health and social care teams (WAG, 2010, p. 14).

So, just as post-devolution, the Welsh Government had shown particular interest in the wider determinants of health, integration, independence and localism, the bolstering of these elements appeared to have explained the creation of the new LHBs and the new Primary and Community Strategy. Moreover, the same themes appeared to have underpinned the Welsh CCM Model (as I explained in the opening pages of this chapter). Just as the latter, in turn, underpinned the National CCM

Demonstrator Programme, in *The National Chronic Conditions Management (CCM) Demonstrator Project: Progress and Achievements in the First Twelve Months* (WAG, 2009a, p. 5) it was reported that:

> ...three National CCM Demonstrators have been established to provide and test a sustainable, affordable generic CCM service model that supports people's needs locally and promotes independent living within the community in order to communicate and inform service change across Wales. They aim to provide an opportunity to focus effort, support and joint resources in localities to test and learn from concerted effort across organisational and professional boundaries.

Once again, attention was drawn to the delivery of joint services that fostered independence, that supported people in their own communities and that responded to local needs. But just as – like in *Setting the Direction* (WAG, 2010) – this was predicated on 'Locality Working' within 'localities', once again the terms were not clearly defined: either in national-level documentation pertaining to the National CCM Demonstrator Progamme, or in local-level documentation pertaining to the Armorshire Collaboration. Notwithstanding, it was reported in the Armorshire Collaboration PID that the project's 'key deliverables' would include: '[the] Development of locality networks of health and social care provision' (App. 9) and '[the] Provision of health and social care services to meet the needs of the locality' (App. 9). Accordingly, it was explained in *CCM Demonstrator Learning Paper 31* (NHS Wales/CCM Demonstrators, 2011) that the Armorshire Collaboration had been divided into the three constituent localities of Tregwen, Aberwrach and Bro-y-Grug. In the next section, I give a brief overview of the first two localities (to set the case study in the county context) before focussing my attention on some of the prevailing socio-economic factors in Bro-y-Grug, thereby outlining why the management of chronic conditions and demographic change were such important factors.

The Bro-y-Grug locality in the county-wide context

Whilst setting the Bro-y-Grug locality in the wider county context, it is important to reiterate that this work is a single case holistic case study of the development of the project within the Armorshire Collaboration. It is therefore outside of my remit to provide a detailed examination of the Aberwrach and Tregwen localities or of their

locally-managed projects. Notwithstanding, just as I have intimated that it would be impossible to investigate the National CCM Demonstrator Programme in isolation from wider contextual factors pertaining to health and social care in Wales, I feel that it would be equally impossible to investigate fully the development of the Bro-y-Grug Project without some reference to its counterparts in Aberwrach and Tregwen. Similarly, in describing her work in Bro-y-Grug, Locality Care Co-ordinator Christine Thompson explained that:

> Aberwrach covers over four fifths of Armorshire, which has huge implications for staff and service users to be able to travel back and forth around different parts. Bro-y-Grug covers quite a large area, about a thirty-mile radius. There's quite a big divide between the Cwm Coch and the Cwm Glas valleys. But we also have boundary issues with Llanyvan and Maeswyn, and we also overlap a little into the Tregwen area and into the Aberwrach patch. Although small, there's an awful lot going on in the Tregwen area. There's an awful lot of people and an awful lot of services that are being put into the Tregwen area to help address issues of income, debt. There's a lot of drug issues and different concerns that the Tregwen locality have to look at. [In] Bro-y-Grug, we've got the highest level of chronic conditions and chronic disease across Armorshire. We've got a lot of COPD, diabetes and asthma within our locality. So there are lots of different reasons as to why we are looking at setting up services and the way we need to be looking at them. We've got post-industrial communities [but] we've also got the rural areas (RMO1: 10).

Speaking at the same 'Review Visit' at which Emma Fletcher discussed the Armorshire Collaboration within the national context, Christine in turn considered the Bro-y-Grug locality in the context of the Armorshire Collaboration. On the one hand, she noted the sheer size of (predominately rural) Aberwrach and the complex socio-economic problems of (predominately urban) Tregwen. On the other hand, she explained that Bro-y-Grug covered 'quite a large area', had 'boundary issues' (so that services were sometimes provided to people who lived outside the locality) and comprised two distinct valley areas plus rural and post-industrial communities. Just as Christine pointed out that specific factors in each locality brought with them specific issues (and required specific responses), she stressed that Bro-y-Grug was the locality with the highest levels of chronic conditions in Armorshire. During another meeting, Bro-y-Grug Social Care Area Manager Gwyn Evans considered why this should be:

> Looking at Bro-y-Grug geographically and socio-politically, it's a very sad picture, isn't it? It was a boom area when the mines were here. You can imagine the wealth that used to be here, and the work. We've got these chronic conditions, and lots of these chronic conditions are a direct fallout of what's happened ... it's a very poor community. People like to talk about the valleys, [they] have a strong community feel etcetera. When you come here, when you actually see what is in Bro-y-Grug, they're culturally dispossessed. So if you think about what happened in the 1950s, the 1960s, the 1970s, the image that I've got, what would women in their seventies do on a Tuesday afternoon, or a Friday evening in Llannuon? I don't know, but the picture I've got from reading history books etcetera is very much that they'd be part of society. And they'd be going to chapels and churches and Women's Institutes, they'd be going to concerts and the local choirs would be singing, that kind of thing. And you look at what is here now, and there's very little. In fact, the community regeneration that's needed in Bro-y-Grug is a tragic picture. The fact that we've got Communities First here, where there used to be so much wealth (LLTMO4: 5).

Gwyn's comments were made during a meeting of the Bro-y-Grug Locality Leadership Team (LLT). The latter comprised a GP Lead, District Nurse Lead and Social Care Lead (Gwyn) and worked in close collaboration with Locality Care Co-ordinator Christine. Following a change to the leadership structure of the Armorshire Collaboration (see the penultimate section of this chapter, 'Timing issues') the three LLTs spearheaded developments in the county's three localities. The meeting in question was convened to present proposed structural changes (as part of the creation of the new CCM service) to six local and regional stakeholders from statutory health and allied health care services. Endeavouring, by way of introduction, to contextualise the need for change, by his own admission the 'picture' Gwyn painted was bleak.

Just as in Chapter One I explained that coal-mining had played an important part in the socio-economic history of Bro-y-Grug (see section, 'The National CCM Demonstrator Programme and the case study locality'), Gwyn's assertion that it had been a 'boom area' demonstrated how significant a role the industry had played. Indeed, a large proportion of the miners who were in employment during the industry's 1930s heyday in Armorshire worked in collieries in Bro-y-Grug (Rees, 2008). Although industrial developments meant that the numbers of miners had dropped in ensuing years, coal-production in Bro-y-Grug had been an important part of the local economy until the 1970s (Rees, 2008). Since the closure of many of the mines, however, the situation had changed dramatically. Thus, noting that

employment rates across Bro-y-Grug had fallen drastically, Gwyn observed – with no little irony – that a locality that had previously enjoyed relative wealth now suffered such poverty that it even had a Communities First[32] area. But it was not just in economic terms that Bro-y-Grug was poor, added Gwyn, but in cultural terms too. Accordingly, he contrasted a bygone age of community involvement and busy social lives with a current era in which local people were 'culturally dispossessed', 'disenfranchised' and had access to 'very little'.

Whilst in Chapter Two I examined the relationship between chronic conditions and social factors (see section, 'Integration and service fragmentation') at this point it is important to note that wealth and income, working conditions, poverty (absolute and relative) and social stratification all play a major role in rates of morbidity and mortality (Scambler and Blane, 2003). Viewing the prevalence of Chronic Obstructive Pulmonary Disease (COPD) in Bro-y-Grug noted by Christine Thompson from this perspective, one could therefore argue that it was a direct consequence of the prevailing poverty and industrial heritage noted by Gwyn Evans. In terms of poverty, firstly, Carrier (2009) points out that there is a direct link between income and chronic illness. Carrier (2009) explains, for instance, that income helps determine housing choices and living conditions, which in turn influence health outcomes, since cold and damp accommodation is associated with respiratory diseases.

As for the industrial heritage, Cohen et al. (2008) note that occupational exposure to coal-mine dusts is one of the major causes of COPD – including emphysema and chronic bronchitis – and may result in restrictive, obstructive, or mixed patterns of impairment on pulmonary function testing. Moreover, the WHO (2007) notes that work-related respiratory conditions can have long latency periods and that once the disease process has begun in an individual, the person concerned remains at risk for many years, even though he/she is longer exposed to the specific risk-factor. Indeed, this may go a long way to explaining why many of the Bro-y-Grug's residents who were living with COPD were older men who had previously worked as miners.

[32] Communities First is a Welsh Government programme, launched in 2001 to tackle poverty in the most deprived communities in Wales (WG, 2013c).

The link between industrial history (and the industry's subsequent decline) and wider issues of social exclusion and health has featured high on the Welsh health and social care policy agenda since devolution, report Bain and Adams (2011). This, Bain and Adams (2011, p. 50) add, reflects the fact that Wales has long borne witness to inequalities in health and wellbeing that are, 'the result of a combination of a decline in traditional industries, economic forces and lifestyle choices'. Indeed, whilst Drakeford (2006) has described Wales' post-devolution interest in the economic and social context of health, he reports that much attention has been paid to the link between the country's legacy of heavy-industry, poverty and ill-health.

Hence, Sullivan (2007) notes that during the first term of devolved government, *Improving Health in Wales: A Plan for the NHS with its Partners* (NHS Wales/ National Assembly for Wales [NAW], 2001) set out a trajectory for Welsh health policy that paid great attention to partnerships, health inequalities and the social determinants of health. Moreover, Birrell (2009) notes that similar considerations lay behind the Welsh Government's adoption – for example, in *Wellbeing in Wales* (WAG, 2002) – of recommendations set out in *Targeting Poor Health*: *Professor Townsend's Report of the Welsh Assembly's National Steering Group on the Allocation of NHS Resources* (NAW, 2001). In particular, just as the latter report noted the general consensus that the foundation of inequalities in morbidity and mortality was to be found in poverty and inequality in material well-being, it also indicated that one of the keys to tackling the problem was to be found in service integration.

Subsequent Welsh health and social care policy documents have continued to bear witness to a marked interest in the socio-economic factors of ill-health (see, for instance, NHS Wales/WAG, 2002; 2005; WAG, 2007a; WG, 2013). The same themes were also fundamental to *Designed to Improve Health and CCM in Wales* (WAG, 2007). So, whilst I have already described the latter's focus on the importance of integration, it was also stressed that the growing prevalence of chronic conditions amongst older people in Wales was compounded by the 'legacy of the impact of heavy industry on people's health' (WAG, 2007, p. 1). Nevertheless, it was also stressed in the document that chronic conditions:

> ...do not exist in a vacuum. In Wales there are currently many existing schemes, initiatives, services and programmes that contribute to the management of chronic conditions (WAG, 2007, p. 10).

In the next section, I therefore turn my attention to some of the schemes, initiatives, services and programmes that existed in Armorshire prior to the launch of the Armorshire Collaboration, in order to illustrate the substantial resource-base on which it could draw.

Pre-existing service-provision for local people living with chronic conditions

During my interview with Armorshire Collaboration Project Manager Jo Marshall, she pointed out that in view of the project's complex backdrop, her main role was to ensure that what happened in Aberwrach, Tregwen and Bro-y-Grug was aligned with the national strategic direction of travel. Hence, having explained that – in view of issues of fragmentation and duplication of services – a radically different approach to chronic conditions management was required Wales-wide, she added that:

> …the Collaboration is there to implement the [Welsh CCM] Model and Framework and its constituent elements. But in doing that I think there's a backdrop, the Collaboration needs to integrate community health and social services. The Collaboration is about ensuring that we can use our resources more efficiently and effectively in order to deal with the demographic changes that are now beginning to hit home. So, coming back to the Model, that's the premise on which the Model hangs. If we don't do these things, we're not going to have a fit service to deal with the demographic change (LARI2: 5).

Thus, just as the primary goal of the Welsh Government in setting up the National CCM Demonstrator Programme was to, 'implement and test the [Welsh] CCM Model ' (WAG, 2008b, p. 1) Jo noted that the latter served as the blueprint for change in Armorshire. Moreover, re-emphasising that the Welsh CCM Model was predicated on integration and better utilisation of existing services, Jo reiterated that parallel changes would need to be made within Armorshire. This need was consequently highlighted in the Armorshire Collaboration Terms of Reference (App. 9), where it was indicated that development of the Armorshire Collaboration would be co-ordinated by the Armorshire Collaboration Delivery Team. The latter comprised fourteen representatives from national and local statutory health and social care services and one representative from the Armorshire Community Health

Council. Just as the Armorshire Collaboration Delivery Team's objective was to 'take forward' (App. 9) the Armorshire Collaboration, so it would also assume overall responsibility for the 're-design of care services for people living with long term conditions in Armorshire, making better use of all resources available' (App. 9).

Thus, in accordance with the Welsh CCM Model and the National CCM Demonstrator Programme, the Armorshire Collaboration was predicated on the redeployment and improved integration of its existing resource-base. When I interviewed Armorshire CDM Nurse Lead Anne Richards, I therefore asked her if she could describe the resources that had pre-dated the Armorshire Collaboration and how they had contributed to its development. In reply, she told me that:

> A lot of the ground-work was done before the Collaboration started. Otherwise we wouldn't be as far along now as we are.
>
> **Ben Duxbury**: By the CDM Team?
>
> **Anne Richards**: Not just the CDM Team, but around chronic conditions generally. The CDM Team, I think, drove things along a lot more. But I think [that] because we had chronic conditions as something important in Armorshire, we'd already made a lot of changes ... and the reason Armorshire was picked – because initially it was never going to be picked – was because of the work that was coming out of here in the first place (LARI6: 1).

Arguably, Anne was particularly well-placed to report that considerable progress for people living with chronic conditions had already been made prior to the Armorshire Collaboration's launch: not only was she a qualified nurse who for many years had worked with people living with chronic conditions, she also had extensive management experience and had been instrumental in the 2006 inauguration of the Armorshire CDM Team. Having led the latter since its inception, she had also worked closely with Project Manager Jo Marshall from the launch of the Armorshire Collaboration. Whilst Anne attributed the latter's apparent rapid progress to earlier developments across the county, she stressed that these in turn explained why Armorshire had been chosen to participate in the National CCM Demonstrator Programme. Indeed, during the course of my research, I learned that in the decade preceding the launch of the National CCM Demonstrator Programme, a series of new initiatives had contributed to the development of both integrated working and

the management of care of people living with chronic conditions across the county which were potentially positive antecedents for implementing an integrated CCM service.

Firstly, I discovered that a number of nationwide programmes had been launched that were premised on the promotion of stronger local integrated-working. Two of the more prominent examples were the Health Social Care and Wellbeing (HSCWB) Partnerships and the Local Service Boards (LSBs). HSCWB Partnerships, firstly, saw local authorities and the NHS jointly tasked with creating strategies to improve health and social services for local residents using 'robust partnership principles' (WAG, 2003, p.35). In Armorshire, these 'partnership principles' began at the level of the membership of the county's HSCWB Partnership Board, which included leaders, chief executives and chairs not only from Armorshire County Council, Armorshire LHB and Owain Glyndŵr NHS Trust, but also from the Armorshire Community Health Council and the Armorshire Association of Voluntary Services. The long-term vision of the Armorshire HSCWB Partnership, moreover, was the promotion of the health and wellbeing of the local population by, 'Delivering and developing locality based primary and community services supported by a more *integrated* [my emphasis] high quality health and social care workforce'.[33]

LSBs, secondly, were partnership bodies responsible for coordinating a collective vision across a variety of local agencies as a means of improving central and local integration and community engagement (WAG, 2009). Like the HSCWB Partnership Board, the Health and Social Care Board of the Armorshire LSB also comprised leaders and chief executives from a range of local bodies, including Armorshire LHB and Armorshire County Council and the Armorshire Association of Voluntary Services. One of the Armorshire LSB's eight key areas of work was, 'Integrating Health and Social Care', which would involve, 'looking at services in both the Health Board and the Council's Social Care division and trying to ensure that the two areas work more closely together'.[34] Alongside these collaborative initiatives, the 1990s and 2000s also saw the launch of a number of new statutory services in Armorshire that contributed – either directly or indirectly – to chronic

[33] Armorshire County Council website. Reference withheld to ensure anonymity.
[34] Armorshire County Council website. Reference withheld to ensure anonymity.

conditions care. These included the Disability Resource Team, the Enablement Service, the Convalescence Service, the Pulmonary Rehabilitation Service, the Falls Prevention Service, the Social Care Occupational Service and the Community Oxygen Service. However, in terms of both the promotion of integrated working and of the management of chronic conditions, perhaps the most significant contribution of the new services set up in the years preceding the Armorshire Collaboration was made by the Llawfon Reablement Service and the Armorshire CDM Team, to which I turn my attention in the following section. These services were frequently referred to by stakeholders whom I interviewed and often used as a point of comparison with the new integrated CCM service, as I explain in this and subsequent chapters.

Two key services

The Llawfon Reablement Service (henceforth Llawfon), first of all, offered community multi-disciplinary rehabilitation to people in need of intensive support, and was predicated on returning service users to independence through holistic care. Comprising three locality teams of Speech and Language Therapists, Social Workers, Dieticians, Reablement Nurses, Occupational Therapists and Physiotherapists, Llawfon had seven satellite offices, including two in the Bro-y-Grug locality. Moreover, in *Joint-working Grant* [35] it was indicated that the Llawfon teams:

> ... work in collaborations with all health (primary and secondary) and social care services within their respective localities of Tregwen, Bro-y-Grug and Aberwrach, common to both the NHS and LA [local authority], to ensure a holistic and preventative model of service. Llawfon is part of a continuum of integrated intermediate care services, catering for people with enablement, rehabilitation and intensive support needs.

Accordingly, Llawfon's approach appeared to be consistent with the collaborative and integrated goals inherent in the Welsh CCM Model and with Wales' wider agenda of localism within a social model of health. When I interviewed Armorshire Clinical Programme Lead for Long Term Conditions and Community Dr Lawrence Morgan, he explained to me that:

[35] Armorshire County Council publication. Reference withheld to ensure anonymity.

> When we started it [Llawfon], we looked at it as a quality-improvement service. I've always said, right from the start of my consulting career, if you do what is right for an older person then you eventually do what is right for the State, so that instead of putting in carers for a frail older person, you rehabilitate them so they can do for themselves. Then you don't have to pay for the carers. It might take twelve weeks of hard work to rehabilitate them, but in the long run it's a lot cheaper than putting in carers.
>
> **Ben Duxbury**: What benefits does that give to that older person?
>
> **Dr Lawrence Morgan**: It gives a huge amount of self-esteem, because they're doing for themselves, they're independent, they're getting around, they're not depressed, they're not constipated, the family aren't worrying about them all the time, you haven't got the daughter or son on the phone to the GP day in day out. That person just gets on with their lives (LARI12:1).

One of the original architects of Llawfon, Dr Morgan stressed that its philosophy – just like his own – had been to help frail older people help themselves. Dr Morgan's words appeared commensurate with another of the basic principles of the Welsh CCM Model, namely the development of a proactive approach based on independence and self-care. Moreover, just as Project Manager Jo Marshall had warned of the need for more efficiency, so Dr Morgan noted that by reducing the need for long-term support, Llawfon's approach saved money. However, whilst suggesting that this was a welcome bonus, he stressed that the team's main goals were to foster self-esteem and independence. Dr Morgan's words seemed borne out by the comments of local resident, Aled Powell, who was living with multiple sclerosis (MS):

> There's an organisation called Llawfon, and they were fantastic, they really were. They'd come in and they'd say: 'Move your finger!' and: 'I can't move my finger!' and: 'Yes you can! Yes, there's a flicker there! Brilliant!' Then they'd come back later that day: 'We got a flicker earlier, so let's see what we can get this time!' And then, progressively, you know, we worked particularly on my arm, so that my hands began to work, and my arm began to work. They were quite wonderful (CLI1: 3).

When I interviewed Aled, he was receiving care from the Bro-y-Grug Community Resource Team (CRT). As I explain in more detail in Chapter Five, CRTs were set up in Tregwen, Aberwrach and Bro-y-Grug during the Armorshire Collaboration's redeployment of existing health and social care services. As part of this reconfiguration, both Llawfon and the Armorshire CDM Team had been discontinued, and their staff incorporated into the county's three CRTs. However,

just like five of the twelve clients of the Bro-y-Grug CRT whom I interviewed, Aled had previously been a client of Llawfon. This was because, having lived with MS for more than a decade, some two years earlier he had suffered a stroke. A programme of rehabilitation with Llawfon had been organised during the period of hospitalisation that had followed Aled's stroke, so that on his return home he received regular visits from the team's occupational therapists, physiotherapists and care practitioners. Just as the extract from my interview with Aled suggested that the visits had done much to help his self-esteem and independence, when I interviewed his wife and main informal carer Jo, she noted that:

> Mandy [Llawfon Occupational Therapist] sat there and did the feeding, you know, the feeding with him, and all that sort of thing. She would come in with the carers from Llawfon and show them what she wanted them to do, along with the physiotherapist.
>
> **Ben Duxbury**: So they came together, with the physiotherapist from Llawfon as well?
>
> **Jo Powell**: Yeah, we had two. He had two physiotherapists, they were both excellent. Llawfon were amazing, and their carers were amazing. They came every day, they came through the weekends and the difference in Aled was amazing (ICI1: 5).

Jo appeared well-placed to assess the high standard of care provided by Llawfon's occupational therapists, physiotherapists and care practitioners, given that she was a qualified nurse with many years experience of working with older people. However, Jo was no longer in paid employment, having recently given up her job in a local nursing home. One of her reasons for leaving the post was that, just like many informal carers of people living with chronic conditions (Alabaster, 2006) Jo too was living with a chronic condition (in her case rheumatoid arthritis). But even though the worsening symptoms of her arthritis meant that Jo was perhaps unable to continue with her life in the same way as some of the family-members alluded to by Dr Morgan, she went on to tell me that Llawfon's front-line professionals had provided much-welcome support, both emotional and practical. Moreover, she added that the team's collaborative-approach gave her confidence in the consistency and continuity of Aled's care.

As will be shown, many other clients and informal carers, front-line practitioners, managers and leaders whom I met during fieldwork also attested to the high quality

of care provided by Llawfon. Moreover, the same was true of the county's erstwhile CDM Team, set up to provide specialist services for the three chronic conditions – COPD, heart failure and diabetes – which had placed considerable demands on secondary care emergency services in Armorshire in the mid-2000s. Consequently, the Armorshire CDM Team comprised three diabetes- and three cardiovascular-specialist nurses and two COPD-specialist nurses (each assigned to one of the three Armorshire localities) as well as one COPD-specialist physiotherapist (covering the whole of the county). The Armorshire CDM Team's objectives, as listed in the *Armorshire CDM Team Information Pack for General Practice* (see App. 10) comprised:

> Advising patients on self management; identifying patients at risk of a crisis or exacerbation; providing care to prevent emergency admissions; providing education on chronic disease management for patients/carers/relatives, in particular COPD, Diabetes and Heart Failure; educating and supporting health professionals in the community; improving access to health care for hard to reach/disadvantaged groups; supporting community projects that encourage healthy lifestyles.

On the one hand, therefore, the Armorshire CDM Team appeared to favour an approach that mirrored the Welsh CCM Model's educative, preventive and proactive objectives. On the other hand, it was also indicated in the *Armorshire CDM Team Information Pack* (App. 10) that the 'Team Philosophy' was:

> To improve the management and care of patients with chronic disease across primary and secondary care, working in partnership with the patients, carers, and multi-professional teams including the voluntary sector. The team will deliver education, support and high quality care to patients with chronic disease in a variety of settings and work with carers and other health professionals, to maintain a seamless approach to chronic disease management.

Just like Llawfon, the CDM Team was predicated on partnership working with a variety of teams and stakeholders. Just like Llawfon, moreover, the team's clients also appeared to have been satisfied with the care they received. Mike Scott, for example, was living with COPD. When I interviewed Mike, he told me that:

> I'm with Janet Williams, the COPD-nurse. Any problems, I've got a phone number to phone, and if she's not in the office, she'll come back to me. I've also got her mobile number. If there's any problem whatsoever, she leaves a

> message with me on the dock-home[36] system, to get in contact or whatever is needed. The care with her is good. If I phone her up and say, 'I'm not feeling too well', she'll make an arrangement to come out, whenever's suiting me. And she'll come – well, she's got to work around, because she gets emergencies now and again – so she'll give me a time, early/late morning or afternoon. And she's prompt, unless, of course, something crops up with her, and she can't make it. Then, of course, she'll give me another appointment. I've got to give it to her, she's good (CLI3:1).

Whilst Mike was more than happy with COPD-nurse Janet Williams' approach – in terms of care, communication and speed of response – it appeared that this was exactly the same approach as when she had worked with the Armorshire CDM Team. Indeed, one of the more noteworthy features of my interview with Mike was that he went on to tell me that he had noticed no changes (positive or negative) in Janet's care in the previous six months (since she had joined the new Bro-y-Grug CRT) compared to the previous three years (when she was still a member of the CDM Team).

In the event, however, not only had none of the clients or informal carers whom I interviewed noticed any difference in the care they received following the Bro-y-Grug CRT's launch, the vast majority of them – including Mike – were not even aware that a reconfiguration had taken place. Whilst I investigate these issues in more detail in Chapter Seven, it was also of note that just as Jo Powell had drawn my attention to the partnership-working of Llawfon front-line professionals, so Mike's wife Rhoswen told me that:

> At the moment, he gets excellent care. Janet is the one that looks after him, anything wrong, she's out here, or she contacts the doctor and puts him on antibiotics or whatever he needs...the only time he goes down to the doctor is if he wants antibiotics, but usually Janet phones through and he picks up a prescription and it's ready for him (ICI2: 1).

Working closely with Rhoswen, Mike and local GPs to ensure that Mike received the care he needed, it therefore appeared that Janet espoused the collaborative, proactive and client/carer-focussed approach advocated by the architects of the Welsh CCM Model. Indeed, these were qualities that I was able to witness for myself, having attended (as a non-participant observer) a respiratory clinic that she ran in conjunction with specialist nurse Elaine Douglas of the Armorshire

[36] The Docobo® dock@HOME HealthHUB, a home telemonitoring system (see, http://www.docobo.co.uk/).

Community Oxygen Service, as part of the preparatory fieldwork that I referred to in Chapter Three. Although my time with Janet and her CDM-nurse colleagues was limited, what I witnessed in terms of high-quality care delivered by knowledgeable and committed front-line practitioners seemed to bear out the positive comments of Mike and Rhoswen and, indeed, those of other clients and carers whom I interviewed.

Hence, whilst a wide range of county-wide statutory health and social care initiatives had been set up in the years immediately prior to the launch of the Armorshire Collaboration, at least two of them – Llawfon and the Armorshire CDM Team – were widely recognised as providing high-quality integrated care. But the existing resource-base was not made up of statutory services alone, as I explain in the following section.

Voluntary/third sector services and self-care programmes

The three Locality Leadership Teams (LLTs) that were responsible for driving local developments of the Armorshire Collaboration met on a weekly basis. In addition, Joint-LLT meetings were held on a more *ad hoc* basis as a forum for sharing information that was of relevance across all three localities. One such meeting was attended by Joan Thomas, Partnership Manager at the Armorshire Association of Voluntary Services (AAVS). The latter was an 'umbrella' organisation that facilitated the representation of voluntary/third sector service groups on planning forums and helped organise partnership-working between statutory and voluntary/third sector agencies. During the Joint-LLT meeting, Joan explained that:

> We've got over six hundred groups registered with us as an organisation, and those groups are split into all sorts of themes, from health through to education. We've got a lot of things, like village halls etcetera. It's a very wide range of organisations. But most of them, I would say, come from the health spectrum. [For] these organisations, we're the umbrella body. We feed them with the information they need, any local information that's of relevance, regional information, and things that come out from WAG, and other places as well. But the groups themselves we see as the actual experts in their field (JLLTMO1: 1).

Invited to the meeting to discuss the potential involvement of a voluntary/third sector broker in the Armorshire Collaboration, Joan indicated that AAVS had access to an

extensive network of county-wide voluntary/third sector groups and that many of these were specialised in the health sector. Whilst the role of AAVS, Joan reported, was to act as a communicational conduit for its member-groups, she indicated that the latter constituted an important resource in terms of local expertise. Moreover, Joan went on to detail that many of these voluntary/third sector organisations had expressed interest in participating in the Armorshire Collaboration, which was corroborated during my interview with AAVS Partnership Manager Claire Peters.

When I interviewed Claire, she told me that Tregwen Locality Care Co-ordinator Lucy Williams had approached her with the idea of organising a '*Locality Connections*' event. Lucy's idea, Claire explained, was to set up a forum whereby stakeholders from statutory health and social care services that were directly involved in the Armorshire Collaboration in the Tregwen locality would be able to engage with representatives from local voluntary/third sector organisations. With the help of AAVS, Claire explained, Lucy had organised a *Locality Connections* event in the Tregwen locality, adding that a second event had been subsequently run in the Aberwrach locality. When I asked Claire what the levels of response to the two events had been from voluntary and third sector organisations, she replied:

> I think it was probably similar numbers [in both] and I know in the second one we had twenty-nine stalls. Not all of those would have been third-sector, but the bulk of them would have been. So, bear in mind that when I contact organisations, I'm contacting in the region of a hundred. But double that in terms of people, because there are more projects out there. So, because of lack of space, we might have had, for instance, British Red Cross turn up. But they were actually giving details on three different projects that they run. So there was a lot more information out there. I was more involved in the second one, and the interesting thing with that was that it seemed to be quite GP-led, which was really good. Because it was a question of [a GP saying]: 'What do we need to know about? Things like the Footcare Service. And all of a sudden, that's an answer to a problem that I've had, and I didn't know where to send anybody'. (VSRI2: 4).

Just as it was stressed in *Designed to Improve Health and CCM in Wales* (WAG, 2007) that the effective management of chronic conditions was dependent upon strong partnerships with voluntary/third sector organisations, so it seemed that the two events had met with considerable success. The apparently high-levels of response of local voluntary/third sector organisations across both Tregwen and Aberwrach suggested that there was considerable interest in engaging with local

statutory health and social care services in taking forward the Armorshire Collaboration. The reciprocal interest of local stakeholders from statutory services also appeared to suggest a willingness to work in partnership with local voluntary/third sector organisations to meet the needs of local people living with chronic conditions. Indeed, in this regard, it is of note that Claire drew particular attention to the interest of local GPs in a voluntary foot-care service, given the importance of podiatry to diabetes management (Alabaster, 2006).

In addition to a sizeable resource-base of local voluntary/third sector services, during the years preceding the launch of the Armorshire Collaboration, the county also witnessed the launch of two new programmes of care predicated on partnership-working between statutory services, voluntary/third sector services and people living with chronic conditions and their informal carers. These were the Educational Programme for Patients (EPP) and the X-PERT Programme (see Chapter One, 'Health and social care systems under pressure: the need for change').

In Armorshire, the EPP ran two courses, each comprising six weekly sessions of two and a half hours: the first was the *Chronic Disease Self-Management Programme*, designed to help people living with chronic conditions to manage their health and wellbeing needs; the second was *Looking After Me*, designed to help informal carers of people living with chronic conditions to manage their own health needs. The X-PERT programme also offered six weekly sessions of two and a half hours, but unlike the EPP was specifically tailored to the needs of people living with type 2 diabetes (with the course also open to informal carers). When I interviewed Armorshire CDM Nurse Lead Anne Richards, she explained that:

> The whole point around a lot of this work is also encouraging self-care, self-management. And if we all will encourage people to do that as well, hopefully the patient will take that on board as well, because we can't look after everybody all the time (LARI6: 6).

Anne worked hand-in-hand with Project Manager Jo Marshall during the development of the Armorshire Collaboration and was therefore well-acquainted with the project's goals. If, as she indicated, these included the fostering of self-management (which was a core feature of the Welsh CCM Model) the X-PERT Programme appeared to have been an important addition to the existing resource-

base. Moreover, it also appeared to have combined the knowledge of the CDM nurses and dieticians who delivered the courses with the knowledge of the people living with chronic conditions who attended them. Bodenheimer et al. (2002) suggest that it is this practitioner/client partnership which is central to self-management programmes, inasmuch as it combines the former's expertise in understanding and supporting the self-management education process with the latter's expertise as principal caregivers.

Although the X-PERT Programme was premised on partnership-working between clients and professionals, it was also built on collaborative-working between the voluntary and statutory sectors, with courses led by care professionals from statutory services. The contribution of care professionals was highlighted by Albert Keenan, a Bro-y-Grug resident living with type 2 diabetes. When I interviewed Albert, he explained that he had attended an X-PERT course run by three community diabetes-specialist nurses and a dietitian. Albert told me that he had lived with diabetes for some eight years, but had acquired more knowledge about his condition during one X-PERT course than in all the years he had been receiving care from his local GP surgery, adding that, 'I'm amazed by what I've learned in the last few weeks compared to what I learned previously, they have been so thorough' (CLI1: 1). With the help of front-line professionals' expertise, Albert reported that his knowledge and confidence had grown considerably during his participation in the six-week programme.

Whilst the X-PERT Programme was run by a charity organisation with courses typically led by care professionals from statutory services, the EPP was funded by NHS Wales and often led by course-tutors who were volunteers. More often than not, these were local people living with a chronic condition who had themselves previously followed an EPP course as participants. One such local volunteer was George Foster, who was living with type 1 diabetes. When I interviewed George, he told me that he had worked in a voluntary capacity with Armorshire LHB for a number of years and that he was variously: patient representative on the Owain Glyndŵr LHB Stakeholder Reference Group (SRG); lay member of the Armorshire Diabetes Network; and co-opted member of the Armorshire Local Committee of the

Owain Glyndŵr Community Health Council (CHC). Moreover, George stressed that:

> My main priority is EPP, the Educational Programme for Patients, which I'm totally committed to. Plus other things I do, the Stakeholder Reference Group, as I mentioned, and the Community Health Council, to a degree. So I try to be aware of what patients' needs are, because I'm a user of the health service. And I need to know myself what I can expect in the way of treatment. And I try to pass that information on to the various participants on the courses that I conduct (VSRI1: 3).

Hence, just as participation in an X-PERT course had allowed Albert Keenan to acquire knowledge specific to his own condition (type 2 diabetes), George also suggested that as an EPP course-tutor, he was able to apprise participants (living with a variety of chronic conditions) of the care available to them. Indeed, one could argue that George's first-hand experience of living with type 1 diabetes (and of negotiating often complex health and social care systems) combined with his work with Armorshire LHB had placed him in an unusual position: that of combining the perspective of service user with the perspective of service-provider. Accordingly, George was another important element in the apparently rich resource-base of services for people living with chronic conditions at the launch of the Armorshire Collaboration. In the next section I briefly describe some factors pertaining to the timing of the Armorshire Collaboration, before ending this chapter with a short summary of the themes covered.

Timing issues

Prior to commencing the first of the three findings and discussion chapters, it is perhaps apposite to make some comments about timing issues related to the development of the Armorshire Collaboration and the impact these had on my fieldwork and the structure of this thesis. These timing issues related to the belated (in terms of the project's three-year duration) inauguration/appointment-dates of what turned out to be the three fundamental elements/roles of the Armorshire Collaboration in the Bro-y-Grug locality: first of all, the Locality Leadership Team (LLT), whose remit it became (inasmuch as these were not part of plans at project initiation) to drive the local development of the Armorshire Collaboration; secondly, the Locality Care Co-ordinator whose task it became to oversee the work of the LLT;

thirdly, the Community Resource Team (CRT), whose task it became (again, inasmuch as the latter was also not part of plans at project initiation) to deliver the new service.

Hence, whereas the Armorshire Collaboration project was launched in March 2008 (and I began my PhD in April 2009) the Bro-y-Grug LLT was inaugurated only in November 2009 (twenty months after project initiation) the Locality Care Co-ordinator was appointed approximately eight months behind schedule (at the end of August 2009) and the reconfigured service was inaugurated only in September 2010 (just six months prior to project closure). It is also worth noting that, owing to the start-date of my scholarship, I was unable to chart the Armorshire Collaboration's development from project initiation, including the creation and subsequent abandonment of the project's organisational structure.

On the one hand, the timing of these inauguration/appointment dates impacted directly on the development of the Armorshire Collaboration and, more specifically, on the extent to which front-line professionals and local service users and carers were involved in service redesign. On the other hand, they also impacted directly on my fieldwork. This meant, for instance, that I interviewed project leaders only in the summer of 2010; that I conducted focus groups with front-line professionals only between March and September of 2011; and that I interviewed service users and carers only from the spring/summer of 2011 (over two years after I had commenced my study). This, in turn, created a distinct schism between the perspectives of project leaders (who were interviewed pre-reconfiguration and whose views on the new integrated service were therefore hypothetical) and that of front-line professionals, service users and carers (who were interviewed post-reconfiguration and whose views were therefore based on their first-hand experience of the new integrated service).

In Chapters Six and Seven I explore how the delays may have arisen and the effect they had on the development of the Armorshire Collaboration's integrated agenda (and in particular service user and carer involvement). But at this point it is perhaps important to emphasise that it is largely because of these timing issues (and the ensuing schism *vis-à-vis* perspectives) that in the first two findings and discussions

chapters (Five and Six) I concentrate for the most part on the perspectives of project leaders, whilst in the last of them (Seven) I turn my attention more fully to the views of other stakeholders, including front-line professionals, service users and carers and voluntary/third sector representatives. Having discussed issues of timing, I now provide a brief summary of this chapter.

Summary

In this chapter, I provided background contextual information to the Armorshire Collaboration and to the Bro-y-Grug locality. I explained that the Welsh CCM Model, the National CCM Demonstrator Programme and the Armorshire Collaboration could be understood as part of a continuum of developments in Welsh health and social care based on locally relevant service-provision, integration and participation, with the decade leading up to the initiation of the National CCM Demonstrator Programme witnessing the launch of a number of national strategies and initiatives aimed at developing this agenda. I also explained that at the same time, Armorshire witnessed the launch of a series of initiatives – from both the statutory and the voluntary/third sector – that were predicated on partnership-working and which had helped improve care for people living with chronic conditions. In the next chapter, the first of the three findings and discussions chapters, I discuss how local leaders of the Bro-y-Grug project set about bringing together existing services for the benefit of local people living with chronic conditions and their carers.

Chapter 5: The prioritisation of service users: project leaders' vision of integration

Introduction

In the previous chapter, I provided contextual background information regarding the Armorshire Collaboration. In this chapter, the first of this case study's three findings and discussions chapters, I begin by briefly revisiting Armorshire's existing resource-base of services prior to the Armorshire Collaboration's launch. I discuss the way in which project leaders considered that existing Welsh health and social care structures were no longer fit for purpose and that local service provision was fragmented and gap-ridden. I explore the widespread recognition that existing services were inefficient before describing the equally widespread conviction that the solution to the problem lay in integration. I describe some important relationships that pre-dated the Armorshire Collaboration's launch and the sharing of a vision of service user-focussed integration, before ending the chapter by discussing the existence of a group of local 'champions of change'.

Building on the past

Just as the Welsh CCM Model was premised not on the utilisation of new resources but on the remodelling of those in place, in *Chronic Conditions Management Update: Issue 7* (WAG, 2008b, pp. 1 – 2) it was reported that:

> The CCM Demonstrators will focus effort, support and resources in localities to implement and test the CCM model, drive improvements and learn across organisational and professional boundaries…Local partners will be expected to actively engage with and support the programme from within existing resources.

Whilst Armorshire Collaboration Project Manager Jo Marshall had also told me that one of the project's main objectives was to make better use of existing resources, it was noted in the Armorshire Collaboration Project Initiation Document (PID) that:

> The Armorshire Collaboration project will build on the chronic disease management developments implemented by the Armorshire health and social care community over the past 2 years (App. 9).

In the previous chapter, I explained that Armorshire had in place a number of nationwide programmes, local statutory health and social care services,

voluntary/third sector services and self-care programmes, each of which appeared to have made a contribution to the development of care services for local people living with chronic conditions. Moreover, just as it was reported in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008, p. 2) that the CCM Demonstrators would strengthen: 'Integrated service planning and commissioning of services in the community', many elements of Armorshire's existing resource-base (like the LSB, the HSCWB Partnership, Llawfon, the Armorshire CDM Team, AAVS, and the EPP and X-PERT programmes) espoused similar principles. During a Bro-y-Grug LLT meeting, GP Lead Dr David Lewis referred to earlier developments in terms of service-provision for people living with chronic conditions and integrated care:

> It is examples like chronic conditions management, nursing coming into the community, which probably form some pretty powerful pilot schemes...there are already attempts at better teamwork which are paying dividends and it's building on that experience across Wales and in the Armorshire Collaboration areas, but also in our practice too. Where we've got effective joint-working, patients have a better deal (JLLTMO3: 2).

Just as Dr Lewis' contention that local initiatives were 'paying dividends' and had shown joint-working to be of direct benefit to patients was corroborated by local stakeholders' accounts of the high quality of care provided by Llawfon and the CDM Team, his comments were also substantiated by a research project commissioned by the Welsh Government (All Wales Alliance for Research and Development in Health and Social Care [AWARD]/Picker Institute/Swansea University, 2009) in which researchers gathered base-line information prior to the launch of the Welsh CCM Model. The research combined a Wales-wide telephone survey of people living with chronic conditions (n=6, 600) with qualitative face-to-face interviews with people living with chronic conditions (n=25).

In the project's supplementary report for Armorshire[37], almost two-thirds (63%, n=408) of respondents (n=700) stated that they felt that healthcare professionals worked well together, whilst just over two thirds (67%, n=470) said that their involvement in decisions about their care was at an appropriate level. Furthermore, the overall standard of care provided by all healthcare professionals was rated by thirty percent of respondents as excellent; by thirty-five percent as very good; by

[37] Reference withheld to ensure anonymity.

twenty-four percent as good; by seven percent as fair; and by just four percent as poor. In the Armorshire PID (App. 9) moreover, it was noted that:

> These [i.e. CCM] initiatives have continuously shown improvements in terms of the number of emergency admissions having a chronic disease as the primary diagnosis and a reduction in lengths of stay for many of these admissions.

It therefore appeared that existing service provision had proved beneficial for people living with chronic conditions. This was the case whether it was measured qualitatively – as evidenced by my interviews – or quantitatively, as indicated in the AWARD/Picker Institute/Swansea University (2009) project and in the excerpt from the Armorshire PID. Additionally, just as the quality of existing services for people living with chronic conditions was consistently reported as high, it also appeared that partnership-working within the various teams functioned well and that the teams were built on collaborative principles. One could therefore argue that conditions were auspicious in terms of Armorshire's participation in the National CCM Demonstrator Programme and the development of integrated care.

According to Shaw et al. (2011) a tradition of partnership working (which was, arguably, already becoming established in Armorshire) may render further steps towards increased integration more straightforward. In a similar vein, Cameron et al. (2006a) argue that agencies which share a history of joint-working are likely to understand each other's ways of working and areas of expertise, and that it is therefore likely that the establishment of new partnerships will be encouraged when anchored within existing services. The importance of such a shared-tradition has been noted in number of empirical studies that have explored integrated health and/or social care projects, including: Gibb et al.'s (2002) qualitative evaluation of integrated multidisciplinary care in English Community Mental Health Teams; Dickinson's (2006) qualitative case study of an English pilot-introduction of the Single Assessment Process; Cameron et al.'s (2006) qualitative evaluation of the English Supporting People Health Pilots; and Rosen et al.'s (2011) international case study of four organisations (two North American, one Dutch and one Scottish).

As for the latter study, Rosen et al. (2011) combined semi-structured interviews (with between nine and fifteen senior executives, clinicians and managers from each

site) with documentary evidence. Noting that a history of joint-working facilitated the process of integration, the researchers drew particular attention to Scotland's North Lanarkshire Health and Social Care Partnership (between Lanarkshire Council and Lanarkshire NHS). The latter, Rosen et al. (2011) pointed out, was built on a number of years of joint-working, with earlier agreements reflecting Scottish health policy's emphasis on networks and partnerships. The researchers drew attention, for example, to the Sinclair Integrated Day Service for older people living with mental health problems, a service that was delivered by an integrated health and social care team. Noting that the service's development required staff (from different professional backgrounds) to work in new ways, to adopt new goals and values, to blend their roles and (in some cases) to refer directly to each other, the researchers stressed that the process was facilitated by a history of joint-working between health and social care services. Despite the progress made in the development of joined-up local services for people living with chronic conditions within Armorshire, the project leaders whom I interviewed nevertheless believed that prevailing health and social care structures (both Wales-wide and regionally) required significant redevelopment in order to deal with major demographic and epidemiological changes, as I explain in the following section.

Obsolete structures at Wales-wide level

In the *Service Improvement Plan* (WAG, 2008, p. 5) it was noted that Wales' health and social care systems were, 'unsustainable with an over-reliance on traditional, and often inappropriate, models of care'. The words were replicated verbatim in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008), just as it was indicated in the Armorshire Collaboration PID (App. 9) that, 'current health and social care models are unsustainable'. In a similar vein, when I interviewed Armorshire Collaboration Project Manager Jo Marshall, she told me that:

> There's no doubt about it, if we were setting up an NHS today, we'd set it up completely differently than what we've got. The NHS remained pretty much unchallenged for fifty[38] years and that takes a lot to unpick, those entrenched ways of working. You know, it's still a very medical model. I mean, even

[38] Perhaps a reference to the fact that in 1999 responsibility for NHS Wales passed to the Welsh Government.

> listening to what Dr Chris Jones[39] says, he uses the phrase: 'If anybody experiences a deterioration, the first person that they need to see is a doctor'. Now, I'd never say: 'You're wrong' to him. But he isn't right (LARI2: 28).

Whilst Jo contended that the NHS had remained long unchallenged, the epidemiological and demographic (and indeed socio-cultural) landscape of Wales in 1948 (at the inauguration of the NHS) was without doubt very different from the landscape in 2008 (at the inauguration of the National CCM Demonstrator Programme). Although Jo suggested that the work of the NHS remained ensconced within the biomedical model of health, she inferred that the latter's position of primacy was supported by Dr Chris Jones (himself a medical practitioner). This is of some significance, given that Dr Jones chaired the National CCM Demonstrator Steering Group, established to help guide and support the project. Accordingly, Dr Jones had a senior leadership position in a project which had as one of its core objectives the implementation of a model of CCM care which was not only premised on the integration of health and social care services (WAG, 2008) but which was based on the *social* model of disability (WAG, 2007).

Moreover – and in contrast with the prevailing biomedical model, whereby service users are viewed as 'passive recipients' of care (see Ellins and Coulter, 2005) – the CCM model was to be implemented in partnership with patients, service users and carers (WAG, 2007). Again, this is of note, given that because of the broad range of health *and* social requirements of people living with chronic conditions, it is widely recognised that CCM care involves a complex interplay between medical, psychological and social problems and must therefore strike a balance between treatment regimens and overall quality of life (Kodner, 2006; Billings et al., 2013).

Whilst Nies (2009) draws attention to the limitations of the traditional disease-oriented view of human functioning, he adds that contemporary thinking instead emphasises the importance of such quality of life (particularly in the care of people living with complex chronic conditions). Accordingly, in keeping with many other experts (for instance, Davies et al., 2009; Goodwin et al., 2012; Billings et al., 2013) Coulter et al. (2013) posit that CCM care should be proactive, holistic, preventive and, moreover, patient-centred and that systems of care and support should therefore

[39] Real name.

be re-designed so that the care planning process is patient-driven. Nevertheless, Coulter et al. (2013) also stress that notwithstanding extensive patient-group lobbying and numerous policy documents that advocate change, progress towards these objectives has been slow and that the disease-focussed (that is, biomedical) model continues to hold sway. It could therefore be argued that the wisdom of appointing an advocate of the biomedical model of health – if, as Jo contended, this was indeed the case – to chair a project underpinned by the social model of disability was questionable and unlikely to help speed up the required change.

Although Dr Jones' apparent espousal of the biomedical model was not in keeping with the underlying ethos of the Welsh CCM Model, Jo's contention that were the NHS to be set up today it would be done quite differently was a view shared by another medical practitioner, Bro-y-Grug GP Lead Dr David Lewis. During my interview with Dr Lewis, he told me – *vis-à-vis* the provision of both health and social care structures – that 'nobody would invent this service now as it is' (LARI5: 3). Whilst he too believed that this was because the system was ill-equipped to cope with major epidemiological and demographic changes, he hastened to add that:

> I feel to a great extent it's because the services, all of them, have historically worked in silos and have evolved in these silos to a place which is now a fairly homogenous cul-de-sac. And we all recognise that evolutionarily, we've gone the wrong way (LARI5: 3).

With Dr Lewis arguing that services had long worked in so-called 'silos', in its metaphorical sense a silo has been defined as 'a system, process, department, etc. that operates in isolation from others' (Oxford University Press, 2014, p. 1). Just as the existence of silos has been widely commented upon in the literature of integrated working in health and social care (see, for example, Good Governance Institute, 2013; Khaldi, 2013) Dr Lewis was one of a number of project leaders/senior managers to draw my attention to this phenomenon. For instance, during my interview with Armorshire CDM Nurse Lead Anne Richards, she told me that:

> We all sit in little silos, all our different teams and we all have exclusion and inclusion criteria, and what happens if that person doesn't quite fit in any of them, where do they go? (LARI6: 2).

Similarly, Bro-y-Grug Locality Care Co-ordinator Christine Thompson told me that:

> At the moment they're all in their own silos, we've got occupational therapists in one room, social workers in another room, Enablement in another room, and Home-Care in another room and they all have their own agenda (LARI3: 7).

During my interview with Armorshire Collaboration Social Care Lead Jill Thomas, she too told me that, 'we've worked in silos for so long' (LARI9: 2) before adding that this was because:

> We've got a very complex system in this country. And I think we've made it more complex sometimes. If you look at health and social care, you've got two hugely bureaucratic organisations. Some of the things that actually work against the integration or about making sensible decisions are because of some of the bureaucracies of the systems or the standards of the system. So in health you've got health-care free at the point of delivery but in social care you've got the means-test for the contribution. That can be a big stumbling block (LARI9: 2).

Positing that the complexities of health and social care systems in Wales militated against both sensible decision-making and integration, Jill suggested that the situation was attributable to prevailing 'bureaucracies' and 'systems', including the respective funding mechanisms of health and social care. Indeed, as Lewis (2001) notes, the cause of the problematic health/social care boundary in the UK has long been attributed to administrative, professional and financial divisions. Humphries (2011) adds that these are legacies of the post-war organisation of health and social care in the UK, whereby the NHS was established as a centrally directed service, whilst personal social services became the responsibility of local councils.

It is of note, however, that the lack of joint health and social care budgets and systemic differences in financing long-term care have been identified as major barriers to integrated working in many other European countries (Leichsenring, 2003; Allen et al., 2011). According to Henwood (2006), financial barriers, in particular, not only impinge on developments at strategic, managerial and operational levels, but also directly affect clients who are frequently caught between what may, to them, seem arbitrary divisions between health and social care services. Just as across Europe populations are ageing and the numbers of people living with chronic conditions are rising – people whose needs span health and social care (Busse et al., 2010) – many countries' health and social systems are beset with structural fragmentation (Alaszewski et al., 2003a). Moreover, despite employing

different systems of policy, funding, infrastructure and provision, many other parts of the world (outside of Europe) also have long-term care services that are similarly disjointed and therefore equally ill-equipped to meet current needs (Kodner, 2009).

At the initiation of the Armorshire Collaboration, Wales' care system – just like the rest of the UK bar Northern Ireland (see Heenan, 2013) – also remained structurally divided in a number of ways. Hence, at macro-level, firstly, there were horizontal divisions between different government ministries responsible for overseeing health or social care services. Between macro- and meso-levels, secondly, there were vertical divisions between bodies responsible for setting out policy and its implementation. At both meso- and micro-levels, finally, there were horizontal divisions between agencies responsible for organising or delivering either health or social care services. In view of this situation, when I interviewed Bro-y-Grug LLT Social Care Lead Gwyn Evans, he told me that:

> Ultimately what I want is to merge and not integrate, because there's a difference isn't there? In that you can have two wheels with cogs which kind of work together and interlink and share some components and ultimately might have a similar aim at the end of the day, to get something done, you know? But they're still two wheels. And, I don't really want to have two, I don't really want to have integrated services, what I really want is to have one wheel (LARI1: 9).

Although Gwyn's ultimate wish was for a merger of health and social care, he hastened to add that in view of the complexities of existing structures, this remained a distant hope. Whilst Armorshire Collaboration Social Care Lead Jill Thomas believed that existing structures continued to weigh against integration, she also told me that:

> We've got some very creative, imaginative people working across these organisations and very dedicated staff, [but] they've been shackled by bureaucracy (LARI9: 4).

Although a number of project leaders believed that prevailing structures militated against integration, it is worth reiterating that in Heenan and Birrell's (2006) and Øvretveit et al.'s (2010) studies to which I referred in Chapter Two (see section,'The determinants of integration: structure or culture?') the researchers found that unless

supported by cultural change, structural integration was of limited benefit. Likewise, in an overview of Joint Reviews of changes in English social services from 1996 to 2003 (Social Services Inspectorate/Audit Commission, 2004) the researchers found that structural change was often only of benefit if simultaneous efforts were made to determine common values and culture and to involve staff and service users. Ham et al. (2011) also suggest that without clinical- and service-level integration, structural change is unlikely to deliver benefits, just as in the wake of the NHS Wales Reforms of 2009, Professor Marcus Longley noted:

> Don't fixate on organisational fixes. We have integrated health care in Wales, and it doesn't make a huge amount of difference in terms of the provision of integrated services for people. So, organisational fixes are amongst the least important of these issues. They can help, but they're not sufficient (Soundcloud, 2014, p. 1).

It is important to note, however, that Professor Longley's comments were made with the benefit of hindsight, which was something which the Armorshire Collaboration project leaders – then going through the NHS Wales Reforms of 2009 – did not possess. Moreover, in the studies of integrated working to which I have referred, it was not indicated that structural integration was not effective, just that it was not effective in isolation. From this perspective, arguably, that a number of project leaders believed that structural integration was important was in keeping with what many researchers to date have noted, namely that it is one of a number of ingredients that can promote integrated working (Lewis et al., 2010; Shaw et al., 2011; Goodwin et al., 2012). Just as in this section I have explained that a number of project leaders believed that existing Wales-wide structures militated against integration, in the next section I describe the way in which many believed that service-provision in Armorshire and Bro-y-Grug could also be improved.

Isolation, gaps and duplication at local level

Whilst in the previous section I explained that a number of Armorshire Collaboration project leaders believed that prevailing UK and Wales-wide health and social care structures were no longer appropriate, Bro-y-Grug LLT Social Care Lead Gwyn Evans also suggested that:

> I think that if we didn't have any health and social care at all in Bro-y-Grug, or anywhere in Armorshire and somebody said, 'Here's a hundred million pounds, set up health and social care in Bro-y-Grug!' You wouldn't do it like this, would you? I don't think *I* would, anyway. I wouldn't set up little teams being highly exclusive and elitist in different corners of the area. All of our teams, we're all like that. And I've been as guilty as anybody. Not because we wanted to do it that way, but because the Welsh Assembly were giving us pots of grants and they were saying: 'Here's a little pot of money, go away and set up that service and please report back on the service exclusively as that service!' Therefore we were forced into being little, small teams, it's a mess (LLTMO5: 5).

Gwyn's comments were made at a Bro-y-Grug LLT meeting attended by an occupational therapy line-manager and Dietician from Llawfon and two CDM Nurses from the Armorshire CDM Team, services that had both been singled out for special praise by local managers, front-line professionals, clients and informal carers alike. Nevertheless, these services were part of a county-wide health and social care landscape that was, according to Gwyn, populated uniquely by teams that were 'small', 'exclusive', 'elitist' and only available in specific 'corners'. However, just as Gwyn contended that it was the Welsh Government that had helped create the 'mess' by providing 'pots of money' (presumably, in the shape of grants) to fund the creation of stand-alone services, similar remarks had been made in a Discussion Paper presented to the National Advisory Board (NAB) by Chair of the National CCM Demonstrator Steering Group, Dr Chris Jones:

> Whilst it appears that all partners aspire to a more primary and community service led NHS, movement in that direction has been largely through pilot projects or new stand-alone services, many funded from new investment following the Wanless review. Whilst delivering significant benefit, these schemes have added to the complexity of the current model and are not uniformly spread. It is apparent that no single vision for the way in which services could be delivered in the future has been developed. In the absence of a clear strategic framework, change continues to be small-scale and piecemeal and existing service tensions remain (NAB, 2009, p. 2 – 3).

On the one hand, therefore, Dr Jones suggested that single schemes (in the shape of pilots or stand-alone services) had delivered 'significant benefit' in Wales, which certainly appeared to be the case with Llawfon and the Armorshire CDM Team. On the other hand, however, (and mirroring the words of Gwyn Evans) Dr Jones suggested that such 'small-scale' and 'piecemeal' initiatives had made the current model of community care more complex and disparate. Whilst Dr Jones added that

there was also no 'single vision' for service delivery, there has been broad agreement that the creation of a 'shared vision' is a critical success factor in the provision of integrated health and social care (see, for example, Fulop et al., 2005; Shaw et al., 2011).

It is worth noting, however, that despite the words of Gwyn Evans and Dr Chris Jones – and notwithstanding the fact that in the *Service Improvement Plan* (WAG, 2008, p. 5) it was indicated that it would be necessary, 'to integrate and more effectively plan, manage and where appropriate reconfigure existing services and support' – concurrent with the launch of the Armorshire Collaboration came approval for funding for the creation of another stand-alone service, the Armorshire Falls Prevention Team. One could therefore argue that the Welsh Government's own planning – at least as far as Armorshire was concerned – was paradoxical. Paradoxical inasmuch as on the one hand, the Welsh Government was providing the county with funds to set up another stand-alone service. On the other hand, however, it was simultaneously providing the county with separate funds to implement a new model of care – the Welsh CCM Model – that, as indicated in the *Service Improvement Plan* (WAG, 2008, p. 6), was premised on the reconfiguration of existing services into, 'integrated multidisciplinary teams'.

Whilst it was also indicated in the *Service Improvement Plan* (WAG, 2008, p. 20) that implementing the CCM Model would help repair a system in which 'resources are not being utilised in the most effective or sustainable way and there are often gaps or duplications', references to analogous problems were made by a number of project leaders from the Armorshire Collaboration. Project Manager Jo Marshall, for instance, reported that:

> We are inefficient at the moment. Because we've got all these people doing different things; there's duplication; people are falling within the gaps; we're not coordinating [care for] people with chronic conditions; it isn't episodic. So we're not efficient in what we are doing (LARI2: 5 – 6).

Just as Bro-y-Grug Locality Care Co-ordinator Christine Thompson noted that:

> There's a lot of duplication going on out there, people not knowing what services there are, people setting other services up when they are happening in another area that we just don't know about (LARI3: 10).

Whilst Armorshire CDM Lead Nurse Anne Richards explained that:

> If I visited a patient and I decided they needed meals on wheels to support them, I would have to refer them to the social worker, who would then go out and do an assessment, and decide whether they needed meals on wheels. Well, why can't they just take my opinion on that? (LARI6: 2).

Furthermore, Bro-y-Grug Social Care Lead Gwyn Evans indicated that:

> We're duplicating, we're wasting: it's not fair for that individual that they have to be re-assessed by different organisations. It's just plain wrong really, you know? (LARI1: 2).

Finally, Consultant in Respiratory Medicine of the Armorshire Division of Owain Glyndŵr LHB Dr Roger Phillips noted that:

> People with lung conditions often have many other conditions as well which may or may not be related to their lung problems. So you need a whole team and a whole raft of experts working on patients to improve their quality of life, to improve their functioning, it's not just a question any more of giving people tablets or inhalers. We do work well as a group, but there is still too much overlap or we are replicating each other's work and each other's knowledge [40].

Thus, there appeared to be consensus amongst a number of project leaders/senior managers that services were: duplicated and gap-ridden, uncoordinated, wasteful and overlapping, and were, in short, inefficient. Whilst I return to the issue of efficiency in the next section, as regards the comments of Dr Phillips, his specific reference to the multiple needs of people living with lung conditions was perhaps explained not only by his own speciality, but also by the fact that chronic obstructive pulmonary disease was an area of special interest within the Armorshire Collaboration.

Notwithstanding, Dr Phillips' remarks *vis-à-vis* the need to transcend the prescription of medication alone (echoing Jo Marshall's allusion to the obsolescence of a reliance on the hegemony of the biomedical model of health) could justifiably be extended to those living with other chronic conditions. This is because of the high prevalence of co-morbidity amongst all people living with chronic conditions (equivalent to over two thirds of those people aged sixty five and over in Wales who are living with a chronic condition [WAG, 2007]) and because the latter's needs are

[40] Excerpt from official demonstrator DVD. Reference withheld to ensure anonymity.

typically, ‘complex and multiple, and influenced by physical, psychological, social and environmental factors’ (Nies, 2006, p. 391).

Whilst Dr Phillips also argued that to improve the ‘quality of life’ of people living with lung conditions, it was necessary to call on ‘a raft of experts’, it could be argued that such expertise was already to be found in the Armorshire CDM Team, predicated as it was on the provision of ‘education, support and high quality care to patients with chronic disease’ (App. 10). Indeed, people living with chronic conditions in Armorshire appeared to have benefitted not only from the existence of the CDM Team but also from the plethora of other stand-alone services which had been inaugurated in the years preceding the launch of the Armorshire Collaboration.

However, whilst this development had – according to Gwyn Evans and Dr Chris Jones – been stimulated by Welsh Government funding, it was perhaps in turn attributable to the fact that advancing knowledge and changing technologies have witnessed a growing replacement of health and social care ‘generalists’ in the UK with health and social care ‘specialists’ (Jelphs and Dickinson, 2008, pp. 18 – 19). On the one hand, argue Jelphs and Dickinson (2008), the detailed understanding that the latter are able to bring to a given field means that specialisation can be viewed in a positive light (just as Dr Jones had referred to the benefits engendered by the launch of numerous stand-alone services in Wales). On the other hand, however, Jelphs and Dickinson (2008, pp. 18 – 19) suggest that concurrent with increased specialisation has been a (re)- emergence of awareness of the importance of the ‘whole patient’ approach and the multifactorial needs of many individuals. Indeed, this appeared to be one of the core themes of the Welsh approach to the management of care of people living with chronic conditions, with the indication in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 3) that:

> Living with chronic conditions can have far reaching implications on all areas of life and can have a particularly profound effect on the social life and independence of individuals, their families and other carers.

Just as Dr Phillips alluded to the multifactorial nature of lung conditions, the management of care of all people living with chronic conditions, as I have already indicated, can be classed as a ‘wicked issue’. Given that these are the issues which

have a propensity to cross organisational boundaries and require the involvement of multiple agencies, there was therefore some irony in Jelphs and Dickinson's (2008) indication that the increased specialisation of health and social care professions has led to health and social care fragmentation, which, according to Axellson and Axellson (2006, p. 78) is, 'a state of differentiation without the integration that is required to achieve unity of effort'.

Fragmentation, it has been argued, not only increases costs, but means that those with multiple health and social care needs (including people living with chronic conditions) receive sub-optimal care (Goodwin et al., 2013). Wagner (2009) argues, furthermore, that the resultant breakdown in communication and collaboration in providing services to an individual leads to, 'deficiencies in timeliness, quality, safety, efficiency and patient-centredness'. However, Curry and Ham (2010) suggest that fragmentation often ensues when organisations, professionals and services operate independently of each other (and that this, in turn, has adverse consequences for service users). Moreover, Rosen and Ham (2008) point out that a common theme in many discussions about service-fragmentation is that the solution may be found in integration.

At this juncture, however, it is perhaps worth noting that no allusion was made to the fragmentation or duplication of services during my individual interviews with service users/carers or during the focus groups with front-line professionals. On the contrary, although a number of the former told me of the high quality of partnership-working between different health and social care front-line professionals prior to the launch of the Armorshire Collaboration, there was no suggestion that this in any way altered (either positively or negatively) following the launch of the Bro-y-Grug CRT. Whilst many of the latter echoed the remarks of service users and carers *vis-à-vis* the collaborative approach to the provision of health and social care prior to the reconfiguration, it was widely reported that post-reconfiguration, services had, on the contrary, become *more* disjointed. These are issues which I discuss in more detail in Chapter Seven. In the next section, however, I examine how Armorshire Collaboration project leaders believed that service fragmentation – and concomitant duplication – had made a significant impact on local health and social care services.

Inefficiency and changing structures

In the previous two sections, I explored how project leaders believed that prior to the reconfiguration, health and social care services operated in parallel but unconnected silos; that the obsolescent organisation of national and local health and social care structures and a systemic failure to adapt to changing demographic and illness patterns were (at least partly) to blame; and that as a result, health and social care in Armorshire was inconsistent, gap-ridden and replete with duplication and wastage. Many of these issues were touched upon in a series of presentations at a Bro-y-Grug LLT meeting organised to introduce the Armorshire Collaboration to representatives from GP practices in the Bro-y-Grug locality. During his presentation, Bro-y-Grug LLT GP Lead Dr David Lewis stressed that a predicted further growth in numbers of older people living with chronic conditions was set to place even greater demands on already over-stretched health and social care services. He then added that:

> All through there's been the theme that 'no change' is not an option. Does anybody here think that 'no change' *is* an option? Is the status quo something that [can continue] despite all of what we can see is going to happen? Do we feel that we can sit in our 'ivory tower' or our practice and just continue to practise in the way that we're practising at the moment? Does anybody really believe that? (LLTMO1: 5).

Although now referring to an 'ivory tower' and the 'status quo' (rather than 'silos' and a 'cul-de-sac'), Dr Lewis nevertheless appeared to count primary care amongst the services that, he felt, worked in isolation (and which, he seemed to infer, evinced a reluctance to change). It was somewhat ironic, therefore, that only one GP from the nine local practices – which had a combined total of some thirty GPs – attended the meeting to learn more about the proposed development. Notwithstanding, just as Dr Lewis challenged the one local GP (and one local Practice Manager) who were in attendance to gainsay his proposition that, 'no change is not an option', when I interviewed Project Manager Jo Marshall, she explained that:

> The demonstrator is about ensuring that we can use our resources more efficiently and effectively in order to deal with the demographic changes that are now beginning to hit home. So, coming back to the [Welsh CCM] Model, that's the premise on which the Model hangs. If we don't do these things, we're not going to have a fit service to deal with the demographic change (LARI2: 5).

Suggesting that in the absence of an adaptation to the way that (existing) resources were used, services would be unable to cope with demographic change, Jo appeared to agree with Dr Lewis' proposition that change was imperative. Moreover, her remarks *vis-à-vis* the concomitant requirement for greater efficiency were echoed by District Nurse Lead Janice Davis:

> I think that the days are gone whereby we can work efficiently as two separate services. I think that there is so much overlapping, there is so much need for liaison, collaboration, and so on and so forth, that if we don't have a structure whereby we come together, then I don't think that we're going to remain, we're not going to improve our efficiency (LARI4: 3).

It is perhaps worth pointing out that healthcare efficiency is, according to Burgess (2012), a poorly understood term about which there is little definitional consensus. However, in view of project leaders' repeated allusions to service replication and duplication, it would seem apposite to draw attention to the comments of Donabedian (2005, p. 717) and his contention that the evaluation of the quality of medical care can be divided into 'logical' and 'economic' efficiency. Suggesting that the former concerns the efficiency used to arrive at decisions, Donabedian (2005) notes that this may relate to the extent to which the information given to the 'physician' (presumably, by the patient/client) is relevant or irrelevant to the clinical business at hand. He then adds that:

> If relevant, one might consider the degree of *replication* or *duplication* [my emphases] in information obtained and the extent to which it exceeds the requirements of decision making in a given situation. If parsimony is a value in medical care, the identification of redundancy becomes an element in the evaluation of care (2005, p. 717).

As for economic efficiency, Donabedian (2005) contends that whilst this deals with the relationships between inputs and outputs (and whether a given output is produced at least cost) it is also influenced by *logical* efficiency, inasmuch as the accumulation of unnecessary or unused information (presumably, as a result of replication of duplication) is a costly procedure which yields no benefit. In view of the extent to which project leaders/senior managers contended that existing services were duplication-ridden and wasteful – and bearing in mind Donabedian's comments *vis-à-vis* the apparent value attached to parsimony in medical care – it would seem apposite to remember that the National CCM Demonstrator Programme was not only

set against a backdrop of increasing numbers of (older) people living with chronic conditions, but that it also coincided with a global economic crisis and concomitant budgetary pressures.

Indeed, just as Jacobs et al. (2006) note that the high proportion of Gross Domestic Product (GDP) typically dedicated to healthcare means that healthcare efficiency is a central objective of most policy makers, they add that ageing populations have only increased pressure on healthcare systems. Whilst Busse et al. (2010) note that various innovative approaches have been developed to tackle the concomitant increased prevalence of chronic disease across Europe, they stress that resources to do so have become increasingly limited. So whereas Wales, for instance, has traditionally received increased health and social care budgets to match rising demands, the country has more recently faced particularly stringent financial restrictions (Longley et al., 2012a).

Under such conditions, argue Mladovsky et al. (2012), one of the options open to governments is the reallocation of funds (rather than the use of new ones) to enhance efficiency. In a similar vein, Ham et al. (2012) report that in view of public spending constraints in England, improvements in care will need to be funded out of existing budgets, existing resources will need to be use more intensively, and health and social care workforces will need to be utilised differently. Additionally, Bennett and Humphries (2014, p. 3) draw attention to the increased need for both local government and the NHS to 'focus on prevention, reducing the demand for services and making the most efficient and effective use of health and social care resources'.

In Chapter Four, I explained that similar principles underpinned the Welsh CCM Model, with the latter predicated on: prevention (of the onset of chronic conditions); reduction in demand (on secondary care services); and more efficient and effective use of existing resources. As for the more effective utilisation of health and social care front-line professionals in the Armorshire Collaboration, during my interview with Jo Marshall, she told me that:

> If we can co-locate the teams, under one roof is the way that I'd describe it, you will start to get those people increasing their communication and understanding (LARI2: 8).

Just as Jo Marshall believed that co-location (of community health and social care practitioners) would improve their communication and understanding, so Armorshire CDM Nurse Lead Anne Richards suggested that:

> If you go and look at what's the problem and why have things fallen apart, often it's just that people don't communicate. Not because they don't want to, but often they get so bogged down with the amount of work they've got to do and get through that they can't find the time to do that communicating. If you're in a room, it's so much easier to stop and have a conversation (LARI6: 4).

In a similar vein, Bro-y-Grug Locality Care Co-ordinator Christine Thompson told me that:

> We're hoping people will have opportunistic dialogue. You know, 'I'm seeing a client today and they're a bit lonely. Does anybody know of any services that would be beneficial to them?' At the moment they're all in their own silos. We've got occupational therapists in one room, social workers in another room, enablement in another room, and Home-Care in another room. They all have their own agendas, whereas if you muddle them up, we're hoping that those agendas will become crossed (LARI3: 7).

Bro-y-Grug District Nurse Lead Janice Davies, likewise, suggested that:

> I know there's been a lot of research done that shows that people that work in the same building speak so many times a day if they're on the same floor and so many times a day if they're in the same room. The results of that have shown that if you are communicating, if you are sharing a central point, if you know the people that you're actually liaising with, then liaison is improved (LARI4: 3).

Just as Bro-y-Grug GP Lead Dr David Lewis suggested that:

> Get the critical mass of the right people in the same place and things will happen that we cannot imagine, simply because they are [in the same place]...when you get to that place where everybody feels: 'That's my working home', things will happen on behalf of clients and patients (LLTMO6: 7).

Whilst a number of Armorshire Collaboration project leaders considered that co-location would improve communication between front-line professionals (thereby improving client-care) in Chapter Two (see section 'The evidence base for integration') I indicated that in Brown et al.'s (2003) comparative study of co-located integrated health and social care teams and 'traditional' teams, the researchers reported mixed findings. So, although the speed of response from assessment to referral was better for the co-located integrated teams, less of their

clients remained living independently after eighteen months, whilst there was no discernible difference between systems and outcomes measures between those using the traditional and the integrated services. Moreover, the researchers noted that people using the co-located integrated teams more often reported depression and scored lower for Quality of Life.

Another study of co-located integration proved equally inconclusive. Imison et al. (2008) explored the delivery of integrated care by polyclinics, which they define as, 'facilities in which primary, community and secondary-care services are co-located' (2008, p. 1). Their study of twelve of England's NHS LIFT[41] partnerships combined site-visits to three polyclinics with structured interviews with key stakeholders (n=28). The latter included clinical staff, managers and representatives from acute trusts based within the new facilities and stakeholders based elsewhere but commissioning services from the polyclinics.

The researchers reported several examples of co-location failing to bring about the anticipated improvements. In one instance, for example, despite being based in the same building, GPs were unable to make direct referrals to the consultant outreach clinic or radiology facility. Indeed, Imison et al. (2008, p. 14) noted that the hopes for co-location of many staff (from a variety of primary, community and secondary care health and social care professions) were not realised, with widespread consensus that despite sharing the same premises, health and social care services still operated in relative isolation. Whilst I return to the issue of co-location – this time from the front-line professional perspective – in Chapter Seven (see section, 'Lack of engagement'), having explored how project leaders believed that current systems needed to change and to become more efficient, in the next section I describe how integration was part of this plan.

Integration: a common need

In the last section, I explained that Bro-y-Grug LLT District Nurse Lead Janice Davis argued that the solution to existing efficiency problems was a structure that

[41] Local Improvement Finance Trust. A capital procurement route supported by public–private partnerships (PPPs) at national and local levels (Imison et al., 2008). See also http://www.communityhealthpartnerships.co.uk/about-the-lift-programme)

would bring services together. In a similar vein, in the *Service Improvement Plan* (WAG, 2008, p. 8) it was stressed that:

> A fundamental review and careful planning of services are now required to ensure firm foundations are set, moving away from 'initiatives' towards a chronic conditions improvement programme of work, fully integrated within mainstream service delivery.

Whilst Bro-y-Grug LLT Social Care Lead Gwyn Evans had suggested that government grants had created isolated, exclusive and elitist teams, it was indicated in the above excerpt that the programme of work (based on the implementation of the CCM Model) would instead ensure that service-provision developed away from (presumably stand-alone) initiatives to become mainstreamed and fully integrated. Such a stance had been set out in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 14), where it was stressed that the implementation of the Integrated Model and Framework (as the Welsh CCM Model was then known) would, 'improve prevention, detection and management of chronic conditions locally through an integrated, holistic approach'. In turn, it was indicated in *Chronic Conditions Management Briefing Sheet 1* (WAG/NHS Wales, 2008, p. 1) that the three national demonstrators would adopt a 'planned, proactive and integrated approach' just as in the Armorshire Collaboration PID (App. 9), it was noted that the objective of the demonstrator project was to deliver, 'Greater integration of health and social care services'. Head of Strategic Partnership and Projects for Armorshire County Council Ellen Rees, likewise, posited that:

> If you're receiving care in your home, you might have someone from health come and visit you in the morning, and then someone from social care come and visit you and do very similar things. Actually integrating our services might mean that you have just one visit instead of two. You don't want to have to deal with our organisational differences. You just want to have the right care in the right place by the right person. Integrating our services does that.[42]

Ellen Rees stated that the provision of the 'right care in the right place by the right person' (a phrase that was repeated – in varying forms – throughout the course of the Armorshire Collaboration) would be ensured by integration. In a similar vein,

[42] Excerpt from official demonstrator-site DVD. Reference withheld to ensure anonymity.

Armorshire County Council Leader Claire Powell reported – as regards the county's involvement in the National CCM Demonstrator Programme – that:

> Integration is vitally important. It's a really exciting time. If you go back a couple of years, you wouldn't get health and social services working around the same table. Not only are we working [together] now but we are really moving ahead and making sure that we are delivering far better services to the people. [43]

It is of note that – like a number of the Armorshire Collaboration project leaders whom I interviewed – Ellen Rees and Claire Powell outlined the benefits of integration without explaining its meaning or precisely what it would entail. Notwithstanding, referring to the centrality of integration as part of Armorshire's future plans for health and social care, Claire Powell went on to point out that it was also a fundamental element of the Armorshire Collaboration. In a similar vein, Project Manager Jo Marshall told me that:

> I think the Collaboration is there to implement the [CCM] Model and Framework and its constituent elements, but in doing that I think the Collaboration needs to integrate community health and social services (LARI2: 5).

Just as Jo intimated that central to the demonstrator's implementation of the CCM Model was service-integration, so Bro-y-Grug Locality Care Co-ordinator Christine Thompson considered that the focus of the Armorshire Collaboration was:

> ...around integration of services, that's how I see it. Looking at how the services can assist a client's pathway through, be it social services care or health-care, so I guess integration of services, *all* services (LARI3: 3).

Whilst Armorshire Collaboration Social Care Lead Jill Thomas had told me that the complexities, bureaucracies, systems and standards of existing health and social care structures militated against sensible decision-making, she also hastened to add that, 'I think that integration is so important, because it breaks down that silo working, and people can start to make sensible decisions' (LARI9: 4). As for Bro-y-Grug GP Lead Dr David Lewis, he contended that integration was:

> ... something that I think we've got to try. And we don't know what the advantages will be until we've tried it. When we have tried it for a little

[43] Excerpt from official demonstrator-site DVD. Reference withheld to ensure anonymity.

> while – and that's probably going to be years rather than months – I hope we're going to be surprised by the number of benefits there will be (LARI5: 16).

In contrast with Ellen Rees, Claire Powell and Jill Thomas – who seemed convinced that integration would guarantee improvements in service-provision – Dr Lewis displayed a cautious optimism as to its potential benefits and argued, moreover, that these would only emerge over a period of years. In a similar vein, Ham and Walsh (2013) note that the experience of organisations that have made the transition from fragmentation to integration has shown this to be a long and arduous process and that leaders must therefore plan change over an appropriate timescale (of, they suggest, at least five years). Likewise, in a House of Commons Health Committee (2009) report into health inequalities, it was indicated that when policies involve complex collaborative interventions (as exemplified, it was noted, by the development of Health Action Zones and Sure Start), it, 'may take a long time for effects to be detectable' (2009, p. 30). But in the same report it was also noted (somewhat pessimistically) that such policies are often 'changed before the effect of the "first wave" can be identified' (2009, p. 30).

Notwithstanding the divergence in opinion as to whether integration would (inevitably) or might (hopefully) bring about improvements, it appeared that there was nonetheless agreement – at least amongst project leaders/senior managers – on a number of points. The first was that demographic and epidemiological developments (exacerbated by increasing budgetary pressures) had rendered existing health and social care systems and structures obsolete. The second was that systems and structures were therefore unsustainable in the long-term and had to change. The third was that central to this process of change was integration (considered by many to be facilitated by co-location). The fourth was that such integration was a core objective of the Armorshire Collaboration.

The importance of such consensus and of the recognition of common needs and issues in the development of integrated services was highlighted in a report of integrated care design and delivery (Integrated Care Network [ICN], Institute of Public Care [IPC] and Community Health Partnerships [CHP], 2010). The report combined: a review of academic literature, policy documentation and guidance

(published by the DH and various health, housing and social care organisations); interviews with stakeholders involved in supporting the development of integrated care at a national policy level; telephone interviews with commissioners, facilities/service managers, finance teams, providers (and associated partners) involved in developing and delivering integrated services; and in-depth case studies of four integrated services and facilities.

One of the report's four in-depth case studies examined the development of Salford's Walkden Centre, one of four local integrated centres (known as Gateway Centres) that were set up to provide a range of primary care and community services (ICN/IPC/CHP, 2010). The development of the Walkden Centre, the researchers reported, followed exploratory talks between the so-called 'Salford Partners'[44] and discussions between the NHS and local authority. These discussions helped establish that the same service users – whose needs were frequently inter-related – often accessed services from both organisations. Moreover, it was found that the NHS and locality authority shared a number of common needs/issues, namely: the renewal of health and community infrastructure; the provision of accessible services and awareness-raising of existing services; and the development of a so-called 'life-trigger' model for signposting and referral to different NHS and local authority services (ICN/IPC/CHP, 2010).

Accordingly, planning-stage collaboration with the local Manchester, Salford and Trafford LIFT Company helped representatives from the NHS and local authority recognise that by working in partnership and integrating services (where possible) they could target their shared audience more effectively and achieve economies of scale to provide better and more appropriate infrastructure, thereby leading to the development of the Gateway Centres. Opening in 2008, the Walkden Centre's services included: a drop-in service for housing and council tax benefit and advice and information on other council services; community and public meeting rooms for use by local groups and organisations providing community services; a dental

[44] Namely, Salford Royal Hospitals NHS Trust; the NHS North West Executive; Salford and Trafford Health authority; Salford City Council; the University of Manchester; Salford Community Health Care NHS Trust; Salford East/West Primary Care groups.

surgery; a GP surgery; physiotherapy services; access to a district nursing team; and other health services such as audiology, orthoptics and occupational therapy.

Arguably, therefore, the fact that – as with the development of the Walkden Centre – the Armorshire Collaboration was also spearheaded by project leaders who recognised a set of common needs and issues boded well for the development of the new CCM service. In the next section, moreover, I explore the way in which an understanding of the need for service integration had been established in Armorshire long before the launch of the demonstrator project.

Longstanding relationships

Whilst I have so far explained that common issues identified by a number of project leaders included fragmentation, duplication, wastage and inefficiency, I have also noted that there was consensus that the solution to the problems was to be found in integration. However, when I interviewed Bro-y-Grug LLT Social Care Lead Gwyn Evans, he told me that:

> I've been working within social services since 1991, and even then there were 'buzz-words', you know, enablement, empowerment. But one of the big 'buzz-words' was integration and everyone was talking about integrating with health and that social care should integrate with health. Well, that's nineteen years ago. But in reality, I would imagine that if Ernest Donald was here, the Director [of Armorshire social services] now, he'd probably say: 'Well, yeah, they were saying that in the 1970s too' (LARI1:1).

It therefore transpired that integration was not only seen as the solution to existing problems (engendered by demographic and epidemiological change) but that it had already been the subject of intense interest in Armorshire for many years. With Gwyn arguing that since 1991 it had been a major health and social care 'buzz-word', it is of note that the apparently intense interest in integration in the Armorshire of that time (and before) seemed to have continued into the ensuing decade (and beyond). For example, during my interview with Armorshire Clinical Programme Lead for Long Term Conditions and Community Dr Lawrence Morgan, he stressed that:

> My role has been there right from the very start, as part of the Services for Older People Planning Group back in the year 2000, with a member of the fledgling Local Health Board and a couple of the adult services managers

> from the local authority. Elizabeth [Jones] was with me all the way through. We set up a 'Services for Older People Planning Group' and it was at that time we talked about comprehensive assessment of the frail in the community and looking after people in the community and came up with the concept of what we eventually called Llawfon, which was a team of combined health and local authority staff (LARI12: 1).

The origins of Llawfon could therefore be traced back to an understanding of the need for combined community health and social care for older people that had emerged during discussions in a forum – the 'Services for Older People Planning Group' – which was itself premised on improved joint-working. Moreover, just as Dr Morgan stressed that Elizabeth Jones – Armorshire Collaboration Secondary Care Lead – was involved from the outset, he went on to explain that:

> Elizabeth and I went to each of the surgeries, spoke to all of the general practitioners, we spoke to the staff working in the Cwm Coch area and we set up a pilot project. The pilot project showed that what we were doing was providing a great deal of benefit, which was efficient and decreasing hospital admissions and improving hospital discharge. It was from that pilot that we eventually moved it out to cover Cwm Glas, we moved out to cover Llanivain, I think. Then we were waiting for the Tregwen general practitioners to say, 'Well, why have they got that in Llannuon, why can't we have it in Tregwen?' Basically, that's the way it just slowly spread out through Armorshire until we had a pretty equitable service (LARI12: 2).

Thus, in addition to their involvement in preliminary discussions for the creation of a comprehensive and combined health and social care service, Dr Morgan and Elizabeth Jones had also visited GP surgeries (as well as calling on other staff) in order to garner support for the new proposals. Whilst their direct approach seemed to have encouraged participation in the pilot project, the latter had proved so successful, Dr Morgan explained, that the service had been gradually rolled-out across the whole of the county (to become the Llawfon Reablement Service). When I interviewed Elizabeth Jones, she described the impact on her thinking of another of her first-hand experiences:

> I have got a passion for community services, so I probably get more involved than I need to, because I actually believe what we're doing is the right thing: to integrate across health and social care. Because many years ago I went to a workshop with the public where, when we were talking about, "What do you think about health and social services?", they told us *then*, "We thought you were working together"; they told us *then*, "Why aren't you sharing information?"; they told us *then*, "I've got six people coming in to see my mother at all times of the day and I don't know what makes sense and I get

> conflicting views"; we were told *then*, 'We're very confused as to what we get free and what we have to be means-tested for'. I've never forgotten all of that, and that's six or ten years ago. And that many years on we're still not there (LARI10: 3).

Elizabeth's professed passion for community services and apparent desire for practical involvement had therefore seen her engage not only with front-line health-care professionals (in the guise of GPs and staff during groundwork for the Llawfon pilot project) but also with 'the public' (in the guise of informal carers during the workshop). Just as the experience of the workshop had apprised Elizabeth of the difficulties facing those arranging the provision of health and social care for their (older) loved ones, it also seemed to have consolidated a belief in integration that had begun with her work – carried out in partnership with Dr Morgan – in the development of the Older People Planning Group and the Llawfon Reablement Team.

In the opening section of this chapter, 'Building on the past', I drew attention to Cameron et al.'s (2006a) indication that new partnerships can benefit from being anchored within existing services. It is therefore perhaps apposite to highlight Cameron et al.'s (2006a) analogous suggestion that partnership-working also benefits from being anchored within existing relationships (akin, presumably, to the one that existed between Dr Morgan and Elizabeth Jones) and that the idea to work together often develops within a small group of professionals who, over time, have identified a problem or a gap in service provision. In this respect, a parallel can be drawn with the National Evaluation of the Department of Health's Integrated Care Pilots (Rand Europe and Ernst and Young, 2012). This was a project premised on exploring a variety of approaches to integrated care, with interventions including: integrated/multidisciplinary teams; multidisciplinary meetings; virtual wards (maintained through a key worker); and case management. Each of the sixteen pilots focused on a particular client group, including people living with long-term conditions, older people living with long-term conditions at risk of hospital admission, people living with chronic obstructive pulmonary disease (COPD) and people living with cardiovascular disease (CVD).

The evaluation utilised a mixed methods approach, comprising: semi-structured questions (in the form of a common template) of staff perceptions of facilitators/barriers to progress (carried out six times at each site by a lead staff member); semi-structured interviews (n=213) with managers and clinicians (at six of the sites); non-participant observation; document reviews; patient/service user surveys (n=700); staff surveys (n=350); and database and cost analysis. Not only were good relationships between individuals identified as an important factor in making early progress with pilot implementation, the existence of continuous and planned communication between senior level executives in partner organisations was widely recognised as promoting developmental momentum and the joint addressing of challenges. Returning to Armorshire, just as a local belief in – and understanding of – the benefits of greater integration had existed in Armorshire for a number of years, relationships forged at this time appeared to have helped pave the way for new services and for the establishment of a fertile environment into which the demonstrator project could be launched. In the next section I examine how a specific conceptualisation of integration – namely one built on the prioritisation of clients – was espoused by two key stakeholders.

A service user focus: leadership and sharing the vision

During my interview with Armorshire Collaboration Secondary Care Lead Elizabeth Jones, she had told me that her awareness of the importance of integration had been fostered by engagement with informal carers. Later on during the interview, when I asked her what integration meant to her, she replied that:

> It means first of all, that the patient or the client is at the front. Not my profession, not my job, it's the client, the patient at the front and we all respect each other for whatever role we bring to the table. And more than that, we respect each others' decisions. So, because you've done an assessment, I will not need to do mine. As long as there's a link in there, a professional link in there, I can respect your judgement on it. That, for me, is true integrated working (LARI10: 4).

Just as Elizabeth's first-hand experience had helped crystallise a particular conceptualisation of integration that was rooted in the prioritisation of clients, when I interviewed Armorshire Collaboration Social Care Lead Jill Thomas, she told me that her guiding principle was:

> ...walk a day in the shoes of the service user. If you can see things from the perspective of the service user, I think it makes sense of how you organise services. That's the bit for me that's key to that: that actually, the service user, I don't think, really cares who comes in through the front-door, providing they come at the right time and they actually deliver services to the right standard. I don't think they really mind who the employing authority is, as long as the standard of care is good (LARI9: 4).

Positing that the key to the sensible organisation of services was an understanding of the perspective of service users, Jill suggested that the latter attached greater importance to quality and timing of care than to either the agent of delivery (presumably, meaning irrespective of whether it was a health care or social care professional) or to the employing authority (presumably, meaning whether it was the NHS or local authority). On the one hand, Jill's comments appeared to be borne out by empirical research. For, example, in their report into older people's definitions of quality services, Qureshi and Henwood (2000) indicated that service users frequently identified competence of staff and continuity of care and staff as important features of quality care. On the other hand, however, I found no evidence that people living with chronic conditions in Armorshire had been asked *their* views on the quality of care during the reconfiguration of services.

The latter is a subject to which I return in more detail in Chapter Seven, when I examine client and informal carer involvement and engagement in the co-design of services. At this juncture, however, it is perhaps worth remembering that whilst Jill Thomas had already told me that the complexities of existing health and social care structures had helped create silos and prevent sensible decision-making, she had gone on to explain that this was why she believed that integration was so important. Moreover, just as Elizabeth Jones attributed *her* belief in (and understanding of) integration to direct engagement with informal carers, Jill in turn explained that *her* conviction – that integration equated to the prioritisation of the client perspective – was also the result of first-hand experience.

Thus, Jill told me of her home-visit with a district nurse to a man living with peripheral vascular disease and severely ulcerated legs who was also awaiting hip-replacement surgery. Explaining that the procedure could only go ahead once the leg ulcers were fully healed, Jill pointed out that this would require ongoing health *and*

social care input that would be provided, respectively, by nurses from the Local Health Board and social carers from the local authority. However, Jill foresaw disagreement between the two organisations in terms of whose responsibility it would be to fund the necessary care. This, she warned, would cause a delay in the provision of that care, which would in turn delay the healing process and the hip-replacement surgery, thereby compromising the man's already limited mobility. Suggesting that any further deterioration in the state of the ulcers or hip might necessitate a costly hospital admittance, Jill concluded that a lack of integrated working (due to the divisions in funding mechanisms) would impact on the man's wellbeing as well as the care system's straitened resources.

It was therefore due to Jill Thomas' first-hand insight into client-care that her conceptualisation of integration equated to the prioritisation of the client-perspective, just as it was due to Elizabeth Jones' first-hand insight into the problems faced by informal carers that *her* conceptualisation thereof equated to the prioritisation of clients. In this regard, it is of note that although there is agreement that complex-care (including chronic conditions management) is better organised by means of integration, there is little consensus regarding the latter's precise meaning (Goodwin et al., 2012). Nor, indeed, is there consensus as to the meaning of integrated *care* (Kodner and Spreeuwenberg, 2002). Although I examined these definitional issues in some detail in Chapter Two (see, section 'The language of integration') it is perhaps worth re-emphasising a seminal distinction between the two: namely, that integrated care, on the one hand, has been defined as 'an organising *principle* for care delivery with the aim of improving *patient care* through better coordination [my emphases]' (Shaw et al., 2011, p. 7); whereas integration, on the other hand, has been defined as, 'the combined set of *methods, processes* and *models* that seek to bring about this better coordination [my emphases]' (Shaw et al., 2011, p. 7).

Returning to the views expressed by both Jill and Elizabeth – and taking into account their respective positions as Social Care Lead and Secondary Care Lead of the Armorshire Collaboration – one could argue that their (analogous) conceptualisations could be assimilated with Shaw et al.'s (2011) definition of integrated *care* (not integration) inasmuch as they described a governing principle (namely, the prioritisation of clients) rather than the way this would be achieved.

Whilst both Elizabeth and Jill therefore appeared to be at pains to explain that integrated working should be based on client-needs, their descriptions of the *mechanisms* by which the voice of clients (and indeed, informal carers) would be heard were, I felt, conspicuous by their absence.

As my research progressed, however, the reason for this silence became clear, as I found no evidence that clients or informal carers had been involved in the creation of the new CCM service. Whilst this is a subject to which I return in more detail in Chapter Seven, at this point it is of note that just as Elizabeth and Jill shared similar conceptualisations of integrated care, Goodwin et al. (2012) suggest that amongst the latter's 'key elements' (2012, p. 11) are 'leadership' and the building of a 'common vision' (2012, p. 14). In a similar, vein, Elizabeth Jones told me that:

> My role has been that as being a leader who's meant to set the vision and monitor its development. I'm not operationally-based any more. As the County Director, I'm not an operational person, and yet the delivery of services is my responsibility. So it's been about setting the time-scales, it's been about setting the agenda, it's been about, 'How do I use my skills to work with different people at different levels to get them engaged in the process?' (LARI10: 6).

Whilst Elizabeth posited that leading, setting 'the vision' and monitoring its development involved drawing on her own skills, her involvement in earlier projects appeared to indicate that these skills encompassed facilitative know-how (inasmuch as she had helped set up the 'Services for Older People Planning Group') and communicational proficiency (inasmuch as she had helped canvass the support of local stakeholders for the Llawfon Reablement Team). Just as Paton and McCalman (2008) suggest that such communicational and facilitative skills are essential qualities for people involved in the management of change, so they add that knowledge of the rationale for the suggested change is also a pre-requisite.

In this respect, Elizabeth's earlier experience with the Llawfon team appeared to have helped crystallise a rationale – and thence a 'vision' – for change that was based on integrated working and the prioritisation of clients. Whilst Gill (2006, p. 98) suggests that a vision, 'defines what or where the organisation wants or needs to be', he adds that both academic research and practical experience (from business leaders) indicate that the existence of a 'clear vision' is essential to the success and

survival of an organisation. Although Spicker (2012, p. 34) suggests that the concept of leadership is so replete with definitions, models and ambiguities that it is, 'perniciously vague', Martin et al. (2010) posit that in the field of health and social care, leadership is the way in which senior managers set out organisational strategy by describing goals, inspiring people to work towards them, providing inspiration and developing a vision.

According to Mullins (2013), the generation of an organisational vision is a key element of transformational leadership. The latter, Barr and Dowding (2012) indicate, encompasses various theories of leadership which view leaders as people who motivate others to perform by encouraging them to see a vision (as contrasted with transactional leadership, which according to Mullins [2013] is based on legitimate authority within the bureaucratic structure of the organisation, and emphasises the clarification of goals, objectives and of tasks and outcomes, and rewards and punishments). As regards the complex and fluctuating environment into which the Armorshire Collaboration was launched (including plans for a radical overhaul of CCM services) it is perhaps helpful to note that whilst Bass (1985) suggests that transactional leadership is appropriate to situations of stability, he argues that transformational leadership, conversely, is better suited to times of significant organisational change.

As regards the Armorshire Collaboration, Elizabeth Jones suggested that her role as Secondary Care Lead involved *setting* the vision, just as Barr and Dowding (2012, p. 199) note that the identification of a healthcare vision is essential if organisations are to, 'drive their people to the same outcome to meet demand'. Similarly, Social Care Lead Jill Thomas (whose own vision, it appeared, was based on a similar belief-system and rationale) told me that:

> I would put money on it that most people who work in my division know what my expectations are and know what the vision is and know what we're striving for. It's hugely important, just being able to describe the vision and hold firm in times of adversity (LARI9: 5).

Wagering that her vision was widely understood by people in her division, the latter, presumably, comprised a wide range of managers and front-line professionals from community, primary *and* social care (given that Jill was also Armorshire Head of

Integrated Services across all three areas). With Jill stressing that the ability to describe the vision to this (professionally diverse) audience was 'hugely important', it is, arguably, of note that whilst transformational leadership involves the *creation* of a vision, Gopee and Jalloway (2014) note that this is with the objective of generating employees' commitment to this vision.

Crosby and Bryson (2005) contend that the shaping of meaning of public problems and the gaining of commitment to proposed solutions is facilitated by 'visionary leadership' when situations involve 'shared-power arrangements' (such as partnerships, coalitions and collaborations). In this regard, one could argue that the Armorshire Collaboration was built on a similar sharing of power, inasmuch as it drew on a number of different bodies to help co-ordinate the project, and that these would facilitate – not mandate – joint-working across health and social care. The status of the Local Service Board, for instance, was not that of a statutory body but, 'an expression of engaged public service leadership locally' (WG, 2012, p. 4). Without the more formal systems of intra-organisational relations that exist with a common management hierarchy, it appeared that the Armorshire Collaboration instead looked to 'looser framed' inter-organisational arrangements (Weick, 1979) and utilised different forms of 'virtual' integration to exploit existing links and networks. This included a range of agencies, organisations and professional groups at national, regional and local levels (NHS Wales/CCM Demonstrators, 2009). Bringing into play the 'multisectoral co-operation' that is considered to play a key role in meeting the needs of people living with chronic conditions (WHO, 2005, p. 129) the National CCM Demonstrator Programme was therefore built on national and local support and collaboration.

Just as Crosby and Bryson (2005) suggest that within such shared-power arrangements 'visionary leaders' create and communicate meaning about historical and current events and prospects for the future, it appeared that Elizabeth and Jill drew on their (historical) experience of service fragmentation to justify their (future) vision of client-focussed integrated care. An important point, arguably, given that Petch (2014, p. 5) notes that:

> Those who embark on the delivery of integrated care and support need to be led by a vision; there needs to be a sense of purpose and a logic for required

> action and change. Integration cannot be an end in itself; it must be for a purpose. Successful delivery of integrated care and support requires a commitment to and a belief in a goal to be achieved.

Whilst the vision, as far and Elizabeth and Jill were concerned, was to build services around clients (and their perspectives) Crosby and Bryson (2005) contend that visionary leaders' effectiveness is also contingent on the provision of direction in situations of uncertainty and difficulty (as was the case for the Amorshire Collaboration, set as it was against a backdrop of demographic and epidemiological flux and economic unease). Whilst Williams (2012) adds that in the development of a common and shared purpose –which he posits, is a basic building-block of collaboration – the articulation of 'key values' and of 'visioning' figure prominently, similar remarks have been made in empirical research. Giordano et al. (2011), for instance, reported on England's twelve Whole System Demonstrator Action Network (WSDAN) sites. One of the key aims of the latter – which were, typically, composed of a primary care trust (PCT) and a local authority – was to examine and assess the impact of new programmes of telecare and telehealth[45]. (As part of its focus on Information Management and Technology, telehealth/telecare was also one of the specific areas of interest of the Armorshire Collaboration [NHS Wales/CCM Demonstrators, 2009]).

In their qualitative study (focussing on the experiences of middle and senior managers responsible for assistive technology, older people's services, the management of care of people living with long-term conditions, and commissioning) Giordano et al. (2011) observed meetings at the WSDAN sites and the Department of Health and (unspecified) regional conferences. In addition, they used interactive audience polling (carried out at the regional conferences) to chart each site's progress and to examine challenges and barriers to the implementation of telehealth and telecare. Subsequently, notes and polls from the meetings/events were used to construct SWOT (strengths, weaknesses, opportunities, threats) parameters which were incorporated into an online survey sent to participants at each site.

[45] Telehealth (remote care)**:** electronic sensors or equipment that monitors vital health signs remotely. Readings are automatically transmitted to an appropriately trained person who monitors health and vital signs and makes decisions about potential interventions. Telecare: personal and environmental sensors in the home that enable people to remain safe and independent in their own home for longer; includes 24 hour monitoring (see DH, 2011).

The survey asked project participants to select a parameter (such as 'innovative ways of working' or 'data management') and to categorise it according to the SWOT criteria, thereby eliciting how stakeholders interpreted the events and challenges and enablers that they identified during the running of the programmes. This was used both to gain an understanding of the projects and as a means of engaging participants to discuss their experiences further (in focus groups). There were eight responses to the online survey from health care staff and six from social care staff (across all twelve sites) following which focus groups (numbers/roles unspecified) were run at six sites, selected to ensure a variety of size and an urban/rural split.

Whilst one of the three 'key themes' that emerged from the research was the importance of leadership and management, one of the 'key factors' that was identified as being fundamental, 'to building collaboration' and to, 'gaining support from multiple stakeholders' was that organisational leaders had a clear vision of telehealth and telecare, and that they could share this vision with employees. Moreover, it was noted that where such leadership existed, 'communication and co-ordination between health and social care organisations was excellent and ongoing' (Giordano et al., 2011, p. 8). Returning to Armorshire, not only did two senior leaders of the demonstrator project share a belief that integrated working should prioritise clients, it appeared that they both considered that one of their key roles within the Armorshire Collaboration was to share this vision. In the next section, I examine the extent to which this vision was shared by other project leaders.

Champions of change, collective support

I have already explained that a number of stakeholders who were involved in leading the Armorshire Collaboration reported that health and social care systems were no longer fit for purpose and that greater integration was required to remedy the situation. Whilst Elizabeth Jones indicated that she believed in integration that placed clients 'at the front', when I interviewed Project Manager Jo Marshall, she told me that:

> I think it's good that we've been able to be as responsive as we have. A lot of that, I think, is because I've been very lucky in Armorshire to be very

> ‘hooked-in’ to middle and senior management and understand the direction of travel and ensure that we are aligned to it. That is tantamount to it all coming together now, with the whole way that Elizabeth Jones – the County Director – is wanting to take things. What was lovely in the last Joint Leadership Group was her saying: ‘We’ve got all the people around the table that I need – as County Director – to make this step-change’ (LARI2: 6).

Given Elizabeth Jones’ strong personal views on the matter, it would seem safe to assume that the step-change to which she referred would be predicated on her own client-centred ‘vision’ of integration and, considering her conviction that the right people were in place to accomplish this, that the vision was shared by the other members of the Joint Leadership Group. The latter was a monthly forum whereby Project Manager Jo Marshall, Armorshire CDM Nurse Lead Anne Richards, the nine core-members of the three Armorshire LLTs and their three Locality Care Co-ordinators – plus various *ad hoc* attendees – could discuss the development of the Armorshire Collaboration in their respective localities. As regards the client-focussed vision and the three members of the Bro-y-Grug LLT, Bro-y-Grug Social Care Lead Gwyn Evans told me that:

> Since I’ve been in any situation where I could influence things, my driver has always been that we need to streamline things, integrate in order to ensure that services are better for people (LARI1: 1).

Just as Bro-y-Grug District Nurse Lead Janice Davis felt that integration would be:

> …an extension of what I’ve always done, which, to me, can only enhance the care that we give. I would hope that they [service users] would just see an improved efficiency within the service, and hopefully lose some of the anonymity that they may experience (LARI4: 9).

Whilst Bro-y-Grug GP Lead Dr David Lewis indicated that:

> Ending up on a long-stay bed in a geriatric ward is a poor outcome, so anything that addresses that for the patients who are coming there – [for example] managing somebody at home – is better (LARI5: 9).

As for Bro-y-Grug Locality Care Co-ordinator Christine Thompson, she explained that integration would, in theory, mean that:

> … the people that were looking after me knew what was up with me. They wouldn’t just have snippets of my condition, they’d look at me as a whole person (LARI3: 6).

With project leaders in the Bro-y-Grug locality agreeing that the goal of integration was to benefit clients, the same was true (as I have already explained) of those of the Joint Locality Group's *ad hoc* attendees whom I have already introduced, such as Armorshire Clinical Programme Lead for Long Term Conditions and Community, Dr Lawrence Morgan and Social Care Lead Jill Thomas, not to mention Elizabeth Jones herself. As for Anne Richards and Jo Marshall, the former told me that:

> Integrated working: I think it just means bringing a load of different disciplines together and us all being able to share information together so that the needs of the patient/client are met (LARI6: 2).

The latter, in turn, told me that integration equated to, 'bringing together people from different disciplines so that they can do their bit of the meeting the needs of people' (LARI2: 7). And just as there was widespread consensus amongst Armorshire Collaboration project leaders (whether they had county-wide or Bro-y-Grug-wide responsibilities; whether they were clinical or non-clinical; and whether they were from health care or social care) that the objective of integration was to benefit clients, so it was indicated in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 31) that, 'champions and local innovators will need to be identified and supported to lead the change'. As for the National CCM Demonstrator Programme, it was indicated in *The National Chronic Conditions Management (CCM) Demonstrator Project: Progress and Achievements in the First Twelve Months* (WAG, 2009a, p. 13) that, 'Engaging the support of clinical and non-clinical "champions" is essential in the process of change and improvement'. In the Armorshire Collaboration PID (App. 9), finally, it was indicated that one of the critical success factors of the project would be the identification of, 'clinical and social care professional champions'.

Whilst Bryson et al. (2006, p. 47) define champions (of collaborative working) as the people who, 'focus intently on keeping the collaboration going and use process skills to help the collaboration accomplish its goals', as early as 1963 Schon remarked that, 'Where radical innovation is concerned, the emergence of a champion is required' (1963, p. 84). Noting that in the field of healthcare, champions have long been looked upon as a key feature of organisational change, Hendy and Barlow (2012) add that (just like transformational leaders) a major part of the role of champions is to influence and facilitate change in others. Moreover, just as a report into social and

health care integration in the UK (Association of Directors of Adult Social Services [ADSS]/Association of Directors of Social Work/ADSS Wales/ADSS Northern Ireland, 2013) drew attention to the need to identify the people within organisations who are capable of translating policy to grassroots change and then to engage them as champions, the key role of champions in partnership working in health and social care has been likewise indicated in empirical research.

A National Leadership and Innovation Agency for Healthcare (NLIAH)/Care Council for Wales (CCW) report on joint-working between health and social care (NLIAH/CCW, 2010), for example, provided many examples of good practice submitted by local authorities and LHBs across Wales. These included reports on some thirty local projects, including: a joint community drug and alcohol team; a joint community mental-health team; an integrated community equipment service; an integrated community intermediate care team; a learning disability service and an HSCWB Partnership. A report submitted by the Betsi Cadwaladr University Health Board detailed Prestatyn's 'Hafan Lles' project, an integrated, co-located health and social care service made up of: district nurses, social workers, occupational therapists, housing wardens, health and social care support workers, practice pharmacists, an Exercise Referral Scheme Officer, and an Older People's Strategy Development Officer. The aim of the service was to improve access and continuity of care for local residents through the provision of services in their own homes (or close-by) and to facilitate greater integration between the four stakeholder GP practices, secondary care, community services, local authority services and the voluntary/third sector. A 'key to success' of the project was the establishment of 'champions' in each of the key service areas (NLIAH/CCW, 2010, p. 15).

The role played by champions of change was also highlighted in Hudson et al.'s (1997) case study of joint-working across primary health care and social care boundaries in five localities. As a result of their work, the researchers developed a 'collaborative continuum' to describe the interface between primary care and social care. Based on the extent to which integration and trust existed, the researchers isolated four points on the collaborative continuum, with (at the lowest level) 'isolation/encounter', then 'communication', followed by 'collaboration' and (at the highest level) 'integration'. Subsequently, the researchers identified a number of

choices and options which often characterise partnership-working, listing these as the 'juxtaposition of alternatives'. The first of these juxtapositions examined the extent to which change was catalysed by organisational shift or individual entrepreneurialism, with the latter focussing on the extent to which developments were contingent on champions of change.

Again, Hudson et al. (1997) referred to the key role in the development of partnership-working that can be played by champions. At the same time, the researchers also found that it was possible for the latter to be expressly appointed or simply to emerge – or indeed disappear – as projects developed. It is therefore perhaps important to note that the forum (the Joint Leadership Group meeting) at which Elizabeth Jones announced that she had around her the people – or champions – who could make the required step-change (presumably based on her vision of a client-centred service) only came into existence (or emerged) because of the break-up (or disappearance) of the Armorshire Collaboration's original structure and subsequent replacement by the three LLTs.

As I explained at the end of Chapter Four, however, the Bro-y-Grug LLT was only inaugurated in November 2009 (over twenty months after the project's launch) with the Bro-y-Grug Locality Care Co-ordinator Christine Thompson only appointed at the end of August. Furthermore, judging by the date of my interview with Jo Marshall (June 2010), Elizabeth's comments were, in all likelihood, made during the Joint Leadership Group's May 2010 meeting. Whilst at this time Elizabeth saw fit to draw attention to the fact that the right people were now in place to take forward the 'step-change', the inference seemed to be, arguably, that hitherto this had not been the case. Given that the new Community Resource Teams were to be inaugurated by the following September, this appeared to leave precious little time to incorporate Elizabeth's client-centred vision into the reconfiguration of services.

On the one hand, therefore, there appeared to be strong support across Armorshire for the creation of a new integrated service that would be premised on the prioritisation of clients, whilst a Bro-y-Grug LLT had been set up whose three core-members (plus its Locality Care Co-ordinator) would be able, in theory, to champion the vision of integration. On the other hand, however, not only had it taken over half

of the three-year duration of the demonstrator project to find these local champions, the time that was left to set up the new CCM service was fast running out. Whilst I explore these issues in more detail in the next chapter, I conclude with a brief summary of the themes explored in the present chapter.

Summary

In this chapter, I examined the perspectives of Armorshire Collaboration project leaders prior to the reconfiguration of services. I explained that, amidst agreement that existing services were of high quality, there was consensus that structures were no longer fit for purpose and that change was essential. Just as I also reported that a number of project leaders suggested that isolated and fragmented services meant that services for people living with chronic conditions were inefficient, I noted that the same people believed that the solution to the problem lay in integration. Subsequently, I explained that the desire for integration pre-dated the launch of the Armorshire Collaboration, whilst reporting the involvement of the latter's senior representative from secondary care in a number of earlier projects that incorporated elements of partnership-working. I explained how the same stakeholder shared a vision of integration that was based on the prioritisation of clients (and their perspectives) with the Armorshire Collaboration's senior representative from social care. Finally, I explained that although this vision was espoused by a number of other key leadership stakeholders, these champions were only identified – and appointed to their various roles – when the project was over half-way through. In Chapter Six, I explore the development of the vision of integrated working as described by project leaders prior to the reconfiguration of services. I pay particular attention to the repercussions – during a period of socio-economic flux and uncertainty – of the ambiguity and lack of clarity and consistency that characterised the development of the Armorshire Collaboration.

Chapter 6: Flux, ambiguity and time-pressures: the impact on the Armorshire Collaboration

Introduction

In the previous chapter, I discussed project leaders' views of health and social care provision for people living with chronic conditions prior to the launch of the new CCM service. In this chapter, I examine the Armorshire Collaboration as a catalyst for change and contrast this with significant time-delays that impacted on the development of the new CCM service. I consider contextual issues such as rising numbers of older people living with chronic conditions and the financial constraints that surrounded the Armorshire Collaboration. I describe how the belated arrival of a new strategy engendered ambiguity *vis-à-vis* the project's aims and contrast the advocacy of linguistic clarity and consistency with ambiguous language and terminological flux. I examine the project's original organisational structure and its subsequent replacement, and contrast the contextual challenges facing local project leaders with the Welsh Government's desire for rapid change. I end the chapter by describing how a project premised on a locality approach appeared to have been directed from the top down.

'Accelerated learning': the demonstrator as a catalyst for change

Although the Armorshire Collaboration was inaugurated in March 2008, the new CCM service for people living with chronic conditions in Bro-y-Grug was not launched until the end of September, 2010, by which time approximately thirty months of the thirty-six month project had already elapsed. During my interview with Armorshire CDM Nurse Lead Anne Richards, however, she told me that:

> All the demonstrator is there for is to move things quicker and have them established to show, elsewhere, whether they will work or not (LARI6: 1).

Anne was not the only project leader who spoke of the Armorshire Collaboration in catalytic terms. Having described her long-standing belief in client-centred integration and her core role in the creation of the Llawfon Reablement Team, Secondary Care Lead Elizabeth Jones also told me that the project:

> ...gave us that focus that we would not have had otherwise. So, for me, the Collaboration has allowed us to fast-track our thinking and our arrangements.

> We wouldn't be where we are today. People would still be talking about it, because people wouldn't have had time to do it (LARI10: 5).

When I interviewed Gwyn Evans – erstwhile manager of Llawfon and now Bro-y-Grug Social Care Area Manager and LLT Social Care Lead – he too outlined his fundamental belief in health and social care integration. Stressing that his views were shared by many of his social care colleagues, he nonetheless indicated that integration had thus far proved an elusive goal. But when I asked Gwyn how this had been affected by Armorshire's involvement in the National CCM Demonstrator Programme, he replied:

> It's something that would have happened regardless, but maybe wouldn't have happened as quickly and not with the same impetus, you know? It's the push, and it's actually giving us the opportunity to do it, because we've all got our day-jobs, we're all busy (LARI1: 2).

The speed of change, presumably, would be key to the 'accelerated learning' (WAG, 2009a, p. 5) that was central to the National CCM Demonstrator Programme's pedagogical aims. Hence, it was indicated in *CCM Demonstrator Learning Paper 6* (NHS Wales/CCM Demonstrators, 2009c, p. 2) that the demonstrators had been established to, 'test in advance of others, so that what works (and what does not) can be learnt and shared'. In a similar vein, in *Chronic Conditions Management: Compendium of Information from across* Wales (NLIAH, 2010, p. 9), it was noted that the demonstrators would carry out, 'advanced learning/testing of elements of [the] CCM Model and Framework'. Just as Project Manager Jo Marshall, likewise, told me that the demonstrators had been set up to 'future-proof the implementation of the Model and Framework' (LARI2: 5), in *CCM Demonstrator Learning Paper 11* (NHS Wales/CCM Demonstrators 2009d, p. 1) it was indicated that:

> ....applying the practical and operational interpretation of elements and the 'whole' of the CCM Model in a real life setting will benefit and *save time* [my emphasis] for non-demonstrators needing to develop, test and understand the Model in their areas. Further testing and evaluation of specific elements of the Model will mean that this does not need to be done elsewhere.

There was therefore some consensus – at Wales-wide and local level – that the demonstrators had been launched: to test the elements of the Welsh CCM Model; to ascertain the extent to which these elements did or did not work; and to share what

had been learned with the non-demonstrator areas of the country. On the one hand, therefore, the fact that the Armorshire Collaboration had, according to local project leaders, sped up the process of change would, in theory, allow the ensuing learning to be shared rapidly with other parts of Wales. Presumably, this would help to implement the Welsh CCM Model quickly enough to meet the deadlines (detailed later in this section) as set out in the *Service Improvement Plan* (WAG, 2008). At the same time, however, it was stressed in *Chronic Conditions Management (CCM) Update: Issue 7* (WAG, 2008b, p. 2) that:

> The CCM Demonstrators are *not* [my emphasis] 'pilot' sites; they will provide a rich and diverse learning experience on applying strategic policy into practice and informing ongoing development across the rest of Wales.

If it was considered important enough to point out that the demonstrators were not pilots, it would seem appropriate to outline how demonstrators and pilots differ. According to Thabane et al. (2010) pilot studies, on the one hand, involve small-scale research projects used as feasibility studies to guide the planning of the broader implementation of an intervention. Brownson et al. (1998) explain that *demonstration* projects (a commonly used alternative term for *demonstrator* projects[46]), on the other hand, are typically large-scale and community-based, and serve to prepare the ground for the introduction of an intervention at the final stage of the progression and application of research (tantamount, arguably, to a 'fine-tuning' of the intervention in question). Brownson et al. (1998) further explain that demonstration projects are frequently run in complex multidimensional and collaborative settings and often combine 'high-risk' and 'population' strategies. The former, Brownson et al. (1998) point out, concentrate on those individuals who are most likely to develop adverse health outcomes. The latter, they add, are directed at entire populations with the goal of modifying the prevalence of risk factors.

In keeping with Brownson et al.'s (1998) description of archetypal health and social care demonstration projects, the National CCM Demonstrator Programme was large-scale (across three Welsh areas) and community-based; its focus was on

[46] The terms demonstrator/demonstration project appear to be used interchangeably in the literature. However, the latter term seems to be used far more frequently. On 06/08/12, for example, I conducted a combined search of health and social care databases including CINAHL, Emerald, HMIC (Ovid), MEDLINE (EBSCO), Social Care Online (SCIE), Web of Knowledge (ISI), Wiley InterScience and ASSIA using the terms 'demonstrator' and 'project' and 'demonstration' and 'project'. Whilst the former gave 3687 hits, the latter gave 93, 947.

collaboration (involving multiple statutory and voluntary organisations, informal carers and service users); and it involved the implementation of a framework of care (the Welsh CCM Model) premised on 'high risk management' (of people living with a chronic condition) and 'primary prevention and health promotion' (for the population at large) (WAG, 2007, p. 19). Furthermore, just as the objective of many demonstrator/demonstration projects seems to be the 'fine-tuning' of interventions immediately prior to large-scale implementation, so the Welsh Government, it would appear, considered the Welsh CCM Model all but ready for roll-out across the whole of Wales.

This belief was perhaps best illustrated by the dates – as set out in the *Service Improvement Plan* (WAG, 2008) – by which time preparatory measures for the introduction of the Welsh CCM Model (and one of its core elements) were to be in place across the country. In the document it was stipulated that: 'By September 2008 all LHBs will stratify the risks and individuals [*sic*] with chronic conditions in their population' (2008, p. 19); 'The CCM Local Action Plan will be developed by LHBs and their partners by April 2008' (2008, p 19); 'By April 2008 LHBs and NHS Trusts will have scoped out and reviewed current service provision in primary and community care and determined local actions' (2008, p. 19); and, 'All areas will have Core CCM Community Teams established as a basis of the CCM service by June 2010' (2008, p. 20).

But with the three CCM demonstrators launched to advance-test the Welsh CCM Model and to show the rest of the country the practicability of its core elements, it is of note that the Armorshire Collaboration was launched in March, 2008, the Gwengampshire Demonstrator in May, 2008 and the Penlevanshire Demonstrator in January 2009 (WAG, 2009a). Paradoxically, this meant that the April deadlines set out in the *Service Improvement Plan* (WAG, 2008) preceded the launch of all three demonstrators, with the September deadline synchronous with two of the three demonstrators' nascent phases (but preceding the launch of the third). As for the stipulation that by June 2010 there should be Wales-wide roll-out of the Welsh CCM Model's 'Core Community CCM Teams' (WAG, 2008, p. 20), this meant that two of the three demonstrators would have had to set up, test and evaluate their own Core Community CCM Teams – and then to have shared their learning with the rest of the

country – within little more than two years of project initiation (with the third demonstrator required to achieve the same objectives in approximately half the time).

By June 2010, however, there were no Core Community CCM Teams in Armorshire. Nor would there ever be, given that by this time the Welsh Government had replaced plans for the Wales-wide roll-out of the Core Community CCM Team model and replaced them with plans for the Wales-wide roll-out of the Community Resource Team (CRT) model, as announced in February 2010 in *Setting the Direction* (WAG, 2010). In the event, the Bro-y-Grug CRT would not be inaugurated until the end of September 2010, over thirty months after the Armorshire Collaboration's launch and with just six months of the project remaining. As I explain in the following section, however, this was not the first time that the Armorshire Collaboration had had to change course.

A complex contextual backdrop to the Armorshire Collaboration

The pre-existing environment into which the Armorshire Collaboration was launched appeared to comprise a challenging mix of complex demographic and epidemiological factors, national and local priorities, historical health and social care divisions and funding difficulties. In the last section, I referred to the expectation that participation in the National CCM Demonstrator Programme would accelerate the pace of change in Armorshire, but pointed out that the Bro-y-Grug CRT was only launched at the end of September 20l0. At the same time, however, I also noted that the introduction of the CRT model was not announced until February 2010. Although this change in strategy was made when the project had been running for nearly two years, when I interviewed Armorshire Collaboration Secondary Care Lead Elizabeth Jones, she told me that by this time the project had already shifted its objectives, and that:

> ... more than just chronic conditions, it's our frail elderly, our demographic time-bomb is *there*. What we've got is an increasing elderly population, so by the time they're as old as they are, they've got a chronic condition. So for me, the focus on chronic conditions, I've moved away from it, in a sense. These are our frail elderly, and of course they've got chronic conditions, whether it's dementia, respiratory, or whatever (LARI10: 6).

Elizabeth's reference to Armorshire's burgeoning population of older people and concomitant growth in numbers of people living with chronic conditions suggested that trends mirrored those found across the UK, Europe and indeed globally (see Chapter One, section 'Demographic change: increasing numbers of people living with chronic conditions'). According to Armorshire CDM Nurse Lead Anne Richards, the sheer scale of demographic and epidemiological change within the county meant that:

> If you're going to progress for chronic conditions, you have to look at community services as a whole, because if you go and look at patients who need community care, I would suggest at least ninety percent of them will have a chronic condition, because chronic conditions is a huge topic. I think that another one of our stumbling blocks is that there are so many different conditions that can fit inside, and how much you can do the same for everybody. You can do quite a lot the same for everybody to a certain point, but then what do you do after that? (LARI6: 2).

In order to put Anne's comments into perspective, it is perhaps helpful to relate the experiences of Bro-y-Grug resident Jeff Stephens. Jeff was husband and informal carer of Lisa, who had been living with multiple sclerosis for some thirty-five years. At the time of my interview with Jeff, Lisa was living with a host of complex social and health issues (which, in Jeff's view, made it impossible for me to interview her). Of these, Jeff explained, the most serious were Lisa's: limited mobility, difficulties with posture and balance and upper body and leg-weakness; her bladder and bowel problems; her speech and cognitive complications; and her emotional and psychological problems. Just as Anne Richards suggested that the development of chronic conditions care required a concomitant development of not just some, but all community services, Jeff told me that Lisa:

> ... gets two girls every morning, except for the weekends, who come and give Lisa a bed-bath, wash her hair, change the sheets, help her to eat her food sometimes if she needs it. She used to have a shower every morning as well, but because of the fact she had to sit in chairs and move over to it, the abscesses caused her problems, so they give her a bed-bath now…the District Nurse comes every day of the week, to change the dressing on her bottom. She's also got a suprapubic catheter, she has that replaced every six weeks…when she was in hospital last time, she developed deep-vein thrombosis, so she has warfarin, so they take her blood sample whenever the warfarin clinic want it...she had about three infections last year, which meant hospital visits…we had a physiotherapist came down to look at what I was doing, OK'd it all, and she's gone to get, I think it's called a T-brace, a brace

> for Lisa's legs...[also] a prevention team dealing with ulcers and suchlike, skin problems, they come out once every four to six weeks (ICI4: 1 – 2).

Illustrating how Lisa's needs affected many different area of both of their lives and spanned many different care services, Jeff's comments again served to illustrate the extent to which the management of chronic conditions can be viewed as one of society's archetypal 'wicked problems', those multidimensional, intractable and complex societal issues which have a propensity to cross professional boundaries, thereby necessitating a collaborative approach. Returning to Anne Richards' comments, it was, perhaps, this very complexity that lay behind her concluding rhetorical question, inasmuch as it hinted at the difficulties of providing the combination of specialist and generic services that people like Lisa invariably require.

Moreover, although Anne proceeded to explain that the main objective of the Armorshire Collaboration was to, 'put the patient in the middle' (LARI6: 2) she added that it was equally important that the new service was sufficiently 'robust' (LARI6: 5); robust, she explained, in terms of meeting the multifarious needs all of the (very many) people for whom care would be provided, and in terms of the prevention of unnecessary hospital admissions. But drawing together all of these factors, Anne stressed, required a detailed knowledge of the care needs of all local people and of the communities they lived in, together with a clear understanding – on the part of front-line practitioners from a variety of (allied) health and social care professions – of the rationale for the proposed reconfiguration of services.

According to Bro-y-Grug LLT District Nurse Lead Janice Davies, however, the process of engagement with front-line practitioners – and, indeed, the development of the entire project – had been affected by factors that were beyond the control of local stakeholders. Accordingly, she told me that:

> I think that the issues that have been discussed within the larger demonstrator project, it is slow, getting on top of problems and getting feedback, because we look at many complex issues. I don't think they are things that can be put right overnight. Certainly, in the case of continuing-care, a lot of directives come from central government or from the Welsh Assembly Government. So even though we are a demonstrator-site, you can't just change things when things are from the Welsh Assembly Government (LARI4: 2).

Appearing to infer that decisions made at central-government level had hampered the project's local development, Janice was not the only stakeholder whom I interviewed to use continuing-care as an example of a potential barrier to progress. On the contrary, this was part of what Armorshire Collaboration Social Care Lead Jill Thomas had dubbed the 'stumbling block' (LARI9: 2) of the funding-divide between health and social services. According to Jill, not only did this work against integration, it also created substantial (but unnecessary and unwarranted) delays in the provision of care. In turn, Jill noted, this had potentially far-reaching implications for clients living with chronic conditions, such as inappropriate and disempowering hospital stays.

Nor, indeed, was this the only instance of a central government-mandated directive that had, it would seem, militated against the collaborative ideals of the Armorshire Collaboration. On the contrary, the simultaneous launch of the Armorshire Falls Prevention Team had, for example, increased the number of 'stand-alone' services at the very time that local project leaders were seeking to create a single 'integrated' health and social care service. Returning to issues financial, however, not only did the funding-*divide* appear to be a sticking point, Bro-y-Grug Locality Care Co-ordinator Christine Thompson stressed that:

> The funding for the whole development of the CRT is appalling. Nobody wants to fund it. We won't stop looking for it yet, but at the moment we can't get funding, even to do the development of the CRT, let alone any new posts (LARI3:14).

Whilst it was beyond my scope to explore in any detail the funding of the Armorshire Collaboration, it is important to reiterate that £4.5 million had been made available to help the establishment of the three demonstrator-sites (WAO, 2008). Moreover, it was also indicated in *Chronic Conditions Management Briefing Sheet 1* (WAG/NHS Wales, 2008) that 'additional resources' would, *inter alia*, support transitional service change and IT infrastructural needs. Whilst Christine Thompson reported that no funding had been made available for the development of the CRT, it is perhaps important to remember that the backdrop to the Armorshire Collaboration seemed to provide a particularly striking example of health care's contextually 'heavy' nature. Hence, the financial shortages facing those involved in the

development of innovative approaches to health and social care worldwide had, in the meantime, been exacerbated in Armorshire (along with the rest of the UK) by the advent of stringent cuts to public expenditure as part of the 'austerity measures' of the Conservative/Liberal Democrat Coalition Government. These factors were not lost on Bro-y-Grug LLT District Nurse Lead Janice Davies:

> At the end of the day, development of a new service means investment, and obviously in the current financial climate that's not always easy (LARI4: 2).

Nor had the situation escaped the attention of front-line professionals, with occupational therapist Paula Davis stressing – during the first focus group – that:

> We are having a financial crisis, and the cost of fuel is increasing. There's talk about our mileage being reduced. So it's cost-efficiency, you know, it's difficult and it's challenging isn't it? (FPFG1: 12).

Financial issues had not gone unnoticed by local people living with chronic conditions and their informal carers either. On the contrary, during my interview with informal carer Jeff Stephens, having described the wide range of weekday community health and social care services available to his wife Lisa, he explained that until recently he had provided for all of her weekend care-needs himself. He went on to point out that:

> Getting old is the pits. You find things are a bit more difficult, and I can't give her a real full bed-bath, because I have to pull her over myself, and push her back. So at the weekends, I just wash her hands and her face. But I've now asked if the girls can come at the weekend as well, to give me that added extra help, so I know she's getting a proper wash and a change. I've asked for two more days. It's quite a while ago since I asked, but somebody rang me a couple of days ago and said they are still looking into it. I think it's the financial side of it that they're more concerned about these days. To extend it means they've got to pay the girls more (ICI4: 1).

Financial pressures were also referred to by Hilda Jenkins. Having suffered a stroke, 'the weekend that Princess Diana was killed' ([CLI5: 11]; that is, the weekend of August 30 – 31, 1997), Hilda was now living with multiple health issues, including hypertension, high cholesterol and rheumatoid arthritis. As a result, Hilda told me that she had become increasingly reliant on the team of social care professionals who visited her four times daily. During the visits, she told me, the carers helped her get out of bed, toilet, wash and dress; they prepared her breakfast and helped her take

her medication; and after returning at midday and in the evening to prepare and serve her food and to help her use the toilet, they made a final visit to help her to bed. Hilda hastened to add that:

> I'm very pleased with what I've got, and I want to remain with them. No way do I want to go into a residential home. My opinion is that, as regards finance, I think they would save much more. Old people would find it much better if they could remain in their own homes as long as possible. If I knew that this changeover would mean that there's the likelihood that I would have to go over to private care, if I'd been made aware of it then, I would certainly have said, 'No, I do not agree with it'. I've heard so many conflicting tales about these agencies, [that] they're only in it for the money and I'm tired of it. They're dealing with a human being, they're not dealing with a clockwork toy (CLI5: 5).

Like all of the clients and carers whom I interviewed, however, Hilda told me that she had not been consulted prior to the reconfiguration of services and like all of them (bar four), the first she knew of the CRT was when I told her of its existence. Whilst I explore these issues in more detail in Chapter Seven, it would seem safe to assume that had Hilda been able to voice her opinion before the CRT's launch, not only would she have emphasised her satisfaction with the care that was already provided, she would also have pointed out that it helped her maintain her independence, to which she attached great importance. As regards financial issues, moreover, it would also seem safe to assume that Hilda would have described her opposition to private (community or residential) care. Just as Hilda was anxious that her independence might be jeopardised by financial issues, Armorshire Collaboration Project Manager Jo Marshall warned – *vis-à-vis* the entire project – that:

> I'm not convinced that it will make a difference, I have to say. I think it will be down to other things, the whole political agenda that is going to hit us, you know? The model doesn't really stand a chance, because we will get cuts, undoubtedly (LARI2: 3).

Whilst Jo Marshall felt that the threat of further cuts hung over the project – and militated against the chances of its success – Bro-y-Grug Locality Care Co-ordinator Christine Thompson told me that a request to apply for a Welsh Government Rural Health Fund grant of £50,000 to help launch the CRT had already been rejected by Owain Glyndŵr LHB. This decision had, she stressed:

> ...put us in a huge dilemma here, because who's going to pay for the one-off cost of setting up the integrated service? Nobody at the moment is agreeing to pay for it. We're still going ahead with it, but we don't know who's going to pay for it. We hope that the CDM nurses, when they come across, we hope they'll come with a small budget to cover their accommodation and, you know, telephone costs, office costs. But there's no additional monies to see this through and the impact of us not having that funding, if I give you an example: the Regeneration[47] are currently in the offices that we need them to vacate, so we can set up the CRT. So we needed that money so we could move the regeneration staff out (LARI3: 14).

Presumably, Owain Glyndŵr LHB's decision was influenced by one of the fundamental principles that had underpinned the Welsh CCM Model since its introduction in *Designed to Improve Health and CCM in Wales* (WAG, 2007). This was that – in view of the ever-increasing but untenable demands that demographic change was placing on health and social care systems – it would not draw on *new* resources but would instead *reconfigure* existing ones. Moreover, given that these demands had only increased – whilst the economic climate had only worsened – in the three years since the document's publication, Owain Glyndŵr LHB's decision not to support a request for Welsh Government funding was perhaps also a reflection of the diminishing resources available to health and social care across the whole of Wales.

But with Ham and Walsh (2013) noting that the experience of health care organisations in many countries provides little – if any – evidence that integrated care can be delivered more cheaply than conventional models, they stress that to be able to free-up existing resources – which, presumably, would be the first step of the Welsh Government's proposed reconfiguration – any innovation in the delivery of health and social care may require a period of initial investment. In a similar vein, investment in 'start-up' is one of the three 'costs to integration' (1999, p. 89) listed by Leutz (1999) in the second of his five 'laws of integration' (1999, p. 78). This law states that, 'integration costs before it pays' (1999, p. 89). Noting that 'successful integration projects' have 'generally been helped by significant start-up grants' (1999, p. 91) Leutz (1999) cites a number of instances from the U.S. and the UK where such grants have been utilised, including the latter's *Caring for People Project* (Social Services Inspectorate, 1994).

[47] The Armorshire Regeneration and Leisure Team.

Just as Leutz (1999) points out that financial investment is a prerequisite of successful integration, so others (such as Leichsenring [2003] and Nies [2004]) suggest that insufficient public funding is a major barrier to integration. (The inadequacy or short-term nature of funding has, for instance, been found to undermine the implementation of integrated services in intermediate care [Regen et al., 2008]). Moreover, Cameron and Lart (2012) warn that financial disputes can seriously compromise the local support that is a key ingredient of successful integration (a local support which appeared to be a salient feature of Armorshire prior to the Collaboration's launch). However, Leutz (1999, p. 91) notes that a failure to provide adequate funding is typical of public initiatives and stresses that these are instead, 'often strapped for cash'. With Christine Thompson and her three colleagues in the Bro-y-Grug LLT confronted with analogous problems, Bro-y-Grug LLT GP Lead Dr David Lewis reflected, somewhat pessimistically, that, '...if there's not enough resources people are going to fight, and that's why we fight at the moment' (LARI5: 17). In the next section, however, I explore how subsequent to the project's launch, two additional (and extraneous) factors would further impact on the project's development.

Changing direction: a different strategy

In the previous section, I indicated that local stakeholders felt that the scope of chronic conditions was vast, that there was – to some extent at least – a clash of central and local directives, and that the prevailing financial climate was a matter of concern. As if the project's backdrop was not already complex enough, it is important to recall – as I indicated in Chapter Four (see section, 'The Armorshire Collaboration in the Wales-wide context') – that, speaking at the *Armorshire CCM Demonstrator Review Visit* in August 2010, Owain Glyndŵr LHB Assistant Director of Primary and Community Services Emma Fletcher had explained that many new developments had taken place in the fifteen months since the Armorshire Collaboration's launch.

Alongside the introduction of new Local Health Boards (as part of the NHS Wales Reforms of 2009) Emma had, for instance, drawn attention to a new care framework, new developments pertaining to chronic conditions and new strategies. As regards

the latter, it is perhaps of note that amongst the approximately forty attendees of the *Armorshire CCM Demonstrator Review Visit* (including representatives from a range of national and local statutory and voluntary/third sector organisations) was Dr Chris Jones, chair of both the National CCM Demonstrator Steering Group and the Primary and Community Services Strategic Delivery Programme Steering Group. In the latter role, Dr Jones was therefore responsible for overseeing the production of one of the new strategies to which Emma referred, namely the Welsh Government's Primary and Community Services Strategy, as described in *Setting the Direction* (WAG, 2010).

On the one hand, both the Welsh CCM Model and the Primary and Community Services Strategy were premised on the replacement of a community service (in localities of 30,000 to 50,000 people) replete with small stand-alone teams and beset with fragmentation with a community service that was fully integrated. On the other hand, whilst the Welsh CCM Model would do this by way of Core Community CCM Teams, the Primary and Community Services Strategy would utilise Community Resource Teams (CRTs). But considering that both strategies were predicated on the provision of integrated care to the same 'localities', two teams, presumably, were one too many.

Accordingly, despite having planned for the implementation of Core Community CCM Teams for the first two years of the project, as of February 2010 (the month that *Setting the Direction* [WAG, 2010] was published) project leaders gave up this objective and instead turned their attention to the introduction of CRTs. During my second interview with Project Manager Jo Marshall, I asked her how this change had affected the Collaboration's development. In reply, she told me that:

> It's all down to interpretation. From a personal perspective, if you're going to call something a Community Resource Team, that, to me, is all of community, all of community resources, by the very definition of the words chosen. On the other hand, if you take the Devon model, a Complex Care Team is a team that is designed to meet the needs of people with complex care needs: it's in the name, isn't it? In the same way that within the Chronic Conditions Model and Framework, it talked about a Core Chronic Conditions Management Team, which, for me, was synonymous with your Complex Care Team. So it was your more focused, smaller team of people who would manage, in a multi-disciplinary team way, people with those complex needs. I don't think that Chris Jones had sufficient understanding of community

> services to get the terminology right, because when you read *Setting the Direction*, you can interpret it in two ways. I think the way that many people interpreted it was that the CRT was the equivalent of the Complex Care Team or the Core CCM Team, but I didn't think the terminology was helpful in that sense (LARI2:13).

Given Dr Jones' senior advisory position at the heart of two Welsh Government health and social care community strategies, Jo's appraisal of his lack of understanding of community services seemed disconcerting. All the more so, arguably, given that she had also questioned Dr Jones' allegiance to the social model of care that underpinned the Welsh CCM Model (as it has underpinned Welsh health and social care policy since devolution – see, for example, Greer, 2004). Whilst it is perhaps impossible to gauge the extent of Dr Jones' 'understanding' of community services or allegiance to the social model of care, there appeared to be little argument that the title of 'Core Chronic Conditions Management Team' implied a focus on a particular field – chronic conditions – that was absent from the title of 'Community Resource Team'.

As for Jo's contention that the CRT as described in *Setting the Direction* (WAG, 2010) could be interpreted in two ways, it was indicated in the document that whilst the team would provide care for people living with chronic conditions, it would nevertheless ensure 'the maintenance of more complex cases in the community' (2010, p. 15). At each of the four levels of care described in the Welsh CCM Model, conversely – and as befits a model that appeared to have drawn on Wagner et al.'s (2001) Chronic Care Model – reference was made to the provision of support for people living with chronic conditions alone. Hence, even though Jo likened the Core CCM Community Team to the Devon Complex Care Team (her reference was, in fact, to the *North* Devon Complex Care Team which, she told me, she had visited in order to help inform the development of the Armorshire Collaboration) the latter, arguably, bore a closer resemblance to the CRTs, inasmuch as it likewise combined: 'supporting people with long term conditions *and/or* [my emphasis] complex needs' (North Devon Healthcare NHS Trust, 2013, p. 1).

On the one hand, the introduction of the CRTs belied the Welsh Government's stated aims in running the National CCM Demonstrator Programme, namely that they would 'develop and test [the] Core CCM Team' (WAG/NHS Wales, 2008, p. 2).

Indeed, no mention of CRTs – or for that matter, of the Primary and Community Service Strategy – was made in *CMM Demonstrator Learning Paper 6* (NHS Wales/CCM Demonstrators, 2009c), despite the document's subtitle: *What are the CCM National Demonstrators?* Instead, it was explained that the three demonstrators would test, 'the individual elements of the [Welsh] CCM Model over time, ensuring that they "fit" with the whole as set out in the strategy' (2009c, p. 2).

On the other hand, however, the Welsh CCM Model and the Primary and Community Services Strategy seemed broadly analogous in tenor. Hence, both were premised on a shift in resources from secondary to primary and community care and a subsequent – and integration-driven – reconfiguration of services. Bearing in mind the widespread recognition that chronic conditions are inherently complex, the replacement of the Core Community CCM Team (focusing exclusively on people living with chronic conditions) with the CRT model (extending its client-base to include anyone living with a complex problem) did not, perhaps, constitute a significant change in direction for the Armorshire Collaboration. Moreover, Secondary Care Lead Elizabeth Jones told me that:

> The funding for the demonstrator, the purpose of applying for that was to get pump-priming for the Community Resource Team. The whole purpose was: we already had an integrated Llawfon team; there was a separate reablement service; there was the investment in chronic disease management. But they were all working separately, they were separate organisations at the time as well. What we had the vision of was, if we could just have some pump-priming of some focused co-ordination and support, then we could actually really make something happen (LARI10: 8).

Despite having informed me that she had 'moved away' from a focus on chronic conditions (LARI10: 6), it seemed that Elizabeth – and the other senior health and social care leaders in Armorshire who had put together the original funding-bid – had never envisaged launching Core Community CCM Teams. Similarly, when I interviewed Armorshire HSCWB Partnership Officer Ian Cooper, he told me that:

> Community Resource Team is a culmination of a long-term project to integrate health and social services in a much more focused way. So what are we trying to do? It's about trying to deliver services to maintain people much more in the community. One way of trying to do that is to create these locality Community Resource Teams (LARI11: 4).

Just as Bro-y-Grug LLT Social Care Lead Gwyn Evans suggested that,

> The Collaboration is simply a name, a tag-name for some money that the Assembly have given us in order to drive modernisation of services. You know, the chronic conditions strategy, I guess, is the driver behind it. However, my definition of the Collaboration is far wider than chronic conditions (LARI1: 1).

It was beyond the scope of this study to explore the implications of applying for funding to improve the care of people living with chronic conditions with the express (but tacit) aim of using it to 'pump-prime' a generic service. Besides, it could be argued that this was a minor issue, given Christine Thompson's report of the Armorshire Collaboration's lack of financial support and Anne Richard's contention that almost everyone who required health and social care at home was living with a chronic condition. Moreover, Gwyn Evans stressed that he and his colleagues:

> ...don't just work with people with chronic conditions. In fact, it would be impossible for us to categorise in that way. While it does make sense to have drivers and strategies specifically regarding certain conditions, at the same time it's got to be acknowledged that we don't have the resources to actually do that (LARI1: 1).

Drawing my attention to its financial impracticability (presumably, owing to the prevailing climate of austerity within which the project was run) Gwyn inferred that the provision of condition-specific care was also precluded by the range of clients served by social services. A significant remark, one could argue, given that Goodwin et al. (2012, p. 3) suggest that the goal of integrating health and social care services should be the improvement of care of '*any* [my emphasis] individual for whom a lack of care coordination leads to an adverse impact on care experiences and outcomes'. Goodwin et al. (2012) point out that this includes all of society's frail or vulnerable people (not just those living with chronic conditions) – just as Glasby and Dickinson (2008) refer to the key role of joint-working in the provision of care to children, the homeless, and people with learning difficulties: in short, all those people whose needs are multi-factorial and therefore span a number of different health and social care services.

However, it is perhaps important to point out that just as Curry and Ham (2010) contend that there is no 'best-practice' model of integrated working, so Nolte and McKee (2008) argue that there is no universally applicable model of chronic

conditions management either. With Busse et al. (2010) also noting that there is little empirical evidence as to the pre-eminence of any specific model of integrated care for people living with chronic conditions, my aim in briefly comparing and contrasting the Welsh CCM Model and the Primary and Community Services Strategy has not been to argue the case for either. Instead, it has been to point out that the Core Community CCM Teams and CRTs were elements of *different* strategies, and that by sanctioning the introduction of a different strategy – irrespective of the potential benefits or shortcomings thereof – the Welsh Government engendered ambiguity as to the aims of the Armorshire Collaboration. Ultimately, this appeared to have detracted from the clear communication of information at a number of different levels and thereby militated against the project's integrated agenda.

Moreover, the objectives of the CRT that sat at the heart of the new strategy were, in Jo Marshall's opinion, open to interpretation, and therefore, arguably, similarly ambiguous. By engendering ambiguity, the Welsh Government appeared to be gainsaying its own advice *vis-à-vis* the reconfiguration and subsequent integration of community CCM services, as set out in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 11), namely that this should be carried out in a 'clear, co-ordinated and consistent way'. According to March (1994, p. 178), it is the absence of these elements that engenders ambiguity:

> Ambiguity refers to *a lack of clarity or consistency* [my emphasis] in reality, causality or intentionality. Ambiguous situations are situations that cannot be coded into mutually exhaustive and exclusive categories. Ambiguous purposes are intentions that cannot be specified clearly.

Just as Jo Marshall suggested that stakeholders had interpreted the Community Resource Team in different ways, so Weick (1995) posits that it is this very co-existence of *contrasting* interpretations of the *same* phenomenon that renders a situation ambiguous. Rittel and Webber (1973), however, argue that ambiguity is a particular characteristic of 'wicked problems' (like chronic conditions management). According to Clarke and Stewart (1997) there are a number of reasons for this: firstly, wicked problems are hard to define (as I have already described in relation to

chronic conditions); secondly, their causal chains are hard to unravel; thirdly, they involve complex interdependencies.

Rittel and Webber (1973) therefore contend that there are no 'true' or 'false' answers to wicked problems and that proposed solutions cannot be perceived as definitive; instead, they can only be viewed as 'good or bad', 'better or worse', or simply 'satisfying or good enough' (1973, p. 163). This means, Rittel and Webber (1973) suggest, that stakeholders' responses will depend on their 'personal interests', 'special value-sets' and 'ideological predilections' (1973, p. 163). Given that they necessitate the involvement of a complex network of partners, there are therefore likely to be many different interpretations of the best way to address wicked problems (Hudson and Henwood, 2002).

As I explained in Chapter Two, however, the entire field integrated working is characterised by a lack of definitional clarity. Although it might seem paradoxical, McLaughlin (2004) suggests that this is what has allowed partnership-working to become so popular. Describing this as 'useful ambiguity' (2004, p. 105), McLaughlin considers that it permits multiple interpretations and allows partnerships to 'mean different things to different people' (2004, p. 105). Noting that ambiguity is characteristic of the legislative and administrative process, Rein (2006) contends that it is often even seen as a pre-requisite in the creation of political alliances, inasmuch as it permits the collective action that would be rendered impossible were policy always clear. In a similar vein, Stone (2002, p. 157) contends that ambiguity facilitates the political decision-making process, insofar as it enables 'the transformation of individual intentions and actions into collective results and purposes'.

On the other hand, however, not only were clarity and consistency key elements in the Welsh Government's plans for the implementation of the Welsh CCM Model, it is also widely contested that clarity and consistency are fundamental principles of all integration of health and social care (see, for example, CSIP/ICN, 2008; HWBPIB, 2013; Goodwin et al., 2012; Cameron and Lart, 2012). The importance of such clarity and consistency was highlighted, for example, by Williams and Sullivan (2009; 2009a-f) in their case study of five Welsh collaborative health and social care

projects (see Chapter Two, section 'The language of integration'). Reflecting on the implications of their research in terms of future policy and practice, Williams and Sullivan (2009f) point out that partnership working in health and social care invariably involves people from different organisations, sectors, backgrounds, professions and cultures with different roles, responsibilities, pressures (social, economic and financial) and accountabilities. With this multi-stakeholder and multi-factorial context shared by all five of the case study sites, Williams and Sullivan (2009f, p. 3) note that the 'glue' which bound together participants in times of difficulty and conflict was a clear vision of the 'wider purpose' of the partnership.

Similarly, in an examination of the barriers and facilitators of integrated working, RAND Europe researchers Ling et al. (2012) carried out additional analysis of existing transcripts of 213 in-depth staff interviews and of semi-structured questionnaires from the national evaluation of the Department of Health's Integrated Care Pilots national evaluation (Rand Europe and Ernst and Young, 2012; see Chapter Two, section, 'The language of integration'). Ling et al. (2012, p. 8) reported that factors associated with successful pilots included 'Clear, consistent communication and efforts to engage all participants, particularly in terms of the overall vision'. The researchers noted that in instances when such clarity and consistency were missing, conversely, staff were de-motivated and, as a consequence, reluctant to engage.

As I will explain in Chapter Seven, however, it transpired that no clear information regarding the aims of the Armorshire Collaboration was provided to the front-line professionals who participated in the focus groups nor to the service users and carers whom I interviewed. One of the reasons for this omission, arguably, was that the belated introduction of the CRT model – and the ambiguity it engendered – meant not only that project leaders had little time to involve other stakeholders prior to the CRTs' stipulated launch-dates, but that they were themselves unclear as to what the project's goals now were. Whilst it could therefore be argued that this effectively excluded many stakeholders from the process of engagement and militated against both clarity and the project's integrated objectives, in the following section I describe how terminological imprecision and inconsistency were endemic in the Armorshire Collaboration.

Terminological flux

In the previous section, I noted the Welsh Government's reference – in *Designed to Improve Health and CCM in Wales* (WAG, 2007) – to the importance of clarity and consistency during the implementation of the Welsh CCM Model. In the *Service Improvement Plan* (WAG, 2008), in turn, it was indicated that, 'A pre-requisite for achieving a strategic shift in resources from hospital to community care are clear definitions for these services' (2008, p. 17) and that amongst the 'foundations for change' (2008, p. 30) were, 'clearly defined functions and roles' (2008, p. 39). In *CCM Demonstrator Learning Paper 1* (NHS Wales/CCM Demonstrators, 2009, p. 2) it was further noted that:

> The language we use when working across agencies and partners is of crucial importance – we can't spend enough time on getting it right. Clear and unambiguous communication of what we are trying to achieve is crucial for understanding and buy-in.

Whilst the introduction of the CRT model had brought with it ambiguity, from the very launch of the Welsh CCM Model, clarity and consistency appear to have been missing. Hence, having introduced, in *Designed to Improve Health and CCM in Wales* (WAG, 2007), the 'Integrated Model and Framework' the latter was renamed the 'Welsh Chronic Conditions Model and Framework' in the *Service Improvement Plan* (WAG, 2008). In official National CCM Demonstrator Project and Armorshire Collaboration documents, the Locality Care Co-ordinator was variously known as the Chronic Conditions Care Co-ordinator, Chronic Conditions Management Care Service Planning Co-ordinator, the Care Services (plural) Planning Co-ordinator, the Care Service (singular) Planning Co-ordinator, the Locality Care Services Planning Co-ordinator, and Locality Care Planning Co-ordinator; and the Locality Leadership Team was variously known as the Community Services Leadership Team and the Locality Leadership Group (see, for instance, WAG, 2007; 2008; 2009a; NHS Wales/CCM Demonstrators, 2009; Armorshire Collaboration PID [App. 9]).

The state of terminological change was equally true of the proposed integrated health and social care service that would provide care to people living with chronic conditions. As preparations were made for its introduction across Armorshire, the service was variously referred to as the Core Chronic Conditions Management Team,

the Core Health and Social Chronic Conditions Management Team, the Core Health and Social Chronic Conditions Management Service and the Core Chronic Conditions Management/Multidisciplinary Team (see, for instance,WAG, 2007; 2008; 2009a; NHS Wales/CCM Demonstrators, 2009; Armorshire Collaboration PID [App. 9]). In the Bro-y-Grug locality, moreover, during their meeting of 26th November, 2009, the members of the LLT – itself then still known as the Locality Leadership *Group* – opted for a different name altogether:

> Discussion held around the roles and purpose of the proposed MDTs [multidisciplinary teams]. The group decided that the name MDT was not appropriate as it did not show an up-to-date modern image but replicates historical thinking of a traditional MDT. The group therefore decided that the proposed working groups would now be called COGs (Community Operational Groups) (LLTMM1: 1).

That the members of the LLT decided against MDT and chose instead to call the service the Community Operational Group appeared to accord with the Welsh CCM Model's 'local approach' (WAG, 2008, p. 29) to the provision of health and social care. It is therefore of note that within a matter of weeks, the LLT's Community Operational Group would have to make way for the Community Resource Team. This, conversely, was a decision that was not decided locally, but mandated centrally following the publication of *Setting the Direction* (WAG, 2010). Notwithstanding the wider impact of the CRT's (belated) introduction, in terms of another name-change alone (at the end of an already lengthy sequence of name-changes) it is perhaps of note that linguistic inconsistency can, according to experts, lead to misunderstandings that weaken communication and collaboration and hamper the development of joint-working (CSIP/ICN, 2008).

However, empirical research seems to suggest that the difficulties experienced by project leaders of the Armorshire Collaboration in finding appropriate terms to describe a new service are not unique. Bell et al. (2008), for instance, explored how NHS and local authority staff in management positions understood the term 'integration'. Their study combined an electronic questionnaire, three structured interviews and a focus group, with participants purposively selected to reflect a variation in age, gender, role and motivation. Of the ten questionnaires sent out, three people responded and were subsequently interviewed. A further eleven people

participated in the focus group interview, comprising seven health care practitioners and four local authority representatives. According to Bell et al. (2008) one focus group participant – an NHS District Nurse – stated that the different approaches and policies of different organisations meant that a planning group she was part of took almost a year to decide on a suitable name for a new integrated service. She felt that this was a reflection of the lack of clear definitions or understanding of integration across the public sector (a phenomenon that was echoed by all eleven focus group participants).

Returning to the Bro-y-Grug LLT's choice of the name 'Community Operational Group', this selection seemed to have been made in direct response to Project Manager Jo Marshall's decision to change the name of the new service from the Core CCM Team to the Armorshire Community MDT, announced during the *Building the Locality Approach to CCM and Community Services in Armorshire Workshop* in August 2009. It is of note, therefore, that this title contained no reference to chronic conditions, despite the fact that in the Armorshire Collaboration PID it was explained that the reconfiguration of services would, '...*focus only* [my emphasis] on people living in Armorshire with chronic conditions' (App. 9). It could therefore be argued that this title carried the same risk of confusing the project's objectives as the later introduction of the CRT. Moreover, in her presentation to the workshop, Jo Marshall explained that the Armorshire Collaboration would put into action the 'Core Health and Social Care CCM Team/Services' (again, a different title) by:

> Identifying workforce representatives reflecting all aspects of community services including voluntary and third sector; establishing *Core CCM* [my emphasis] MDT process [*sic*] to respond to service users who have either: complex needs, e.g. co-morbidities, non-compliance, social isolation, falls risk, general frailty; complex psychosocial needs; specialist chronic disease intervention with or without social needs (BLMO: 2).

On the one hand, therefore, Jo Marshall suggested that the reconfiguration would focus on meeting the needs of people with complex needs. This would be achieved by means of a 'Core *Chronic Disease Management* [my emphasis] Multi-disciplinary Team process' (BLMO: 2). On the other hand, however, she indicated that the team/service would identify workforce representatives from, 'all aspects of

community services' (BLMO: 2). Later in the workshop, attendees were to learn that the 'Main CCM Delivery Providers' would include:

> Social Care, District Nursing, Llawfon [Reablement Service], DRT [Disability Resource Team], CDM [chronic disease management], General Practices, Out of Hours, Ambulance Trust, Voluntary Sector, Independent Sector, ART [Acute Response Team] (BLMO: 4).

Hence, whilst the CRT would call on virtually every community health and social care professional to provide care for people living with *complex needs*, so the Armorshire Community MDT appeared to call on virtually every community health and social care professional to provide care for people living with *chronic conditions*. Furthermore, the title of Community MDT appeared to contradict one of the 'keys to success' as set out in the Armorshire Collaboration PID (App. 9), namely that the reconfiguration of services would deliver:

> A team that is *interdisciplinary rather than multidisciplinary* [my emphases], i.e. members participate in the team's activities and rely on one another to accomplish outcomes rather than treat patients independently and share information about what has been done to a patient.

Just as in the Collaboration PID the participatory and collaborative nature of interdisciplinary teams was stressed, so Abramson (2002) suggests that one of the salient features of interdisciplinary teams is their adoption of an holistic approach, with team-members planning collectively and employing skills and techniques interdependently. Furthermore, just as it was explained in the Collaboration PID that although members of multidisciplinary teams share information, they work independently of one another, so Dziegielewski (2004) notes that members of multidisciplinary teams carry out assessments and evaluations independent of one another before sharing information at a later date. The DH (2005) further specifies that practitioners in multidisciplinary teams work in parallel but not necessarily collaboratively, whereas practitioners in interdisciplinary teams work jointly towards a single set of agreed goals for each client.

Given that Kodner and Spreeuwenberg (2002, p. 3) suggest that integration is a set of methods and models designed 'to create connectivity alignment and collaboration', it could be argued that an interdisciplinary approach lies closer to a model of

integration than a multidisciplinary approach. From this perspective, the introduction of a Community MDT model seemed to presage a shift away from the establishment of '*integrated* [my emphasis] care delivery models' (Armorshire Collaboration PID, App. 9) as set out at project initiation. It could therefore be argued that the ambiguity surrounding the new service which Jo Marshall attributed to the terminology of the CRT model (as part of a strategy that was introduced from outside the project) was just as much a result of *internal* linguistic inconsistencies.

However, Huxham and Vangen (2004) stress that during fifteen years of conducting action research into collaborative working in a variety of situations and with a variety of actors (including facilitators, consultants, trainers and managers) they have learned that more often than not, the one element that is missing is clarity. This absence, Huxham and Vangen (2004) note, is one of the main reasons that 'collaborative advantage' is often stymied by 'collaborative inertia'. The former, according to Huxham (1993, p. 603) is:

> ... concerned with the creation of synergy between collaborating organisations. Collaborative advantage will be achieved when something unusually creative is produced – perhaps an objective is met – that no one organisation could have produced on its own and when each organisation, through the collaboration, is able to achieve its own objectives better than it could alone.

Whereas the latter, Huxham (1996, p. 4) notes, is:

> ...the situation when the apparent rate of work output from a collaboration is slowed down considerably compared to what a casual observer might expect it to be able to achieve.

According to Huxham and Vangen (2004, p. 191), managers involved in collaborative initiatives consistently argue that the starting point of joint-working should be aims that are 'common, (or at least compatible), agreed or *clear* [my emphasis]'. In practice, however, Huxham and Vangen (2004) suggest that confusion, misunderstanding, unintended assumptions (*vis-à-vis* shared values) and even deliberate concealment mean that there is frequently little clarity as to what the aims actually are. Just as Huxham and Vangen (2004) suggest that collaborative inertia often results from a lack of clarity, in their guide to effective partnership working in health and social care (based, they note, on the findings of their own

literature review [see Willams and Sullivan, 2007]) Williams and Sullivan (2007a, p. 9) point out that such a lack of clarity will 'invariably build up problems in the future'. As for the Armorshire Collaboration, the storing up of later problems in achieving an integrated service – partly, at least, as a result of linguistic confusion and lack of clarity – is a theme to which I return in Chapter Seven. In the following section, however, I explain that it was not just terminology that was in a state of flux.

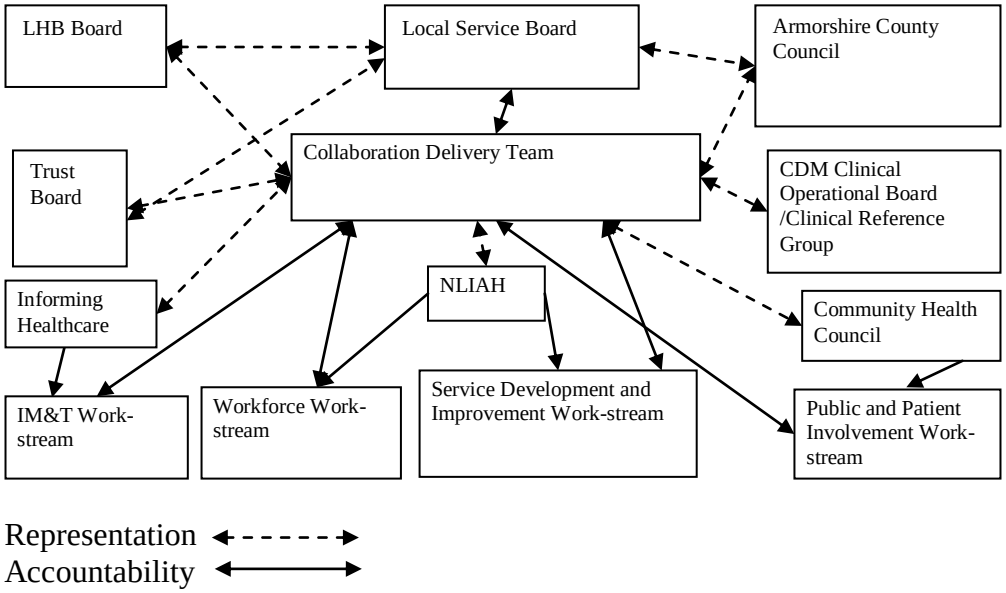
Changing structures

Two-thirds of the way into the Armorshire Collaboration, plans to launch Core Community CCM Teams were replaced with plans to launch CRTs. However, six months earlier, the introduction of Locality Leadership Teams – when the project was already nearly half-way through – also signalled the replacement of an existing leadership structure. As described in the Armorshire Collaboration PID, this structure comprised a Delivery Team and four work streams. The former, it was noted, would meet monthly, provide a forum for 'member bodies' to work together and, by coordinating the contribution of statutory, independent and voluntary sector agencies, would ensure better utilisation of the existing resource base. Accordingly, one of its 'key tasks' would be to:

> Develop a multi-agency strategic approach to deliver agreed outcomes for the population of Armorshire through improved and modernised specialist and core services. The multi-agency strategic approach will form the foundation for any future joint planning of services (App. 9).

As befits this multi-agency approach, it was reported that the Delivery Team would include a chief executive and directors, senior managers and chief officers from a range of both national and regional agencies, such as Informing Healthcare, NLIAH, Owain Glyndŵr NHS Trust, Armorshire LHB and Armorshire County Council. Amongst its fifteen members would be a number of the local 'champions' of integration to whom I have already referred, such as Anne Richards, Elizabeth Jones, Jill Thomas, Gwyn Evans and Claire Peters. Figure 4 (overleaf) displays the position of the Delivery Team at the heart of the project's original organisational structure:

Figure 4: Armorshire Collaboration Original Organisational Structure



By inaugurating a Delivery Team, project leaders appeared to have heeded one of the core messages of an Audit Commission (AC) management paper for senior NHS, local government and police representatives involved in partnership working, *A Fruitful Partnership: effective partnership working* (AC,1998). In the paper, attention is drawn to the existence of four main partnership models, namely: distinct organisations with a single legal structure; 'virtual' organisations with a single identity but separate legal structures; informal co-locations of staff (perhaps with a pooled budget) working towards a common goal but managed separately; or committees that aim to achieve greater co-ordination but with no dedicated staff or resources (AC, 1998, p. 17 – 18). But irrespective of the model, it is emphasised that an 'essential structural requirement' is a decision-making mechanism – in the guise of a 'board' or 'steering group' – that is recognised as such by all partners (AC, 1998, p.19; see also: Cabinet Office of the Third Sector, 2008; Crump and Mavro, 2011; Beresford, 2013).

Similar conclusions were reached in McNab et al.'s (2013) evaluation of the Chronic Care Aged and Complex Care arm of the HealthOne project in Mount Druitt, Sydney, New South Wales (NSW), Australia. McNab et al. (2013) explain that HealthOne projects deliver care via multi-disciplinary teams and are predicated on increased integration and co-ordination of primary and community health service.

HealthOne Mount Druitt (HOMD), the researchers add, provides care in three specific areas: chronic aged and complex care; children and their families; and disadvantaged communities. Noting that the evaluation of HOMD combined quantitative and qualitative data collection, McNab et al. (2013) reported that the former comprised: patient outcome measures, organisational and health service delivery measures, and a partnerships survey – sent to all service providers with HOMD enrolled patients – on barriers and facilitators to effective partnerships between GPs and Community Health. The latter, the researchers add, comprised: semi-structured individual interviews (n=32) with NSW Health policy and decision Makers, HOMD Steering Committee members, HOMD staff, clients enrolled in HOMD (and their carers) and local GPs and one focus group with Mount Druitt Community Health Centre staff involved in the care and treatment of chronically ill patients.

Pointing out that policy and decision makers attributed the successful implementation and continuing operation of HOMD to strong leadership, successful partnerships/relationships, support from senior management and clear governance structures, McNab et al. (2013) suggested that these factors were facilitated by the existence of a Steering Committee. The latter comprised key leaders, managers and staff from participating partners, local GP Associations and two GP Liaison nurses. Moreover, not only did McNab et al. (2013) suggest that the Steering Committee helped conceptualise an integrated patient-centred model, they added that its clearly defined ideas *vis-à-vis* the structure of an integrated primary care sector derived from a personal philosophy developed over long years of experience.

Whilst the existence of an Armorshire Delivery Team therefore appeared to bode well for the project's integrated agenda, it was further indicated in the Armorshire Collaboration PID (App. 9) that the Delivery Team would oversee four work-streams (as set out in Figure 4). Each of the latter would comprise some twelve members and would, like the Delivery Team, include senior representatives from national agencies and from the Owain Glyndŵr NHS Trust, Armorshire LHB and Armorshire County Council. These senior partners would be joined by stakeholders from a wide range of local statutory health and social care and voluntary sector organisations. Hence, there would be, *inter alia:* directors of Armorshire's CDM-, district nursing-

and Acute Response-teams; representatives from primary care and allied healthcare services; officers from social care, health and housing; specialist nurse practitioners; chronic conditions consultants; HSCWB Officers; members of local voluntary sector organisations; PPI Officers; and EPP delegates. Moreover, each of the local 'champions' of integration who were members of the Delivery Team would also join one (or more) of the work-streams.

Each work stream, it was explained in the Armorshire Collaboration PID (App. 9), would have its own 'purpose'. The Service Planning and Delivery Work Stream, firstly, would, 'ensure that sustainable services are developed in line with the needs of the population of Armorshire'; the PPI Work-stream, secondly, would, 'ensure that people with chronic conditions and their carers have a strong voice in the Armorshire demonstrator'; the Information Management and Technology Work-stream, thirdly, would, 'identify, develop and provide a range of technologies to support clinicians/care professionals and patients in the delivery of integrated services which aim at [*sic*] manage patients with chronic conditions in or as close to their home as possible'; and the Workforce Management and Development Work-stream, finally, would, 'ensure the development of a flexible and sustainable workforce to support the effective delivery of the CCM identified [*sic*] and the Human Resource Management systems and processes to underpin effective implementation'.

However, by the time I observed my first meeting of the Armorshire Collaboration – the *Building the Locality Approach to CCM and Community Services in Armorshire Workshop* in August 2009 – the project's organisational structure had already been abandoned. When I later interviewed Project Manager Jo Marshall and asked her why this had happened, she explained that it was in large part attributable to the NHS Wales Reforms of 2009. She added that:

> Key individuals that were involved at the beginning of the Collaboration were fully committed to what it was proposing to do, but were unable to give the commitment that it required. We went from being a partnership across Armorshire to key individuals becoming part of Owain Glyndŵr Trust, which then became Owain Glyndŵr Health Board. I think it had a significant impact at the time, because everyone agreed with the infrastructure for the project being these four work-streams and the work-streams had programmes

> of activities, but then failed to get the commitment required to drive them forward, because they were being pulled away (LARI2: 7).

Just as work-streams are a common feature of integrated health and social care projects, so it would appear that their abandonment due to extraneous factors is not unheard of either. On the contrary, Jo Marshall's attribution of their abandonment – which took place within the project's first year – to the impact of the NHS Wales Reforms seemed to parallel the dropping of plans by Trafford Primary Care Trust (PCT) to create an integrated care trust facilitated by six work-streams (after just six months 'proof of concept' year) because of NHS North West's withdrawal of economic support (Shaw and Levenson, 2011). This, Shaw and Levenson (2011) explain, was because of doubts as to the project's longer-term viability and the 'challenging financial climate' (2011, p. 8).

Indeed, alongside the lack of funding and the belated entrance of the CRT model, the concurrence of the Armorshire Collaboration with the NHS Wales Reforms of 2009 and the subsequent abandonment of the Delivery Teams and work-streams once again appeared to display the 'context heavy' nature of health and social care. Moreover, the loss of expertise from a broad cross-section of stakeholders appeared to have detracted, once again, from the project's integrated agenda, as did the loss of specific work-streams devoted to the involvement of clients and front-line professionals.

Following the loss of the original organisational structure, plans for the replacement of the Delivery Team and work-streams were unveiled during the *Building the Locality Approach to CCM and Community Services in Armorshire Workshop*. In her presentation to the workshop, Project Manager Jo Marshall explained that new plans involved a 'locality approach' to the reconfiguration of services which would see the creation of two GP practice clusters, two sets of generic support workers[48] and two CCM Multidisciplinary Teams in each of the three Armorshire localities of Aberwrach, Tregwen and Bro-y-Grug. In each locality, Jo explained, the entire reconfiguration of services would now be overseen by a Locality Leadership Group

[48] Plans for the implementation of generic support workers were also subsequently abandoned.

of Social Care-, GP-and District Nurse-Lead and a Locality Care Co-ordinator (BLMO: 5).

Whilst these plans were only set out in August 2009, the first meeting of the Bro-y-Grug Locality Leadership Group would not take place for another three months. But during my interview with Jo Marshall, she explained that there had been recruitment problems with the GP Lead and District Nurse Lead positions. As for the former, these had gone out to general advert but interest had only been shown by salaried locum GPs. In the absence of any other formal applications, Jo explained that the three GPs who had been appointed Strategic GP Leads of the three Armorshire localities in the new Owain Glyndŵr LHB were therefore also appointed to the three new posts. As for the latter, Jo told me that because of district nurses' heavy workloads and community nursing's 'state of flux' – again, due to the NHS Wales Reforms of 2009 – it had proved difficult to arrange the necessary 'back-fill' to cover their absences during the Locality Leadership Groups' proposed weekly meetings.

As a result, Jo added, the District Nurse Leads in the Tregwen and Aberwrach localities had only been able to take up their posts at the beginning of 2010. Whilst delays had been less significant in the Bro-y-Grug locality, the first Locality Leadership Group meetings did not take place until November, 2009. By this time, however, some twenty months of the project had elapsed. It was hardly surprising, then, that during my interview with Locality Care Co-ordinator Christine Thompson the following June, she told me that:

> Some people historically have just implemented change for change's sake. We haven't got the money to do that now, we haven't got the resources to do that, and we haven't got the time either. This [the Locality Care Co-ordinator] post is only around for a short-term, so we've got to implement a lot, driven by the strategy, and implemented operationally in quite a short period of time (LARI3: 4).

Drawing my attention to money and resource-issues, first of all, Christine had already described the lack of funding to help set up the CRTs. Now adding that time was in equally short supply, the abandonment of the original organisational structure together with the delayed launch of the Locality Leadership Groups had left Christine and the three professional leads less than sixteen months to achieve their

objectives. Whilst the subsequent introduction of the new Primary and Community Services Strategy had, it would seem, further complicated matters, Christine also stressed that her post was only 'around for a short-term'.

Indeed, in the Armorshire Collaboration PID it was noted that a 'Care Service Planning Co-ordinator[49]' would be established in each of the Armorshire localities as of January 1st, 2009 (App. 9). By this time, however, the project would have already been running for some eight months. This appeared to be somewhat late in the day for the entrance of someone with, it would seem, a seminal role to play in its development. This was indicated by the statement – made in the *Service Improvement Plan* (WAG, 2008, p. 18) – that Care Co-ordinators would be 'essential to ensure [*sic*] the CCM model works effectively'. Just how essential this would be was indicated by the list of responsibilities as set out in the Collaboration PID (App. 9). These responsibilities were, *inter alia*, to:

> ...identify, plan and co-ordinate services to meet the needs of the locality population at each level of the CCM pyramid; assist the Core CCM Team and other care providers to access and negotiate complex delivery systems, arrange and schedule services; facilitate communication among multiple providers, and monitor patient progress and service delivery across primary, secondary and community care; develop and co-ordinate appropriate primary care collaborative networks and networked services; and develop and maintain locality-based CCM profiles.

But during my preliminary meeting with Jo Marshall and Anne Richards in July 2009, I learned that resource issues meant that the posts had only recently been advertised, with the closing-date for applications several weeks away and short-listing of candidates scheduled for the tenth of August. In the event, the three Locality Care Co-ordinators were appointed some eight months after the date set out in the Armorshire Collaboration PID. (During my interview with Jo Marshall, I learned that she too – again due to resource issues – was only appointed to her post some six months after the project had been launched). For a number of reasons, therefore, the Bro-y-Grug Locality Leadership Group (or, as it would come to be known, the Bro-y-Grug Locality Leadership Team) did not first convene until November 2009, some twenty months after the Collaboration's launch. As I explain

[49] One of the many names applied to Christine's post, see section, 'Terminological flux' in this chapter (above).

in the next – and final – section of this chapter, this appeared to leave precious little time for the team to deliver change.

A fire-fight

Whilst the Armorshire Collaboration was all about increasing the pace of change, the 'integrated' service that would provide care for people living with chronic conditions was only launched in September 2010, some thirty-six months after the project's launch. However, during my interview with Armorshire CDM Nurse Lead Anne Richards, she told me that, taking into account the impact of the NHS Wales Reforms:

> ...all in all, we've done pretty damned well. We're being asked to move on when everyone's sitting in a state of flux and we seem to have managed to have moved on anyway. When I look back, I think we've come a long way, but sometimes you feel like you're still talking and talking. But I think that was the issue as well. People don't understand that to get people on board, well, what the Welsh Assembly Government don't understand, is that you've got to talk and discuss and get the trust and get everybody to agree on the way forward. Then you move on to start planning. And that took us a good year (LARI6: 9).

In the midst of instability, Anne suggested that local stakeholders had made considerable progress. Whilst she also acknowledged that discussions had been lengthy, she stressed that this had been key to gaining the requisite trust and agreement that would allow the project to develop. Arguing that the importance of such factors had been overlooked by the Welsh Government, however, Anne stressed that the latter was:

> ... looking for answers now and things to be done now. I think sometimes we're running before we can walk. If we do that, then we're going to come up against a lot more barriers or more problems than if we'd gone a bit slower. But then we're fixed with our time-frames. Sometimes, I think these CRTs starting at the end of September, we're really pushing it, especially when IT hasn't been resolved (LARI6: 5).

On the one hand, it could be argued that from the perspective of the Welsh Government, there had been sufficient time to make tangible gains. The original June 2010 deadline for Wales-wide launch of Core Community CCM Teams had, after all, been set out as early as February 2008 in the *Service Improvement Plan*

(WAG, 2008). Considering that the Armorshire Collaboration was launched just a month later, in theory this meant that local project leaders had more than two years to set up an 'integrated' service. On the other hand, however, one could argue that since the Armorshire Collaboration's launch, contextual complexities had rendered the inherently challenging task of launching an integrated health and social care service considerably more problematic. This is perhaps best evidenced by a brief review of just some of the extraneous factors that had impacted on the project's development.

First of all, Project Manager Jo Marshall and Bro-y-Grug Locality Care Co-ordinator Christine Thompson – two of the project leaders who, according to the Armorshire Collaboration PID, would play a prominent role in ensuring that the project's stated objectives were met – were appointed, respectively, six months and eighteen months after project initiation. Secondly, the Armorshire Collaboration had coincided with the NHS Wales Reforms of 2009, which, in turn, appeared to have forced a revision of the organisational structure. Thirdly, two-thirds of the way through the project, a new strategy and new model of care had been introduced. Finally, the Armorshire Collaboration was also run at a time of major cutbacks in governmental spending UK-wide.

Nevertheless, Anne Richards suggested that the Welsh Government's sense of urgency remained unaltered. At this juncture, it is perhaps worth remembering (as I pointed out in Chapter Five, section, 'Integration: a common need') that in a House of Commons Health Committee (2009) report into health inequalities, it was indicated that whilst the effects of policies involving complex collaborative interventions can often only be felt after a long time, they are frequently changed before the effects are detectable. In the same report, moreover, it was emphasised that because of political (and other) constraints, policies are often rushed-in and programmes often manipulated and that this is exacerbated by a state of, 'endless fiddling' (2009, p. 32).

One of the report's 'academic witnesses' was Michaela Benezeval. A member of the Health Action Zone (HAZ) evaluation team, Ms. Benezeval told the committee that HAZ stakeholders had been set impossible policy goals, given no time to show

results, and asked to implement policies and achieve targets that were constantly changed. Another academic witness was Margaret Whitehead, Professor of Public Health at the University of Liverpool. Professor Whitehead, in turn, told the committee of the general state of disruption caused by the '"continual procession" of changing initiatives' (2009, p. 32), with programmes accorded insufficient time to become established before being replaced. Indeed, many commentators have argued that one of the key ingredients for the success of any initiatives that are built on collaboration is stability (see, for instance, House of Commons Health Committee, 2012b; Priest, 2012; Thistlethwaite, 2011).

But just as health and social care in the UK is characterised by repeated structural reform (see Means et al., 2008; Hudson, 2011; 2012; Glasby, 2012; Baggott, 2013) so it is characterised by short-termism and the frequent introduction of new initiatives (House of Commons Health Committee, 2009). But the literature of integrated working suggests that the concomitant absence of stability and continuity has numerous negative repercussions. This means, for instance, that: projects that have crystallised around a joint-vision and common purpose risk losing the very stakeholders and relationships which were fundamental to their genesis and development (Huxham and Vangen, 2004); the proposed benefits of reforms cannot be achieved, as the system has again reorganised before accurate evaluations can be made; that the system becomes 'change-resistant' as staff become disillusioned *vis-à-vis* their ability to bring about sustainable improvements (Parker and Glasby, 2008); that the complexity of new developments is increased (Glasby et al., 2008); and that attention is diverted away from operational issues (Taylor, 2001).

But not only did the Armorshire Collaboration project leaders have to replace the initial strategy – for the implementation of the Welsh CCM Model – with a different one –for the implementation of CRTs – they also had to cope with many other contextual factors that I have detailed throughout this chapter. Notwithstanding, Anne suggested that they remained under pressure from the Welsh Government to make progress 'now' and to come up with answers 'now'. However, it was not just project leaders from the Armorshire Collaboration who were under pressure to bring about rapid change. On the contrary, Jo Marshall told me that during a meeting

between Welsh Government CCM Policy Lead Helen Howson[50] and all three National CCM Demonstrator Project Managers:

> ..the old Penpolshire Demonstrator Lead Jean Simpson came up with a wonderful phrase, within the first six months of the demonstrator, when there were tensions between what we were doing out in the field compared with what the Welsh Assembly Government were looking at, i.e.: 'What have you actually achieved?' Jean Simpson said to Helen Howson, 'Helen, you have to remember that just because you've written something down in the Assembly does not mean that it'll happen out there in the field'. There has to be that connection out there in the field for people to pick up strategy and implement it and translate it to, 'What does this mean for us?' (LARI2: 2).

Helen Howson's standpoint was perhaps a reflection of the dates – set out in the *Service Improvement Plan* (WAG, 2008) – by which time preparatory measures for the Welsh CCM Model were to be established and of the June 2010 deadline for the Wales-wide launch of Core Community CCM Teams. Nevertheless, the comments of Jo Marshall, conversely, were consistent with the scope for locally flexible implementation – in partnership with all stakeholders – that had been a central tenet of the Welsh Government health and social care agenda since devolution and a core theme of the Welsh CCM Model. In turn, moreover, it was indicated in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008) that the three demonstrators would, adopt a 'proactive, planned and integrated approach' (2008, p. 1); that they would 'facilitate the cross-boundary collaborative agenda and local partnership working' (2008, p. 2); and that they would 'engage local support and involvement from local people, patients, carers and communities in service design and delivery' (2008, p. 2).

According to Anne Richards, however, the entire process of planning for change with local stakeholders – and the securing of the requisite trust and agreement – had taken 'a good year' of 'talking and talking' (LARI6: 9). Furthermore, just as Anne's comments seemed to suggest that the process had been drawn-out and challenging, so Ham and Walsh (2013) contend that most organisations making the transition from fragmentation to integration – a transition which underpinned the Welsh CCM Model – have found the process to be long and arduous. Yet the comments of both Jo Marshall and Anne Richards seemed to suggest that these factors had been overlooked by the Welsh Government.

[50] Real name.

Moreover, just as their comments hinted at the latter's apparent impatience to witness concrete developments across each of the national demonstrators, during my June 2010 interview with Bro-y-Grug LLT Social Care Lead Gwyn Evans, he told me that similar sentiments had been expressed by the Chief Executives of Owain Glyndŵr LHB. In particular, he drew my attention to the fact that:

> ... the Chief Execs have given us a target. They're saying they want everyone to be working to the same terms and conditions etcetera. They've given us the first of October...they want integration by the first of October. What they will have is a group of twenty-four people, all on the same terms and conditions, on the same salary, with the same management structure. They won't have an ethos and they may still be in different rooms, working on different projects, doing different jobs, not joined-up at all. But to tick the box for the Chief Execs, we will have integrated that team (LARI1: 10).

Although Gwyn suggested that pressure to bring about rapid change was also exerted by Chief Executives, the latter – like the CRTs – were late arrivals, their posts within the new Owain Glyndŵr LHB having only been created as part of the NHS Wales Reforms of 2009. Somewhat ironically, therefore, that they were even in a position to stipulate a specific start-date for the CRTs was the result of the very restructuring which – according to Anne Richards – had engendered the 'state of flux' (LARI6: 9) that had slowed the Armorshire Collaboration's development. Notwithstanding, Gwyn suggested that the creation of a team with anything other than the structural elements of integration would be impossible in the given time-period.

On the one hand – despite Gwyn's air of pessimism – it is possible to locate each of the structural elements to which he referred amongst Lewis et al.'s (2010, p. 12) 'typologies' of integrated care. Hence, the joint terms and conditions and salaries were an instance of 'organisational integration', whereby separate organisations are brought together 'virtually' by way of contracts (2010, p. 12); the twenty-four-strong team an instance of 'service integration', whereby different services are provided 'through teams of multi-disciplinary professionals' (2010, p. 12); and the single management structure an instance of 'systemic integration' whereby 'there is coherence of rules' (2010, p.12). From a structural perspective, the proposed model of the CRT would therefore incorporate a number of elements that are considered beneficial to achieving successful integration. On the other hand, however, not only did Gwyn posit that certain structural elements (such as shared office-space, joint-

projects and joint-roles) *might* be missing, he was certain that what *would* be missing was an 'ethos'.

The latter also features in one of Lewis et al.'s (2010) integrated care typologies, namely 'normative integration'. In fact, Lewis et al. (2010, p. 12) go so far as to define normative integration as, 'an *ethos* [my emphasis] of shared values and commitment to co-ordinating work'. However, whilst Lewis et al. (2010, p. 12) stress that such an ethos 'enables trust and collaboration in delivering healthcare', Anne Richards inferred that the 'fixed' time-frames of the CRTs' launch would work against the securing of trust and agreement. Instead, both she and Jo Marshall contended that the challenges and complexity of the Armorshire Collaboration had been overlooked by the Welsh Government, just as Gwyn Evans suggested that Owain Glyndŵr LHB Chief Executives had failed to take account of the need to develop normative integration.

However, one could argue that in view of the Welsh Government's desire for rapid answers, it was hardly surprising that regional Chief Executives were more concerned with establishing the tangible components of integration – a joined-up *structure* – than in establishing its intangible components – a joined-up *ethos*. But in order for the Chief Executives to be able – in Gwyn's words – to 'tick the box' of integration for the Welsh Government, the box had first to be ticked – as rapidly as possible – by local leaders. This was not lost on Bro-y-Grug CRT Occupational Therapist Toni Ellis. Speaking during the second focus group – conducted in March 2011, some six months after the CRT's launch – Toni reported that:

> I feel a little bit that it was kind of forced through. I think our managers, or people above us, were given dates when it had to be seen to be working. There was a little bit of pressure on them, I think, and I don't think they really knew what form [it would take] or how it would develop (FPFG2: 4).

Just as Toni felt that pressure to change had been passed on to team managers, so Physiotherapist Michelle Roberts suggested – during the first focus group (conducted a month earlier) – that front-line professionals had been told by their managers that:

> ‘This is going to happen!’ And it became a fire-fight, it became a sort of last minute, ‘Let’s talk about it!’ With all the dates in place, as in, ‘We’re moving on September the whatever, but it’s July now. So we should really have a meeting about this’ (FPFG2: 2).

In a similar vein, during the third focus group the following May, Occupational Therapist Lauren Price suggested that:

> When it was established first of all, I don’t think everybody was included in the actual process. Instead of being included, we were told (FPFG3: 3).

Finally, during September’s final focus group, Senior Enablement Practitioner Emma Stone reported that, ‘We were told what was going to happen’ (FPFG4: 3). All of this seemed a far cry from the co-operation, partnership-working and local design and delivery of integrated services which was to have underpinned the Armorshire Collaboration. According to Flynn and Talbot (1996), however, the public sector is dominated by a prescriptive approach to strategy-making that is characterised by a sequential and ordered approach that is ‘top-down’. Advocates of such an approach, note Howlett et al. (2009), discern a clear distinction between policy formation and policy implementation and view effectiveness in terms of adherence to original policy intent. Pressman and Wildavsky (1973) add that top-down theorists argue that if there are clear and robust causal links between goals and actions as well as appropriate resources and distinct chains of command, then failure to implement policy can be attributed to errors in strategy and machinery. Any divergence from the original policy intent, adds Hill (2005), is therefore considered by top-down theorists to be a shortcoming on the part of those responsible for enacting the policy, tantamount to an implementation ‘deficit’.

At the same time, however, Buse et al. (2005) note that the top-down approach has attracted a number of criticisms, including: a neglect of the contribution of individual actors at various stages of implementation that is beyond the control of central decision makers; an incompatibility with complex situations involving multiple policies and agencies; an over-estimation of the impact of government action; and an over-reliance on unrealistic preconditions. Just as Stacey (1990) contends that the inflexibility of the top-down approach has very often proved ill-suited to a fast-changing and turbulent world, so Williams and Sullivan (2009f) argue that the problems of predicting the future with any degree of accuracy and the separation

between the design and delivery stages of implementation have called into question the value of such a prescriptive stance.

However, Williams and Sullivan (2009f) add that such shortcomings have not prevented the continued and widespread utilisation of a top-down approach to strategy making. Likewise, despite the fact that the backdrop to the Armorshire Collaboration also appeared to be fast-changing, turbulent and, indeed, unpredictable, the remarks of many stakeholders implied that key elements of the project had been mandated from the top down rather than negotiated at local level. In the next chapter I explore this theme in more detail and discuss how this may have impacted on the Armorshire Collaboration's 'integrated' agenda. As regards the current chapter, it only remains for me to summarise its main themes.

Summary

In this chapter, I contrasted project leaders' views of the Armorshire Collaboration as a catalyst for change with the significant delays in establishing some of the project's key elements. I examined the challenges posed by changing demographic and illness patterns and the lack of resources available to project leaders to establish the new CCM service. I described how the introduction of a new strategy – combined with a lack of terminological clarity – appeared to have engendered ambiguity *vis-à-vis* the aims of the Armorshire Collaboration and explained that this would later impact on engagement with front-line professionals and service users and carers. I explained how extraneous factors – in the shape of the NHS Wales Reforms of 2009 – caused the abandonment of the Armorshire Collaboration's original organisational structure and described the belated introduction of its replacement. I ended the chapter by contrasting the Welsh Government's desire for rapid change with the contextually challenging environment in which the Armorshire Collaboration was run and the belief that – despite the project's integrated agenda – elements of the project were directed hierarchically. In the next chapter (the last of the findings and discussions chapters) I describe how these factors impacted on the integrated approach of the Amorshire Collaboration.

Chapter 7: Integrated working and community engagement: rhetoric and reality

Introduction

In the previous chapter, I described some of the contextual challenges that faced the project leaders of the Armorshire Collaboration. In this chapter, I attempt to assess to what extent a project that was premised on increasing integration, partnership working and wider community participation met these aims, and how the reconfiguration affected client care. I begin with a brief discussion of community participation, before examining the relationship between self-care/self-management and collaborative-working. Moving on to information-sharing with front-line professionals, I explore how changes were communicated to centrally- and peripherally-based practitioners, before examining the extent to which they were engaged in the reconfiguration of services and how this affected service delivery. Subsequently, I turn to information-sharing, communication and engagement with service users and carers, and describe how changing structures and ambiguity affected the extent to which people living with chronic conditions 'co-designed' the new model of care. I then examine the extent to which the voluntary/third sector were involved in the reconfiguration of services, before concluding with an examination of why, in a project premised on community engagement and client-centred integration, these objectives were not met.

CCM, partnership-working, community participation

In *NHS Wales: Improving Health in Wales: A Plan for the NHS with its Partners* (NHS Wales/NAW, 2001, p. 32) the Welsh Government described a vision of partnership-working that included individual patients and communities and of the NHS, 'driven by the views and involvement of individuals and communities in the design, delivery and monitoring of health services'. Subsequently, in *Designed for Life* (WAG/NHS Wales, 2005) a vision was set out for the development of health and social care that was likewise based on, 'service user involvement' (2005, p. 4), 'active participation of citizens and communities in service development' (2005, p. 13), 'strong community partnerships (2005, p. 38) and 'empowering individuals' (2005, p. 12). In view of the increasing numbers of older people living with chronic

conditions and their key relationship with health and social care front-line professionals, it was further noted in *Designed for Life* (WAG/NHS Wales, 2005, p. 13) that:

> We can only achieve a wholesale transformation of our services if those who use services and deliver them at the sharp end are put in the driving seat of redesign. It is the service users and staff who know best the reality of what it feels like to be cared for in Wales (2005, p.13).

In a similar vein, in *Designed to Improve Health and CCM in Wales* (WAG, 2007, pp. 13 – 14) it was indicated that the Welsh CCM Model would ensure, 'patient and carer involvement' and that, 'working in partnership with all stakeholders' and 'working with the home and the local community', the new model would increase the, 'participation of people with chronic conditions and their carers'.

In Chapter Two I explained that whereas integration is described in many different ways, there is little consensus as to its precise meaning and that this – coupled with the interchangeable use of similar (and yet distinct) terms – appears to have militated against conceptual clarity. Researchers of 'community participation' appear to have faced similar problems, with the terminology in this field also imprecise and contested (Baggott, 2013). Taylor (2003, p. 2), for instance, points out that the word community has been, 'invested with a variety of meanings, depending on the perspectives of the people and the institutions that have espoused them', with Baum (2002) suggesting that it is often used as a rhetorical device to conjure up the notion of a closely knit and supportive social framework. Laverack (2007, p. 17) notes, however, that it is important that practitioners move beyond the customary view of communities to understand that they consist of, 'heterogeneous individuals with dynamic social relations'.

With Baggott (2013, p. 90) suggesting that 'participation' has been affected by similar terminological confusion, Coulter (2009, p. 7) points out that this is true of the entire, 'phenomenon of involving groups of people in tackling issues of relevance to their local communities'. Indeed, in Chapter Two (see section, 'Patient and public involvement initiatives') I noted that many different terms – such as participation, involvement and engagement – are used interchangeably, but with little agreement as to what they mean, and that the entire field of PPI is characterised by

ambiguity and complexity. But with many PPI-related terms included in both *Designed to Improve Health and CCM in Wales* (WAG, 2007) and the *Service Improvement Plan* (WAG, 2008), here too the absence of definitions militated against the conceptual transparency which, as I also explained in Chapter Two, is considered fundamental to the development of involvement, and, in turn to integrated working.

Notwithstanding, in *Designed to Improve Health and CCM in Wales* (WAG, 2007) it was indicated: that the creation of improved CCM services would require the, 'engagement of all key partners' (2007, p.31); that developments would be supported by the establishment of mechanisms, 'to encourage involvement of service users, carers and local people' (2007, p. 34); and that monitoring and evaluation would be carried out by way of 'public/patient consultation' (2007, p. 19). In the *Service Improvement Pla*n (WAG, 2008), in turn, it was indicated: that implementation of the new model would be aimed at, 'supporting and empowering people to maximise their independence in all areas of life' (2008, p.5); and that ongoing monitoring and evaluation would be based on, 'the participation of people with chronic conditions and their carers' (2008, p. 9).

Many of the same terms – but again undefined – featured in documentation pertaining to the National CCM Demonstrator Programme. Hence, in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008, p. 2) it was indicated that the demonstrators would, 'involve and engage local people in the design of local services'; in *The National Chronic Conditions Management (CCM) Demonstrator Project: Progress and Achievements in the First Twelve Months* (WAG, 2009a, p. 14) it was noted that monitoring and evaluation of the Welsh CCM had been facilitated by way of 'public/patient consultation'; and in the *Progress and Achievements Year 2: CCM Demonstrators* (NHS Wales/CCM Demonstrators, 2010, p. 15), reference was made to the existence of 'empowered citizens (through meaningful participation of service users)'. As for the Armorshire Collaboration, it was likewise noted (but again, without definitions) in the Project Initiation Document (PID) that the project would, 'empower people to make improvements to their self-care'; 'increase the involvement of service users, carers and the public'; increase 'the participation of people with chronic conditions and their carers'; 'utilise existing consultation and

communication mechanisms'; and 'ensure full engagement from all stakeholders' (App. 9).

Although making equally extensive use of the rhetoric of community participation, particular attention in the PID was drawn to, 'community engagement' (App. 9) with the indication that in its absence, 'care services will not respond as well as they can to the care needs and circumstances of the various communities the project is serving' (App. 9). It was further explained that community engagement equated to 'a continuous dialogue and the development of a good working relationship' (App. 9) and that it required a:

> ... dialogue of equals [between] individuals and local communities who are properly informed about their health needs and what the care services can offer. They are also empowered to talk as equals to care planners and professionals, while recognising the expertise of care planners and professionals (App. 9).

No definition of community engagement was given in the PID. Whilst Coulter (2011, p. 10) notes that engagement is both ambiguous and difficult to define, she nevertheless suggests that it can be considered:

> ...working together to promote and support active patient and public involvement in health and healthcare and to strengthen their influence on healthcare decisions at both the individual and the collective level.

The Wales Centre for Health (2009, pp. 3 – 4) defines engagement as a, 'two-way process' that transcends consultation to encourage, 'deliberation, reflection and learning on issues of policy, planning and the decision-making process' and NICE (2008, p. 5) indicates that, 'Community engagement refers to the process of getting communities involved in decisions that affect them'. The same collective and collaborative features of engagement were stressed in *Designed to Improve Health and CCM in Wales* (2007). Hence, it was indicated that the implementation of the Welsh CCM Model would involve the, 'engagement of all key partners' (2007, p.31), with the latter including, 'health and other professionals, the voluntary sector and local people living with chronic conditions (2007, p. 32).

The same features were also stressed in documentation pertaining to the National CCM Demonstrator Programme. In *CCM Briefing Sheet 1* (WAG/NHS Wales,

2008), for instance, it was reported that the demonstrator-sites would, 'include the role of carers, volunteers and the voluntary sector in supporting and meeting local needs as well as supporting self care' (2008, p. 2); 'engage local support and involvement from local people, patients, carers and communities in service design and delivery' (2008, p. 2); and 'facilitate the cross boundary collaborative agenda and local partnership working' (2008, p. 2). As for the Armorshire Collaboration, it was explained in the PID (App. 9) that, 'engagement of stakeholders' was 'essential' to the project, with the latter:

> ...a collaborative that will produce improvement by harnessing the collective wisdom and enthusiasm of participants from a wide network of multidisciplinary teams in a number of health, social and voluntary care sectors...this approach will bring participatory and empowering consensus-building techniques to the process of re-designing services and care delivery for people living with chronic conditions in Armorshire.

In keeping with these themes of collaboration, participation and empowerment, it was noted in the PID that the project would foster, 'partnership working with service users and all those involved in providing their care' (App. 9). An important point, arguably, given the altered dynamic in relationships between clients/informal carers and health and social care professionals that has accompanied the recognition that most care for people living with chronic conditions is delivered by the people themselves rather than health and social care professionals (APPGs[51], 2014). It is to this altered dynamic that I turn in the next section.

Self-management and self-care: collaborative-working and empowerment

With references to participation, involvement, engagement and partnership-working running through the Armorshire Collaboration PID, it was also indicated – echoing the call, in *Designed for Life* (WAG/NHS Wales, 2005, p. 13) for staff and service users to be placed in the 'driving seat of redesign' – that alongside 'clinicians leading change', patients would be involved in 'designing the new care delivery' (App. 9). The messages, it seemed, were not lost on project leaders in Bro-y-Grug. Hence, during the meeting organised to present the planned reconfiguration of services to

[51] All Party Parliamentary Groups on Global Health; HIV/AIDS; Population, Development and Reproductive Health; Global Tuberculosis; and Patient and Public Involvement in Health and Social Care.

Bro-y-Grug's GP community, Bro-y-Grug LLT GP Lead Dr David Lewis explained that:

> I've underlined the commitment again from the Local Health Board and from the people who are going to decide on how proceedings will move forward. Clinical priorities will take precedence. I think it's worth recognising that clinical means coal-face workers: the people who are with the patient, whether it's doctor, nurse, social worker: they are the clinicians and their priorities, along with those of the patients, will set the agenda of change (LLTMO1: 3).

Dr Lewis' emphasis that the agenda of change would be set by both coal-face workers (that is, front-line professionals) and patients suggested that project leaders had recognised that integrated working has seen a repositioning of service users living with chronic conditions from passive recipients to active partners in care. In a similar vein, Holman and Lorig (2000, p. 526) point out that patients, 'must become a partner in the process, contributing at almost every decision- or action-level'. Indeed, I noted in Chapter Two (see section, 'Integration and service fragmentation') that given the interplay of symptoms, disability, emotional impacts, complex medication regimens and difficult lifestyle adjustments, many physical, psychological and social demands are faced by people living with chronic conditions.

In order to cope with these many demands, it is widely recognised that the latter need to be able to self-care and self-manage their conditions (Carrier, 2009; Coulter et al., 2013). Coulter et al. (2013) note that self-management assumes an active role for people living with chronic conditions, who are encouraged to increase their knowledge about their conditions and to become actively involved in decisions about their care. Indeed, it has been argued that care strategies must reflect the long-term nature of chronic conditions and provide clarity for clients and carers as regards their roles and responsibilities in managing conditions (WHO, 2002). This is especially true considering that what people do for themselves on a daily basis influences their health far more than medical interventions alone (WHO, 2002).

In turn, there has been a movement away from the pre-eminence of the biomedical model and its focus on curative techniques and treatments to an holistic model of client empowerment (see, for example, Nolte and McKee, 2008; Rijken et al., 2008;

Nies, 2009; Coulter et al., 2013). The messages, it seemed, were not lost on the architects of the Welsh CCM Model. Hence, in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 28) it was indicated that a, 'large proportion of care for people living with chronic conditions is provided through self-care by individuals, their carers and local communities' and that one of the, 'foundations for change' of the new model would be, 'independence and self-care'. In the *Service Improvement Plan* (WAG, 2008, p. 31) it was further noted that self-management programmes (such as the Expert Patient Programme) would help to, 'maintain independence and ability to self-care' and that self-management training and education would be, 'incorporated into interactions between the patient and health and social care staff'. As for the National CCM Demonstrator Programme, it was pointed out in *CCM Briefing Sheet 1* (WAG/NHS Wales, 2008) that action was required to support, 'self-care within the community', just as the Armorshire Collaboration would aim to, 'enable and empower people to make improvements to their self-care' and to 'improve healthy lifestyles and wellbeing in the community' (App. 9).

As regards partnership working, it has been argued that at the heart of both self-care and self-management is a close relationship between service users, their informal carers and front-line professionals (Rijken et al., 2008). Hence, just as in NHS Scotland's *National Framework for Service Change in Scotland* (NHS Scotland, 2005, p. 5) it is indicated that self-care initiatives can only be successfully implemented with the 'full backing of care professionals', Coulter (2012, p. 6) notes that collaborative relationships between clinicians and patients who work together are, 'key to encouraging better self-management', with Bodenheimer et al. (2002b) adding that self-management is based upon collaboration, with clients viewed as experts in their own lives, and health care professionals as experts in diseases. Likewise stressing the important role of practitioners in providing information to patients that better enables them to self-manage, both Corben and Rosen (2005) and Nolte and McKee (2008) contend that this necessitates an ongoing collaborative relationship, the purpose of the support being, in the words of Bodenheimer et al. (2005, p. 4), 'to aid and inspire patients to become informed about their conditions and take an active role in their treatment'.

Returning to Dr Lewis' comments, his insistence that clinicians and patients would set the agenda of change, arguably, reflected an awareness of the importance of the close patient-practitioner relationship in improving the care of people living with chronic conditions. It is therefore worth reiterating that when I interviewed Bro-y-Grug LLT Social Care Lead Gwyn Evans in June, 2010 (seven months later), he explained that it was Chief Executives from the Owain Glyndŵr LHB – and therefore, presumably, *neither* clinicians *nor* patients – who had stipulated the launch-date of the Bro-y-Grug Community Resource Team (CRT). The very launch-date which, it seemed, had led to the last-minute rush to begin wider consultation with front-line professionals. This, despite the fact that Gwyn also told me that:

> We've all got our day-jobs, we're all busy. Actually sitting down and planning change and consulting with staff and taking staff with us is probably the most important part of any change. But with your own day-jobs it's very difficult to do that, so the demonstrator gave us the opportunity to do that (LARI1: 2).

Just as Gwyn's words indicated that it was this time and space – away from the demands of their busy daily schedules – that had allowed staff consultation to take place, so it was reported in *The Chronicle: Newsletter Issue 2* (NHS Wales/CCM Demonstrators, 2009f, p. 6) that:

> Through weekly sessions together, the [Locality Leadership] Team will be responsible for the following in their locality: ensuring engagement and consultation with their professional colleagues and service users within the locality and wider, where necessary.

At this juncture, however, it is important to re-emphasise that it was only following the demise of the original delivery team/work-stream structure that the Bro-y-Grug LLT came into existence, with its first meetings not held until November 2009. The first reference to the involvement of front-line professionals in the reconfiguration of services was made in the minutes of the Bro-y-Grug LLT meeting of December 10th, 2009, when it was noted that:

> GE [Gwyn Evans] highlighted the need *to begin* [my emphasis] formal information sharing process and discussion with potential staff that would be affected by COG[52] working. Meetings are planned for the New Year to discuss with individual teams: 5th January Bro-y-Grug Management team

[52] Community Operational Group. See Chapter Chapter Six, section, 'Terminological flux'.

> 9.30 – 12.00; 13th January SW [social work] team, Home Care Managers, Business Support Team; 18th January OT [occupational therapy] and Enablement teams. Anne Richards [CDM Nurse Lead] invited to first meeting with the aim that she will get the CCM Nurses on board. A power point presentation will be given by CT [Christine Thompson] and GE highlighting the Collaboration and the discussion around the COGs. Staff will be encouraged to ask questions and raise issues that may concern them (LLTMM3: 1).

Despite the indication, in the Armorshire Collaboration PID (App. 9), that one of the project's, 'assumptions' was that staff would be, 'motivated to engage with developing new care models, approaches and ways of working', with the project now entering its twenty-first month, it appeared that the process of formal information sharing and discussion had yet to commence. Whilst a recognition of the need to remedy the situation saw a series of meetings organised for the new year, the invitation of Anne Richards to the first of these to, 'get the CCM Nurses on board' appeared to suggest that the nurses themselves would be absent. In the minutes from the next meeting of the Bro-y-Grug LLT (on February 4th, 2010), it was nevertheless reported that:

> Consultation events with staff discussed and lists of positives, negatives and questions were the result. A management training-day is to be arranged and [to] include the Lead GP, Nurse and Social Care Manager to take forward the *CRT* [my emphasis] process (LLTMM4: 2).

The date of this second meeting seems to be of note, given that it was in February 2010 that *Setting the Direction* (WAG, 2010) – the document announcing plans for the implementation of the CRT model – was published. Just as the publication, presumably, accounted for the arrangement of a management training-day to discuss the CRT's development, the January consultation dates with staff suggested that front-line professionals had not yet been informed of the change in direction. But the minutes of the February 4th meeting contained no details of these discussions (which I had not been invited to observe). With the minutes of meetings prior to June 2010 containing no further references to 'information-sharing' or 'discussion' with front-line professionals, at this stage I knew nothing about front-line professionals' knowledge of the forthcoming plans. It is to this subject that I turn my attention in the following section.

Front-line professionals: communication and information-sharing

In Chapter Three (see section, 'Focus groups') I indicated that my academic supervisors and I felt that CRT front-line professionals required sufficient 'bedding-in' time in the new team before being invited to participate in focus groups. Thus, having waited until February 2011 before arranging the first focus group, I began the session by asking participants of their experiences of the establishment of the Bro-y-Grug CRT. First to reply was CDM Nurse (and former Armorshire CDM Team-member) Janet Williams, who explained that, 'I wasn't looking forward to the move at all, I just felt it was thrown upon us' (FPFG1: 1). Janet's remarks prompted Physiotherapist Michelle Roberts to liken the process of information-sharing and consultation to a fire-fight, to which I referred at the end of Chapter Six. Michelle then explained that:

> I only interviewed for my post a year last October and there was no mention of the fact that the teams were likely to integrate, although subsequently I've found out that in fact it was tabled and planned at that time. So I was applying for a post that was based in a team called Llawfon. It was saying, 'Award winning team', and really hard-sell on that aspect of the job. I hadn't been in post very long and we were told: 'It's disbanding and it's going to change'. But I never had that information given to me (FPFG1: 2).

Michelle's lack of prior-knowledge of plans to integrate seemed a far cry from Gwyn Evans' contention that demonstrator-status had facilitated consultation and made possible the process of, 'taking staff with us' (LARI1: 2). On the contrary, Michelle's former Llawfon Reablement Team colleague, Occupational Therapist Toni Ellis, explained that the first Llawfon staff knew of any change was when:

> ...we saw people disappear from the team. We lost a nurse, and then we lost a care management assistant and we lost another social worker. They were being pulled either to here [Ty'r Felin[53]] or pulled back into their health roles somewhere else. Then we lost the site. So we came into the office one day and we were told we had to go somewhere else. It was piecemeal and I think the information that we got at the time wasn't accurate. Because we had a team-leader, and then we didn't have a team-leader. So she was pulled back into another role as well. You just had to run with the changes. From an occupational therapy point of view, our manager did what she could. To be fair to Diane Webb [Armorshire Community Occupational Therapy Lead] I think she's done what she can and she's tried to involve us as much as she

[53] The Social Services Business Support Centre in Llannuon.

> can, from a professional line-manager point of view. But from the organisational point of view, it was just a mess (FPFG2: 2 – 3).

Rather than the 'formal' process described in the minutes of the Bro-y-Grug LLT meeting, information-sharing, according to Toni's account, had been *ad hoc*. But instead of holding individuals directly responsible, Toni attributed the 'piecemeal' nature of information-sharing to the organisational 'mess'. She was not alone in expressing such sentiments. Occupational Therapy Assistant Gemma Denton, for instance, reported that:

> ...they waste so much money going round in circles, and [say]: 'Oh, that's not working, we'll try something else'. Instead of sitting down and getting one thing working, and carrying on (FPFG2: 5).

Care Management Assistant Leslie Jones, likewise, noted that:

> Phone numbers are constantly changing and Careline[54], how many times has that changed its name? People haven't got a clue, they really don't know (FPFG1: 6).

Similarly, Community Speech and Language Therapy line-manager Elaine Dutton stressed that, 'there's change within change happening, things are changing all the time' (MM1: 6). In a similar vein, referring to the backdrop of flux which a number of project leaders had described, Gwyn Evans told me that:

> Health has re-structured and social care's about to re-structure again ... they said, 'Armorshire Trust, that's not good enough, we're going to have to create an Owain Glyndŵr NHS Trust'. Which is what they did first, if you remember? Then, they had the Local Health Board re-structured and then the Local Health Board and the Health Trust merged again ... it just shows you how bloody daft it is. And through all of that we haven't actually got to a point where we're working together (LARI1: 3).

Similar remarks were made by Priest (2012) in a report detailing a British Medical Association (BMA) online survey of BMA Intouch Research Panel members' views on integrated working (BMA, 2011). The survey, completed by 369 British doctors (from a sample-size of 2,500), highlighted a number of barriers to integrated working such as conflicting organisational priorities, lack of coherent technology systems, lack of leadership, but also recurrent structural change. The latter, note Burgess (2012a) and the NHS Future Forum (2012), is a widely recognised barrier to

[54] The single point of entry mechanism to access health and social care services. See section, 'Lack of engagement' below.

integrated working, just as in their systematic review of factors that promote or hinder joint-working, Cameron et al. (2012, p. 14) point out that this has been undermined by, 'the continual drive to reform welfare services'. Indeed, returning to the BMA online survey, Priest (2012, p. 12) notes that one respondent suggested, 'Give us stability, not constant restructuring', before adding that:

> Recent evidence has confirmed that it is very difficult to produce rapid change in a system as complex as health and social care, yet ideas are seldom given the time to become established before something else is introduced. When this is placed alongside the frequent structural and system changes seen in the NHS it is perhaps not difficult to understand why integration has not taken off in any major way.

Moreover, to Gwyn Evans' list of national and regional changes to NHS Wales could be added the overhaul – after twenty months of the Armorshire Collaboration had elapsed – of the project's internal organisational structure and the introduction – after a further four months had elapsed – of the new CRT model. Returning to the comments of occupational therapist Toni Ellis, one could therefore argue that it was hardly surprising that the state of flux had impacted not only on front-line staff but also on their managers. Indeed, similar remarks were made by the managers themselves during a managers' consultation-meeting that I observed on September 9th, 2010.

Organised to discuss managers' views on the new CRT's launch (though held just three weeks before this took place) the meeting was co-ordinated by Corporate Development Officer Jill Sutherland. When, during the first of several groupwork sessions, Jill asked local line-managers to consider their own and their teams' readiness for the imminent reconfiguration of services, Llawfon's physiotherapy line-manager Frank Davies pointed out that:

> I know we've talked today about people changing places and things like that. Over the last few weeks I've been doing the consultation with my staff about what they feel about what's going on. Moving base was not an issue, certainly. It was process and how the team was going to work, because what we covered was that we just don't know how it's going to work (MMO1: 6).

Thus, ex-Llawfon Physiotherapist Michelle Roberts' account of minimal information-sharing seemed to be substantiated by her own line-manager's account.

But it was not just former-members of Llawfon who seemed to have known little about the reconfiguration of services. Rhian Lewis, for example, had been a member of the Armorshire CDM Team. During the first focus group, Rhian – visibly upset and struggling to control her voice – described her experience of the CRT's launch:

> We were a large team of eleven. Within that team there were Heart Failure specialist nurses, three, and there were COPD Specialist Nurses, and there were Diabetes Specialist Nurses. Within that team you had smaller teams which supported each other. Then, within a month it was happening, whether you liked it or not (FPFG1: 5).

I had not foreseen that my first question at my first focus group would bring someone to the point of tears. Immediately after the session, I therefore noted in my reflexive diary that:

> I drastically underestimated the impact of the move to Ty'r Felin on staff and was ill-prepared for the emotional reaction of some participants, e.g. CDM Nurse Rhian Davis. There was much anger and incredulity, e.g. Care Management Assistant Leslie Jones' expression of disbelief at Llawfon's break-up (RD, p. 6).

Leslie Jones had begun by describing her pride at working with Llawfon, adding that its service had been universally admired. (Indeed, I explained in Chapter Four that both Llawfon and the Armorshire CDM Team had won the plaudits of managers, front-line professionals, clients and informal carers alike). Leslie then explained that the move to the CRT had been:

> ... upsetting, because this was a team that was working. It was having all these awards and people were raving about it. Then, all of a sudden, you feel you're not wanted any more, it's gone, all the hard work that we've done in the community. As if it wasn't appreciated (FPFG1: 5).

Whilst leaving supportive, successful and popular teams had, it seemed, been a traumatic experience for some former-members of the Llawfon and CDM teams, the abruptness of the announcement and lack of information-sharing regarding the move to Ty'r Felin appeared to have compounded the situation. Nor, it seemed, had it helped create an attachment to the CRT. On the contrary Rhian Lewis added that:

> Even saying who we are. I'm not sure who we are. Am I a Chronic Disease Management Nurse? Am I just one of the nurses within the CRT? I still don't know (FPFG1: 9).

Arguably, Rhian's comments – after nearly five months in the CRT – suggested that she was in a position of 'role ambiguity' (Handy, 1993, p. 63). According to Handy (1993, p. 63), the latter exists, 'when there is some uncertainty in the minds, either of the focal person or of the members of his role set[55], as to precisely what his role is at any given time'. Although Handy notes that role ambiguity is not inherently problematic – inasmuch as it can, he argues, give the focal person the freedom to shape their own roles – he adds that it can lead to, 'role stress' (1993, p. 68). With Handy (1993) explaining that the latter often manifests itself in low morale – which certainly appeared to be the case for Rhian Lewis and Leslie Jones – Glasby and Lester (2004) point out that this has been viewed as a barrier to successful partnerships.

Gorman (1998), moreover, suggests that maintaining an allegiance to an organisation outside of the team in which one works – which again, appeared to be the case for Rhian Lewis, Leslie Jones and a number of other former members of the Llawfon and Armorshire CDM teams – can hinder effective multidisciplinary teamworking. With West and Markiewicz (2006) positing, conversely, that one of the seven dimensions of effective partnership working is a shared commitment to goals and objectives, it could be argued that the apparent lack of information-sharing had done little to encourage the development of any such commitment.

In turn, this would seem to re-emphasise the importance of clarity and consistency in the communication of a joint-vision in the promotion of partnership-working. Whilst Huxham and Vangen (2004, p. 191) argue that the theory of 'collaborative advantage' is premised on clarity of goals, they note that in its absence there is a heightened risk of 'collaborative inertia'. Indeed, Williams and Sullivan (2009f, p. 3) indicated that clarity of the 'wider purpose' of the partnership was the 'glue' that held together heterogeneous stakeholders in their case study of five Welsh collaborative health and social care projects. Whilst the CRT also comprised a heterogeneous combination of front-line professionals from different (allied) health and social care specialities, reports of a lack of information-sharing – and therefore,

[55] 'The particular individual with whom one is concerned in the analysis of any situation is usually given the name of *focal person*. He has the focal role and can be regarded as sitting in the middle of a group of people, with all of whom he interacts in some way in that situation. This group of people is called his role set' (1983, pp. 59 – 60 original emphasis).

presumably, an attendant lack of insight into the Armorshire Collaboration's wider purpose – were nevertheless made by all front-line professionals who, prior to the reconfiguration, had *not* been based at Ty'r Felin. These included front-line professionals who were now part of the CRT, but did not share office-space with the rest of the 'co-located' team at Ty'r Felin, as I explain in the next section.

A team divided

That there even *were* members of the CRT who were not based at Ty'r Felin was something that I only learned of during the first focus group. At that time, ex-Llawfon physiotherapists and occupational therapists explained that whilst they had responsibility for care-programme design, hands-on delivery was carried out by teams of social care support staff. However, the former noted that the social care support staff had not joined them at Ty'r Felin after the reconfiguration, and had instead been relocated to other sites (outside of Llannuon). This despite the fact that prior to the reconfiguration, they had worked in close collaboration, with regular joint-meetings at the Llawfon office to discuss and organise programmes of care. It transpired that not only were the allied health care professionals and social care support staff now based at different locations, but that their direct channels of communication had also been blocked.

Keen to capture the views of these peripherally-based CRT-members, I set about organising another focus group. With their busy schedules, variety of bases (some, since the reconfiguration even having to work from their cars) and loss of mobile-phones (a cost-cutting measure) this turned out to be a challenging proposition. However, in addition to one Ty'r Felin-based practitioner, the fourth focus group included seven peripherally-based social care support staff, one of whom was Domiciliary Care Practitioner Judith Price. When I asked Judith what information she had received about the reconfiguration of services prior to the CRT's launch, she replied, 'None at all' (FOFG4: 2).

With Senior Enablement Practitioner Annabelle Ford adding that all she had known was that, 'this new team had been set up' (FPFG4: 2), I inquired as to how information *had* been shared. In reply, her fellow Senior Enablement Practitioner Emma Stone explained that, 'We had a meeting. But we were just told what we

needed to be told' (FPFG4: 3). Emma's reply contrasted sharply with the pre-reconfiguration responses – to my question 'What are the key elements of integrated working?' – of a number of project leaders. Hence, Gwyn Evans had told me that: 'You can't put a price on having joined-up thinking and open discussion, regular communication' (LARI1: 9); Project Manager, Jo Marshall had suggested that: 'communication and information-sharing are absolutely pivotal' (LARI2: 7); District Nurse Lead Janice Davies had argued that they included: 'sharing of information which, I think, is very important' (LARI4: 4) and CDM Nurse Lead Anne Richards had told me that they included, 'Communication, because if you go and look at what's the problem and why have things fallen apart, often it's just that people don't communicate'(LARI6: 3).

The repeated references to the importance of communication seemed understandable, given Cameron et al.'s (2006a, p. 50) assertion that it is the, 'bedrock of successful joint-working'. Indeed, analogous comments have been made by many experts of integrated working in health and social care (see, for example, Curry and Ham, [2010]; Ham et al., [2012]; CSIP/ICN [2008]; Gilburt and Peck [2014]; Harris et al., [2013]). When I asked participants in the fourth focus group to what extent they had been asked their views on the reconfiguration of services, however, Judith Price also stressed that, 'We weren't, were we?' (FPFG4: 3). However, a quite different answer – to the same question – was given by participants in the second focus group:

> **Heather Edwards** (Assessor Care Manager): There were several meetings weren't there? We were consulted and we were asked about our views.
>
> **Caroline Thomas** (Social Worker): They were the CRT Development Meetings, weren't they? They were usually held on the Friday, weren't they? We must have had four or five of them (FPFG2: 6).

Unlike the majority of the focus group participants, however, Heather and Caroline were two (of a total of just seven) front-line professionals (all of them from social care) who had been based at Ty'r Felin before the CRT's launch. This meant that throughout the Armorshire Collaboration (not just after the CRT's launch) Heather and Caroline had worked at Bro-y-Grug's Social Services Business Support Centre, alongside Social Care Area Manager – and local 'champion of change' – Gwyn Evans. As of the Bro-y-Grug LLT's launch, moreover, Locality Care Co-ordinator

Christine Thompson had been based at Ty'r Felin (next door to Gwyn Evans, now also the Bro-y-Grug LLT's Social Care Lead) and Ty'r Felin had become the venue of the LLT's weekly meetings.

With Caroline explaining that Ty'r Felin was where the CRT Development Meetings were also held (though, it would seem, only for Ty'r Felin-based staff) one could therefore argue that if the hub of the Collaboration in the Bro-y-Grug locality was anywhere, it was at Ty'r Felin. This could go some way to explaining why, during the first groupwork session of the managers' consultation-meeting of September 9th, Ty'r Felin-based Enablement Team Manager Janet Butler pointed out that:

> When you look at some out in the community, they're in a lot of disarray, when they don't really know as much as we know, because we're in the office, knowing what's going on (MMO1: 7).

The discrepancy, it seemed, had not escaped the attention of Christine Thompson. On the contrary, on August 16th she had advised front-line health and social care professionals (by email) that:

> There is currently a Health and Social Care Board at the top of the stairs in Ty'r Felin where any developments, dates, or important pieces of news relating to the CRTs will be displayed. We would like you to read this and keep yourself up to date. For those who are not based in Ty'r Felin, we can email any information out to you (EMA1: 1).

Despite working next door to Christine and attending the same Bro-y-Grug LLT weekly meetings, it appeared that the message had not been received by Gwyn Evans. On the contrary, on hearing (in the same consultation-meeting) of local line-managers' concerns *vis-à-vis* their and their staff's lack of knowledge of the forthcoming changes, Gwyn suggested that:

> Maybe we need to look at a communication strategy, how we filter information. Do we need to have a local newsletter at this time of change? Is it something that we should be putting together regularly over the next few weeks? So [for example] there's an email that goes out every week, saying, 'This is the latest' (MMO1: 8).

Given that Gwyn seemed to know nothing of Christine's earlier email, it could be argued that his comments called into question the effectiveness of the LLT's *internal*

system of information-sharing. Moreover, both his and Christine's recognition of the need to establish an *external* 'communication strategy' seemed to have come somewhat late in the day, with less than two weeks remaining until the CRT's launch. During the managers' consultation-meeting, however, I learned that Christine's belated plans for wider communication had come to nothing. So, having reported that the Business Support Team's Dawn Griffiths had been tasked with updating the information board and sending out the required emails to staff based outside of Ty'r Felin, Christine hastened to add that, '... because poor Dawn has been pulled from pillar to post, that hasn't happened' (MMO1: 9).

It transpired that, with no funds available to rent extra accommodation, the CRT's imminent arrival meant that the Business Support Team had been required to move to a smaller office. As a consequence, communication systems had been suspended, with the resultant lack of sharing of plans with externally-located staff. A case in point, it could be argued, of Leutz' (1999) warning that by failing to provide start-up costs, support systems will not be developed, staff will not participate in planning and as a result, integration can be compromised. But even after an alternative office *had* been found, Assessor Care Manager Heather Edwards noted that Ty'r Felin's layout meant that:

> ... some staff are quite isolated, they've ended up working alone, not attached to anybody. It's affected Business Support. Whereas where we were situated before we'd be walking through and they'd see us [and] the relationships were better, they've now been moved into a room, isolated from us. Unless we go in to find them with an envelope or whatever, we don't see them and they don't see us (FPFG2: 20).

Heather's comments *vis-à-vis* the isolation of staff had been borne out by the comments of CDM Nurse Rhian Lewis. Moreover, the apparent failure to consider communicating plans to all front-line professionals – rather than just those based at Ty'r Felin – until less than a month prior to the CRT's launch appeared to belie some of the key messages, firstly, inherent in the Welsh CCM Model:

> Effective communication and information systems form the basis of good service delivery and patient care in managing chronic conditions in the community (WAG, 2007, p. 29).

Secondly, of the National CCM Demonstrator Programme:

> Clear and unambiguous communication of what we are trying to achieve is vital for understanding and buy-in (NHS Wales/CCM Demonstrators, 2009, p. 2).

Finally, of the Armorshire Collaboration:

> The successful implementation of the Collaboration project entails major organisational change and to achieve a successful and sustaining change, effective communication and the engagement of stakeholders is essential (Armorshire Collaboration PID [App. 9]).

In their case study of five Welsh collaborative health and social care projects, Williams and Sullivan (2009f, p. 11) likewise reported that many stakeholders felt that the role of communication in providing a clear direction during the process of engagement could 'not be over-emphasised'. This appeared to be particularly true of the last of the five cases – and one that seemed to correspond in a number of ways to the Armorshire Collaboration – namely, the Delivering Integrated Services (DIS) Project. This, note Williams and Sullivan (2009e), was a multi-agency project led by the then Bro Morgannwg NHS Trust which sought to redesign local care by relocating services for older people and people living with long-term conditions from secondary care to the primary and community-based environment.

Just like the Armorshire Collaboration, Williams and Sullivan (2009e, p. 2) indicated that the DIS was conceived as a 'collaborative initiative' comprising a range of statutory and voluntary partners, with involvement from the Bro Morgannwg NHS Trust, three Local Health Boards, three local authorities, and three Councils for Voluntary Services (representing Bridgend, Neath Port Talbot and the Vale of Glamorgan). Whilst one of the main challenges of the DIS Project, reported Williams and Sullivan (2009e), was to ensure effective engagement of a disparate group of stakeholders over a long period of time, they pointed out that one of the important messages to emerge was that this was achieved by way of regular communication. However, just as all seventeen of the Bro-y-Grug CRT-members who had not worked at Ty'r Felin prior to the reconfiguration gave analogous reports *vis-à-vis* the lack of communication and information-sharing, in the next section I

describe how – perhaps unsurprisingly – all of them reported that their engagement in the reconfiguration had also been minimal.

Lack of engagement

In the previous section, I noted that Heather Edwards and Caroline Thomas – who, prior to the CRT's launch, were based at Ty'r Felin – explained that they had attended several CRT Development Meetings and had been asked their views. Having listened to their comments, ex-Llawfon Care Management Assistant Rhodri Jones – who, prior to the reconfiguration, had *not* been based at Ty'r Felin – pointed out that:

> When Llawfon was still up and running, towards the end of our existence, we were invited to one CRT meeting. Basically it was more of a presentation: 'This is how it's going to be'. We were told we could make comments, post comments if we wanted to, or send emails, have suggestions. But that's as far as consultation went. So when I left Llawfon and came here, the thing was on the tracks and running, there was no more consultation after that.
>
> **Heather Edwards** (Assessor Care Manager): No. I think that it was [already] planned, so you've just got to go with it, haven't you?
>
> **Gemma Denton** (Occupational Therapy Assistant): Yes. It was going to happen, so you had to either embrace it with both arms or get frustrated, angry, and still have the change.
>
> **Caroline Thomas** (Social Worker): They just gave you the opportunity to put suggestions in the suggestion box, and emails, but you knew it was going to happen anyway (FPFG2: 5- 6).

Similar opinions were expressed during the third focus group:

> **Louise Thomas** (Occupational Therapy Assistant): We were invited into some of the meetings. It was encouraged that we had a view on what we felt and there was even a box for us to put our views in if we didn't want to say. But we were also told that we were not to be negative, that we were to be positive. So, to me, that was a waste of time. Because, if you're feeling negative, you need to say [so] and somebody needs to explain [it] to you, to bring you out of it. [But] it was told that we weren't allowed to be negative. So, we had nothing to say at that moment, because that is how we *did* feel.
>
> **Lauren Price** (Occupational Therapist): In a way, it was positive criticism, because all we were doing was giving our views on how the changes should be implemented.

> **Deborah Hale**: (CDM Nurse): We were allowed our views, weren't we? But they didn't listen to our views.
>
> **Vanessa Lewis** (Care Management Assistant): They'd already made their decisions anyway.
>
> **Deborah Hale**: Yes, they'd already made their decisions. We were put into these little boxes, and that's where we were going to go. They wouldn't listen to our views and our concerns (FPFG3: 3- 4).

One of these concerns related to administrative issues, with Rhodri Jones pointing out that, 'We're not being supported by business support, because we have to do everything ourselves' (FPFG2: 21) and Physiotherapist Michelle Roberts explaining that in the absence of any printed documentation, she had had no option but to continue sending out letters with Llawfon's letterhead and logo long after its closure. This meant, Michelle added, that as late as January 2011, her clients – presumably ignorant of the CRT's existence – were still leaving messages for her on Llawfon's answer-machine. Given Christine Thompson's report of the lack of funding to help launch the CRT, this appeared to provide another instance of the negative impact on integration that, Leutz (1999) warns, can result from a failure to provide adequate start-up costs.

Another concern related to joined-up IT systems. When I asked participants what they considered to be the key elements of integrated working, Deborah Hale replied 'One system' (FPFG3: 11), with Louise Thomas adding, 'It has to be one system' (FPFG3: 11). However, Lauren Price hastened to add that:

> We *did* mention that, and I was told: 'We can't do anything about the IT system, so we've got to work around that'. [But] I don't think they had any processes in place. Nobody could say anything. Remember, we were in that physiotherapy and occupational therapy meeting? And I said: 'Well it's the database system'.
>
> **Vanessa Lewis**: Nobody could say how we could refer to other professionals, nobody had any answers (FPFG3: 11).

But with no answers forthcoming, Physiotherapist Michelle Roberts stressed, in the first focus group, that, 'We are still on two very separate systems: a health system, and the social care system is separate' (FPFG1: 16). In the third focus group, Lauren Price further explained that:

> The data system hasn't really caught up with the integration, so we're on completely different databases. For example, if one of the occupational therapists has gone out and done an assessment, and [then] gone off sick, I can't access her database. So I would feel very uncomfortable going out to evaluate that work, I'd have to go out and re-assess the situation (FPFG3: 9).

But it was not only because of sickness that colleagues might not be able to pass on information. On the contrary, Occupational Therapy Assistant Louise Thomas pointed out that:

> If you're working on completely different systems, you may as well be in a different town. It doesn't matter if you're sitting next to her, because if she's not there, you haven't got the information. So it doesn't matter where she is based (FPFG3: 10).

In Chapter Five (see section, 'Inefficiency and changing structures') I explained that prior to the reconfiguration of services, a number of local project leaders anticipated the benefits of co-location, suggesting that situating health and social care practitioners in the same offices would facilitate opportunistic dialogue and that, as a result, information-sharing, communication and client-care would improve. However, at the same time I noted that Imison et al. (2008) reported – in their exploration of the delivery of integrated care by polyclinics – that many stakeholders' initial expectations of co-location had not been realised.

Indeed, mirroring the comments of a number of the CRT's front-line professionals, Imison et al. (2008) suggested that many staff in the study-sites felt that subsequent to co-location, services continued to operate in isolation and that without the support, for instance, of joined-up IT-systems, co-location was not sufficient to foster co-working or integration of care. Whilst other evaluations of partnerships have cited computer problems as a significant barrier to information-sharing (Richardson and Asthana, 2005) many experts (see, for example, Lewis et al., 2010; Shaw et al., 2011) suggest that 'functional integration' (including integrated patient records) is a key dimension of integration. Moreover, returning to Imison et al.'s (2008, p. 48) study, one of the researchers' 'key conclusions' was that:

> The primary focus should be on developing new pathways, technologies and ways of working rather than new buildings. Co-location alone is not sufficient to generate co-working between different teams and professionals.

> Investment in change management and strong clinical and managerial leadership will be required.

As for the co-location in the Bro-y-Grug CRT, however, in addition to not being supported by joined-up IT systems, there appeared to be another basic flaw in project leaders' predictions that it would facilitate communication: namely, that this assumed that practitioners from different disciplines would be working in the same office at the same time and would have time to engage in discussions. As the comments of Michelle Roberts and Louise Thomas indicated, however, this could not be taken for granted. Instead, as the name suggested, the *Community* Resource Team practitioners spent the lion's share of their time in the community at their clients' homes or – given Bro-y-Grug's rurality – travelling between them, with office-time further eroded by the substantial increase in case-loads – but no concomitant increase in staff – that was reported by many front-line practitioners. So, just as Care Management Assistant Vanessa Lewis noted that, 'the physios, you know, are hardly ever here, they're still based in the hospital, people are still out and about doing their assessments' (FPFG3: 17) so Occupational Therapy Assistant Gemma Denton reported that, 'I did over ninety miles yesterday, because I was out at the back of beyond' (FPFG2: 12). Moreover, Gemma added that once the day's visits – often to multiple clients with the surname Thomas – were over:

> ... you come back to the office, you get sidetracked by somebody and then you pick up the first one and you think, 'Right, I'll do this now, which Thomas is this?' It's so confusing. Before, I could do eight or nine visits a day and just do handwritten documentation. Great, you had a hard copy. But now, just say for argument's sake, I needed social work input. For me to put an activity on for them I need to go to administration (FPFG2: 12).

In a similar vein, Care Management Assistant Rhodri Jones pointed out that sitting in the same room as someone did not guarantee that the care of clients would be shared. On the contrary, he stressed that:

> ... even if you wanted an OT [Occupational Therapist] who's sitting at the desk next to you to be involved with one of the clients, first of all you have to create an activity on Careline. That has to go to a senior practitioner. It then has to be allocated an OT. You don't know how long it's going to take, and it may not even be the OT sitting next to you, it could be any one of them. And that applies right across all the professions. Whereas in Llawfon, I know it may have had lots of shortcomings, but at least it was proper team-

> working. Every client was shared, they belonged to the team, not to an individual; and we were working as a team (FPFG2: 10 – 11).

Given the apparent obligation to utilise Careline (the single point of entry mechanism to access health and social care services) it seemed that the result of co-location in the CRT was at odds with the one described by Hudson (2002) in his study of interprofessionality in the provision of health and social care services to frail older people in northern England. In the study sites in which staff were co-located, Hudson (2002, p. 13) noted that there was improvement in the, 'frequency and quality of information-sharing'. However, whereas the CRT's co-located front-line professionals were required to follow formal procedures (via separate IT systems) the health and social care professionals working in the co-located teams in Hudson's (2002) study had been given the leeway to modify them.

Indeed, Hudson (2002) argues that given the diversity of professionals' tasks, the development of individual cases cannot be predicted, which renders the task itself uncertain, thereby requiring each case to be assessed on its own merits. Just as Hudson (2002) argues that this means that practitioners require adequate freedom and autonomy to act in accordance with the demands presented, this appeared to be of particular relevance in the two localities in which health and social care professionals were co-located and where, Hudson (2002, p. 14) noted, there was evidence of a 'shared and informal approach to allocations'. In a similar vein, Occupational Therapist Toni Ellis pointed out that when she had worked with Llawfon, she had been able to:

> ... step in and out without having to have this constant referral back and forth. And the client then *did* develop a relationship and began to recognise who we were and how we identified with this team called Llawfon. But now, like Rhodri was saying, it's a bit more disparate, and a bit more fragmented. So even though we are a team, Mrs. Jones, for instance, could get a physiotherapist allocated to her and she could get an occupational therapist allocated to her and she could get a social worker allocated to her. And we'd all be doing our individual little bits and we would all have done it based on our individual little assessments and from our own professional perspective (FPFG2: 11).

Whereas in Llawfon it appeared that front-line practitioners had had the freedom to work together in informal ways – thereby assuring a common and client-focussed

approach – it appeared that in the CRT the rigorous application of official referral channels had resulted in a more profession-specific and fractured service. This was a far cry, arguably, from the pre-reconfiguration contention – on the part of national, regional and local project leaders alike – that the reconfiguration would reduce fragmentation and duplication, would guarantee a focus on clients (rather than on processes) and promote a shared vision (rather than a profession-specific one). Instead, the words of Rhodri and Toni seemed to suggest that by insisting (from the top down) on the use of formal referral channels, project leaders had overlooked the role of professional discretion on the part of the CRT's practitioners, a discretion which, argues Lipsky (2000), is part and parcel of the work of public service employees (or 'street-level bureaucrats' [2000, p.3]) who interact directly with the public.

In Chapter Two (see section, 'The language of integration') I described how integration is a multi-faceted and complex phenomenon, and that there is little consensus as to what it means and no single 'best-practice' model. However, I explained that recent years have seen the emergence of two distinct themes: on the one hand, that whatever model of integrated care is adopted, it should be client-focussed and organised around the client's perspective; on the other hand, that in and of itself, structural integration does not ensure integrated care (see section, 'The determinants of integration: structure or culture?'). However, I also noted that successive UK governments have focussed on structural parameters of integration, despite limited evidence as to its effectiveness and despite recognition that successful integration has a number of other 'key requirements' (Fulop et al., 2005, p. 4). One of the latter, note Fulop et al. (2005, p. 4) is, 'normative integration', which they explain is, 'the role of shared values in co-ordinating work and securing collaboration'.

With the CRT's structure appearing to have militated against the sharing of values (in terms of fostering a profession-specific rather than an holistic perspective on client care), one could argue that the situation brought into focus the question of structure and agency. McAnnula (2002) explains that structure, on the one hand, relates to context and the material conditions defining the range of options available to actors and that agency, on the other, relates to the abilities of individuals or groups

to affect their environment. Whilst Williams (2012) points out that structuralists believe that social, political and economic outcomes can be explained by structure and that intentionalists and behaviouralists, conversely, argue that agency is the determining factor, a number of other commentators – including Giddens (1984), Jessop (1990), Sewell (1992), Hay (1996) and Archer (1996) – have adopted a dialectical approach whereby weight is given to both structure and agency. Gidden's (1984) 'structuration theory', for example, posits that structure and agency are not separate entities but are instead dynamic, mutually dependent and internally related. Giddens (1984, p. 25) therefore indicates that 'the constitution of agents and structures are not two independently given sets of phenomena but represent a duality'. In turn, Giddens argues that structure only exists through agency and that agents have rules and resources between them that will facilitate or constrain their actions. As far as collaborative working is concerned, Crosby and Bryson (2010, p. 227) suggest that structuration theory, 'provides a useful way of thinking about how actions and practices create, recreate and stabilize the structures that then provide rules and resources to draw on and guide further action and collaboration'.

With both Hay (1996) and Jessop (1990) drawing a clear distinction between structure and agency, they argue that action only takes place within a pre-existing structured context that is structurally selective, thereby favouring certain strategies over others. McAnnula (2002, p. 271) indicates that the structure-agency question concerns the extent to which people have, 'the ability to shape our destiny as against the extent to which our lives are structured in ways out of our control', with Hay (2002, p. 254) suggesting that, 'actors make outcomes but the parameters of their capacity to act is ultimately set by the structured context in which they find themselves'. One could therefore argue that it was the very 'structure' of the CRT that militated against front-line professionals' 'agency' and their capacity to act in an integrated manner for the benefit of clients.

Moreover, just as Occupational Therapist Lauren Price had pointed out that prior to the reconfiguration of services, front-line professionals had drawn project leaders' attention to the lack of joined-up IT, so Rhian Lewis noted that a host of questions pertaining to communication within the CRT had been:

> ... raised before, because we had concerns. When you run a team and you run a service, and then the service is no longer [in existence] you need to know what happens when you are here, but it was never...
>
> **Janet Williams** : ... planned.
>
> **Rhian Lewis**: We were never given any answers to our questions.
>
> **Paula Davies** (Occupational Therapist): We raised the practicalities during the consultation process. And the concerns that we raised with regard to our own practice and to the provision of a service were pretty much swept under the carpet (FPFG1: 8).

But with Rhodri Jones' indication that the CRT was already 'on the tracks and running' (FPFG2: 7) before he and his Llawfon colleagues were invited to any meetings at Ty'r Felin, and ex-Armorshire CDM Team-member Deborah Hale arguing that, 'our views and concerns' (FPFG3: 5) were ignored, it appeared that little heed had been taken of the concerns of front-line professionals. This despite the indication, in *Leadership and Engagement for Improvement in the NHS: Report from the King's Fund Leadership Review* (King's Fund, 2012, p. 3) that staff who feel fully involved in an enterprise 'work harder, think more creatively and care more'. In a similar vein, in another King's Fund publication, *Improving NHS Care by Engaging Staff and Devolving Decision-Making: Report of the Review of Staff Engagement and Empowerment in the NHS* (King's Fund, 2014, p. 15), it was noted that, 'Highly engaged employees are more likely to deliver high-quality care'.

Moreover, the end-result of the failure to listen to front-line professionals appeared to be a service that was now: more (rather than less) fragmented and more (rather than less) duplication-ridden; but less (rather than more) client-focussed, and less (rather than more) collaborative. Arguably, this brought into sharp focus the discrepancy between the pre-reconfiguration rhetoric of integration and a post-reconfiguration reality of division. But there were other concerns that appeared to have been similarly 'swept under the carpet', as I explain in the next section.

No joint-meetings: no 'knitting together'

One of these other concerns was the issue of joint-meetings. Again, this issue appeared to display the rhetoric/reality divide, considering the discrepancy between pre-reconfiguration guarantees that joint-meetings would be held, with post-

reconfiguration reports that these had been ruled out. Thus, during the second-focus group, when I asked participants what they considered to be the key elements of integrated working, Occupational Therapist Toni Ellis explained that:

> I would say it would be multidisciplinary team, face-to-face meetings, which managers are not keen on, because they say they're very time-consuming and not productive. But I find them useful because you can often exchange information and pick up stuff that isn't immediately apparent from a formal process of communication through your documentation or your forms (FPFG2: 15).

The organisation of meetings in the CRT had been discussed during the managers' consultation-meeting of September 9th, 2009. At that time, Llawfon physiotherapy line-manager Frank Davies – and a number of other line-managers – drew Locality Care Co-ordinator Christine Thompson's attention to staff concerns as to how meetings would be arranged post-reconfiguration. In reply, Christine noted that:

> We have talked about how often people are meeting, where they're meeting, why they're meeting, what they're doing with the meeting and who they feed back to after they've met. It appeared that people were meeting lots of times, on different occasions. How do we think now? Because remember, we're not going to have a social work team, or a CDM Team. We are going to be a Community Resource Team. How do you think we need to be doing this? How do you think we need to be meeting? Because the meetings, presumably, are about clients within our CRT?
>
> **Frank Davies**: It's quite a difficult question to answer isn't it? Because of the different patients, clients, that are going to be coming into the team, because...
>
> **Dr. David Lewis** (GP-lead, Bro-y-Grug LLT): ... I think you have to go back a step before you start discussing clients and patients, which is an MDT meeting. It would be incredibly unwieldy to try to do an MDT meeting at the same time. You've got the service of the CRT and how that's developing. That's what we would really like to know in the first few weeks: how's it going? How's everybody gelling? How is the team performing? (MMO1: 9).

Despite Christine's apparent interest in garnering line-managers' views on the future development of meetings, Frank Davies' reply was interrupted by Dr Lewis. Thus, it was instead the latter who voiced *his* opposition to MDT meetings. Before Frank Davies had a further chance to reply, another member of the Bro-y-Grug LLT – Gwyn Evans – took up the argument:

> We want the CRTs to come together, especially in the first few weeks, I guess. With the opportunity, with some of us as managers, maybe – I'm happy to go to those – to facilitate discussion about the development of the CRTs, how things are going and any updates of what's going on. Again, we're back to information-sharing (MMO1: 9).

In the event, neither Frank Davies nor any of the other line-managers were given another opportunity to answer Christine's original question. With discussions swiftly moving on, this left her no closer to ascertaining their views. Nevertheless – and with his use of 'we' appearing to indicate that his views were representative of project leaders (although appearing to contradict his LLT colleague Dr Lewis) – Gwyn expressed *his* support of joint-meetings (albeit with the aim of discussing the CRT's development rather than clients) and indicated that these were part of existing plans. During the second focus group, however, Social Worker Caroline Thomas explained that:

> I don't think we've ever met as one CRT. We're supposed to be one CRT. I don't think I've ever spoken to Toni.
>
> **Toni Ellis** (Occupational Therapist): No, I think it's the first time.
>
> **Caroline Thomas**: Exactly. We have our own social work meetings with our social work manager, which has always happened. Then we get put into this team and we're meant to be an integrated team. But we've never had a team-meeting. We are supposed to be a team as well. So, I find, maybe that hasn't helped, because I don't think we've ever sat down and had a meeting of mixed professionals. If you're supposed to be a team of mixed professionals, we need the meetings, not separate social work meetings. You're keeping us separate then. I know it can be difficult because of what you discuss, but then you leave the social work things for the social work meetings and then, possibly, the same with you guys?
>
> **Toni Ellis**: No, we don't have [joint] meetings, do we?
>
> **Gemma Denton** (Occupational Therapy Assistant): No.
>
> **Caroline Thomas**: It would be something for them to discuss as the CRT, wouldn't it? Even if it's every two months, not monthly. Because I don't think we've ever met and we've been sitting here since last September.
>
> **Heather Edwards** (Assessor Care Manager): If you *did* have a case that you wanted to bring up, perhaps we could discuss it generally and then find a way forward that's to improve the service for that person.
>
> **Toni Ellis**: Give you a bit of guidance, yes.

> **Caroline Thomas**: I think that's what's missing for me. I think that would knit us together a lot better (FPFG2: 16 – 17).

Positing that integration had been hampered by the perpetuation of social work-only meetings and the non-initiation of CRT team-meetings, Caroline's words contradicted Gwyn's assurances that the CRTs would, 'come together' to facilitate discussion. The absence of a joint-forum was all the more significant, perhaps, given Heather Edwards' observation that:

> ...we are just ships that pass in the night, aren't we?
>
> **Caroline Thomas**: Yes, that's all it is, we're just sharing a room.
>
> **Heather Edwards**: We see each other in the corridors.
>
> **Gemma Denton**: But that's the only time we *do* see each other (FPFG2: 16).

Not only did front-line professionals appear to be engaged in minimal opportunistic dialogue, Caroline's contention that team-meetings would help 'knit us together' suggested that in the absence of such meetings, the joint-ethos of client-centred care espoused by Gwyn (amongst others) had been given little chance to develop. This, despite the fact that during my interview with Gwyn, he had emphasised that:

> If we don't have the nurses, the social workers, physiotherapists, occupational therapists, if we don't have those people signed-up, believing it's a good idea, wanting it to happen, it doesn't make a blind bit of difference who the manager is or what the structure is, it makes no difference. Nothing will change unless we've got the staff on board. You have to get that culture in place first (LARI1: 4).

As I have already indicated (see Chapter Two, section, 'The determinants of integration: structure or culture?') a recurrent issue in discussions relating to partnership working between health and social care services is organisational culture. Bearing in mind the latter's pervasive nature, Stewart (1997) and Naylor (2004) note that to engender organisational change – which, in the case of the CRT, project leaders hoped, would see the development of a joint-ethos of client-centred care – requires a concomitant cultural change. Indeed, the eight-step processes of organisational change suggested by Covington (2002) and Kotter and Cohen (2002) both include the development of a clear vision and also the nurturing of a new culture of shared values. But with Mullins (2013) emphasising that it is far from

easy to change organisational ethos and culture, he adds that an important priority in minimising the problems this poses is to create an environment of trust and shared commitment and to involve staff in decisions and actions that affect them. With this in mind, it was hard to see how, in an environment in which front-line professionals from different professions rarely had the opportunity to speak to each other, *any* changes (cultural or other) could occur.

On the contrary, with at least two participants from each of the focus groups comprising only Ty'r Felin-based front-line professionals *never* having previously spoken (just like Caroline and Toni) the situation again appeared to gainsay project leaders' pre-reconfiguration suggestion that co-location would improve inter-professional knowledge (and again displayed the rhetoric/reality divide). Hence, Social Worker Rebecca Griffiths suggested that being a member of the CRT had not changed:

> ... in a positive way, my way of working, or my way of tapping into other professions. I feel I've still got the same understanding that I had before, and I haven't really developed much more of an understanding of other people's professions (FPFG1: 1).

Rebecca's words appeared to provide another refutation of project leaders' contention that co-location would lead to improved communication. As regards the impact of this lack of knowledge on client-care, moreover, CDM Nurse Rhian Lewis pointed out that:

> ...it's very difficult to be able to see what is available to them, because we don't know what we do. I know what *I* do, but we still haven't had the understanding of other people's roles (FPFG1: 14 – 15).

Accordingly, in addition to experiencing ambiguity as to whether or not she was a part of the CRT, it appeared that Rhian (like Rebecca) was unclear as to the role of other front-line professionals too. With social workers (and, it transpired, physiotherapists, occupational therapists and CDM nurses) continuing to attend profession-specific meetings, one could argue that arrangements were doing little to promote interprofessional understanding or the development of the 'cultural congruity' which, contend West and Markiewicz (2006, p. 81), is one of the dimensions of effective partnership-working. This, despite the fact that in a paper reporting on discussions on best practice for the successful integration of health and

social care services during the spring 2013 seminar of the Association of Directors of Adult Social Services (ADASS/ADSW/ADSS Wales/ADSS Northern Ireland, 2013, p. 5), it was noted that:

> Culture binds the organisation together, defines what values and behaviours are acceptable and, crucially, the organisation's orientation towards performance. Achievement is dependent upon culture.

In their international case study of four organisations that integrated health and/or social care between different providers, Rosen et al. (2011, p. 31) explored what they consider to be a key ingredient of integrated working, namely, 'normative integrative processes'. Explaining that the latter, 'relate to developing shared values and aligned professional standards across participating individuals, groups and organisations' (2011, p. 31) Rosen et al. (2011) noted that one of the organisations they examined was the Regionale HuisartsenZorg (RHZ) Heuvelland project in Maastricht, the Netherlands. With the project established, explained Rosen et al. (2011), to redesign diabetes care by way of an integrated payments system and delivered by multi-professional teams, they added that one of the ways in which an understanding of the 'vision' of integration was assured was by communicating agreed goals during group meetings. However, in addition to 'knitting together' the CRT (and thereby, presumably, helping develop a joint-vision) there was another reason why CRT front-line professionals believed that joint-meetings were key, as I explain in the following section.

Communication-channels blocked

As well as helping 'knit' people together and discuss cases 'generally', a number of front-line professionals felt that joint-meetings were important because of the physical separation of the Ty'r Felin-based allied health care professionals from the peripherally-based social care professionals. But during the first focus group, Physiotherapist Michelle Roberts noted that after the latter had attended just one physiotherapy team-meeting:

> ...we were actually told that they shouldn't attend that weekly meeting any more. Even though they were the ones going out to deliver the programmes, they were told that they shouldn't attend the meeting (FPFG1: 22).

This despite the fact that at a joint-consultation meeting for CRT health and social care professionals, Physiotherapist Diane Smith explained that:

> In the rehabilitation programme, once we've done our assessment, we heavily rely on our support worker, our reablement worker, to work with the patients. So how are we going to get the feedback from the support worker, is there anything in place? So the one way is the client meeting. We need to involve the support worker or the reablement worker to get the feedback about the client's progress (FPCO1: 10).

This was the only consultation event with front-line professionals that I was invited to observe during the Armorshire Collaboration. In fact, despite being held the week *after* the CRT's launch (thus appearing to contradict Dr Lewis' indication that clinicians would *lead* change) I also learned that it was the first *joint*-consultation event for health and social care practitioners since the project's launch. Moreover, despite providing a unique (if belated) opportunity to garner front-line practitioners' views in a joint-forum, none of the Bro-y-Grug LLT's three professional leads nor Locality Care Co-ordinator Christine Thompson attended. Although this meant that none of the local project leaders could reply directly to Diane Smith's question, Social Care Manager Sue Jenkins assured her that her comments would be passed on. Moreover, event co-ordinator Jill Sutherland explained that:

> ...you're in a new team, you're dealing with new systems, you're dealing with different people. How do you want to communicate? How do you want to make sure that that works in terms of the way that you communicate? A while ago, I did an exercise. I went to one of your managers' team-meetings and we talked about how this was going to work. We talked about what is negotiable: what's got to be the way that it is and what can people influence. One of the things that managers were quite keen that people influenced was how you communicate (FPCO1: 2).

The exercise to which Jill referred (which took place during the earlier managers' consultation-meeting that she had also co-ordinated) had produced a list of 'negotiable' (MMO1: 26) and 'non-negotiable' (MMO1: 26) elements to put forward to CRT front-line professionals. Arguably, the very listing of elements (such as 'how to integrate systems' [MMO1: 27], and the existence of 'evaluation systems' [MMO1: 27] and 'multidisciplinary teams' [MMO1: 27]) that were deemed 'non-negotiable' (MMO1: 26) again belied Dr Lewis' claims that clinicians would lead the change and that engagement of front-line staff was a priority. Moreover, Jill's suggestion that communication *was* negotiable (during the meeting, 'how we

communicate and circulate information' [MMO1: 27] was indeed listed as such) failed to match the accounts of any of the front-line professionals who participated in the focus groups, as summed-up by CDM Nurse Rhian Lewis' contention that, 'there was no negotiation' (FPFG1: 28). The end-result of this ostensible lack of negotiation was that, during the fourth focus group – which included the support workers on whom Michelle Roberts and Diane Smith relied to deliver their programmes of care – Domiciliary Care Practitioner Julie Morgan explained that:

> We don't get any feedback. Only in the patch-meetings, which perhaps you go to twice a year. And that's not individual, you can't get feedback on individual clients (FPFG4: 8).

Since the only meetings attended by the peripherally-based support practitioners were now profession-specific (the so-called 'patch-meetings'), I could only conclude that Diane's request had been discounted. In the absence of meetings with the physiotherapists and occupational therapists who designed and oversaw the programmes of care they delivered, I therefore asked participants how they shared information. Explaining that all communication was now conducted via line-managers, Julie Morgan noted that, 'Once we've passed the message on, that's it. We don't know what's happening then' (FPFG4: 2). Even though Julie added that this made it impossible for her to feed back information to clients, Enablement Worker Helen James insisted that one of the key elements of integrated working was the ability to give:

> ... anybody a ring that you feel that you need to. To be able to have it fed back to you as well. It's important for clients really, isn't it? You know where you stand with them. Like, if they're waiting for something, a piece of equipment to come in, you can say to them, 'It's not in yet, but it will be soon, hopefully'.
>
> **Julie Morgan**: That would be better, if we could do that. If we could speak to the social workers instead of having to go through your manager and the manager goes to the social worker (FPFG4: 8).

But as things stood, Julie explained that:

> ...we get questions from our clients and we refer back to management and management refer back to somebody else and then we're out of the picture, so we don't know what's happening.
>
> **Ben Duxbury**: What sort of questions?

> **Julie Morgan**: Well, the client that you went out to see once.
>
> **Ben Duxbury**: John Butler?
>
> **Julie Morgan**: I don't know what they're called? 'Monkey bars', is it? To pull themselves up in bed? Well, he asked about a month ago for it and we're still waiting (FPFG4: 1).

John Butler, whom I had interviewed some months earlier, was living with diabetes and chronic obstructive pulmonary disease, but had also undergone a lower leg amputation (which explained his request for the 'monkey-bar' pole hoist). Replying to Julie, Senior Domiciliary Care Practitioner Frances Evans explained that the delay was attributable to the occupational therapists' volume of case-loads and backlog of work and to a shortage in available equipment. The reason Frances knew was that she was both a line-manager and the one participant in the fourth focus group who, like the occupational therapists, was based at Ty'r Felin.

Just as the first three focus groups had provided a unique opportunity for Ty'r Felin-based colleagues to discuss the CRT's development, so the fourth had provided a unique opportunity for client-focussed information to be exchanged between Ty'r Felin- and peripherally-based practitioners. It could therefore be argued that the focus groups themselves displayed the communicational value of joint-meetings; the very meetings which had been ruled out by project leaders. A decision which had, it seemed, only served to exclude practitioners – and, as a consequence, their clients – from the information-sharing process, despite the expert-opinion and empirical evidence regarding the communicational value of joint-meetings.

Furthermore, one could perhaps equally well argue that in ruling out joint-meetings, project leaders had also paid little heed to the widespread recognition of the importance of self-care and of the core practitioner-client relationship in chronic conditions management and to the indication, in the Armorshire Collaboration Terms of Reference (ToR), that the project would foster community engagement by ensuring a 'dialogue of equals' between expert professionals and well-informed clients (see App. 9). On the contrary, not only did the inability of Julie Morgan to give John Butler any information regarding his request risk undermining the confidence which – judging by his evaluation of his care as, 'eleven out of ten' (CLI6: 4) – he had thus far had in her and her colleagues' expertise, it appeared to

have left him far from well-informed *vis-à-vis* the delivery of what seemed to be a vital piece of equipment. But John was not the only client whose care had been affected by a lack of information-sharing, as I explain in the next section.

Fighting for care-services: the impact of the lack of communication on service users and carers

In Chapter Four, I explained that many clients and informal carers whom I interviewed told me of their satisfaction at the quality of care provided by both the Armorshire CDM Team and the Llawfon Reablement Team. One such informal client was Jo Powell, whose husband Aled was living with multiple sclerosis and had suffered a stroke. During my interview with Jo, she told me that Aled's stroke had affected his sense of balance, so that he often slumped to one side of his bed. Jo therefore explained that on his return home from hospital, she had arranged for his bed to be equipped with safety-rails. However, Jo explained that shortly after the latter were fitted, Aled had fallen out of bed with one of the rails lodged across his throat. Unable to move Aled, Jo dialled 999. Whilst a swift paramedic-response had ensured that Aled sustained no serious injuries, Jo explained that to avoid a repetition, she had set about ordering a specially adapted bed. However, Jo added that:

> I couldn't get hold of Liz [Barton, Social Worker]. I don't know why I couldn't get hold of her, but I was phoning everybody, I was leaving messages saying: 'I need something in place for Aled, for him to be safe in bed!' But it was Angela in the end, and the MS [multiple sclerosis] people, that really pushed and got me a bed (ICI1: 8).

As with John Butler, Jo's initial request had met with little success. On the contrary, it appeared that it was only thanks to her persistence – and that of Armorshire Disability Resource Team Specialist Physiotherapist Angela Rees – that Aled had finally received what he required. But Jo hastened to add that:

> It wasn't until Aled had his stroke that any thought that we needed help kicked in. When he just had his MS, the support wasn't there. It was only when he had the stroke and Tregwen Hospital contacted Llawfon, and their social worker came that anything actually kicked in properly.
>
> **Ben Duxbury**: To what extent are there parallels with the way the new service has functioned since September?
>
> **Jo Powell**: Well, I didn't know that there's a new service that's started.

> **Ben Duxbury**: Have they asked if there is anything that can be done to help you?
>
> **Jo Powell**: No, because until you told me, I didn't know a new service had started. So I don't know what's on offer for us ... unless I need something and I phone them and ask them: 'What is there?', nothing would happen for us. They have not told me that there's a new service, they have not told me who to contact, they have not told me how it's going to impact on Aled's care. They haven't told us anything. I didn't know there has been a new service in place since September (ICI1: 15 – 16).

Given that Jo's remarks intimated (as she subsequently confirmed) that she had not been asked her views about the reconfiguration of services either, I asked her what she would have said had the opportunity arisen. She replied that:

> I made use of who I knew, and that was Liz. I think, perhaps, if your GPs had contact numbers, then I could say: 'Look, I'm in this situation, give me a number to phone'. Because I knew of nobody to phone ... there was no communication. As it stands now, I would automatically think: 'Oh, I'll phone Liz'. But perhaps Liz won't be responsible for us. I don't even know who we're supposed to phone now. Because they haven't told us, we've had no notification, we've had nothing (ICI1: 8).

A similar story was told by Claire Price, wife of Stephen, who was living with paraplegia due to complications following spinal surgery. After leaving the hospital where the operation was performed, Stephen remained in a specialist spinal rehabilitation unit for two years before returning home in 2005, since which time Claire had been his main carer. When I interviewed Claire, however, she explained that it was only two years later that she learned that NHS-funded help was available and that:

> ...the only reason that we found out about continuing care was when Stephen was admitted with his sore. Stephen uses a thin sling. Instead of having the ones that just slot in, he sits on his sling. They were using them in the spinal rehabilitation unit, because they thought it would be better, because of the friction of positioning the sling four to six times a day. So I phoned up the occupational therapist and asked: 'Could I have some slings?' She said: 'Oh, you'll have to have a social worker'. And bear in mind we had a social worker when Stephen was first discharged. But then they signed him off and said: 'Well, you don't need any more help now!' And that was it. So anyway, I phoned and I said, 'I need some slings, I need a social worker!' 'Right, OK!' This lady came out and she was brilliant, she was a phenomenal social worker, and she said: 'Why haven't you got continuing care?' And I said: 'Well, excuse me, but what *is* continuing care?' I'd never heard of it (ICI5: 15).

Just as Jo Powell only learned of the Llawfon reablement service as an indirect result of Aled's admission to Tregwen Hospital, so Claire Price only learned of NHS continuing care as an indirect result of Stephen's re-admission to the spinal rehabilitation hospital. In the latter case, moreover, even when they *were* told about continuing care, this was only because Stephen's 'phenomenal' social worker had taken it upon herself to inform them. Given that just like Jo Powell, Claire Price neither knew of the CRT's existence nor had been asked her views on the design of the new service during the reconfiguration, I likewise asked her what she would have said given the opportunity. She replied that:

> When people are put in this situation, I think it would be good if there was a sort of universal booklet, instead of having all these different pamphlets that are handed out to you, which you never read anyway. Or even if there was one person that could come and tell you what you're entitled to. You don't get that and I feel you need more guidance. Because it's a thing that you don't think you're ever going to need. It would be so brilliant if someone could come and say, 'OK then, let's sit down and see what you need and what you don't need, and what you're entitled to'. You don't seem to get that. This has all been word of mouth and fighting for this, and fighting for that, you know? It doesn't flow. To me, this should have been told. Everything that Stephen gets now should have been pointed out to me when he was in hospital, which it was not. They haven't got the time, have they?
>
> **Ben Duxbury**: How has it made you feel, that you've had to fight?
>
> **Claire Price:** Oh gosh, it's hard work. And the thing is, I'm not afraid to write letters, and I'm not afraid of getting on the phone to people. But not everybody is articulate enough to do it. Or they haven't got the gumption to do it. Because I always worked in an office, I'm used to talking on the phone, and I'm used to typing letters to different people. I'm quite *au fait* with it. But not everybody's like that (ICI5: 16).

But Jo and Claire were not the only informal carers or clients who had received no information and who described communication in reactive terms. This, despite the indication, in the *Service Improvement Plan* (WAG, 2008, p. 5), that the Welsh CCM Model would be based on a 'planned, *proactive* [my emphasis] and integrated approach' and the indication, in the Bevan Commission Report (WAG, 2011, p. 9) that, 'Transparent information, freely and openly provided to funders, patients and public, can enable and encourage excellence in healthcare in Wales'. Moreover, according to the European Network on Patient Empowerment (2012, p. 8):

> Empowered patients will better understand how to navigate the many players

> in the healthcare system including family, physicians, health insurers, healthcare regulators, pharmacists and when unsure about where to go or what to do next, will feel confident to ask for the information they need.

A further client, Ray Hughes, told a similar story. Living with chronic obstructive pulmonary disease (COPD) for a number of years, Ray had been referred to the Bro-y-Grug CRT following an emergency admission – due to severe breathing difficulties – to Tregwen Hospital. Ray explained that it was a nurse at the hospital who arranged for him to attend COPD rehabilitation and to be visited by Bro-y-Grug CDM Nurse Janet Williams, despite the fact that:

> ...I had been to the GPs for years and I had asked them to take me for COPD rehabilitation, because it would have helped me really, because they have a special unit in Aberwrach for cardiac and respiratory problems. They said, 'We've never had any request from your practice for you or anybody else'. And that GP was telling me he had written to them. [He said] 'Here's the letter'. But I think it was never sent. He didn't refer me to anybody. They don't know how the system works, they have no idea (CLI9: 3).

Whilst Ray appeared to attribute his GP's failure to refer him to the CRT to his lack of knowledge of the system, when I interviewed Bro-y-Grug GP Dr Edward Thomas and asked him to what extent he had been told about the CRT's development, he told me that:

> I, as a GP, haven't been informed, really, at all of how they're getting on.
>
> **Ben Duxbury**: How do you feel about that?
>
> **Dr Thomas**: It's a bit difficult to actually say when you don't really know totally what they're capable of doing or what they're there for. I mean, I know what they're there for, but you don't know the scope of what they do. That may be partly my fault, because I haven't gone out to research it and seek out what their jobs actually are and what is available. But on the other hand, we have not been informed (GPI2: 1).

Accepting some of the blame for his lack of knowledge, Dr Thomas was one of the many local GPs who failed to attend the meeting expressly organised to introduce the planned reconfiguration of services to Bro-y-Grug's GP community (see Chaper Five, section 'Inefficiency and changing structures'). During my interview with Locality Care Co-ordinator Christine Thompson, however, she also told me that:

> In the locality we don't get the buy-in, if you like. The [Lead] GP [Dr Lewis] informs on some issues, but doesn't feed back to the other GPs. I don't get

> any feedback from the other GPs through the Lead GP. I was hoping that he would feed back to them and that they would feed back to him. But I've had no feedback off them at all (LARI3: 5).

Just as Christine suggested that there had been little information-sharing with other GPs, so another local GP, Dr Jan Fielding, told me that neither she nor the other GPs in her practice had been given the opportunity to have any involvement in the reconfiguration of services and that, 'nobody's been telling us anything much from Bro-y-Grug' (GPI1: 2). As regards the referral of clients to the CRT, Dr Fielding told me that she had only used the service, 'a couple of times' (GPI1: 5). As for Dr Thomas, he told me that:

> I haven't used them a great deal. I think it's because we have done without that sort of set-up for so long that we have managed to overcome a lot of the difficulties that they deal with, and we've found other ways of doing things (GPI2: 3).

Despite the fact that I spoke to both local GPs over a year after the CRT's launch, their utilisation of the CRT appeared to have been minimal. Whilst it could be argued that they would have been more disposed to refer patients had they had more information about the services available, as I have already explained, they were not the only front-line practitioners to tell me that information-sharing had been minimal. So, just as one of those front-line practitioners – Care Management Assistant Leslie Jones – had described how she and her colleagues at Llawfon had only belatedly learned of the team's closure, she hastened to add that:

> ... when we were told, just a month before, when we were telling the service-users that we wouldn't be working with them anymore as Llawfon, [they said] 'Why, what's happening? We haven't been told' (FPFG1: 7).

Similar remarks were made during the other three focus groups. In the second, for instance, Assessor Care Manager Heather Edwards reported that her clients were:

> ... confused. The Tre-Gwylan team were doing the Cwm Coch area and then they came over to us, and then that was settling down, people were getting to understand that the social worker is now coming from Llannuon rather than Tre-Gwylan, even though they lived in Port Gwen or down that end, and they'd always been covered by Tre-Gwylan. Just as they were getting that it changed again. They've just lost the plot now, they were getting their heads round it, and then the CRT came (FPFG2: 9).

In the third, Occupational Therapy Assistant Louise Thomas and Occupational

Therapist Lauren Price explained of their clients that:

> **Louise Thomas**: I don't think they know about it.
>
> **Lauren Price**: No. I go to clients and they're still asking me: 'Oh, Llawfon came out'. And I say, 'Llawfon has disbanded, there is no Llawfon any more, we're all part of one team now' (FPFG: 15).

In the fourth, when I asked the peripherally-based CRT members to what extent their clients and carers knew of the changes, all participants told me that they did not. In fact, none of the focus group participants knew of anyone living with a chronic condition or of an informal carer who *had* been told about the CRT's launch.

A similar picture emerged during all of my interviews with CRT clients and their informal carers, with no-one reporting having been informed of the reconfiguration of services. The following excerpts from two of my interviews – one with a person living with a chronic condition, the other with an informal carer – were broadly representative of all of the interviews (all conducted at least eight months after the CRT's launch). Both participants were replying to my question: 'To what extent are you aware of any changes in the care you have been receiving since last September?' (the launch-month of the CRT). First of all Hilda Jenkins, who was living with rheumatoid arthritis:

> Not really.
>
> **Ben Duxbury**: Do you know why I'm asking you?
>
> **Hilda Jenkins**: No, I don't know why you're asking me that question.
>
> **Ben Duxbury**: Because since September the care you receive has been organised by a new integrated health and social care team, the Community Resource Team. Were you informed that this was going to be happening?
>
> **Hilda Jenkins**: No, I wasn't aware of that. As far as I'm concerned, it's been the same lot all the time (CLI5: 4 – 5).

Secondly, Rhoswen Scott, wife and main informal carer of Mike (living with chronic obstructive pulmonary disease):

> No, not really I don't think. The nurses have stopped calling here.

Ben Duxbury: The *district* nurses?

Rhoswen Scott: Yes, the district nurses.

Ben Duxbury: The reason I'm asking about September is that September is when they set up a new Community Resource Team that Paula [Evans, Bro-y-Grug CRT Occupational Therapist] is now a part of. They're based in Llannuon. Before they set up this new team, were you informed that there was going to be a new team?

Rhoswen Scott: No (ICI2: 4).

In the event, only two of the clients (but none of the informal carers) whom I interviewed knew that there been a change in the organisation of care. The first of the two was John Butler (see previous section) the second was Tony Evans, who was living with chronic obstructive pulmonary disease (COPD). When I put the same question to John as I had to Hilda and Rhoswen, he replied that he was aware of:

nothing different.

Ben Duxbury: Rather than teams that are separate, like nursing care and social care in different offices...

John Butler: ... they're all *combined*?

Ben Duxbury: Yes, they're all combined in one office now.

John Butler: In Llannuon?

Ben Duxbury: Yes, in Llannuon.

John Butler: I knew that.

Ben Duxbury: How did you hear about that?

John Butler: Somebody came. I've seen somebody this week, and she's based there. Somebody checking up that I'm alright, [because] we've lost the warden on the site. This lady came and she's based in Llannuon, but with the same gang and Deborah Hale [CDM Nurse] is based in Llannuon (CLI6: 5).

Although John knew that the nursing and social care teams were 'combined', this did not seem to have been the result of official notification, but of his awareness that Deborah Hale was Llannuon-based. On learning that this was also the case for his social care visitor (to his sheltered-housing bungalow) John appeared to have surmised that they worked together. Tony Evans, in a similar vein, told me that

when, due to his increased breathlessness, he had called out CDM Nurse Janet Williams the previous year, she had told him that she would soon be:

> ... moving office to Llannuon from Tregwen. It's in Llannuon now, the same office as Home Care, isn't it? Well, care managers and things (CLI4: 7).

Just as John's awareness of the change was attributable to an impromptu call and Tony's to a non-scheduled visit, when I asked participants in the second focus group to what extent their clients (and their carers) had been informed of the changes, Assessor Care Manager Heather Edwards explained that the CRT's launch was:

> ...not very well advertised. You weren't told about it until after the event really. We have to go out and tell them, and they've got so many problems, they can't deal with our problems as well, of changing teams and changing workers (FPFG2: 10).

Notwithstanding their own lack of prior-knowledge of the CRT as well as the disruption caused by the reconfiguration, it seemed to have been left to front-line professionals to explain the changes to their clients and informal carers. A challenging proposition, arguably, given Care Management Assistant Rhodri Jones' observation that:

> ... we're not told anything. We don't know what they're planning, if they are planning anything, what they might be thinking of developing, if anything (FPFG2: 22).

In a similar vein, Occupational Therapist Toni Ellis explained that her clients:

> ... were barely getting their heads round what Llawfon was. Now we're coming out and saying, 'We are the CRT' and we don't really know what we're saying and what we're about yet (FPFG2: 8).

This despite the fact that formal systems of communication and information-sharing were to have underpinned the Welsh CCM Model, the National CCM Demonstrator Programme and the Armorshire Collaboration and despite Jo Marshall's contention that:

> ...if we can improve the patient and service user experience by improving the communication and information exchange, then that is ultimately going to give 'Mrs. Jones' more confidence that we know what we're doing (LARI2:10).

However, just as it was hard to envisage how Julie Morgan's lack of knowledge of John Butler's request for a monkey-bar would increase his confidence in front-line practitioners, it appeared equally hard to envisage how front-line professionals' lack of insight into project leaders' plans for the CRT and attendant inability to relay these plans to the notional CRT client 'Mrs Jones' could improve communication with her or see her confidence in practitioners grow. On the contrary, one could argue that the apparent exclusion of front-line professionals from the project's planning stages again risked jeopardising the seminal client-carer relationship in the management of chronic conditions to which I have already referred. This is of note, given that Coulter (2012) points out that whilst people living with chronic conditions who are informed and empowered have the knowledge, skills and confidence to manage their own health and healthcare, they also require guidance and support from professionals.

In a study of networking and knowledge in service user involvement comprising individual interviews and group discussions with service users (n=126), Branfield and Beresford (2006), for instance, noted that one of the four key ways of strengthening service user knowledge in order to make a greater impact on policy and provision that was identified by service users was a commitment to change. With Branfield and Beresford (2006, p. 43) reporting that service users recognised that the commitment in question needed to be made by themselves and by professionals, they pointed out that one respondent reported that, 'We need mutual empowerment. Learning from each other and our history, mutual commitment to support and community development'. But it was hard to see how the CRT front-line professionals could make any analogous commitment to change or share their learning about the new service when they appeared to know as little about what was happening as the clients and informal carers. However, it was not just front-line professionals who appear to have been left out of the process of community engagement, as I explain in the following two sections.

Lack of service user involvement in the reconfiguration of services

Just as it was noted in *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 32) that a 'prerequisite' of integration and service improvement was: 'actively

engaging' with 'local people living with chronic conditions', so it was indicated in the Armorshire Collaboration PID that the process of change would: 'Engage service users as *co-designers* [my emphasis] of new care delivery models' (App. 9). Whilst the Social Care Institute for Excellence ([SCIE], 2013, p. 8) defines co-design as, 'managers and citizens working together in the planning stages of projects', Corrigan et al. (2013, p. 15) further indicate that:

> Co-design is a process of facilitation and transformation, supporting the design and creation of better organisations. This involves both creating services and reconfiguring the system to foster communities.

With Bradwell and Marr (2008, p. 18) pointing out that co-design differs from engagement and participation in that it places the, 'involvement of users at the *very heart* [my emphasis] of the design of a public service', a similar philosophy appeared to have been espoused by the Armorshire Collaboration's leaders in the Bro-y-Grug locality. During the November 2009 meeting organised to present the planned reconfiguration of services to the local GP community, not only did Bro-y-Grug LLT GP Lead Dr David Lewis stress that patients – alongside coal-face workers – would set the 'agenda of change' (LLTMO1: 3), Bro-y-Grug LLT Social Care Lead Gwyn Evans also insisted that:

> ... we are actually trying to create a completely new ethos for social care. We're looking at the whole way Social Services is working. For the first time, in my opinion, for the first time ever, we're going to put our money where our mouths have been for years. I started working in social care in ninety-one. Back then they were talking about enablement, empowerment, promoting independence, all these kinds of 'buzz-words'. But no way have we done it, no way have I ever seen that really happening. Here in Armorshire we're on the starting-line. We're not on the finish-line. [But] we are actually saying: 'We want to change'. And we're *going* to change (LLTMO1: 5).

Although Gwyn suggested that the new ethos would be premised on increasing enablement, empowerment and independence for service users, as I have previously indicated, there is little consensus as to what many of the terms pertaining to the involvement of communities in determining their own care actually mean. But this did not appear to have escaped Gwyn's attention. On the contrary, when I interviewed him the following June, he returned to the 'buzzword' status of enablement and empowerment. Aware of the semantic uncertainty surrounding

notions of service user independence, he told me that he had been meeting with all the teams in order to discuss this very issue. He explained that:

> I've been trying to quiz them on it, and I offer my definition, which would be the country/political one. If you look historically at what India, America, Ireland were fighting for, they would say independence. But they would call that home-rule, self-rule. They wanted the opportunity to actually make decisions about their own destiny as a country. I try to then pull that back to say that when we're talking about independence with service users, that's what we're talking about. We're talking about giving people the opportunity to make their own decisions, choices about their own lives, having control over their own lives, over their own destiny (LARI1: 7).

Given that effective chronic conditions management, as I have previously explained, is premised on facilitating self-care, Gwyn's likening of service user independence to national self-rule, arguably, was well-placed. Moreover, just as his insistence that independence equated to affording service users the,'opportunity to make their own decisions' seemed to tally with the co-design principle of the Armorshire Collaboration, his suggestion that it would also give them control over their, 'own lives, over their own destiny' appeared to be consistent with one of the core principles of the Welsh CCM Model, namely that it would, 'increase self-management, independence and the participation of people with chronic conditions and their carers' (WAG, 2007, p. 14).

As I explained in the previous section, however, the only two clients or informal carers whom I interviewed who knew that a change in the organisation of care had taken place were John Butler and Tony Evans; and their knowledge of developments, moreover, was limited to what they had learned in an informal manner during home-visits from Ty'r Felin-based staff. It therefore goes without saying that neither they nor any of the other clients or informal carers whom I interviewed told me that they had been involved in the co-design of services or given an opportunity to decide their 'own destiny' (again, arguably, providing an example of a rhetoric/reality divide). Once again, the views expressed in the following two excerpts – one from my interview with Jo Powell, the other from my interview with her husband Aled – were similar to those expressed during all of my interviews with clients and informal carers. Again, both Aled and Jo were replying to my question,

‘To what extent are you aware of any changes in the care you have been receiving since last September?’ Aled, first of all:

> No, I can’t think of any differences.
>
> **Ben Duxbury**: Do you know why I’m asking this?
>
> **Aled Powell**: No.
>
> **Ben Duxbury**: Because in September of last year, the team that I’m looking at were set up. It’s called the Community Resource Team. Were you informed that the service was changing?
>
> **Aled Powell**: Not that I know of.
>
> **Ben Duxbury**: Were you asked your opinion about changes to the service?
>
> **Aled Powell**: No (CLI1: 3 – 4).

Secondly, Jo:

> Well, like I say, we go for hydrotherapy. So that is something that we’ve carried on doing that has [already] been in place. We haven’t had any physiotherapists come to the house. The Llawfon team don’t come any more, so the only care that we have now is the care where the carers come in to get him up.
>
> **Ben Duxbury:** Were you asked your opinion about any changes to services?
>
> **JoPowell**: No.
>
> **Ben Duxbury**: Do you know why I’m asking you?
>
> **Jo Powell**: Yes, because they have changed, you explained that. But we haven’t been informed of anything (ICI1: 5 – 6).

A similar story was told by front-line professionals. So, when I asked the latter whether they knew of any involvement of clients and informal carers in the reconfiguration of services, in the first focus group Social Worker Jenny Cole replied, ‘I can’t think of anybody mentioning anything to me’ (FPFG1: 7). In the second focus group, Assessor Care Manager Heather Edwards and Care Management Assistant Rhodri Jones both replied: ‘I don’t think so’ (FPFG2: 8). In the third focus group Occupational Therapy Assistant Louise Thomas and CDM Nurse Deborah Hale explained that:

> **Louise Thomas**: I've never seen a piece of work. I've never seen a questionnaire. I've never seen anything that's gone out.
>
> **Deborah Hale**: None of my patients have had letters or anything (FPFG3: 8).

Louise Thomas explained, moreover, that the role of clients in the redesign of services was:

> ...never mentioned in the initial meetings we had to talk about the Community Resource Team. There was something on the screen with the client in the middle and all of these people shooting off, you know, different professionals. But it was never mentioned whether the client would be asked which way *they'd* like it to go (FPFG3: 17).

In the fourth focus group, finally, all participants pointed out that since none of their clients or informal carers even knew that there was a CRT, they felt sure that they had not been asked their opinion about the reconfiguration of services either. A similar story was also told by Bro-y-Grug resident – and EPP tutor – George Foster (see Chapter Four, section, 'Voluntary/third sector services and self-care programmes'). When I asked George to what extent the views of local people living with chronic conditions had been taken into account during the reconfiguration of services, not only did he know of no consultation events, he also described the lack of awareness of existing service provision. So when, for instance, I asked him what participants in EPP courses knew of the CRT, he told me that:

> They don't know much about that. On week six I ask them what help there is in the community, and it worries me that they don't know. They don't know what's going on in the Armorshire area. I say to people on the courses, 'You obviously know what the CDM Team is?' And, 'What's that?', they say. [So I tell them]: 'The Chronic Disease Management Team, your primary course of contact if you've got diabetes or multiple sclerosis or any issue that's long-term, chronic'. They need to know, and they're not even aware of *that* (VSRI1: 3).

Ironically therefore, whilst alluding to the ignorance of the CRT's existence amongst EPP course-participants, George's comments appeared to betray his own unawareness that it had replaced (not complemented) the CDM Team and that the latter no longer existed. If someone with such a longstanding local involvement in the welfare of people living with chronic conditions was not fully cognisant of the changes, it was perhaps little wonder that course participants knew even less. Combined with the lack of information-sharing and involvement reported by all

focus group participants and clients and carers, George's comments seemed a far cry from the 'user-centred' design-principle of *Designed for Life* (WAG/NHS Wales, 2005, p. 13). As did the comments of Armorshire CDM Nurse Lead Anne Richards when – in June 2010 – I asked her how clients and informal carers had been involved in planning the integrated service. She replied that:

> We've never gone off and told them: 'This is what's happening, what do you think?' Or involved them round the table, not specifically individual clients. I mean, we've had representatives, you know, like from the third sector or from the voluntary sector, who represent people, [but] I don't think we've ever had real patients around the table (LARI6: 10).

Bearing in mind that my interview with Anne took place after the discontinuance of the Delivery Team and the PPI Work-Stream, one could argue that her comments were tantamount to a tacit admission that the latter had failed in their stated objectives to ensure client/informal carer involvement. Indeed, considering that the abandonment of the Armorshire Collaboration's original organisational structure was largely attributable to the NHS Wales Reforms of 2009, the lack of involvement of clients and informal carers appeared to tally with one of the main reasons why, Huxham and Vangen (2004) note, 'collaborative advantage' can turn into 'collaborative inertia'. Hence, Huxham and Vangen (2004) suggest that the latter can be caused by the instability engendered by external policy influences, which may necessitate a reorganisation of the collaborative structure and cause stakeholders to join or leave the project, thereby bringing about a change, 'in the relevance of the collaboration to its members' (2004, p. 196).

Moreover, considering that the Bro-y-Grug LLT started meeting in November 2009, this meant that only sixteen months of the project remained for its three professional-leads (together with Locality Care Co-ordinator Christine Thompson) to secure the client and informal carer involvement that had hitherto been missing. However, when I interviewed District Nurse Lead Janice Davies eight months later, she reported that:

> I know that there are plans afoot to take the public's opinion into consideration. My time within the Armorshire Demonstrator project was limited to a day a week, and obviously, around that comes all my district nursing. Christine Thompson, as project leader, tends to, well *does*, not *tends*

to, *does* assume responsibility for the wider picture of things. And we did discuss in a meeting a couple of weeks ago about public consultation.

Ben Duxbury: One of the LLT meetings?

Janice Davies: Yes.

Ben Duxbury: Did you learn anything from that?

Janice Davies: No, I can't say I learned anything from it, but it was discussed, you know, and the need was recognised (LARI4: 11).

At this time, more than two years of the three-year Armorshire Collaboration had elapsed and there were just two months remaining until the CRT's launch. This was somewhat late in the day, arguably, to have recognised the need to take the public's views into consideration. But with Janice's professional commitments militating against her own involvement in the project, she suggested that the responsibility to ensure public-consultation had, in any case, been assumed by Locality Care Co-ordinator – or, in Janice's words, 'project leader' – Christine Thompson. This was a rather different interpretation of Christine's role to the one that emerged during a Joint-LLT Meeting:

Why wasn't I involved in this email?

Dr Lewis: Pardon?

Christine Thompson: I wasn't copied into this email.

Dr Lewis: It was copied to Gwyn and Janice.

Christine Thompson: The Leadership Group?

Dr Lewis: It doesn't matter, does it?

Christine Thompson: Well, it does really, because there's quite a lot of work that I'll be involved in.

Dr Lewis: OK, I just didn't. I apologise if I should have sent it to you. I didn't know that I needed to.

Christine Thompson: Only because this impacts on things to do with me and Melanie Peters [Armorshire Demonstrator Project Officer].

Dr Lewis: I don't really want to get bogged down in that really. I think I'd like the Leadership Group of a District Nurse-, GP- and Social Services-Lead

> to discuss where we're going and to have a clear work-programme. And we ask you to co-ordinate it and feed back (JLLTMO2: 7).

Although the immediate trigger of the exchange was Dr Lewis' failure to copy Christine into an email, its root cause seemed to lie in their divergent understandings of Christine's role as Locality Care Co-ordinator. Dr Lewis, on the one hand, appeared to view the role in purely organisational and communicational terms, arguing that it was for the LLT's three professional leads (not Christine) to decide on the project's direction of travel, including, presumably, the way that clients and informal carers would be involved. Whilst Dr Lewis reinforced the distinction by way of his emphasis of 'we' and 'you', during my interview with Christine, she told me that:

> ... the decisions I'm making and also who I'm feeding up to – to director level – mean I've got to know what's going on operationally, because I'm feeding up. There's not been that in the past. There hasn't been anybody feeding up and saying, 'This is an issue, this is what we're going to do to solve it'. Historically, it's just been, 'Oh, there's a problem', but nobody's been doing anything about it, because they haven't had the capacity in their job. So having this role has meant that integration can start to take place, because there is somebody who's got that in their job description, it's not just part of another role. I think that's made a huge difference. You've got to know what's going on strategically to make sure that you drive what happens operationally in the right direction (LARI3: 3).

With no mention of the LLT, Christine argued that *she* was the one making decisions, feeding back to directors and driving operational change. Thereby positioning herself, it would seem, at the very heart of the project's development, Christine nevertheless acknowledged – echoing Janice – that, 'we haven't involved clients as such yet'. This despite the fact that her description of her role seemed closer to Janice Davies' qualification of her as 'project leader' than to Dr Lewis' intimation that she was an adjunct to the LLT. But like Janice, Project Manager Jo Marshall argued that all three Locality Care Co-ordinators had been:

> ... pivotal to getting the locality approach up and running. I *do* see their role evolving over time as well, because they may well evolve into managing or overseeing the CRTs, ensuring that as the referrals come in, they're divvied up, and making sure the information is coming out of the hospitals as to who's been in A&E over the weekend, who's been in the CDU [Clinical Decisions Unit], who's been emergency admissions, looking at that information, making sense of who's on the books at the moment...somebody with that helicopter-view across the locality (LARI2: 21).

Jo Marshall's description of the 'pivotal' role and 'helicopter-view' of the Locality Care Co-ordinators, in turn, was in keeping with the wide-ranging responsibilities of the role as set out in *Designed to Improve Health and CCM in Wales* (WAG, 2007). Hence, it was indicated in the latter document that the 'Chronic Conditions Care Co-ordinator' (note the name-change) would help:

> ...stratify practice populations across the four levels [of the CCM Model]; identify, plan and co-ordinate services to meet the needs at each level; liaise with patients, carers and service providers from private, voluntary statutory and independent agencies; monitor patient progress and service delivery across primary, secondary and social care; co-ordinate primary care collaborative networks and networked services; advise on the commissioning of chronic conditions services (2007, p. 24).

But in *The Chronicle, Newsletter Issue 2* (CCM Demonstrators/NHS Wales, 2009f, p. 7), on the other hand, it was indicated that in Armorshire, the 'Locality Care Service Planning Co-ordinators' (note the further name-change) were:

> ...part of the Locality Leadership Team, supporting it with information and data analysis derived from using tools such as Prism, a data extraction tool, Audit+/Quality and Outcomes Framework (QoF), Patient Episode Data for Wales (PEDW), Carefirst, the IT system used by social services, and combining this with information relating to services available, workforce etc.

Notwithstanding the indication that Locality Care Service Planning Co-ordinators were *part of* – not, as Dr Lewis suggested, *external* to – the LLTs, one could argue that the emphasis on the position's support-role bore a closer resemblance to Dr Lewis' comments than to Janice Richards' qualification of Christine Thompson as 'project leader' and to Jo Marshall's suggestion that the three Locality Care Co-ordinators had played a, 'pivotal' role and could, in time, become CRT managers. But Janice's and Jo's words, in turn, appeared to bear a closer resemblance to the indication, in the *Service Improvement Plan* (WAG, 2008, p. 18), that:

> *CCM care co-ordinators* [my emphasis of further name-change] are *essential* [my emphasis] to ensure the CCM model works effectively... they will anticipate the needs of the population and individuals as well as *plan* [my emphasis] and co-ordinate the service responses across primary, secondary, community and social care and housing.

However, just as there appeared to be some difference in interpretation of the role of the Locality Care Co-ordinators amongst project leaders, in *CCM Demonstrator*

Learning Paper 4 (NHS Wales/CCM Demonstrators, 2009b, p.1) it was indicated, as regards, 'Defining the locality care coordination function and developing the role', that:

> ...time was taken on the local interpretation and definition of the proposed Model of Care within the Demonstrator and it was felt that until the model was clear it was impossible to describe this new role to develop a job description. From the outset there was an element of confusion for front line staff in both the NHS and social services where the term 'Care Co-ordinator' was used.

This, despite the fact that one of the prerequisites of successful partnership-working is deemed to be clarity of terminology and aims, particularly at project initiation. Whilst the excerpt from the Learning Paper appeared to suggest that clarity *vis-à-vis* the Care Co-ordinator's role had been missing from the outset, when I interviewed Christine Thompson – in June, 2010 – in addition to seeing her job-title changed several times, she explained that:

> This role, I guess, enables us to dip in and out of lots of services, [but] the Collaboration management side of things, I don't get that really, in that, sometimes we'll go to a Chronic Conditions Board Meeting, and then they'll suddenly say: 'Oh, that's the responsibility of the care co-ordinators'. Whereas nobody will have ever discussed that with us.
>
> **Ben Duxbury**: Do you think the specifics of your role have changed?
>
> **Christine Thompson**: Yes, it's much more strategic than what they thought in the first place (LARI3: 3).

So, even after having been in post for nine months, Christine seemed to have an unclear understanding of what was expected of her. Allied with the fact that the understanding she *did* have diverged quite sharply from that of Dr Lewis, her situation, just like that of CDM Nurse Rhian Lewis, appeared to bear the hallmarks of Handy's (2003) 'role ambiguity'. Whilst Handy points out that job descriptions may serve to mitigate role ambiguity, he adds that at middle-management level (the level, arguably, occupied by Christine Thompson) they are rarely complete. With Handy arguing that this can lead to uncertainty *vis-à-vis* the scope of responsibility, Øvretveit (1995) suggests that for the development of recognised and achievable decision-making procedures within a team, it is imperative that responsibilities *are* made clear. With Huxham and Vangen (2004) explaining that collaborative situations are frequently characterised by ambiguity *vis-à-vis* who the collaborators

are, they note that this is another reason why potential 'collaborative advantage' can instead turn into 'collaborative inertia'. Indeed, Huxham and Vangen (2004, p. 196) note that:

> Clearly, it is hard for managers to agree on aims, build mutual understanding and manage trust and power relationships with partners if they do not unambiguously know who their partners are. Equally, it is difficult to manage collaborative working in complex systems in which different elements must be affecting each other but there is little clarity on the nature of the inter-relationships.

However, aside from the fact that Christine's role was interpreted in different ways by different members of the Bro-y-Grug LLT, given that the latter did not even exist at project initiation, the Armorshire Collaboration PID contained no information regarding her relationship with the team's three professional leads. On the contrary, I was unable to find any mention of the involvement of LLTs in the Armorshire Collaboration prior to Jo Marshall's presentation at the *Building the Locality Approach to CCM and Community Services in Armorshire Workshop*. This despite the fact that by this time, the project had already been running for some seventeen months. Moreover, with Jo Marshall pointing out that the 'Locality Leadership Group' (BLMO: 3) (note the original title) of part-time GP-, Social Care- and Community Nursing-Leads would be '*supported by* [my emphasis] the Care Services Planning Co-ordinator' (BLMO: 3; again, note the original title) this was, however, the only reference to the latter that she made during her presentation.

In failing to elaborate on the role of the Care Services Planning Co-ordinators (which, given Dr Lewis' attendance at the event, may help explain why he viewed Christine's role as he did) Jo Marshall also failed to detail the latter's relationship with the LLT or the part they would play in the involvement of clients and informal carers in the reconfiguration of services. With no mention of the then non-existent LLTs made in the Armorshire Collaboration PID, the latter, of course, contained no information as to the part the three professional leads would play in ensuring the involvement of clients and informal carers (or front-line professionals and the voluntary/third sector). But nor did it contain any information as to the part that the 'Care Service Planning Co-ordinator' would play in any of these areas either. The same was also true, moreover, of various official documents, including: *Designed to*

Improve Health and CCM in Wales (WAG, 2007); the *Service Improvement Plan* (WAG, 2008); *Chronic Conditions Management Update: Issue 7: Realising CCM Policy into Practice* (WAG, 2008b); or *CCM Demonstrator Learning Paper 18: Progressing Locality Care Co-ordination in the Chronic Conditions Model and Framework* (NHS Wales/CCM Demonstrators, 2009e).

In fact, I was unable to find any official documentation relating to the Welsh CCM Model, the National CCM Demonstrator Programme or the Armorshire Collaboration that described the role of Locality Care Co-ordinators in relation to the involvement of clients and informal carers, front-line professionals or the voluntary sector. Nor was I able to find any official documentation (again, whether this related to the Welsh CCM Model, the National CCM Demonstrator Programme or the Collaboration) that described how such involvement would be assured by the Locality Leadership Teams. Nor, for that matter, was there any reference to the role of either the LLTs or Locality Care Co-ordinators *vis-à-vis* such involvement in any of the meetings I attended (whether they related to the National CCM Demonstrator Programme or to the Armorshire Collaboration).

In the absence of any such precision, it seemed that no-one had sought to ensure the involvement of clients and informal carers and that, as a result, this had simply not materialised. This, despite the fact that Coulter et al. (2013) note that calls for a more person-centred approach to managing care for people with long-term conditions have been made by numerous advisory bodies, advocacy groups, governments and international agencies alike. A case in point, arguably, of Huxham and Vangen's (2004) warning that ambiguity heightens the likelihood of 'collaborative inertia'. As I explain in the following section, however, this 'collaborative inertia' regarding involvement seemed to have extended to the voluntary/third sector too.

Voluntary/third sector: belated involvement

In the opening section of this chapter, I noted that the architects of the Welsh CCM Model and of the National CCM Demonstrator Programme and the project leaders of the Armorshire Collaboration all stressed that the improvement of CCM care was

premised on partnership-working with all stakeholders, including voluntary/third sector representatives. But like so many areas of this case study, the voluntary/third sector is characterised by a lack of terminological consistency and described by a range of contested terms (see Alcock, 2010). However, Kendall (2012, p. 229) explains that a 'structural operational' definition of the 'non-profit sector' (the 'non-profit status' of the voluntary/third sector forms the basis of most definitions, notes Baggott [2013]) includes:

> ...formally organised entities which are constitutionally/legally separate from the State, bound not to distribute surpluses ('profits') to owners, and demonstrably benefitting from some degree of *voluntarism* [original emphasis] (uncoerced giving) of money ('donations') or time ('volunteering').

In *Designed to Improve Health and CCM in Wales* (WAG, 2007, p. 3) it was indicated that:

> The effective management of chronic conditions does not lie with health alone, but is dependent upon strong partnerships with patients, carers and other service providers such as social services and the voluntary sector.

In *CCM Demonstrator Learning Paper 6:* (NHS Wales/CCM Demonstrators, 2009c, p. 2) it was indicated that:

> Each of the three Demonstrators is organised so that they have their own local Delivery Board to ensure that there is strong steer and representation from the key players across a wide range of sectors such as health, social care and the voluntary sector.

In the Armorshire Collaboration PID, finally, it was indicated that:

> The Collaboration has been established as a collaborative that will produce improvement by harnessing the collective wisdom and enthusiasm of participants from a wide network of multidisciplinary teams in a number of health, social and voluntary care sectors (App.9).

However, when I asked CDM Lead Nurse Anne Richards to what extent representatives from the voluntary/third sector had been involved in the reconfiguration of services, she replied that:

> Up to now they haven't really been involved. They were at the meeting yesterday, where the Armorshire Association of Voluntary Services came along. But we've always had the idea that we want them to have a broker role. But how do you take that? You saw the discussion yesterday... I think

> they are important. I mean, one: they offer services that we can't often provide; and two: they've got quite a big scope out there and are willing to do it but aren't being used. And the NHS is over-stretched, so why not use them? (LARI6: 8).

Given that my interview with Anne took place in August 2010 – some twenty-seven months after the Armorshire Collaboration's launch and less than a month before the inauguration of the CRT – once again the process of community engagement appeared belated. Nevertheless, when I interviewed Bro-y-Grug Locality Care Co-ordinator Christine Thompson, she told me that she had worked in the voluntary sector and that its involvement in the project was important. Indeed, during the meeting with a representative from the Armorshire Association of Voluntary Services to which Anne Richards referred (a Joint LLT meeting which I had attended) Christine explained that:

> Sometimes you go as a voluntary sector person and you've got more knowledge than the local authority- or health-manager sitting around the table about the wider picture. That can be really beneficial when you're developing the services. We could use our CRT as an example. Sometimes they [the voluntary/third sector] are leaps ahead of us (JLLTMO1: 3).

Just as Christine suggested that the service development of the voluntary/third sector was sometimes 'leaps ahead' of that of statutory services, when I interviewed Albert Keenan – who had been living with type 2 diabetes for some eight years (see Chapter Four, section, 'Voluntary/third sector services and self-care programmes') – he told me that:

> Until recently, I didn't think much of the care, because I was getting it all through my GP. An incident was that when I first became insulin-dependent, they said, 'You'll have to come to a foot-clinic'. There's a nurse there that checks your circulation in your legs and everything, checks your feet, checks your nails and all this kind of business. She was very good, very efficient. But that was five years ago, and I haven't seen anybody since ... it seems to have tailed off a bit, the diabetes care (CLI12: 1).

After attending one foot-clinic, it seemed that Albert had received no specialist diabetes care, despite the importance of regular monitoring of people living with diabetes, given their increased risk of developing neuropathy as well as a number of other long-term complications, such as retinopathy, nephropathy and cardiovascular disease (Carrier, 2009). However, although Albert appeared somewhat disillusioned at the lack of care offered by his local GP surgery, he hastened to add that, 'it's now

come really good again, now that I've got these people' (CLI12:1). 'These people', Albert explained, were the instructors from the X-Pert Programme, the six-week course for people living with diabetes (see Chapter Four, section, 'Voluntary/third sector services and self-care programmes') that he had recently attended. Describing how this had helped transform his knowledge of diabetes, Albert told me that in comparison with the help he had received from his GP surgery, it was:

> ... nothing and everything, do you get the idea? I've learned a tremendous amount. These are so thorough, they're really good about diet, I've learned so much about diet in the last few weeks that nobody at the surgery was telling me about...particularly about certain products, [for instance:] 'You shouldn't eat that, you should eat this instead'... I'm really happy with these people (CLI12: 2).

In a similar vein, experts argue that the voluntary sector has much to offer the statutory sector (see, for example, Martikke and Moxham, 2010; Hogg and Baines, 2011). Kelly (2007), for instance, points out that voluntary sector organisations: have specialist knowledge of the needs of their client-group, which allows them to represent clients and, by giving the latter a voice, enhances empowerment; are, because of their unique structures, well-suited to involving interest groups and enhancing social cohesion and social capital and are advantaged by being free from the culture of conventional service delivery bodies. Indeed, it has been argued that the voluntary sector has a distinctiveness that gives it a comparative advantage in service-delivery (see, for example, House of Commons Public Administration Select Committee, 2008; Buckingham, 2009; Dickinson et al., 2012; MacMillan, 2012). These qualities include being innovative, personalised, trusted and responsive to local need (Bolton, 2003); strengthening active citizenship and democracy through engaging volunteers and campaigning (Brown et al., 2000); and nurturing social environments in which individuals and communities can develop and interact (Wolch, 1983; Conradson, 2003).

I have twice referred (in Chapter Four, 'Voluntary/third sector services and self-care programmes' and earlier in this section) to my observation of a Joint LLT meeting with a representative from the Armorshire Association of Voluntary Services (AAVS), the 'umbrella' organisation that facilitated the representation of voluntary

service groups on planning forums and organised partnership working between statutory and voluntary agencies. I have also explained (see Chapter Four, 'Voluntary/third sector services and self-care programmes') that I subsequently interviewed one of AAVS' Partnership Managers, Claire Peters. During the interview, Claire described how she had been tasked with helping the three LLTs liaise with voluntary sector organisations. As I then noted, she had therefore helped organise a *Locality Connections* event that brought together representatives from social services, GP practices, community and specialist nursing, and some thirty voluntary sector organisations. When I interviewed Bro-y-Grug District Nurse Lead Janice Davies, she told me that she had attended the event and that:

> I've been a long time in district nursing, but there was a huge variety of things that I wasn't aware of. I'm at the coal-face, and if I'm not aware of them, how am I going to impart that information to the clients and the carers? To raise awareness is very important, as to how these voluntary services can support the statutory caring services (LARI4: 10 – 11).

Just as Janice believed that to raise awareness of the voluntary sector would be of direct benefit to clients and informal carers, so Hudson and Henwood (2002, p. 164) suggest that the exchange of knowledge between people with a variety of experiences is an important element of what they term 'new partnerships', namely those that bring together disparate organisations with 'a shared purpose' to tackle complex social issues. Moreover, Williams and Sullivan (2007) contend that a major benefit of collaborative working is the way that it can enhance learning, allowing people and organisations from diverse backgrounds to join forces and to share understanding in tackling complex societal problems. Returning to Janice's comments, I had been surprised that an experienced district nurse felt that she had such little knowledge of voluntary sector organisations. During my interview with Bro-y-Grug Locality Care Co-ordinator Christine Thompson, however, she told me that the primary care community as a whole knew precious little of what the voluntary sector had to offer and that:

> ... they don't understand that the voluntary sector could be delivering services for local authorities on contracted agreements, and are therefore answerable to local authorities. They see it as just a small group of, you know, 'twin set and pearls' people just helping out. They don't understand that they are businesses delivering quite big services (LARI3: 13).

However, Claire Peters told me that a second *Locality Connections* event, this time in the Aberwrach locality, had been:

> ...quite GP-led, which was really good, because it was a question of [the GPs saying] 'What do we need to know about? Things like the foot-care service', and all of a sudden [a GP says]: 'It's an answer to a problem that I've had and I didn't know where to send anybody' (VSRI2: 3).

When I asked Claire what had triggered the GPs' interest, she replied that it was:

> ... because of the Locality Care Co-ordinator, Emma. She liaised with the two of us and took me along so that I could meet George Owen, who was the Lead GP. [It was] through his voice, him saying, for instance: 'We want presentations from the third sector'. So rather than *me* choose, it was a question of, 'OK, these are the ones that want to do it, what are you interested in?' They knew that they needed something around mental health and they knew that they wanted to find out more about foot-care, so we could cherry-pick what *they* wanted (VSRI2: 3).

With local GP interest in the Aberwrach *Locality Connections* event facilitated by the collaboration between Locality Care Co-ordinator Emma Jones, GP Lead George Owen and Claire, I asked Claire how this compared with her experience of working with the Bro-y-Grug LLT and Christine Thompson. She replied that:

> Nothing happened in Bro-y-Grug. Literally, all I had from Bro-y-Grug was when the person [i.e. Christine Thompson] came into post, I had a phone-call asking me about the Health and Wellbeing Forum and telling me that she would be attending and would feed back information to the other co-ordinators. She never attended and the other two did, interestingly enough. There was absolutely no contact whatsoever (VSRI2: 4).

Given Christine Thompson's professed support for voluntary/third sector involvement, the success of the *Locality Connections* events in Tregwen and Aberwrach and, moreover, the testing and shared-learning principles of the National CCM Demonstrator Programmes, it could be argued that her failure to take up the offer and to attempt to replicate the success of the other two localities was paradoxical. Moreover, given that the agenda of integration in Armorshire had been premised on the reconfiguration of existing services and the use of existing expertise (including that of the voluntary/third sector), it could be argued that the failure to draw on Claire's knowledge was a missed opportunity.

All the more so, arguably, given that in their evaluation of the Supporting People Health Pilots, Cameron et al. (2006) stressed that the existence of local voluntary sector support was of great benefit in the early stages of integrated projects, helping to create a culture in which partnerships were more likely to flourish. Cameron et al. (2006, p. 23) noted, for example, that *Sure Footed in Salford* (a joint-project between English local authorities and PCTs to develop integrated falls services) was helped by a, 'tradition of co-operation with and between the statutory and voluntary sector'. Whilst there appeared to have been little contact between the Bro-y-Grug locality and AAVS, when I interviewed Christine Thompson, she told me that:

> ...this week I've emailed the Disability Partnership, because some of their members will be coming along to one of our Leadership Group meetings in a few weeks' time, so that they can understand what's happening about the CRTs and for them to give us any ideas that we should be considering (LARI3: 15).

The Disability Partnership was, like AAVS, an 'umbrella' voluntary sector organisation, but with special interests in the care of people living with physical and mental disabilities. Invited to observe the subsequent meeting, I heard Disability Partnership Chairperson Ruth Johnson emphasise that one of the organisation's main objectives was to be engaged in the creation of new health and social care services. Ruth explained that:

> What we want is consultation and to be involved, not only in social care and the integrated services, but in the planning stages of developments; because things are going wrong in not consulting: access rights aren't being developed. That's what it's all about. Starting from the beginning and making an improved and better society for everybody to access everything (LLTMO3: 2).

As with so much of the language of community participation, consultation and involvement are contested terms. However, whereas the former, argue Purtell et al. (2012, p. 211), is concerned with, 'inviting people to comment on and contribute to *existing* [my emphasis] ideas and structures', the latter, note Harrison and Mort (1998, p. 60), is a, 'local attempt to include organised groups of service users in the *planning* [my emphasis] and occasionally the management of services'. With Ruth Johnson stressing that the Disability Partnership sought both consultation *and* involvement, her fellow-member Jeff Stewart noted that the lack of both during the

construction of a new shopping complex in nearby Penafan had resulted in the poor layout of steps and lamp-posts and lack of tactile-paving. As a result, Jeff added, people living with disabilities had been effectively barred from entering the new complex. In reply, Bro-y-Grug LLT Social Care Lead Gwyn Evans stressed that:

> I want to see a strong lobby. Harry Jenkins [Disability Partnership member] used to tell me off, because I used to use the word 'consult'. I used to go to the Disability Partnership meetings and say, 'We want to have this group so that we can work with them, consult with them'. Harry used to always pick me up on it and say: 'Consultation is not enough, we need involvement'. [So] we've been looking at involving the Disability Partnership. It's about involvement, about trying to ensure that we're involving the Disability Partnership in all our day-to-day work, our decision-making, our planning (LLTMO3: 2).

During my interview with Gwyn, his references to the 'buzzword' status of integration and the local interpretation of user-independence had revealed his appreciation of the importance of semantic clarity. Whilst his comments from the meeting seem to have been prompted by similar concerns, they also revealed his wider understanding of the relationship between partnership-working, involvement and consultation. So, with Baggott (2013) noting that community/citizen involvement is an increasingly important dimension of partnership-working, Gwyn's indication that efforts would be made to ensure greater involvement, arguably, were a tacit acknowledgement of the assurance – given in the Armorshire Collaboration PID – that the project would be based on 'partnership working with service users and all those involved in providing their care' (App. 9). Moreover, Gwyn's recognition of the need to go beyond consultation seemed to chime with Arnstein's contention – made in her study of 'citizen participation' (Arnstein, 1969, p. 219) – that:

> Inviting citizens' opinions, like informing them, can be a legitimate step toward their full participation. But if consulting them is not combined with other modes of participation, this rung of the ladder is still a sham since it offers no assurance that citizen concerns and ideas will be taken into account.

Indeed, in a number of frameworks that set out community participation in hierarchical terms – such as Arnstein's (1969) 'Ladder of Citizen Participation'; Brager and Specht's (1973) 'Ladder of Community Participation'; and Charles and DeMaio's (1993) 'Dimensions of Lay Participation in Health Care Decision Making' – partnership-working ranks above consultation. With Gwyn – like Harrison and

Mort (1998) – referring to the importance of involvement at the decision-making and planning stages, his comments appeared to be in keeping with the client-focussed vision of the Armorshire Collaboration's secondary and social care leads and the project's 'co-design' principles. However, just like Gwyn's calls for a 'shared-ethos' amongst CRT front-line professionals and for 'independence' for local service users, his call for 'involvement' of a local voluntary sector organisation appeared to be belied by its timing. This is because this first meeting between the Bro-y-Grug LLT and representatives from the Disability Partnership took place on August 5th, 2010. At this time, the Collaboration had already been running for nearly two and a half years and just six weeks remained until the CRT's launch.

The result of this was that by the time the latter was launched, I found no evidence that there had been any voluntary/third sector involvement in its design, just as I had found no evidence of front-line professional or client/informal carer involvement either. Accordingly, it appeared that the Armorshire Collaboration – at least in the Bro-y-Grug locality – had failed in its stated objective to harness the, 'collective wisdom and enthusiasm of participants from a wide network of multidisciplinary teams in a number of health, social and voluntary care sectors' (see section, 'CCM, partnership-working, community participation' above). Moreover – as I indicated in Chapter Two (see section, 'The language of integration') – many contemporary commentators argue that to achieve integrated care, those involved with planning and providing services should impose the service user's perspective as the organising principle and that the goal of integrated working should be to improve client-care (see, for instance, Øvretveit, 1998; Lloyd and Wait, 2005; Shaw et al., 2011; Goodwin et al., 2012; Billings et al., 2013).

Given that, alongside the lack of involvement of service users, I also found no evidence that the implementation of the new service had in any way changed their experience of care, this would therefore suggest that the Armorshire Collaboration – again, at least in the Bro-y-Grug locality – also failed in its stated objective to provide an integrated approach (and that there had indeed been a gap between the 'rhetoric' and 'reality' of integrated working). Whilst I consider the implications of these findings in detail in the next – and final – chapter of this case study,

‘Discussion, final conclusions and implications’, I end this chapter by providing a brief summary of the issues discussed.

Summary

In this final findings and discussions chapter, I described how, despite project leaders’ pre-reconfiguration espousal of a joint-vision of client-focused integrated care, the Bro-y-Grug CRT was designed and set up in a top-down fashion. I explained that there was negligible involvement of front-line health and social care professionals, people living with chronic conditions and their carers and representatives from the voluntary/third sector. I provided a number of examples of the way in which the absence of involvement militated against improved client care and resulted in a service that was – as far as service users and carers were concerned – no different from the one it replaced. On the contrary, I provided some examples of the way that the reconfiguration resulted in a service that was less rather than more integrated and explained that ultimately, the Armorshire Collaboration – at least in the Bro-y-Grug locality – failed to provide an integrated approach. In the next – and concluding chapter of this case study – I discuss the implications of my research in terms of the future development of health and social care integration and the care of people living with chronic conditions and set out some recommendations for future policy, practice, research and education.

Chapter 8: Discussion, final conclusions and implications

Introduction

In this case study, I set out to explore the development of a new integrated health and social care service for people living with chronic conditions and to shed light on the nature of integrated working by a way of a qualitative exploration of events and perspectives at Wales-wide, regional and local levels. By incorporating four methods of data collection, exploring a range of perspectives, and utilising an interpretevist stance, I was able to provide new data and add to what is already known about integrated working and the limited body of research that has examined integrated working from the perspective of people living with chronic conditions and their carers. In this final chapter, I begin by examining the extent to which the study's aim and objectives were met. I then explore the strengths and limitations of the case study, before describing its original contribution to the evidence base of integrated working and chronic conditions management. Subsequently, I review the main findings of the case study, before discussing their implications in terms of the further development of practice, research and education in integration and chronic conditions management (including a consideration of what might be included in a good practice guide).

Meeting of aim and objectives

My aim in conducting the research was to answer the question: How has integrated care for people living with chronic conditions developed during the implementation of the new CCM service? My objectives, in turn, were to answer the following five sub-questions:

1. How have different stakeholders been involved in the establishment of the new CCM service?
2. What do the stakeholders involved in the establishment of the new CCM service say about integration?
3. What do people living with chronic conditions and their carers say about the new CCM service and the care they receive?

4. What do front-line health and social care professionals say about their work in the new CCM service compared to their work in their previous teams?
5. How has the development of the new CCM service been affected by pre-existing services, roles and relationships and concurrent developments in health and social care?

As I explained in Chapter One, however, rather than answering the question and sub-questions individually and consecutively, these were incorporated into a narrative account of the development of the new CCM service. I now consider the extent to which, in so doing, the study's objectives were met and, in turn, the extent to which the study's aim was met.

As regards the way in which different stakeholders were involved in the establishment of the new CCM service, firstly, there were numerous reports of a lack of communication and information-sharing relating to the establishment of the new CCM service and of belated notification of the disbandment of existing teams from front-line health and social care professionals and their line-managers alike. Although a joint-consultation event was organised for both stakeholder groups, for line-managers this was held three weeks before the CRT's inauguration, whilst for front-line professionals it was held subsequent to its launch. Not only did the timing of these events appear to militate against the capacity of either stakeholder group to make a significant contribution to the organisation of the CCM service, the suggestions that were then volunteered – such as the need for MDT meetings, joined-up IT systems and more streamlined referral mechanisms – were either immediately deemed 'non-negotiable' or were later ruled out. With the organisation of the CRT appearing to have remained largely unchanged when my fieldwork ended, the involvement of both stakeholder groups in the establishment of the new CCM service up to then had been negligible.

Whilst GP referrers to the new CCM service drew attention to a similar lack of communication and information-sharing, there was acknowledgement that this situation was in some measure attributable to a reluctance, on their part, to explore what the new CCM service could offer. Indeed, with just one GP from the nine GP practices in Bro-y-Grug attending a meeting specifically organised to outline plans

for the new CCM service to the local primary care community, it could be argued that GP buy-in was minimal. But considering the reports of the Bro-y-Grug LLT GP Lead's failure to connect with local GPs, the conditions for effective engagement were perhaps somewhat less than optimal. Irrespective of the cause, I found little evidence of GP involvement in the establishment of the new CCM service.

Communication and information-sharing with representatives of the voluntary/third sector regarding the establishment of the new CCM service was variable, so that complete ignorance of the CRT's existence on the part of some could be contrasted with detailed knowledge of its development on the part of others. Furthermore, the Bro-y-Grug LLT's rejection of one offer to participate in an awareness-raising event from one voluntary/third sector organisation could, in turn, be contrasted with its extension of an offer to attend a consultative meeting to another. Once again, however, the timing of this meeting – just six weeks prior to the CRT's launch – appeared to militate against the organisation's capacity to make a significant contribution. With no voluntary/third sector representation in the CRT when my fieldwork ended, at that time I had found little to indicate that this stakeholder group's involvement in the establishment of the new CCM service had been anything but nominal.

With only two of the twelve clients and none of the five carers whom I interviewed cognisant of the fact that their care was now delivered by a different team, I found no evidence of any official information-sharing concerning the establishment of the new CCM service with this stakeholder group. Instead, any knowledge that the latter had of developments was limited to what had been gleaned – in an *ad hoc* and arbitrary manner – by way of informal channels of communication. With only two of the service users and none of the carers whom I interviewed aware of any changes to their care, none of the seventeen had received official notification of the launch of the CRT or been offered the chance to volunteer their views. On the contrary, amidst reports that no questionnaires had been circulated and no consultation events or information-sharing meetings organised, I found no evidence that service users and carers had had any involvement in the establishment of the new CCM service.

The three members of the LLT and Locality Care Co-ordinator, whilst ostensibly spearheading developments, had little meaningful influence on many facets of the establishment of the new CCM service in the Bro-y-Grug locality. Hence, whilst they were in a position, for instance, to rule out MDT meetings and to decide on the seating arrangements for the new CCM service, they had no say in the latter's launch-date (the end of September, 2010), configuration (by means of a co-located team) or resource-allocation (with no funds made available to cover start-up costs). With these elements instead decided by actors at central-government and Local Health Board level, the relative incapacity to influence developments on the part of the LLT and Locality Care Co-ordinator is perhaps nowhere better illustrated than by the replacement of their suggested title of Community Operational Group with the centrally-mandated title of Community Resource Team. Hence, whilst perhaps having the greatest input into the establishment of the new CCM service of any local stakeholders, their involvement took place within parameters that had been decided at national and regional levels.

Accordingly, the study showed that local stakeholders at all levels had little involvement in the establishment of the new CCM service and that the service was largely a result of 'top-down' decision-making. With no involvement of service users and their carers, crucially, the organisers of the new CCM service did not use their perspective as its organising principle. According to this commonly agreed criterion of integrated care (Shaw et al., 2011; Goodwin et al., 2012) the new CCM service was not integrated.

As regards what stakeholders involved in establishing the new CCM service said about integration, secondly, project leaders across the Armorshire Collaboration and in the Bro-y-Grug locality agreed that existing health and social care systems at Wales-wide and regional levels were characterised by fragmentation, lack of co-ordination, long-standing divisions, an over-reliance on the biomedical model of care and 'silo-working' and at local level by duplication, lack of co-ordination, waste and inefficiency. The widespread consensus that existing service-provision was, as a result, ill-suited to the joined-up, multiple and complex needs of people living with chronic conditions was matched by the general agreement that the solution to the problem lay in integration. This, in turn, was mirrored by a correspondence of views

vis-à-vis conceptualisation: with a joint-vision of integration built on the prioritisation of the needs and perspectives of service users and aimed at improving their care; and *vis-à-vis* implementation: with a shared conviction that fundamental to integration was the co-location of health and social care professionals (which, in turn, was based on the conviction that this would lead to an increase in service-user focused 'opportunistic-dialogue').

Front-line (allied) health and social professionals made little reference to the Wales-wide, regional and local organisational problems so often cited by project leaders, but often spoke of the way in which repeated structural reforms had engendered instability, confusion (amidst front-line professionals, service users and carers alike) and wastage, whilst delivering little in the way of tangible change. Furthermore, even though front-line professionals shared project leaders' conceptualisation of integration, the same could not be said of their views on how it should be implemented. On the contrary, drawing attention to their frequent absences from the office due to their busy day-to-day schedules and the peripatetic nature of their work, front-line professionals stressed that the supposed benefits of co-location – and of the opportunistic dialogue this would generate – had not been borne out in practice (as exemplified, arguably, by the fact that in each focus group, at least two participants had never previously spoken).

In addition to their near-universal ignorance that a service reconfiguration had taken place and lack of involvement in the establishment of the new CCM service, none of the service users and carers whom I interviewed was aware that their care was now delivered by way of an 'integrated' team. As this meant that they had given the subject no prior consideration and as they had, moreover, noticed no change to their care – the quality of which was universally praised – the subject of integration was conspicuous by its absence from virtually all interviews with service users and their carers.

Voluntary/third sector representatives suggested that integration could further their sector's development by facilitating the creation of an informational conduit between different stakeholders and that the establishment of a brokerage position within the CRT and organisation of awareness-raising events, for example, could increase the

knowledge of representatives from the statutory sector regarding the range of services they could offer. Voluntary/third sector representatives also argued that integration could facilitate their own involvement in the development of new projects and programmes from the planning stages through to full service-delivery, thereby ensuring that new services were built around the needs of the people using them rather than according to the wishes of service-providers.

Accordingly, the study showed that there was not consensus across all of the stakeholder groups as to the meaning of integration and that the way it was implemented – by way of co-location of health and social care professionals – was decided by project leaders alone. Once again, this took no account of the perspective of service users and carers.

As regards what people living with chronic conditions and their carers said about the new CCM service and the care they received, thirdly, in addition to having no knowledge of the creation of an 'integrated' team, none of the service users or carers whom I interviewed could discern any difference in the care they received since the CRT's inauguration, an event of which most were only cognisant because I informed them of it during the interviews. Whilst this meant that there were no reports of any improvement – or, indeed, deterioration – in the quality of care, the vast majority of service users and carers told me that both prior to the previous October (the month in which the CRT had been established) and thereafter, they had been extremely satisfied with the care they received. In particular, repeated reference was made to the professionalism, commitment and expertise of front-line (allied) health and social care professionals. Any negative comments related to communicational issues, such as the lack of information-sharing pertaining to the availability of services and support mechanisms or absence of notification in the case of delays to home-visits.

Given that the goal of integrated working should be to improve client-care (see, for instance, Øvretveit, 1998; Shaw et al., 2011; Goodwin et al., 2012; Billings et al., 2013; Coulter et al., 2013) the study therefore showed that the new CCM service failed to adopt an integrated approach.

As regards what front-line health and social care professionals said about their work in the new CCM service compared to their work in their previous teams, fourthly, many expressed incomprehension and discontent at having to leave teams that were, by comment consent, providing high-quality care. With widespread agreement that co-location had failed to deliver the anticipated increase in opportunistic dialogue, there were a number of reports that it had engendered isolation, reduced profession-specific support and increased uncertainty *vis-à-vis* professional roles. Additionally, it was felt that many features of the CRT worked against – rather than facilitated – integrated working and had, in contrast with the joint-vision that had underpinned the reconfiguration, resulted in care delivery that was now dictated by structures and systems rather than the needs of service users. So whilst, like project leaders, front-line professionals felt that the objective of integrated working was the improvement of service-user focused care, many felt that the teams they had left were better equipped to provide it than the CRT and that service user care had, as a result, not improved.

With front-line health and social care professionals – just like service users and carers – reporting no improvement in the care of people living with chronic conditions, the study again showed that the new CCM service failed to adopt an integrated approach.

As regards how the development of the new CCM service had been affected by pre-existing services, roles and relationships and concurrent developments in health and social care, fifthly, the numerous references to the shortfalls of existing health and social care structures at Wales-wide, regional and local levels can be contrasted with the equally numerous references to the progress that had been made in the years preceding the launch of the Armorshire Collaboration in the fields of both chronic conditions care and integrated working both across Armorshire and within the Bro-y-Grug locality. Amidst the launch of many new programmes, services and initiatives at Wales-wide, regional and local levels, attention was drawn to the high quality care – by project leaders, front-line professionals, representatives of the voluntary/third sector, GPs, service users and carers alike – delivered by two specific services, namely the Llawfon Reablement Service and the Armorshire CDM Team. With many project leaders suggesting that this existing resource-base had helped pave the

way for the establishment of the new CCM service, other earlier developments had also laid solid foundations for the future, including the forging of strong relationships between key stakeholders with a common and shared purpose, the widespread espousal of a clear joint-vision of service user focussed integration and the existence of numerous 'champions of change'. Conversely, the establishment of the new CCM service appears to have been adversely by a number of contextual factors that were contemporaneous with the demonstrator project, such as the NHS Wales Reforms of 2009, the harsh economic backdrop and the introduction of a new strategy built on a different model of care.

In meeting the study's objectives by answering the five sub-questions, I was able to meet the aim of the study by answering the main research question: How has integrated care for people living with chronic conditions developed during the implementation of the new CCM service? With many contemporary commentators arguing that to achieve integrated care, those involved with planning and providing services should impose the service user's perspective as the organising principle and that the goal of integrated working should be to improve client-care (see, for instance, Øvretveit, 1998; Lloyd and Wait, 2005; Shaw et al., 2011; Goodwin et al., 2012; Billings et al., 2013) the study therefore showed that the establishment of the new CCM service in the Bro-y-Grug locality had failed in its stated objective to provide an integrated approach (and that there had been a gap between the 'rhetoric' and 'reality' of integrated working). Having discussed the extent to which I met the aim and objectives of this case study, in the next two sections I discuss the strengths and limitations of the research.

Strengths of the case study

One of the main strengths of case study research, it is argued, is the way in which it can provide an in-depth analysis of a phenomenon that is 'bounded' in time and space, but not divorced from its context. I bore this in mind throughout my research, as I charted the development of the Armorshire Collaboration within the wider political and socio-economic environment of the rest of Wales and the UK. By means of a 'thick' description of events, I provided an account of the complexities and challenges of introducing a new CCM service against a backdrop of fluctuation

and extraneous pressures. In collecting the data to render this detailed description of events, my 'prolonged engagement' in the field enhanced the credibility of the case study. Not only did this help me develop an in-depth contextual understanding of the project – and the events surrounding it – but it also allowed me to establish rapport and trust with a broad cross-section of local stakeholders and thereby to encourage openness and honesty. In turn – and by means of my interpretevist stance – I portrayed local stakeholders' subjective experience of the development of the new CCM service and its impact on their lives.

This was of particular importance with regard to the experience of service users and carers, given that many commentators argue that the organising principle of integration should be the service user's perspective and that its main objective is to improve client-care. At the same time, however, there is little evidence that shows that integration benefits clients and carers or that they are involved in the design, planning or commissioning of services. By incorporating the views of service users and carers – something that few previous studies of integrated working and chronic conditions management have done – this case study highlights both their lack of involvement during the development of the new CCM service, but also their lack of awareness of change to service-provision following integration.

Nevertheless it is important to stress that the numbers of older people living with chronic conditions in Bro-y-Grug – as across the whole of Armorshire, the rest of Wales and the UK and indeed worldwide – have risen sharply in recent years. Hence, that none of the clients and carers whom I interviewed was involved in developing the new CCM service or reported any improvements in the delivery or quality of their care does not denote that the same was necessarily true for everyone living with chronic conditions in the Bro-y-Grug locality. In this respect, however, the case study's credibility and dependability was enhanced by triangulation of data. Hence, that similar reports of non-involvement of clients and carers emerged during focus groups with front-line professionals, individual interviews with voluntary sector representatives and even project leaders – together with a marked absence of any mention of service user involvement in any of the meetings I observed – led me to conclude, with some confidence, that this had not taken place.

The same triangulation of data, moreover, allowed me to conclude with equal confidence that during the development of the CCM service there was also a lack of participation of front-line professionals and of voluntary sector representatives. Moreover, I did not set out to enumerate frequencies but to examine 'how' and 'why' questions of process and to provide a rich enough description for the reader to gain a 'vicarious experience' of events and to be able to transpose these onto his or her own situation. This detailed rendering, in turn, can allow readers to make informed decisions about the transferability of the findings of the development of the Armorshire Collaboration in the Bro-y-Grug locality to their own specific contexts.

Returning to the establishment of rapport and trust with stakeholders, whilst these facets of the case study enhanced credibility, they also carried with them the risk that I might become too close to participants and that my representation of events could be unfair or biased. However, the case study's confirmability was enhanced by my self-aware and self-critical stance to the research process. This was helped by my regular meetings with my academic supervisors, at which time we discussed the development of my relationship with local stakeholders and the importance of maintaining critical distance. Additionally, I kept a reflexive journal, thereby providing transparency *vis-à-vis* my personal beliefs, preferences and biases and their influence on the research process. Confirmability was also enhanced by the fact that I maintained – alongside a case study database – a study journal in which I charted my developing theories and the different stages of the research, thereby recording a clear decision/audit trail of the research process.

The study journal also included details of my use of purposive sampling. In this way, I was able to select a case study locality – Bro-y-Grug – that illustrated features of my research that were of particular interest, such as the impact of demographic change and the concomitant increase in prevalence of chronic conditions, in addition to providing an interesting instance of integrated working during the creation of the new CCM service. At the same time, I was able to select documents to read and meetings to observe that provided me with an enhanced understanding of the main issues of my research, in addition to choosing stakeholders to interview – both individually and in focus groups – with knowledge of questions that were central to the case study.

As the research progressed, moreover, I was able to identify additional key informants whom I subsequently interviewed, such as voluntary/third sector representatives and lead agency representatives who had been involved in earlier integrated projects. On the one hand, this provided me with further insights into the lack of community engagement during the development of the new CCM service. On the other hand, it illustrated that the Armorshire Collaboration was part of a continuum of developments in integrated working. Indeed, with the inclusion of the chapter entitled, 'Setting the context for the case study', I was able to describe in detail the resource base of services for people living with chronic conditions in Armorshire prior to the launch of the Armorshire Collaboration. This helped display how the project built on earlier developments and, rather than being introduced into a vacuum, was instead anchored within existing services as well as within existing relationships between people who shared a common vision and who had, over time, identified a problem and a gap in service provision. The fact that, despite these auspicious beginnings, the Armorshire Collaboration – at least in the Bro-y-Grug locality – failed to deliver an integrated service provides an indication of its particularly complex contextual backdrop. The use of case study research – incorporating multiple perspectives – therefore provided an important window into events as they unfolded. In the next section, I discuss the limitations of this case study.

Limitations of the case study

There were three major limitations of the case study. The first of these related to the case study locality. Hence, whilst I was able to select a case that illustrated the features of demographic change and increasing prevalence of chronic conditions that were of particular importance to my aim and objectives, it is important to bear in mind that my research was conducted in just one Welsh locality and that what was true for Bro-y-Grug would not necessarily apply to other parts of Wales or the rest of the UK. The lack of ethnic diversity within Bro-y-Grug (which, as I noted in Chapter One, is over ninety-nine percent White), for instance, militates against the transferability of findings from this case study to areas of the UK with a greater ethnic diversity. Whilst I attempted to address this limitation by clearly indicating the context of the case study – and thereby seeking to enhance transferability – more

research into chronic conditions management and integrated working in more ethnically diverse areas of the UK is required.

The other two limitations of the case study both relate to issues of timing. Firstly – as I indicated at the end of Chapter Four 'Setting the context for the case study' – whereas the Armorshire Collaboration was launched in March 2008, my PhD scholarship began a year later in 2009. This precluded my charting of the development of the project during its nascent stages and meant, for instance, that I was unable to witness the establishment and subsequent demise of the Armorshire Collaboration's original organisational structure of Delivery Team and four work-streams. Attending PPI Work-stream meetings, for instance, could have allowed me to gauge the extent to which plans for client and carer involvement in the launch of the new CCM service were being developed before key stakeholders were pulled away from the project as a result of the NHS Wales Reforms of 2009. On the one hand, therefore, it could be argued that the case study is incomplete. On the other hand, however, the time-delays to which I referred at the end of Chapter Four meant that no significant developments in the creation of the new CCM service in Bro-y-Grug appeared to have taken place before I commenced my fieldwork which, moreover, I was able to continue unbroken until the end of the project.

As regards the second issue of timing, this relates to the considerable investment in time which is necessary to ensure the cultural change that, it is argued, is key to ensuring integration. Despite the fact that I attempted to ensure sufficient 'bedding-in time' to front-line professionals by waiting over five months before arranging the first focus group, it could be argued that this was little in comparison to the five years which, suggest Øvretveit et al. (2010), would have been necessary to discern whether integration had been of benefit in their case study of the creation of an integrated health and social care service (see Chapter Two, section, 'The determinants of integration: structure or culture?'). Similar issues relate to individual interviews with clients and carers, many of whom I also interviewed within six months of the CRT's launch.

However, the last of the focus groups took place approximately a year after the CRT's launch, whilst I conducted five of the client interviews six months later. At

this time, similar reports of a lack of change in service delivery were given, thereby enhancing the case study's credibility and dependability. Moreover, as regards the widely reported lack of involvement of clients and carers – and indeed of front-line professionals – during the development of the CCM service, the timing of the majority of the focus groups and interviews with clients and carers could also be considered as enhancing the credibility of the case study, since at this time the events being commented upon were still comparatively fresh in their memories. Having discussed some of the strengths and limitations of the case study, in the next section I discuss the original contribution made by this study.

Original contribution

This thesis makes an original contribution to research into integrated working and the management of care of people living with chronic conditions in a number of ways. Firstly, it comprises a novel combination of three topics of current international interest in a single study. Hence, amidst general agreement that existing care systems are ill-suited to the complex and multifactorial needs of people living with chronic conditions, many have called for structural reform based on increased integration (Nolte and McKee, 2008). Whilst there have been a number of studies of structural reform in health and social care, of the management of care of people living with chronic conditions, or of different facets of integration, to date these three topics have not, to my knowledge, been combined in one piece of research. By jointly exploring these three topics, this thesis provides an original insight into how their complex interplay can affect different aspects of health and social care provision and, ultimately, the care experienced by people living with chronic conditions.

Secondly, this thesis provides a novel examination of service user and carer perspectives during a health and social care project premised on increasing integration. With some consensus that the objective of integrated care should be the improvement of care delivery to individual service users and that services should be co-ordinated around their needs and perspectives (Goodwin et al., 2012), it is recognised that there are two fundamental weaknesses in the evidence-base: the overwhelming focus of research on the processes of integration rather than on the

outcomes of integration; and the general failure of research (a failure that extends, moreover, to many different areas of health and social care provision) to take account of the service-user and carer perspectives (Cameron et al., 2012). In this thesis I have addressed both of these issues by incorporating semi-structured qualitative interviews in which service users and their carers set out – freely and at length – their opinions of the integrated health and social care they receive.

Thirdly, this thesis provides an original combination of perspectives in a study of integrated working. Moreover, these perspectives were often recorded at different stages of the demonstrator project: the views of government-level actors, for instance, were often expressed prior to the launch of the demonstrator project; the views of lead agency representatives were often expressed during the demonstrator project but prior to the establishment of the new CCM service; and the views of front-line health and social care professionals, service users and clients were expressed – exclusively – after the new CCM service had been in existence for a number of months. This provision of a multiplicity of perspectives – recorded at different stages of the project – means that this thesis has been able to provide a novel comparison of the way in which stakeholders in one project described how integration would hypothetically effect care provision – and the factors that would facilitate or hinder this process – with the way in which others described how it had actually affected care provision – and the factors that had facilitated or hindered this process.

Fourthly, this thesis takes into account previously unexplored contextual factors that can affect health and social care integration. Hence, by providing a detailed examination of the demonstrator project in real time (but also taking account of its antecedents) located in its specific social milieu and paying particular attention to its economic, political and cultural backdrop, this thesis examines a number of factors that influenced the development of the new CCM service. On the one hand, for instance, it describes: the range of agencies and services premised on facilitating integration or improving chronic conditions care that were established in the years directly preceding the launch of the demonstrator project; the key relationships – forged, likewise, prior to the demonstrator's launch – between stakeholders who recognised a set of common needs and issues; the existence of a joint-vision of

integration and of a number of local 'champions of change'. On the other hand, it describes: the demonstrator project's backdrop of economic austerity; the contemporaneous restructuring of health structures across Wales; the introduction of a different strategy prior to the demonstrator project's completion; and the ever-present significant financial and time pressures. This thesis therefore provides an original insight – one that is, arguably, of great value to those seeking to launch similar projects – of how the process of integration can be affected by contextual factors.

Fifthly, this thesis adopts novel analytical and conceptual approaches to understanding integration in the care of people living with chronic conditions. By incorporating qualitative data-collection techniques and analysis and an interpretevist stance, it provides a novel examination – and hence understanding – of the establishment of an integrated CCM service and an elucidation of the subjective meaning of this process to a range of stakeholders. Moreover, it makes original use of the theory of collaborative advantage (and inertia), of structuration theory and of role ambiguity. These are concepts that have been used, respectively, to analyse how complex social problems can be addressed, how outcomes are arrived at in a variety of economic and political contexts, and how issues of leadership play out in business environments. To my knowledge, however, these concepts have not previously been applied to the field of integrated working in the management of care of people living with chronic conditions. By using these analytical and conceptual approaches in a novel way, I have provided an original understanding of the conceptualisation of the development of integrated working and chronic conditions management.

By incorporating an original combination of topics, a novel examination of service user and carer perspectives, a novel combination of multi-stakeholder perspectives, an examination of previously unexplored contextual factors and an original application of analytical and conceptual approaches, in this thesis I have made a number of original additions to existing knowledge in the field of integrated working and CCM. Firstly, I have shown that, alone, co-location of front-line health and social care professionals does not enhance co-working or service users' or carers' experience of care delivery; secondly, I have shown that concurrent structural reform and the launch of different strategies have a disruptive influence on initiatives

premised on the integration of health and social care for people living with chronic conditions; thirdly, I have shown that the lack of involvement of service users and carers during the development of integrated initiatives militates against the improvement of their experience of care; fourthly, I have shown that the lack of involvement of front-line professionals in the development of integrated initiatives militates against effective integrated working; finally, I have shown that there is a significant gap between the 'rhetoric' of integrated CCM care based on service user involvement and improvements to care and the 'reality' of no service user involvement and no improvements in service user care. Having set out the study's original contribution, in the next section I review its main findings.

Main findings

Many commentators argue that the organising principle of integration in health and social care is the service user perspective and its objective the improvement of care outcomes. According to these criteria, in this thesis I have shown that the new CCM service in Bro-y-Grug failed to provide an integrated service. But what this thesis also illustrates is that establishing a new service that is premised on delivering integrated care is a highly complex process, the ultimate success of which is dependent on a multiplicity of factors and their interrelationships.

A key feature of the development of the new CCM service in Bro-y-Grug and one that contributed – both directly and indirectly – to the locality's failure to deliver integration was the prevailing lack of clarity that surrounded the entire project. The problem was endemic, affecting the Welsh Government policy documents that described the Welsh CCM Model, the National CCM Demonstrator Programme documents that described the Model's introduction across the three demonstrator-sites, and the Armorshire Collaboration Project Initiation Documents that described, in turn, its local implementation. The imprecision and incoherency meant, for instance that terms such as integration, partnership working, collaboration, involvement, participation and engagement were not clearly defined and were used interchangeably; it meant that terminology was in a state of perpetual flux (with the names of teams, services, roles – and even the Welsh CCM Model itself – repeatedly changed); and it meant that the roles of stakeholders from statutory services were

either frequently redefined (as was the case for the Locality Co-ordinator) or not defined at all (as was the case for the three members of the LLT). The lack of clarity extended to the objectives of the project. Hence, as one of the National CCM Demonstrator Programme's three demonstrator-sites, the Armorshire Collaboration's stated aim at project initiation was to implement the Welsh CCM Model and to ensure sustainable services for people living with chronic conditions. Subsequently, however, project leaders were required to accommodate a new strategy (the Primary Care Community Strategic Delivery Programme) and its model of care (based around a Community Resource Team) that, albeit espousing the integrated principles of the Welsh CCM Model's Core CCM Team, did not share its principal objective of providing improved care for people living with chronic conditions.

On the one hand, the prevailing lack of clarity reflects the frequent references in the literature of integration to the definitional, semantic and conceptual imprecision that has adversely affected the development of integrated working (see Goodwin et al., 2012; Graham et al., 2013; Walker et al., 2013). On the other hand, however, this thesis shows that little attention was paid by actors at central-government or locality level to those who argue that, in any enterprise built on joined-up working, clarity is of seminal importance (Glasby and Dickinson 2008; Williams and Sullivan, 2010) and that the success of joint-projects is contingent on the establishment of clear objectives at project initiation (Huxham and Vangen, 2004). Despite its auspicious beginnings – anchored, as it was, within the existing network of local services and relationships that are of such importance in the development of new partnerships (Cameron et al., 2006a) – the project subsequently suffered significant delays, failed to involve many key stakeholders and provided a service that was – in terms of the service users' experience of care delivery – in no way different from the services it replaced. This accorded with Williams and Sullivan (2010) assertion that the absence of clarity at project initiation will invariably lead to problems at later stages of joint-projects and Huxham and Vangen's (2004) prediction that this will see collaborative advantage turn to collaborative inertia.

When the Armorshire Collaboration was launched, however, a forum had been set up – the Armorshire Collaboration Delivery Team – to coordinate the contribution of statutory and voluntary/third sector agencies, front line health and social care

professionals and service users and carers and to facilitate the establishment of a clear and joined-up vision for the development of the new CCM services across the county. In this respect, local project leaders had paid heed to the evidence base of integrated working, which contains numerous references to the importance of the formation, at the launch of joint-projects, of a 'steering group' (or analogous body) to act as a forum in which joint-aims and joint-objectives can be clearly set out and developed (AC, 1998; Cameron et al., 2006; 2006a; Beresford, 2013). A useful example of the successful use of such a steering group is provided by the Lambeth Living Well Collaborative, a partnership platform for commissioning integrated mental health services that established a core 'Collaborative Group' to take forward the platform's joint-ethos and which, through regular meetings, ensured the maintenance of a shared-vision of co-design and co-delivery (Langford, 2013).

One of the main aims of the Armorshire Collaboration Delivery Team was to help reconfigure the existing network of services which, it was widely recognised, had made significant headway in developing the integrated agenda and in improving the care of people living with chronic conditions in Armorshire. Accordingly, one frequently-cited facilitator of integrated working, a steering group (in the guise of a Delivery Team), would, in theory, pave the way for the improved utilisation of another frequently-cited facilitator of integrated working, an existing network of local services and relationships. This ostensibly propitious situation was, however, short-lived. With the Armorshire Collaboration run at a time of major country-wide structural change – coinciding as it did with the NHS Wales Reforms of 2009 – key stakeholders from the Delivery Team were drawn away from the project. This resulted in its disbandment and that of the four work streams which, like steering groups, are a common structural feature in integrated health and social care projects (see, for instance, Shaw and Levenson, 2011). Whilst the disbandment of the Delivery Team militated against the establishment and development of the joint-vision and objectives that are so important to integrated working, the disbandment of the four work streams – and more specifically, the one dedicated to PPI – militated against the development of another fundamental component of integrated working, the involvement of service users and their carers.

The existence of the initial organisational structure of the Armorshire Collaboration indicates that, in order to help guide the development of the new CCM service across the county, local project leaders had looked to the evidence base of integrated working. The same cannot be said of the actors at central government level who chose to run the National CCM Demonstrator Programme at the same time as conducting another Wales-wide structural reform in health care (following the previous reorganisation of 2003). Nor had actors at central government-level looked to the evidence base of integrated working when they opted to make the demonstrator programme of just three years' duration or to introduce, before its completion, a strategy that was different from the one it was set up to implement.

On the contrary, those involved in implementing or evaluating integrated or collaborative projects in health and social care – particularly those involving society's 'wicked issues' (like the provision of care for people living with chronic conditions) – have made repeated calls for conditions of stability and continuity and for the provision of adequate developmental time (House of Commons Health Committee, 2009; 2012b; Glasby et al., 2011; Robertson, 2011; Thistlethwaite, 2011; Cameron et al., 2012; Priest, 2012). Potentially informative comments regarding the way in which a lack of continuity and stability can detract from the development of integrated projects were given to the House of Commons Health Committee (2009) by the Programme Manager of a Sure Start project, Pauline Naylor:

> Recruiting staff, training staff, embedding them, building a sustainable team, engaging with clients and creating major outcomes in a year/18months/two years has been a real challenge. It takes about two years to try something. If it does not work, rethink it, review it, try something else, and, if it does not work, try something else. We have not had the time to really make mistakes, try things and embed good practices, before we have been expected to change the strategy, change the targets and work towards different outcomes. I think that has been really challenging and it has resulted in quite a lot of waste of funds as well (2009, p. 32).

Amidst widespread recognition that repeated structural reforms, a plethora of new initiatives and lack of time to display benefits have had a disruptive effect on many integrated projects, one notable exception is the development of integrated health and social care services for older people during the creation of the Torbay Care

Trust. Central to this process was the long-term commitment to change of NHS leaders who, recognising existing shortfalls in care, had developed strong working relationships based on a shared vision of service user focussed integrated care (Thistlethwaite, 2011). The backdrop to the launch of the Torbay Care Trust, therefore, appeared analogous to the backdrop to the launch of the Armorshire Collaboration. But in Armorshire, the NHS Wales Reforms of 2009 coincided with the Armorshire Collaboration, thereby pulling away key stakeholders during its early stages. In Torbay, conversely, the 2005 establishment of the Care Trust meant that it was unaffected by organisational changes to Primary Care Trusts that took place the following year across the rest of England; with local stakeholders not working within the strict confines of a pre-determined time-schedule or expected to accommodate a different strategy, the prevailing climate of stability and continuity meant that the project was able to report the effective development of integrated care (Thistlethwaite, 2011).

Decided by actors at central-government level, the NHS Wales Reforms of 2009, the three-year duration of the National CCM Demonstrator Programme and the introduction of the Primary and Community Services Strategic Delivery Programme were factors over which local stakeholders had no control, despite the programme's stated 'locality approach' and the ethos of localism – and concomitant emphasis on partnership-working between health, local government and the voluntary/third sector – which, according to Sullivan and Drakeford (2011), has characterised the post-devolution NHS in Wales. There were other contextual factors, however, which were beyond the control of both local stakeholders and actors at central-government level. Most important of these, perhaps, were the National CCM Demonstrator Programme's backdrop of severe economic austerity and the mounting demands on existing care systems due, in part, to the rising numbers of older people living with chronic conditions. Indeed, the preparation of systems to deal with these dual factors was the 'underlying ethos' (Phillips, 2011, p. 3) of the Welsh CCM Model, premised as it was not on the utilisation of new resources but on the redeployment and integration of existing ones (WAG, 2007; 2008).

With many local project leaders, in turn, referring to the need to redeploy existing resources in a health and social care system that was, in their view, obsolete and no

longer fit for purpose, there was widespread agreement amongst them that integration – built around co-location of front-line health and social care professionals – would bring about a reduction in service fragmentation and duplication. Other local stakeholders rarely mentioned these systemic failures or the need to reduce service duplication or fragmentation by way of integration. Many front-line professionals, moreover, indicated that co-location had not helped them to work more closely, just as the literature of integrated working indicates that co-location alone does little to improve co-working or integration of care (see Brown et al., 2003; Imison et al., 2008).

Many local stakeholders, however, made references to the increasing demands on health and social care services and reduction in availability of resources. Front-line professionals, for instance, contrasted their ever-growing case-loads with the lack of corresponding strengthening of staff numbers, just as service users explained that requests for extra care remained unanswered – a situation attributed to the lack of funding to pay social care professionals – or described their worries that increasing privatisation and drives for efficiency-savings would see a reduction in standards of care. Whilst the prevailing resource issues and rising demands on existing services underpinned, in part at least, the Welsh Government's desire to implement the Welsh CCM Model, these joint-pressures – and concomitant inadequacy of start-up funds – had significant repercussions as regards the establishment of the CCM service in the Bro-y-Grug locality and, in turn, the provision of integrated care.

For instance, this meant that there were delays in the appointment of the Armorshire Collaboration Project Manager, the three Locality Care Co-ordinators, and two of the three members of the Bro-y-Grug LLT (set up following the demise of the original organisational structure) thereby creating attendant pressures for the entire project. The lack of additional resources to help launch the CRT, in particular, meant that there was no provision of the joined-up IT systems that many consider a pre-requisite of integration (Leutz, 2005; Imison et al., 2008) whilst depriving front-line professionals of basic administrative support, thereby detracting from the communication and information-sharing that, according to many, constitute the bedrock of integrated working (see Cameron et al., 2006; 2006a). Rather than moving into premises that were expressly arranged for the purpose of integrated

working, moreover, the lack of funding also resulted in *ad hoc* office-arrangements (leaving some staff isolated) and a temporary halt to the activities of the Business Support Team (leading to a lack of information-sharing).

The prevailing climate of austerity and increased demand on existing services were contextual factors that were beyond the control of any of those involved in the National CCM Demonstrator Programme. However, the Welsh Government's reported lack of provision of additional resources to the Armorshire Collaboration and Owain Glyndŵr LHB's reported refusal to support the Bro-y-Grug locality's application for a grant from the Rural Health Fund show that actors at both country-wide and regional level had, as regards funding requirements, looked neither to the evidence-base of the introduction of new innovations in health and social care (in general terms) nor to that of integrated working (in specific terms). On the contrary, existing research indicates that all new developments in health and social care require a period of initial investment (Ham and Walsh, 2013) and that in order to bring about integration, it is necessary to provide adequate start-up costs (Leutz, 1999; 2005).

Nevertheless, just as numerous collaborative projects are set against a backdrop of instability and absence of continuity, so numerous collaborative projects are also provided with insufficient funding (Leutz, 1999). For instance, as well as linking the 2003 abandonment of Health Action Zones (after seven years of existence) to the fact that they were conceived and implemented too hastily, lacking in clear direction and run at a time of frequent policy change, Professor Ken Judge (who participated in the national evaluation of the Health Action Zone Programme [see Barnes et al., 2003]) also linked this to the fact that they were poorly resourced and provided with inadequate support (House of Commons Health Committee, 2009).

Despite the 'locality approach' that was to have underpinned the Armorshire Collaboration, therefore, many of the ways in which the new CCM service in Bro-y-Grug developed were attributable either to contextual factors that were beyond the control of any stakeholders or to decisions made in a 'top-down' manner by actors at central-government or regional LHB level. Given the project's sheer complexity, these contextual factors and top-down decisions cannot account for all of the

decisions and actions of local stakeholders. They cannot explain why, for instance, having asked front-line health and social care professionals what they needed to facilitate joint-working, local project leaders failed to take heed of the requests over which, ostensibly at least, they could decide (such as the provision of regular joint-meetings). Nor can they explain why the Bro-y-Grug LLT GP Lead was opposed to the participation of the Bro-y-Grug Locality Care Co-ordinator in the decision-making process.

However, these contextual factors and top-down decisions provide a frame of reference by way of which many of the decisions and actions made at local-level can be understood. This can help explain why, for instance, front-line professionals' request for joined-up IT systems was refused (inasmuch as actors at central-government level had provided the project with no start-up funds and actors at LHB level had refused to sanction a request for a Rural Health Fund grant) and why the process of joint-consultation with front-line professionals did not begin until after the new CCM service had been set-up (inasmuch as the launch-date of the CRT – itself part of a changed strategy decided by actors at central-government level – was imposed by actors at regional LHB level). This can also help explain why the Bro-y-Grug LLT GP Lead was able to interpret the role of the Bro-y-Grug Locality Care Co-ordinator in the way he did (inasmuch as there was no specification – at National CCM Demonstrator Programme level – of how the Locality Care Co-ordinators would participate in the programme, engendering a situation characterised by 'role ambiguity' [Handy, 1993]). Most importantly, perhaps, this frame of reference can help elucidate why – despite the auspicious pre-existing conditions – the Bro-y-Grug locality ultimately failed to deliver an integrated service, as I now explain.

In keeping with the evidence-base of integrated working – which indicates the importance of the creation of a steering group (or analogous body) in which jointly-agreed objectives can be set out and of the pre-eminence of the service user perspective – local project leaders in Armorshire began by setting up a Delivery Team and four work streams, one of which was devoted to PPI. But contrary to the evidence-base of integrated working – which describes the negative consequences of concurrent structural reform – actors at central-government level had opted to run the National CCM Demonstrator Programme at the same as conducting a Wales-wide

restructure of health services. With the latter pulling away key stakeholders from the Armorshire Collaboration, the resultant demise of the Delivery Team and work streams saw the responsibility for the development of the new CCM service in the Bro-y-Grug locality transfer from some fifty stakeholders to an LLT comprising one Social Care Lead, one District Nurse Lead and one GP Lead, together with a Locality Care Co-ordinator.

In terms of the establishment of the new CCM service, the organisational restructure had pragmatic implications, inasmuch as what was originally to have been taken forward by some fifty people – a number of whom were experts in integrated working, the care of people living with chronic conditions or PPI – would now be taken forward by just four people – three of whom had busy full-time posts, three of whom were appointed behind schedule and only one of whom had any specific background in the care of people living with chronic conditions, integrated working or PPI. In terms of the project's integrated agenda, moreover, the disbandment of the twelve-strong PPI work stream – whose specific remit it had been to take forward the involvement of local people living with chronic conditions – was not accompanied by any indication of whose responsibility it would now be to involve service users.

On the contrary, no mention of the latter's involvement was made in any documents I read, meetings I observed or interviews or focus-groups I conducted. As for the new LLT, there was likewise no indication of how its three members would go about involving service users – if, indeed, securing such involvement was considered to be one of their responsibilities – with the absence of any job-description for the Locality Care Co-ordinator shedding no further light on this issue. With the arrival of a different strategy and the LHB executives' expectation that a main element of the strategy, the CRT, would be launched seven months later, a programme that was already short-term became, in the words of one focus group participant, a 'fire fight'. In the ensuing haste to set up the CRT, the involvement of service users and carers and also that of front-line health and social care professionals and representatives of the voluntary/third sector failed to materialise. This despite the indication, in *Designed to Improve Health and CCM in Wales* (WAG, 2007), that one of the Welsh

CCM Model's core principles was the promotion of strong partnerships between social and health care agencies, the voluntary/third sector and clients and carers. The lack of involvement also militated against the empowerment of service users – even though this was another core principle of the Welsh CCM Model (WAG, 2007; 2008) – inasmuch as involvement is a basic tenet of service user empowerment (Means et al., 2008). Given that Gibson (1991) notes that the facilitation of empowerment by supporting service users – in meeting their needs, in problem solving, and in arranging the necessary resources to take control of their lives – is a key responsibility of care professionals, the fact that front-line professionals were also not involved in establishing the new CCM service – and often knew little about it before joining the new CRT – also worked against service user empowerment. This is despite the fact that empowerment, it is argued, underpins both self-management (Long-Term Conditions Alliance Scotland, 2008) and the management of care of people living with chronic conditions (Coulter et al., 2013).

But the lack of service user involvement, crucially, meant that the 'organising principle' of the new CCM service could not be the perspective of service users, for the simple reason that they were not given the opportunity to volunteer that perspective. With the lack of involvement of service users precluding their capacity to influence the way their care was delivered – just as the front-line professionals' lack of involvement precluded their capacity to influence integrated working – they reported no change – and therefore no improvement – in their experience of health and social care delivery. The contextual factors and top-down decisions, ultimately, meant that neither of the commonly recognised criteria of integrated care were met. In the next section, I discuss the implications of this study's main findings in terms of the development of policy, practice, research and education related to integrated working and the management of care of people living with chronic conditions.

Implications for policy, practice, research and education

In this case study, I explored how a Welsh Government initiative for integrated working in the care of people living with chronic conditions played out in practice. The findings therefore offer insights into how such initiatives – and, indeed, those that involve integration and other complex areas of health and social care – could be

developed in the future. In this section, I set out the implications of this study's findings for policy makers, project leaders, team-managers and front-line professionals who are involved in implementing integrated initiatives for people living with chronic conditions. I then consider the utilisation of a good practice guide for integrated working for people living with chronic conditions. Finally, I discuss the implications of this study for those involved in research and education.

As regards the implications of the findings of this study for policy makers:

- There is a need to give careful consideration to issues of clarity of language and terminology. It is important that the way in which integration is conceptualised within the sphere of a specific intervention is clearly set out and the rationale and underlying principle for its use identified, articulated and then consistently applied. Terms such as involvement, engagement, participation and empowerment should also be clearly defined and then consistently applied. In addition to the concepts that sit at the heart of a given intervention, the need for clarity and consistency extends to the titles, definitions and descriptions of roles, services or teams that are integral to its implementation. The objectives of a given intervention should also be clearly described when it is introduced and then maintained – unless a joint-decision is made, with the involvement of all stakeholders, to change them – for its duration;

- Consideration should be given to issues of stability and continuity in general, and to issues of timing, duration and moratoria on the concurrent implementation of strategies in particular:

    - In terms of timing, firstly, it is important that efforts are made to avoid the synchronicity of the running of complex interventions with major structural reforms in health and social care. With the latter's regularity and frequency in the UK suggesting that the likelihood that this can be assured is remote, it is therefore important that efforts are made to mitigate their impact by, for instance, ensuring protected time

for key stakeholders, such as members of steering groups and work streams;

- In terms of duration, secondly, it is important to recognise that planning and implementing complex interventions is a long-term process and that adequate time is therefore provided to ensure the involvement of a range of stakeholders (and sometimes the recruitment of new personnel), the embedding and subsequent functioning of new practices and the evaluation of change;

- In terms of moratoria on the concurrent implementation of strategies, thirdly, it is important that interventions that are introduced to implement a given strategy (with specific objectives and delivered by a specific service) are not subjected to the potentially disruptive influence of the subsequent introduction of different strategies (with different objectives and delivered by different services);

- Careful consideration should be given to issues of resourcing. In this regard, it is important to recognise that there is little evidence that integration can be delivered more cheaply than conventional models of care and that there is, conversely, substantial evidence that inadequate funding and lack of initial investment militate against integration. With many integrated projects premised on the co-location of front-line health and social care professionals (with the apparent expectation that this will incur little or no extra cost) it is important to recognise that there is little evidence that, alone, this improves co-working or integrated care. Indeed, with little evidence that any one specific factor can ensure successful integration – but widespread agreement that it is, instead, a multi-faceted process – it is important that, alongside structural elements, careful consideration is given to the provision of adequate resources to ensure, for instance: the development of normative integration (by way of, for example, joint-training initiatives); or the development of multi-stakeholder involvement (by way of, for example, the creation of specific posts/services/teams tasked with taking forward PPI or involvement of the voluntary/third sector).

As regards the implications of the findings of this study for project leaders (at regional/county/local level):

- There is a need to draw on existing networks of relevant services and existing relationships, thereby building on potential earlier gains and incorporating earlier learning;

- If the introduction of a new intervention at county-level is to be sub-divided into constituent localities, careful thought should be given to the recruitment of those who will lead the project: consideration needs to be given, for instance, to their previous experiences of leading projects, working collaboratively and to their areas of expertise. If necessary, appropriate training/mentoring should be made available. Consideration should be given to utilising a steering-group (and work stream) model not just at county-wide level, but also at locality-level. This model should include representatives from all stakeholder groups and/or incorporate a structure comprising work streams with a specific remit to ensure the involvement of service users, front-line professionals and the voluntary/third sector;

- There is a need to recognise that the absence of wider involvement severely compromises the chances of successfully delivering an integrated service. Efforts should therefore be made to ensure that the involvement of all stakeholders is integral to the entire process of the establishment of new integrated CCM services, including the preparatory, design and developmental stages as well as post-inauguration. This requires a clear delegation of responsibility – whether to an individual, steering group or work-stream – to secure this involvement, in addition to the provision of adequate time – as part of a clearly defined role – for this to happen. Again, relevant training, support and mentoring for those tasked with taking forward involvement should be made available.

As regards the implications of the findings of this study for managers of integrated health and social care teams:

- Consideration should be given to the provision of training for front-line health and social care professionals that promotes team-allegiance and clear understanding of roles and shared commitment to goals. When possible/appropriate, forums/training should be co-facilitated by service users and carers;

- There is a need to recognise that the peripatetic and busy nature of the work of community health and social care practitioners militates against 'opportunistic dialogue' in co-located offices. Consideration should therefore be given to the provision of regular 'protected time' – in the shape of, for example, weekly multi-disciplinary team meetings – for front-line professionals to discuss issues related to integrated working, partnership-working with their clients/patients and client care;

- Front-line health and social care professionals who often work in tandem – such as the physiotherapists and occupational therapists who design programmes of care and the social care professionals who deliver them – should be able to communicate regularly, efficiently, and directly (not just via line-management). Again, this may require the provision of regular 'protected time' in the shape of meetings (particularly if one profession is centrally- and the other peripherally-located).

As regards the implications of the findings of this study for front-line health and social care professionals:

- There is a need for ongoing awareness that the needs of people living with chronic conditions are complex and multifactorial, with the concomitant requirement to work in collaboration with care professionals from a range of health and social care services. Accordingly, there is a need to respect and

value the professional cultures, learning and specific areas of expertise that members of other care professions can contribute;

- There is a need to recognise the value of: participating in training in such areas as advocacy, involvement and joint-working; regularly consulting relevant literature and referring to evidence-based practice;

- There is a need for ongoing awareness that self-care, self-management and empowerment are fundamental to the lives of people living with chronic conditions and to respect the expertise that these people have in managing their conditions; there is also a need to recognise that care management should be proactive, holistic and preventive with an active role for service users facilitated by close partnership-working, whereby support is provided in such areas as motivation, knowledge, skills, and confidence-building.

Having discussed some of the implications of this study for the policy makers, project leaders, team-managers and front-line professionals who are involved in implementing integrated initiatives for people living with chronic conditions, I now set out some key themes that could usefully be included in a good practice guide for the integration of health and social care services for people living with chronic conditions (or other complex areas of health and social care):

- The early identification and involvement of all stakeholders, including people living with chronic conditions and their carers;
- The provision of a forum – such as a steering group – whereby all stakeholders can meet regularly;
- The early discussion of issues of terminology – including the meaning of key terms (such as integration) – and selection of definitions, titles, roles, services that will be used consistently for the duration of the initiative;
- The setting out of clear and jointly-agreed objectives and maintenance of these objectives (unless a joint-decision is made to change them);
- Continual and open dialogue between project leaders, front-line health and social care professionals, service users, carers and representatives of voluntary/third sector organisations in order to build a culture of transparency and trust;
- The creation of clear channels of communication and information-sharing between all stakeholders;
- Careful consideration of the evidence-base of integrated working;

- Careful consideration of the literature of implementation research to facilitate the introduction of new initiatives;
- Careful consideration of the literature of PPI to facilitate involvement;
- The delegation of an individual/role/service to ensure service user and carer involvement;
- The development of a clear and shared understanding of why integrated working is important;
- The development of a clear and shared understanding of how integrated working will be achieved;
- The provision of a forum – such as regular weekly meetings – in which front-line professionals can discuss progress and put forward suggestions for improved integrated working (based on their experience of care-provision and key messages from their clients);
- The provision of mentoring/ongoing training for line-managers and front-line health and social care professionals, focusing on areas such as: involvement; self-care; self-management; empowerment; professional cultures; implementation research;
- The maintenance of a focus on outcomes for service users (rather than structures, systems and processes);
- The establishment of systems/measures to gauge progress (perhaps with the incorporation of 'patient stories');
- The sharing of learning with those involved in other integrated projects.

A good practice guide could also include specific sections on: the principles of integration; communications planning; communicating with target groups; a history of integrated working; a legislation overview; regulations and guidance; service users' and carers' personal experiences; supporting statistics; partner organisations; examples of local integrated service provision; frequently asked questions (and their answers); a glossary of terms; and useful information (such as links to guidance, reports, legislation, organisations and resources). There are a number of guides and resources on integrated working and the involvement of service users and carers in the development of health and social care services that are in the public domain and a list of these is provided at the end of this chapter.

In exploring the development of integrated care for people living with chronic conditions during the implementation of the new CCM service, this case study has identified several areas that require further research:

- There is a need for more research that includes the multiple perspectives of all of the people typically involved in integrated projects (and, in particular,

those of service users and carers) and for further research into assessing, conceptualising, measuring and demonstrating the success of integrated working;

- There is a need for research focusing on the outcomes of integrated working from the perspective of service users (rather than on processes of integrated working from the perspective of service providers);

- There is a need for further research into issues of terminology and definitions, not only in integrated working, but across other (complementary) fields that have been discussed in this study, such as: chronic conditions management, PPI and implementation research. This research is necessary to facilitate the establishment of an intellectual and theoretical basis for the further development of all of these fields, and hence, of integrated care; in turn, this will provide greater public understanding of integrated care and thereby improve its visibility, strengthen public accountability, helping to build confidence and trust;

- There is a need for further research into the implementation of policy in integrated working for people living with chronic conditions and the use of implementation research to facilitate this process. This would, for instance, provide greater transparency *vis-à-vis* the extent to which innovation is driven by policy (and its communication downwards through the health service organisation) and/or bottom up initiatives originating from existing relationships, service user/practitioner partnerships, innovative teams and champions of change;

- There is a need for further research into the impact of the rising numbers of people living with chronic conditions on front-line health and social care professionals' roles and their relationships with service users and carers;

- There is a need to carry out research that focuses on integrated care that targets people from a range of ethnic groups.

In exploring the development of integrated care for people living with chronic conditions during the implementation of the new CCM service, this case study has identified some implications for education:

- There is a need to consider an education and training infrastructure which reflects a more integrated system of health and social care; consideration should be given to interprofessional education (IPE) of health and social care professionals;

- There is a need for specialist curricula to support future health and social care professionals to work in integrated care systems; curricula should be delivered by health care and social care educators and should be supported by placements in integrated care settings;

- Mentoring should be provided for trained health and social care professionals who move from the acute care sector into the community setting.

In the next, and final section, I provide a summary of the main themes examined in this chapter.

Summary

In this chapter, I explained that in conducting this case study by way of a narrative account of the establishment of the new CCM service, I was able to meet the objectives of the thesis and that, in so doing, I was also able to meet its aim by providing an answer to the main research question. Subsequently, I discussed the strengths of the case study – such as the way in which the 'thick' description of events provided an account of the complexities and challenges of introducing a new CCM service against a backdrop of fluctuation and extraneous pressures – and its limitations – such as its lack of ethnic diversity. I then considered the original contribution this study has made – drawing attention, for instance, to the novel combination of topics, perspectives and analytical and conceptual approaches – and explained that in so doing, I had made a number of original additions to existing

knowledge in the field of integrated working and chronic conditions management. I then reviewed the study's main findings and considered how these connected with the evidence base of integration and chronic conditions management. I ended the chapter with a consideration of its implications for policy, practice, research and education (including a consideration of what might be included in a good practice guide).

List of guides/resources for involvement/integrated working

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Web resources

Collaborative Care: Joint Improvement Team (JIT)
http://www.jitscotland.org.uk/

Coordinated care: National Voices
http://www.nationalvoices.org.uk/coordinated-care

Integrated care: The King's Fund
http://www.kingsfund.org.uk/topics/integrated-care

Integrated care: The Nuffield Trust
http://www.nuffieldtrust.org.uk/our-work/integrated-care

Integrated Care and Support: NHS England
http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/

Integrated Care and Support Exchange (ICASE)
http://www.icase.org.uk/

Integrated care: Better Care Fund:
Local Government Association
http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE;

Integrated care value case toolkit
http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/4060433/ARTICLE

International Foundation for Integrated Care
http://www.integratedcarefoundation.org/

International Journal of Integrated Care
http://www.ijic.org/
Open access journal

Social Care Institute for Excellence (SCIE): Integration
http://www.scie.org.uk/topic/keyissues/integration

Social Partnership Forum
http://www.socialpartnershipforum.org/