NIHR Service Delivery and Organisation programme

National Institute for Health Research

Unplanned admissions of older people: exploring the issues

Catherine Henderson[1], Rod Sheaff[2], Angela Dickinson[3], Roger Beech[4], Gerald Wistow[1], Karen Windle[5], Sue Ashby[6] and Martin Knapp[1]

[1] Personal Social Services Research Unit, London School of Economics and Political Science
[2] Faculty of Health, University of Plymouth
[3] Centre for Research in Primary & Community Care, University of Hertfordshire
[4] Arthritis Research UK Primary Care Centre, Primary Care Sciences, Keele University
[5] Personal Social Services Research Unit, University of Kent
[6] School of Nursing and Midwifery, Clinical Education Centre, Keele University

Published March 2011

Project 08/1618/136

Address for correspondence:

Professor Martin Knapp
Director, PSSRU
Co-Director, LSE Health and Social Care
London School of Economics and Political Science
Houghton Street, London
WC2A 2AE

Email: m.knapp@lse.ac.uk

This report should be referenced as follows
Henderson C, Sheaff R, Dickinson A, Beech R, Wistow G, Windle K, Ashby S, Knapp M. Unplanned admissions of older people: the impact of governance. Final report. NIHR Service Delivery and Organisation programme; 2011.

Contents

List of tables 8

List of figures 10

Glossary of terms/abbreviations 12

Acknowledgements 19

Executive Summary 20

- Background 20
- Aims 20
- Methods 21
- Results 21
- Conclusions 22

1 Introduction 25

2 Study aims 28

3 Overarching context: the IFOP programme and national policy 29

- 3.1 The Innovation Forum for Older People 29
  - 3.1.1 Introduction 29
  - 3.1.2 The IFOP headline target 30
  - 3.1.3 Barriers to agreement of the headline target 32
- 3.2 National policy background 34
  - 3.2.1 Introduction 34
  - 3.2.2 Health policy and older people at risk of unplanned hospitalisation 35
  - 3.2.3 Local government and social care 38
- 3.3 Incentives or targets? 38
- 3.4 Partnership and mandated collaboration 40
- 3.5 Underpinning constructs for change 42

4 Methods 45

- 4.1 Introduction: evaluation schema 45
- 4.2 Sampling 47
  - 4.2.1 Selection of phase 1 sites 47
  - 4.2.2 Questionnaire for phase 1 sites 47
  - 4.2.3 Selection of phase 2 sites 48

4.2.4 Identification and recruitment of the patient sample 50
4.3 Data collection 51
4.3.1 Exploratory phase documentary analysis 51
4.3.2 Exploratory phase structured questionnaire 52
4.3.3 Explanatory phase interviews with strategic managers 53
4.3.4 Explanatory phase non-participant observation 54
4.3.5 Explanatory phase patient journeys 54
4.4 Data analyses 56
4.4.1 Content analysis of documents 56
4.4.2 Questionnaire analyses 56
4.4.3 Patient, carer and staff interviews 56
4.5 Ethics and research governance 56
5 Site characteristics 58
5.1 Demographic characteristics 58
5.2 Social care performance 58
5.3 NHS performance 59
5.4 Market-like approaches 62
5.5 Supply of hospital beds 62
5.6 Partnership arrangements: the local context 63
5.7 Types of social partnerships 67
5.8 Local strategic partnerships and Local Area Agreements 68
5.9 Other partnership arrangements, joint posts and joint commissioning . 69
6 Governance structures 73
6.1 Introduction 73
6.2 Governance through networks and partnerships 73
6.3 Governance structures found in IFOP sites 77
6.3.1 Membership 77
6.3.2 Decision-making structures 80
6.3.3 Structures for user involvement 81
6.3.4 Structures for implementation 83
6.4 Differences in governance structure between the networks 88
6.5 Governance structure and the selection of intervention projects 90
7 Local initiatives to reduce unplanned hospital stays 93

7.1 Introduction 93
7.2 Innovation Forum projects 93
7.3 Funding arrangements 97
7.4 Comments on the IFOP projects from the initial questionnaire 99
7.4.1 Local structures and initiatives, outside of the IFOP programmes, to reduce the use of EBDs 101
7.5 Conclusions 103
8 Roles of non-NHS agencies 104
8.1 Introduction 104
8.2 Multi-agency forums 104
8.3 Joint working 108
8.4 Perceptions of integration mechanisms 110
8.5 Contracts and commissioning 111
8.6 Performance indicators 113
8.7 Shifting care closer to home 114
8.8 Public and user involvement 115
8.9 Other comments on the questionnaire 116
8.10 Conclusions 117
9 Reducing emergency bed days 119
9.1 Meeting targets 119
9.2 Unscheduled acute admissions and average lengths of stay 121
10 Patients’, carers’ and professionals’ experiences of different governance models 128
10.1 Introduction 128
10.2 Feedback from patients 129
10.2.1 Care delivery processes: the initial (and pre-)crisis phase 130
10.2.2 Care delivery processes: the acute phase 131
10.2.3 Care delivery processes: the intermediate care or rehabilitation phase 133
10.2.4 Patients’ and carers’ assessments of services: efforts to avoid admissions 134
10.2.5 Patients’ and carers’ assessments of care in A&E 135
10.2.6 Patients’ and carers’ assessments of hospital environment and staffing 135
10.2.7 Patients’ and carers’ assessments of hospital discharge 136

10.2.8 Patients' and carers' assessments of services following (or instead of) a hospital stay 136
10.3 Feedback from professionals 138
10.3.1 Initial crisis 138
10.3.2 Hospital discharge planning 140
10.3.3 Rehabilitation in bedded units 143
10.3.4 Community-based rehabilitation 145
10.3.5 Other organisational issues 146
10.4 Conclusions 147
11 Conclusions: governance through local networks, national targets or financial incentives? 149
11.1 Introduction 149
11.2 Governance and network effectiveness 149
11.3 Key outcomes and governance models 152
11.4 Attribution: causal linkages 154
11.4.1 Shared governance characteristics of the 'successful' networks ..154
11.4.2 Manager and staff perceptions of the network linkages and effectiveness 155
11.4.3 Centralised and local policies, incentives, targets and their perceived importance 156
11.4.4 Focus and coverage of adopted services 158
11.4.5 The patient experience 160
11.5 Network governance or central targets and incentives? 162
11.6 Relevance to the current policy climate 163
11.6.1 Barriers and facilitators to effective social networks 164
11.6.2 The essential and 'model' network? 167
11.7 Relevance for practitioners, operational managers, commissioners and researchers 167
11.7.1 Services to avoid acute admissions 168
11.7.2 Hospital care and hospital discharge 168
11.7.3 Rehabilitation in community units and at home 169
11.7.4 Overarching/systems issues 169
11.7.5 Key messages 169
11.7.6 Directions for future research 171
11.8 Conclusion 171

References 173

Appendix A Unplanned hospital admissions of older people (75+). The impact of governance and incentives: detailed proposal for Phase 2 of the study 186

Appendix B Information sheet for patients 204

Appendix C Data collection form...208

Appendix D Improving Services for Older People to Reduce the Use of Unplanned Hospital Care Questionnaire 212

Appendix E Topic guide for senior managers interviews 228

Appendix F Improving services for older people to reduce the use of unplanned hospital care: topic guide 231

Appendix G Questionnaire results...237

List of tables

Table 1 Research schema 46

Table 2 Features of selected Phase 2 sites 49

Table 3 Patient diagnosis at each site.. 50

Table 4 Questionnaire response rates 53

Table 5 Number of 'Tracking Interviews by site'... 55

Table 6 Local authority area profiles 60

Table 7 Performance: star ratings, delays and balance of community care....... 61

Table 8 PCT performance 64

Table 9 Acute trusts within PCTs participating in the Innovation Forum: performance 65

Table 10 Indicators of market-like approaches 66

Table 11 Partnership arrangements related wholly or partly to the local planning and delivery of older people's services (2005-2007), by site......................... 68

Table 12 IFOP: member-organisations of the networks 2004–2007 79

Table 13 IFOP programme strategic decision-making bodies 80

Table 14 Methods for ascertaining user views... 82

Table 15 How IFOP sites implemented their decisions.................................. 84

Table 16 Governance links between network decision-makers and other network members 88

Table 17 Governance structures and managerial practices 89

Table 18 Diversity of aims of the IFOP projects 94

Table 19 Organisations involved in managing the projects 94

Table 20 Types of IFOP initiatives.. 95

Table 21 IFOP programme projects: sustainability over three years............... 96

Table 22 Innovation Forum projects: sustainability over three years, by site ... 97

Table 23 IFOP initiatives: Sources of funding in 2006 97

Table 24 Performance on headline target 2004 to 2007, by PCT (partners and non-partners)...122

Table 25 Length of stay weighted by admissions from baseline to final year of the Innovation Forum 125

Table 26 Percentage change in admissions per 1000 population between 2003 and 2007 126

Table 27 Total bed days per 1000 per year from baseline to final year of the Innovation Forum 126

Table 28 Admissions per 1000 from baseline to final year of the Innovation Forum 126

Table 29 Delayed discharges (all delays, medically fit to discharge) per 100,000 population aged 65 and over,+ from baseline to final year of the Innovation Forum 127

Table 30 Percentage change in the number of delayed transfers of care per 100,000 population aged 65 or over between 2003 and 2007....127

Table 31 Governance structures and managerial practices 151

Table 32 Governance links between network decision-makers and other network members 152

Table 33 IFOP site performance against bed usage objectives 153

Appendices

Table A1 Presenting condition and type of service use impacting on bed-day reduction 187

Table A2 Patient conditions for inclusion in sample....187

Table A3 Details of patient tracking process and data collection. 188

Table G1 Responses by site, respondent background....237

Table G2 Data on relevant multi-agency groups/meetings attended by respondent 238

Table G2 (Continued) Data on relevant multi-agency groups/meetings attended by respondent 239

Table G3 Priority respondent's organisation gives to the following objectives when planning service developments 240

Table G4 How much potential does respondent think that interventions have on decreasing acute bed day use for older people in their local area 241

Table G5 Source of funding accessed by multiagency groups....242

Table G6 From respondent's perspective, how much of a contribution did each type of organisation make to decreasing emergency bed days locally 242

Table G7 From respondent's perspective, how much of a contribution did each type of organisation make to decreasing emergency bed days locally – other organisations listed by respondents 243

Table G8 Multi-agency groups/meetings – processes and interactions....243

Table G9 Contingency table: Domination of group by one organisation and resolution of issues within the group 244

Table G10 Partial tables: Domination of group by one organisation and resolution of issues within the group, controlling for IF-specific forum 244

Table G11 Results of exact logistic regression for probability of “issues are resolved without repeated discussion”..244

Table G12 Contingency table: Disagreements between the member organisations in the past year and frequency of meetings 245

Table G13 Results of exact logistic regression for probability of “disagreements between member organisations in the past year”, indicator variable approach 245

Table G14 To what extent does participant agree on the basis of direct experience – Pooling funds..246

Table G15 To what extent does participant agree on the basis of direct experience – Lead commissioning 247

Table G16 To what extent does participant agree on the basis of direct experience – Joint commissioners 248

Table G17 To what extent does participant agree on the basis of direct experience – Joint appointments 248

Table G18 How likely the following multiagency approaches are to be used in respondent’s local area, based on respondent’s experience 249

Table G19 The impact of central government performance indicators that have had an impact on bed day use by older people: ranked within respondents’ top three impacts 250

Table G20 Indicate what impact the respondent expects the following to have on the shift of resources from secondary (acute) care into community health care in the local area 251

Table G21 Indicate what impact the respondent expects the following to have on the shift of resources from secondary (acute) care into social care in the community in the local area 252

Table G22 The impact of barriers on the shift of resources from secondary (acute) care into community health care: ranked within respondents’ top three impacts 253

Table G23 The impact of barriers on the shift of resources from secondary (acute) care into social care in the community: ranked within respondents’ top three impacts...253

Table G24 Indicate the importance of the following mechanisms for public representation...254

List of figures

Figure 1 Policy guidance and key legislation 2001–2007 35

Figure 2 Underpinning constructs for change in the IFOP programme 43

Figure 3 Percentage change in available general and acute beds within NHS trusts in IFOP PCTs between 2005/06 and 2006/07, by site [1] [2]...................... 63

Figure 4 A visual representation summarising the physical movement and transitions made by patients during their journeys......................................128

Figure 5 Diagram summarising the services accessed by patients in their journeys through the health and social care system 129

Glossary of terms/abbreviations

Terms

Term	**Description**
Comprehensive Performance Assessment	Comprehensive Performance Assessment (CPA), carried out by the Audit Commission, focused on the overall corporate performance and capacity for improvement of English councils, summarised by a rating of between 0 and 4 stars. Replaced in 2009 by the Comprehensive Area Assessment (which has since been discontinued, following the change of government).
Local Area Agreement	A statutory agreement between local area partners and central government to meet defined targets. Funding levels (streams) are also agreed between the centre and local area partners.
Local Public Service Agreements	An agreement between local authorities and central government, whereby a council would negotiate 'stretch' targets, over a period, usually 3 years, to achieve a performance beyond what would have been achieved in the absence of the agreement. For councils achieving the stretch target there was a performance reward grant (PRG); at the beginning of the period central government gave a pump priming grant, allowed additional borrowing, and considered granting certain 'freedoms and flexibilities'. After the first round of LPSAs were introduced in 2005, there was a second round (LPSA2), after which these became part of the 'reward element' of the LAAs.
Local Strategic Partnerships	Non-statutory and non-executive multi-agency partnerships, aligned with council boundaries, that provide strategic coordination between the statutory services of the local area. Responsible for producing Sustainable Community Strategies and for developing Local Area Agreements.
Multidisciplinary team	A team of health care professionals, which could also include social care professionals, that coordinates and plans treatment for individual patients. Typically an MDT involved in the healthcare of older people may consist of medical and nursing professionals, also occupational and physiotherapists and other allied health professionals and social workers or care managers.
Payment by Results	A system linking the payment of acute hospital providers to activity and case mix. Hospitals are paid a fixed price, from a national tariff, for each activity, using Healthcare Resource Groups as the unit of activity.
Performance Assessment Framework	A central data collection system contributing to a set of performance indicators, or targets. All adult service departments in England were required to provide supporting data to central government. Collection superseded in 2008 by the National Indicator Set, collected across government departments (e.g. Health

	and Education).
Practice Based Commissioning	From 2005, GPs received an indicative budget from their primary care trust, covering that practice's share of the NHS budget. Local consortia of general practices could commission care for their patients using these budgets.
Public Service Agreements	First introduced as part of the Comprehensive Spending Review of 1998, these were agreements between the Treasury and the major central government departments, setting out departmental priorities and objectives, and measuring departmental performance against a set of targets. They were replaced by Structural Reform Plans in 2010 after the change in government.
Rapid response team	A multi- or uni-disciplinary team of health professionals, working within an acute hospital or in the community, that provides a service quickly to people (often older people) who are at risk of hospitalisation

Abbreviations

Abbreviation	**Description**
A&E	Accident and Emergency Department
CAF	Common Assessment Framework for Adults
COPD	Chronic Obstructive Pulmonary Disease
CPA	Comprehensive Performance Assessment
EBD	Emergency bed days
IFOP	Innovation Forum for Older People
LA	Local Authority
LAA	Local Area Agreement
LPSA2	Second round of Local Public Service Agreements
LSP	Local Strategic Partnership
MDT	Multidisciplinary Team
NHST	National Health Service Trust
PAF	Performance Assessment Framework
PbC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
POPP	Partnerships for Older People Projects

PSA	Public Service Agreements
QOF	Quality and Outcomes Framework
R&D	Research and Development Departments of NHS and Primary Care Trusts
SAP	Single Assessment Process
VCO	Voluntary and Community Organisation

List of tables 8

List of figures 10

Glossary of terms/abbreviations 12

Acknowledgements 19

Acknowledgements 19

Executive Summary 20

- Background 20
- Aims 20
- Methods 21
- Results 21
- Conclusions 22

1 Introduction 25

2 Study aims 28

3 Overarching context: the IFOP programme and national policy 29

- 3.1 The Innovation Forum for Older People 29
  - 3.1.1 Introduction 29
  - 3.1.2 The IFOP headline target 30
  - 3.1.3 Barriers to agreement of the headline target 32
- 3.2 National policy background 34
  - 3.2.1 Introduction 34
  - 3.2.2 Health policy and older people at risk of unplanned hospitalisation 35
  - 3.2.3 Local government and social care 38
- 3.3 Incentives or targets? 38
- 3.4 Partnership and mandated collaboration 40
- 3.5 Underpinning constructs for change 42

4 Methods 45

- 4.1 Introduction: evaluation schema 45
- 4.2 Sampling 47
  - 4.2.1 Selection of phase 1 sites 47
  - 4.2.2 Questionnaire for phase 1 sites 47

4.2.3 Selection of phase 2 sites 48
4.2.4 Identification and recruitment of the patient sample 50
4.3 Data collection 51
4.3.1 Exploratory phase documentary analysis 51
4.3.2 Exploratory phase structured questionnaire 52
4.3.3 Explanatory phase interviews with strategic managers 53
4.3.4 Explanatory phase non-participant observation 54
4.3.5 Explanatory phase patient journeys 54
4.4 Data analyses 56
4.4.1 Content analysis of documents 56
4.4.2 Questionnaire analyses 56
4.4.3 Patient, carer and staff interviews 56
4.5 Ethics and research governance 56
5 Site characteristics 58
5.1 Demographic characteristics 58
5.2 Social care performance 58
5.3 NHS performance 59
5.4 Market-like approaches 62
5.5 Supply of hospital beds 62
5.6 Partnership arrangements: the local context 63
5.7 Types of social partnerships 67
5.8 Local strategic partnerships and Local Area Agreements 68
5.9 Other partnership arrangements, joint posts and joint commissioning 69
6 Governance structures 73
6.1 Introduction 73
6.2 Governance through networks and partnerships 73
6.3 Governance structures found in IFOP sites 77
6.3.1 Membership 77
6.3.2 Decision-making structures 80
6.3.3 Structures for user involvement 81
6.3.4 Structures for implementation 83
6.4 Differences in governance structure between the networks 88
6.5 Governance structure and the selection of intervention projects 90

7 Local initiatives to reduce unplanned hospital stays 93
7.1 Introduction 93
7.2 Innovation Forum projects 93
7.3 Funding arrangements 97
7.4 Comments on the IFOP projects from the initial questionnaire 99
7.4.1 Local structures and initiatives, outside of the IFOP programmes, to reduce the use of EBDs 101
7.5 Conclusions 103
8 Roles of non-NHS agencies 104
8.1 Introduction 104
8.2 Multi-agency forums 104
8.3 Joint working 108
8.4 Perceptions of integration mechanisms 110
8.5 Contracts and commissioning 111
8.6 Performance indicators 113
8.7 Shifting care closer to home 114
8.8 Public and user involvement 115
8.9 Other comments on the questionnaire 116
8.10 Conclusions 117
9 Reducing emergency bed days 119
9.1 Meeting targets 119
9.2 Unscheduled acute admissions and average lengths of stay 121
10 Patients', carers' and professionals' experiences of different governance models 128
10.1 Introduction 128
10.2 Feedback from patients 129
10.2.1 Care delivery processes: the initial (and pre-)crisis phase 130
10.2.2 Care delivery processes: the acute phase 131
10.2.3 Care delivery processes: the intermediate care or rehabilitation phase 133
10.2.4 Patients' and carers' assessments of services: efforts to avoid admissions 134
10.2.5 Patients' and carers' assessments of care in A&E 135
10.2.6 Patients' and carers' assessments of hospital environment and staffing 135

10.2.7 Patients’ and carers’ assessments of hospital discharge 136
10.2.8 Patients’ and carers’ assessments of services following (or instead of) a hospital stay 136
10.3 Feedback from professionals 138
10.3.1 Initial crisis 138
10.3.2 Hospital discharge planning 140
10.3.3 Rehabilitation in bedded units 143
10.3.4 Community-based rehabilitation 145
10.3.5 Other organisational issues 146
10.4 Conclusions 147
11 Conclusions: governance through local networks, national targets or financial incentives? 149
11.1 Introduction 149
11.2 Governance and network effectiveness 149
11.3 Key outcomes and governance models 152
11.4 Attribution: causal linkages 154
11.4.1 Shared governance characteristics of the ‘successful’ networks 154
11.4.2 Manager and staff perceptions of the network linkages and effectiveness 155
11.4.3 Centralised and local policies, incentives, targets and their perceived importance 156
11.4.4 Focus and coverage of adopted services 158
11.4.5 The patient experience 160
11.5 Network governance or central targets and incentives? 162
11.6 Relevance to the current policy climate 163
11.6.1 Barriers and facilitators to effective social networks 164
11.6.2 The essential and ‘model’ network? 167
11.7 Relevance for practitioners, operational managers, commissioners and researchers 167
11.7.1 Services to avoid acute admissions 168
11.7.2 Hospital care and hospital discharge 168
11.7.3 Rehabilitation in community units and at home 169
11.7.4 Overarching/systems issues 169
11.7.5 Key messages 169
11.7.6 Directions for future research 171

11.8 Conclusion 171
References 173
Appendix A Unplanned hospital admissions of older people (75+). The impact of governance and incentives: detailed proposal for Phase 2 of the study 186
Appendix B Information sheet for patients 204
Appendix C Data collection form 208
Appendix D Improving Services for Older People to Reduce the Use of Unplanned Hospital Care Questionnaire 212
Appendix E Topic guide for senior managers interviews 228
Appendix F Improving services for older people to reduce the use of unplanned hospital care: topic guide 231
Appendix G Questionnaire results 237

Acknowledgements

We wish to thank all the project leads of the Innovation Forum for Older People for supporting this study. Our thanks must go as well to all those who replied to our questionnaire, and to the managers and frontline staff of local authorities, NHS bodies and voluntary organisations who took part in our interviews. We also must thank Ann Harris for her involvement in the collection of documentary data and the research steering group and Jennifer Cove (CRIPACC), who carried out some interviews. Above all we owe thanks to those patients and their carers who shared their experiences in interviews with the research team.

This project was funded by the National Institute for Health Research Service Delivery and Organisation Programme (project number 08/1618/136).

Executive Summary

Background

National strategies, local initiatives, cross-agency agreements, various targets and financial incentives have all been deployed in an effort to reverse the growth in emergency bed days (EBDs). Within this rapidly changing context there was another effort underway: the *Improving the Future for Older People* (IFOP) programme of the Innovation Forum. A group of nine English councils created their own network in 2003, with the primary aim of reducing use of emergency bed days. Specifically, they agreed to work in partnership with health and third sector organisations to achieve the 'headline target' of a 20% reduction in EBDs for people aged 75 and over, over a three-year period from 2004 to 2007.

Aims

We examined how these nine councils and their partners approached this challenge of reducing EBDs for older people, the interventions they adopted, the opportunities and difficulties encountered, and the consequences for patients. In particular, we were interested in whether governance through such a partnership (i.e., networks) achieved change in EBD numbers or were centrally articulated incentives or targets stronger influences? The overarching study aim, therefore, was to examine the impact of different governance models as local health and social care economies sought to reduce utilisation of unplanned inpatient bed days by older people.

Six objectives specified the activities necessary to achieve this aim:

- Explore the changes in emergency bed days within each of the nine participating sites before and after the IFOP project.
- Identify the characteristics and mechanisms of governance arrangements that are seemingly effective in reducing utilisation of unplanned bed days by older people while ensuring quality and equity.
- Identify, measure and profile local initiatives to reduce unplanned hospital stays by older people.
- Examine roles played by non-NHS agencies in achieving NHS targets in relation to hospital bed use.
- Explore professionals' experiences of different governance models.
- Compare and contrast the user/patient experience within three key conditions: falls, chronic obstructive pulmonary disease (COPD) and stroke.

Methods

A multi-method approach was used, grounded within the framework of 'realistic evaluation'. There were two main phases: exploratory and explanatory. In the first we worked with all nine sites, relying particularly on documentary analysis and structured questionnaires. For the explanatory phase we selected three of these sites to test and understand the initial descriptive outputs. We relied particularly on semi-structured interviews with key informants, non-participant observation and individual patient journeys through the health and social care system.

Results

We described the key characteristics of participating councils and PCTs, their performance on relevant indicators (such as delayed discharge, intensive home care, contract types, direct payments, supply of hospital beds and per capita expenditure). Most network arrangements were directed social partnerships – a type of enacted social partnerships differentiated by the level of involvement of government, which establishes or sponsors such networks to achieve specific policy goals. Sites were either moving or aspiring to move towards an increasingly 'joined-up' approach to commissioning.

Governance structures in the IFOP networks were essentially similar in a number of respects. The main decision-making body was a steering group of senior managers. Statutory bodies were much more strongly represented than other organisations, or users. IFOP networks operated in environments where other networks with closely-related remits were also operating. All the IFOP networks inherited and re-badged some of their projects for reducing unplanned bed-day use by older people from their member-organisations or from earlier networks, and so were constrained to some degree by existing managerial hierarchies. Each network had some structures for involving users, but these were somewhat marginal to the networks. Every network felt the need, above all, to respond to a complex of policy mandates that bore more heavily upon their health than upon their local government member-organisations.

Where there were differences in governance structures, two main models were identified. One was a 'joined-at-the-top' model, where the member organisations' senior managers met to coordinate projects which remained owned, managed and implemented by those organisations severally and independently. This was a network of hierarchies. The other was a horizontal 'network-of-networks' model, where the IFOP network substantially relied on other external networks to implement its decisions and for critical inputs (such as user views) to those decisions. Both were clearly quasi-networks. Despite the emphasis given in policy documents and IFOP objectives, quasi-market models of governance were not found.

The majority of the service models and initiatives that sites introduced to address IFOP targets seemed to have multiple aims. These included: preventing acute events and patients needing an emergency attendance at a hospital; diverting emergency attendees to services that provided community-based care; facilitating the timely hospital discharge of those patients that did need urgent care in a hospital bed.

Most IFOP projects were funded and managed by PCTs and/or local authorities. Acute trusts were seldom perceived to take the lead in reducing acute bed day use by older people. Senior managers also indicated that relationships with the acute sector could be difficult. Acute trusts also tended to make up a small proportion of the membership of such groups. Given the pivotal position of acute hospitals in effecting change in terms of care pathways, this must be a concern. A lack of commissioning expertise and capacity within PCTs were the barriers most frequently identified as key barriers to 'shifting the money' from the acute sector to community health and social care. The underdevelopment of joint commissioning posed a barrier to more integrated working.

The nine councils that established the IFOP programme agreed that achievement of the headline target would be assessed across the programme *as a whole*, rather than at the level of the individual network. The 20% reduction in EBDs between 2004 and 2007 was collectively achieved. But there was variation between sites. In comparing the performance of networks, we included this headline target, along with three further outcomes: decreases in emergency admissions, decreases in delayed discharges, and whether those adopted projects were sustained beyond the end of IFOP programme.

We also examined patient journeys. Adherence to IFOP goals would have been expected to generate care processes that delivered: patient-centred care; timely access to appropriate preventative, assessment and treatment services with the goal of reducing avoidable acute bed use; ready access to community and institutional services for supplying rehabilitation and long-term care; and integrated working between all relevant service providers and adequate continuity of care. Evidence generated by our study of patient journeys offered examples of 'good practice' conforming with this vision, but also demonstrated many ways in which practice fell short of expectations These included sub-optimal use of services for preventing crises and acute events, a narrow range of services used in a crisis, distrust of nursing staff, concerns about poor communication between professionals, delays in discharge and carer burden.

Conclusions

When juxtaposing these outcomes alongside the differentiated governance models, we found no simple association between the model of governance adopted within the study sites and the outcomes achieved. Strong governance conditions within networks did not necessarily predict successful achievement of the outcomes. The results generated by the patient journey study identified that the strategic goals of the IFOP were not always translated into operational practice. From the theoretical arguments and from the empirical data collected, analysed and brought together, we can only offer an equivocal response to this question, although one that is in the spirit of realist evaluation. A number of mechanisms need to be brought together to achieve change and there is not just one governance structure that can be relied upon to produce the stated outcomes. Central targets and incentives are necessary to focus action, networks are essential to negotiate cross-cutting problems, whilst the mechanisms put in place to meet any targets (which are the local interventions) need to move away from the usual scatter-gun approach of large numbers of 'boutique' pilot projects to focus on a smaller number of services that can be mainstreamed.

This study offers a framework for analysing some of the potential impacts of the changes proposed in the recent NHS White Paper. The proposed changes are likely to erect some barriers to the horizontal coordination of services through provider networks, particularly the sheer extent of reorganisation and the risk that the continuing shift towards market-like structures will lead to further service fragmentation. Balancing these, the development of local authorities' 'place shaping' roles may constitute a potential facilitator for network development and a focus on whole system reform.

The study's findings reinforce messages surrounding the delivery of high quality care that have been emphasised in previous research and policy papers. Single-point-of-access telephone numbers should be encouraged; and efforts are needed to increase the uptake of community care and treatment alternatives, and that are available 'out of hours'. Patients and carers should be involved in decision-making in regard to their hospital care, particularly in discharge planning. Co-location of staff of different agencies and the development of cross-organisational networks at a practitioner level, would help practitioners to share learning and foster trust between agencies. The proposed creation of GP-led commissioning through consortia creates opportunities to strengthen links at practitioner level between primary, social and domiciliary care, with contract monitoring brought closer to the patient level. For improvements to occur, local networks will have to recruit the new consortia as active network members; representatives of these networks might also be involved in the management of the consortia.

Rather than demonstrating a direct causal relationship between outcomes and individual modes of governance, the project suggested the relevance of interdependencies between modes of governance and contextual factors to secure the results observed. A direction for future research would be to explore the possibility that different configurations of governance models and other conditions may produce desired outcomes, rather than seeking the optimal fit between outcomes and causal factors. Researchers, commissioners and the policy community could usefully explore the implications of adopting this perspective, based on an understanding of complexity theory and associated methodologies.

One mechanism that we have identified to combat the threat of increasing service fragmentation is the fostering of trust through strong horizontal networks. As the policy agenda moves to give further emphasis to personalisation, the use of networks in successfully implementing policy goals will become essential. Through categorisation of published governance models we were able to draw some inferences around those structures necessary (though not always sufficient) for networks to achieve their objectives. These included: the necessity of a network-based implementation group; that localities should set up single networks to focus on specific discrete changes, rather than developing a number of competing networks with a similar remit; and that there should be a ‘joined-at-the-top’ model of governance.

1 Introduction

There has long been a central policy commitment to reducing the utilisation of inpatient beds by older people, particularly unplanned utilisation. During the 1980s the policy emphasis was on reducing long-stay episodes. Among other things, this led to a reduction in 'geriatric' beds from 53,000 in England in 1987/88 to 28,000 in 2002/03.[1 (p 3) 2] Three principal considerations underpinned this commitment. One was the recognition that admission to, and long stays in hospital were not necessarily the most appropriate care arrangements for older people.[3 4] For example, one study identified that 50% of older people in hospital needed rehabilitation rather than acute care,[5] and another concluded that inappropriate use of in-patient bed days by older people was 'greater than 20% across a wide variety of settings'.[6 (p 157)] A second consideration was the requirement to meet waiting list and access time targets by solving what was perceived as unnecessarily long in-patient stays: the 'bed-blocking problem'.[7-9] Third, there was a wish to constrain spiralling costs within secondary care.[10-12]

Over the 1980s and early 1990s, the Conservative government's policy emphases included enactment of numerous structural and process changes, including competitive tendering,[13] the removal of managerial control from clinicians to general managers[10] and the introduction of the internal market. The latter in particular was expected to deliver the benefits associated with competitive markets: 'reduced costs of services, increased quality of service, better use of NHS assets and streamlined management'.[14 (p 3)]

The Labour Governments of 1997 onwards aimed to improve the quality and accessibility of care and to reduce emergency bed use by taking a twin-track approach: on one track, a system of performance management, and on the other, a framework of statutory and third sector partnerships. In order to achieve the former, the 'weapons in the government's armoury for achieving change [were] regulatory systems, standards, targets and arrangements for monitoring performance'.[15 (p 975)] At the same time, partnerships were at the heart of Labour's health and social care policies.[16 17] As a symptom of this emphasis, 'the word "partnership" was used 6197 times in Parliament during 1999, compared to just 38 times 10 years earlier'.[18 19]

Each sector had its own set of targets: for example, the quality and outcomes framework (QOF) set standards for the performance of primary care. Some targets were cross-sectoral: public service agreements (PSAs) required local agencies to work toward achieving progress across a number of strategic and operational areas. The status of cross–sector health and social care partnerships was given additional statutory backing through the *Local Government & Public Involvement in Health Act 2007*.

Targets set to constrain the seemingly inexorable rise in the use of emergency bed days (EBDs) were embedded first within national strategies.[20 21] However, to such targets were soon added financial ‘incentives’, such as the cross-charging of local authorities by the NHS for avoidable discharge delays (Community Care (Delayed Discharge Act) 2003). Two public service agreements (PSA) were also put in place requiring local authorities and their health partners to reduce EBDs by 5% by 2008 (also known as the *Long-Term Conditions target*) and to increase the number of older people supported to live at home by 1% a year in 2007/8.

Prior to these national initiatives, a group of councils created their own network to reduce the use of emergency bed days by agreeing to participate in the ‘Improving the Future for Older People’ (IFOP) programme of the Innovation Forum. The over-arching purpose of the Innovation Forum was to promote dialogue between central and local government and its partners on new ways of working to deliver better services to local communities. Set up by the Office of the Deputy Prime Minister (ODPM) 2003, four areas of work were identified: early years and school safety, community safety, integrating public services, and reducing unscheduled hospital bed days for older people (http://www.lga.gov.uk). To address the last theme, nine councils rated as ‘excellent’ and their corresponding health and third sector organisations were invited to work in partnership to achieve the single outcome measure or ‘headline target’ of a 20% reduction in EBDs for older people (defined as those aged 75 and over) over the three years from 2004 to 2007. The study described in this report explores the extent to which and how the IFOP programme achieved its goals.

The shift from government to governance through the ‘hollowing-out’ of the state has been a dominant discourse in public management in recent years. Yet such a discourse seems to be at odds with the strengthening of centralising forces in the NHS such as those represented by the introduction of non-negotiable targets or incentives. A key purpose of this study was to reflect on these approaches in seeking to understand the responses of the nine local authorities and their health and third sector partners to the Innovation Forum objective of reducing emergency bed days. We were particularly interested in the opportunities and difficulties encountered when working across health/social care and NHS/council boundaries.

Earlier research carried out as part of the IFOP programme had identified a number of (short-term) barriers and facilitators to achievement of the target, including: sectoral integration, commissioning, level of involvement of users and carers, the impact of government policies and centrality of targets.[22] This follow-on SDO-supported study sought to explore whether whole-systems governance through partnership models produced the changes in EBD numbers or whether such processes were merely a ‘side-show’, compared with the influence of centrally articulated incentives or targets to the detriment of ‘whole-systems working’.

The next section of the report sets out the study aims, and is followed by a discussion of the wider policy context (Section 3). In Section 4 we describe our research methods and the challenges of such a study – in particular, the ‘perpetual revolution’ that we were working within and which affected how far the outcomes could be adequately measured and linked to changes in context, governance and mechanisms. Section 5 describes the sites. Section 6 then identifies possible governance models to provide a conceptual context for our exploration of the influences that shaped outcomes in the nine study sites. There is also a description of the governance arrangements in those sites. In Section 7 we explore and categorise the many and various local initiatives that were either set up or included within the local areas as part of their strategy to achieve the headline target of a 20% reduction in EBDs; and in Section 8 we move on to explore the roles of non-NHS agencies in achieving the target. Section 9 provides empirical evidence on the extent to which the headline target was actually achieved.

Following this strategic-level analysis, Section 10 explores what the targets meant for patients, carers and professionals. It draws on their reported experiences of the health care 'journey' to reflect on the influence of different governance models at the micro level. Finally, Section 11 brings the theoretical discussion and empirical data together to assess how far the achieved reduction in bed days was a result of innovative and appropriate governance structures.

2 Study aims

The overarching aim of the study was to compare and critically analyse the impact of different governance models as local health and social care economies sought to reduce utilisation of unplanned inpatient bed days by older people aged 75 and over.

Six objectives specified the activities necessary to achieve this aim:

- Explore the changes in emergency bed days within each of the nine participating sites before and after the IFOP project.
- Identify the characteristics and mechanisms of governance arrangements that are seemingly effective in reducing utilisation of unplanned bed days by older people while ensuring quality and equity.
- Identify, measure and profile local initiatives to reduce unplanned hospital stays by older people.
- Examine roles played by non-NHS agencies in achieving NHS targets in relation to hospital bed use.
- Explore professionals' experiences of different governance models.
- Compare and contrast the user/patient experience within three key conditions: falls, chronic obstructive pulmonary disease (COPD) and stroke.

These objectives generated a number of research questions. For example, within the latter two objectives, six research questions were developed to explore processes and outcomes. These ranged from how professionals interpreted and integrated different governance structures within their operational practice to the factors that patients perceived as contributing to the prevention of unplanned hospital admissions or the reduction of lengths of stay. A multi-method research project was employed (see Section 4).

3 Overarching context: the IFOP programme and national policy

3.1 The Innovation Forum for Older People

3.1.1 Introduction

The Innovation Forum (IF) was set up by the Office of the Deputy Prime Minister (ODPM) and the Local Government Association (LGA) in 2003. It was designed to provide a structure within which central government could come together with excellent-rated councils and pioneer new ways of delivering public services. The IF encompassed four areas: early years and school safety, community safety, integrating public services and 'reducing hospital admissions of older people'. The principal purpose of the last of these was to prevent hospital admissions by promoting independence for older people and enabling them to experience a better quality of life in the community. This focus on better outcomes led to the project subsequently entitled 'Improving Futures for Older People' (IFOP).

The project involved nine councils that had achieved an 'excellent' rating in the first comprehensive performance assessment exercise (CPA). Each agreed to take on a 'community leadership' role on behalf of their local residents to secure a coordinated approach from the NHS and other local statutory and voluntary partners. The project brief or 'commissioning template' for IFOP was developed jointly by Kent County Council and the Department of Health (2003), following widespread consultation and with the agreement of all nine authorities. It adopted a place-based perspective on improved outcomes, arguing that:

> *Older people thrive, retain their independence, maintain a quality of life, and stay healthy, when they live in good housing with access to a range of facilities (especially for transport, leisure and entertainment) and to families or friends. They may also need the services of a number of public agencies, sometimes only for the short-term.*
>
> 23 (p 1)

The IFOP programme would therefore, it was hoped, enable older people to live healthier and more independent lives, 'with greater choice of service, more means of support and increased community participation'. [23 (p 2)] Fewer hospital admissions and shorter lengths of stay were seen as a means to a better quality of life:

> *Where possible, it is better to avoid using hospital admissions … or if not, to keep these stays to an absolute minimum. Stays can undermine self-confidence, disrupt diet, and increase dependency and the likelihood of infection. The consequences are often more medical treatment and expensive long-term institutional care.*
>
> 23 (p 1)

3.1.2 The IFOP headline target

The nine councils and their local statutory and voluntary partners agreed to adopt a single measure for measuring their collective success. This *headline target* was based on reducing the number of days spent by people aged 75 years and over in hospital following an emergency admission rather than the number of emergency (or 'unscheduled') admissions themselves. The target was defined, therefore, as 'a 20% reduction in unscheduled hospital inpatient bed days occupied by people over 75 years old over the three years from 2004/05 to 2006/07', compared with what would otherwise have been the case if the project had not been put in place. This target was applied to older people living in partner PCT areas and was defined as being derived from the product of admissions for first finished consultant episodes and average lengths of stay. While the primary impact of the proposal was expected to be on reducing the number of such episodes, it was also recognised that the target would also mean reducing lengths of stay 'where this reflects more modern care and treatment, but not where this leads to inefficient discharges'. A number of subsidiary indicators were also to be monitored so that activities could be adjusted elsewhere in the service system and any unintended consequences identified.[1]

The 20% target was innovative and ambitious: neither local authorities nor the NHS had previously set any kind of numerical targets for reducing the use of acute hospitals; and the 20% level was seen as a figure that could reasonably be claimed to represent a significant level of achievement if it could be attained. Although it was not based on any kind of trend analysis or feasibility study within the IFOP authorities, there was also an evidence-based rationale for choosing the 20% target. In general terms, there was growing evidence of acute hospital services 'being used inappropriately, either by people admitted to hospital when they could be cared for in alternative settings, or by people who are medically fit to leave but are unable to do so…..'[24 (p 12)]. More specifically, the National Beds Inquiry (NBI)[25 (p 8)] had cited a study by McDonagh et al.[6] suggesting that the inappropriate use of hospital beds could be as great as 20%. The report also cited that study as evidence of 'inappropriate or avoidable' bed use 'if alternative facilities were in place'. Other evidence obtained by the NBI confirmed that the 'availability of community health services and social care are key to differences in acute bed use, while in some cases variations in primary care service delivery are also material'[6 (p 10)].

Thus the IF prospectus was based on evidence in good currency at the level of national policy about the nature of the problem (substantial levels of inappropriate usage of hospital beds) and also its solution (the provision of

---

[1] The following were identified as subsidiary indictors: acute bed occupancy, delayed discharges, day and outpatient episodes, booked admissions, bed capacity (for patient choice), waiting times, intermediate care places used, residential care places used, GP referrals, primary care access targets, equipment delivered and adaptations made, (intensive) domiciliary care hours, and extra-care housing placements.

community-based services). If the former might be as high as 20%, then setting the target at this level would enable the IFOP to argue convincingly for the efficacy of a local authority-led partnership to shift the balance of care. There was, however, an outstanding issue: the measure to be adopted. In drawing up the prospectus, local authority representatives were aware of two possible measures: admissions and bed days. The latter was adopted because, at the time, they believed it to be the more demanding measure. In practice, it is arguable that this view was inaccurate both historically and since the target was set. The number of acute beds had fallen substantially from a peak of 250,000 in 1960 to 147,000 at the turn of the century[25 (para. 18)], largely as a result of reductions in the length of stay including a substantial growth in day cases. Yet, hospital admissions had also shown a long term trend of 3.5% growth annually, and the increase in emergency admissions during the winter became a particular policy concern.[25]

The primary concern of those selecting bed-days rather than admissions as the measure to be adopted was to avoid the perverse consequences associated with target setting. The indicator adopted was the number of 'unscheduled acute hospital inpatient bed days occupied by people over 75 years old, living in partner PCT areas'. This figure was defined as the product of admissions for 'first finished consultant episodes' (FFCEs) and 'average lengths of stay'. The primary impact of the initiative was expected to be on reducing the number of such episodes. However, it was recognised in the prospectus that the target might mean reducing lengths of stay, 'where this reflects more modern care and treatment, but not where this leads to inefficient discharges. Occupied bed days will therefore be the measure'.[23] This decision reflected a common concern at the time that admission figures were being artificially inflated by counting the admission of a patient with more than one condition requiring treatment as more than one episode of care and thus more than one admission. From this perspective, monitoring admissions might simply lead to a re-definition of what constituted a single admission without equivalent changes in the number of days spent in hospital. Whatever the logic, the important issue is that the target was set with regard to the possibilities of gaming and unintended consequences. Subsequent meetings with those responsible for setting the target suggested that the bed days measure was purposively chosen because it was considered 'the more demanding figure'.

The project brief did not include a fully developed model for quantifying the headline target and applying it to individual authorities. This task was taken on by the project leads with support from an independent evaluation team. It proved to be a challenging exercise both technically and politically. Agreement was required on how to calculate what the level of bed days would have been if the IF project had not been initiated. Ultimately, the formula took into account both projected demographic changes and the historic trend in the level of emergency bed days used by older people. Similarly, there were detailed negotiations about whether national or local data sources could most accurately be adopted. The final agreement allowed flexibility in relation to the use of local or national demographic data where it could be demonstrated that local data were more up-to-date as a result of (say) recent local planning decisions (see Section 6). Arrangements were also made to collect local data for monitoring progress against the headline target because of the long lag in publishing the relevant national data set (HES).

The agreed formula was applied to eight of the nine authorities. One site was excluded from the calculation because its local project operated at the level of two general practice lists rather than the whole authority and/or whole PCT level of the other eight councils. For the latter, the 20% headline target was expressed in two ways:

- compared with the projected level of bed days for 2006/07 (i.e. the level estimated to have been reached without the intervention of IFOP programme)
- compared with the baseline year of 2003/04 (i.e. the level being utilised before the intervention of IFOP programme).

The first calculation produced a headline target of 269,480 emergency bed days fewer than would otherwise have been used by 2006/07, and the second was equivalent to an absolute reduction of 96,206 emergency bed days over the three years after 2003/04. Overall, therefore, the target represented an absolute reduction in emergency bed days compared with the 2003/04 baseline and not merely a reduction in the rate of growth. Individual targets were calculated for each authority for monitoring purposes but it had been agreed from the beginning that the success of the project would be judged as a whole and not on the basis of the figures from individual areas. In practice, therefore, the participating councils were adopting a collective target. While not eliminating all elements of competition between councils, this approach did tilt the structure of incentives towards collaboration and shared learning within a network of more or less equal partners, supported by national and local evaluation teams. Hereafter we will discuss target achievement in terms of the projected level of bed days in year 3, rather than the reductions in bed days compared to the baseline year.

3.1.3 Barriers to agreement of the headline target

The time taken to calculate the headline target reflected the influence of a number of factors. The target was entirely voluntary, and was to be applied over and above any other national or local targets. It did not attract any additional funding to pump-prime new services capable of reducing hospital admissions and lengths of stay.[2] In addition, having been signed up by senior members and officers to this challenging voluntary target, project leads individually (and their managers less directly) were alert to the risks of agreeing a target which might put their own reputations at a

---

[2] Subsequently, however, a number of the councils included the IFOP target in the Local Public Service Agreement (LPSA 2), which ran for three years from 2005/06 and was accompanied by 'reward' monies from central government.

disadvantage, especially if it failed to take into account the peculiarities of their own local contexts. National targets have been criticised precisely because of their inflexibility, particularly in failing to discriminate between local contexts: 'the incidence of disease (size of problem), deprivation (difficulty of implementing a response), or the fact that different places may have different local problems'.[26 p 15] By contrast, the IFOP programme provided an opportunity to avoid being locked into another crude or arbitrary measure and to co-design something which was locally meaningful. At the same time, the high profile of the overall IF in the local government policy community and the 'excellent' rating of the councils involved provided strong incentives to avoid failure. The reputation of local government as well as individual councils was at stake, and the care with which the target was operationalised undoubtedly reflected this wider context.

Despite the difficulties in setting the headline target, IFOP was an offer by local government to adopt and take the lead in delivering a target measured in terms of NHS activity levels rather than its own – predating the 'place-shaping' role described in the Lyons Inquiry.[27] The logic for this approach was identified in terms of securing a better quality of life for local residents. However, the project brief identified a further logic in terms of providing a practical demonstration of the capacities and capabilities of councils to exercise an effective community leadership role across sectors and especially the NHS. It was explicit about what it described as 'this exciting community leadership challenge':

> *[IFOP] will require high performing pilot councils to provide strong community leadership, to form effective local partnerships, and to direct investments in health and social care. The pilot councils will play a 'strategic commissioning' role, ensuring that partners take a broad view of how resources are used across the whole system, including both acute and community care, and a broad range of preventative measures, across all local public services.*
>
> 23 (p 1)

In concrete terms, the local authority role was to carry out four specific actions. First, each was tasked with bringing together the different statutory and voluntary partners to assess and explore the available services supporting older people. Second, from such discussions, they were to facilitate changes in existing services that would mirror the governance of partnership working as well as working across the different organisations to identify and jointly commission 'new' services that would 'promote community health and well being, maintain independent living and improve care and treatment services'.

The third task of the local authority was to lead, in partnership, negotiations around and modelling of mechanisms that would enable monies to be moved around the health and social care system. That is, those monies that were in principle 'saved' through the targeted reductions in bed use by people aged 75 and over would be redeployed to support improved community care for older people. However, it was also recognised that any developed models or mechanisms should not disrupt service delivery to other groups of patients. It was not expected that the development of mechanisms would only be carried out locally. It was recognised that the

Department of Health (DH) would provide support through national policy changes; those policies being considered and initiated including fixed pricing – the Healthcare Resource Group (HRG) tariff. The fourth and final task for the local authorities was seemingly perceived as an educative role. That is, as health commissioners developed their new pricing and contracting methods under the HRG system, local authorities should share their more established expertise around in commissioning.

Two aspects of such activities deserve highlighting. First, PCTs working in partnership within the IFOP councils would be able to reduce expenditure in the acute sector and reallocate the funds saved to community services, although this would be reversed if progress was less than anticipated. Second, however, it was not assumed that PCTs would be able to make such resource redeployments without support from the NHS hierarchy. The IFOP brief specified that input from the centre was necessary, and would be forthcoming, to help councils to deal with resource release and resource redeployment issues. Thus, the brief recognised that the government, through the DH and its 'agent' local authorities would need to work together to overcome obstacles to the delivery of the target. In addition, councils and their partners were explicitly given 'permission' to develop such mechanisms as contributions to good practice nationally.

The commissioning brief of IFOP did not, however, envisage that funding for community services to substitute for emergency (or 'unscheduled') bed days would be obtained only by redeploying existing spending in secondary care. Rather, 'such investments in alternative community services may be a combination of new investments and reinvestments, and there will be synergy between this work and commissioning to reduce delayed discharges and charging for delays'. Moreover, funds could be held by the PCT(s), or placed in a pooled budget, or transferred to the local authority to be used for services within primary or social care or indeed community health services. The key principle was that such commissioning activities should be directed from a single point at the heart of the whole systems strategy for re-balancing service provision.

3.2 National policy background

3.2.1 Introduction

We argued above that the IFOP programme was intended to promote 'dialogue' and subsequent systemic change at three levels to tackle unplanned admissions: between central and local government, across the different local government partners to IFOP, and within the local sites themselves, involving their statutory and local partners. Nevertheless, the IFOP could not be described as an entirely new initiative. Rather, it acted as a vehicle both to develop a pre-existing aspect of national policy for health and social care and also to progress its implementation. The proposed structural and process changes of the intervention therefore cannot be fully understood without discussion of the overall national policies intended to control and shape health and social care. Three areas are discussed here:

health policy, local government, and the partnership and collaboration across the boundaries of health and social care. The more significant legislation and guidance from 2001 to 2007 is summarised in Figure 1.

Figure 1 Policy guidance and key legislation 2001–2007

Preventing the unplanned admission of elderly people to hospital has long been perceived as a 'wicked issue'.[28] It is one of 'that class of social system problems which are ill-formulated, where the information is confusing, where there are many clients and decision-makers with conflicting values, and where the ramifications in the whole system are thoroughly confusing'.[29]

3.2.2 Health policy and older people at risk of unplanned hospitalisation

Reform of the NHS during the period of the IFOP concentrated on the introduction of increasingly diverse governance structures. From 1997 onwards, the Labour government's reforms were increasingly multi-dimensional, over-layering increased supports and resources for professionals and hospitals with top-down approaches (performance targets, professional regulation and 'special measures' for failing hospitals) and market approaches involving patient choice and the diversification of supply.[30] There may also have been a motivation to create 'constructive discomfort'[30] or even 'creative destruction'[31] within the NHS to overcome organisational inertia. The Labour government began its first term by fulfilling its commitment to replace competition with collaboration, but the break with the internal market was short-lived. By the time of Labour's second term in 2001, competition was returning alongside the strengthening of hierarchy and setting of national targets (see below).

The changing balance between collaborative networks and market forces can be seen in different structural and process changes. One structural change was the creation of NHS foundation trusts,[32] with the first foundation hospital in place in 2004. Foundation hospitals were perceived as radically changing the governance relationship between central government and NHS organisations.[33-35] As independent not-for-profit bodies, run by locally elected boards of governors, 'promoting a greater community involvement in and governance of NHS organisations',[36 (p 109)] foundation trusts were said to be being de-coupled from central government control, able to decide locally the type and extent of services that should be put into place and given greater financial freedoms, allowing income generation and reinvestments in patients services. Such local planning around investments and thus reinvestment, it was argued, ensured appropriate budgetary control and the delivery of health services 'effectively, efficiently and economically'.[37 (p 77)]

Alongside the creation of foundation trusts in the NHS came the encouragement of a more mixed economy of supply involving third sector and private (for-profit) organisations working in partnership with informal and state sector care. Private sector hospitals were given a permanent NHS role, while a US insurer was invited to provide case management for frail elderly people in nine PCTs.[38] The NHS would still pay for health care, but independent for-profit organisations would provide an increasing proportion of all treatment procedures (surgery and diagnostic treatments). The government argued that the involvement of the private sector would provide greater system capacity, addressing the long-standing waiting list problem (see below), but more importantly would bring a much needed managerial and financial discipline to health care, 'serving as examples of efficiency and responsiveness to patient needs for NHS Trusts to emulate'.[39 (p 510)] It was expected that the private sector would increase open competition, create choice and drive down the costs of care.[40 41]

The key structural change in the organisation of commissioning during the lifetime of IFOP was the reconfiguration of PCTs in England in autumn 2006, leading to a 50% reduction in the number of PCTs.[42] The ostensible purpose of such re-structuring was to strengthen the commissioning role of PCTs to 'deliver a fit-for-purpose health system with an effective and objective commissioning function able to deliver high quality care and value for money'.[42 (p 3)] New and innovative ways to improve services with a range of providers across the health and social care economy would be sought through the strengthening of commissioning. Thus rigorous performance management would need to be implemented. Such restructuring was also identified as a way of reducing management and administration costs, as well as kick-starting the slow-to-be-implemented practice-based commissioning (see below). However, this policy was also perceived as providing the necessary underpinning framework of multi-sectoral partnership through coterminosity with local authorities.

Widespread criticism of the policy was voiced following publication of the plans: the process was seen as 'incoherent' given the average of 18 months necessary for restructuring to be undertaken and performance to return to previous levels.[43] Moreover, restructuring was seen as more likely to fracture, rather than strengthen, relationships across organisational boundaries.[43] There is some evidence to support the concerns expressed by the Committee: the Partnerships for Older People Projects (POPP), a programme set up soon after IFOP, encountered huge problems around the development and maintenance of partnerships.

Personnel within PCTs were often initially unsure whether they would have jobs, contacts between managers within partner agencies temporarily broke down as personnel changed, and PCTs were often perceived to be too preoccupied with reorganisation to concentrate upon the POPP programme.[44] (p 49) The impact of this restructuring at a crucial stage in the IFOP programme is discussed further in later sections of this report.

Two process reforms concentrated on creating incentives to encourage appropriate and efficient commissioning within the NHS that would control unplanned admissions and lengths of stay: payment by results (PbR) and practice-based commissioning (PBC). Announced in *Creating a Patient-Led NHS*[45] and implemented incrementally during the study period (2004-07), PbR was intended to replace existing block contracts with a more transparent financing system whereby the payment of acute health service providers was linked to activity and case mix (e.g. the mix of type of patients and/or treatment episodes), and on the basis of a national price tariff. This mechanism was expected to result in a reduction in admission and readmission rates, to reduce lengths of hospital stay, and to allow flexibility on the part of primary care to commission a plurality of providers. The savings made from the reduction of acute service activity would then be re-invested to stimulate the development of community alternatives to hospital care.

PBC was similarly intended to be implemented within the time-frame of IFOP, although progress in implementation was initially slow.[46] From April 2005, each GP practice was able to ask for a delegated indicative budget from their PCT, covering that practice's share of the NHS budget. From 2006, all PCTs were developing arrangements to support and facilitate GP practices to become involved. Through utilising their local knowledge, GP practices were to work with their social care partners to plan, develop and implement services around the needs of their population. By tracking care pathways across health and social care, it would be possible to minimise duplication of services and to identify areas where health partners might effectively commission services from social care.[47]

3.2.3 Local government and social care

The extension of the market and the changes in commissioning seen across the health sector were mirrored within social care. The involvement of the voluntary sector in social care expanded hugely under the Labour governments, with voluntary and community organisations (VCOs) at the centre of the strategy.[48] VCOs were tasked with four key activities:

- to act in full partnership with central and local government in strategic development;[49-51]
- to deliver 'social and other services that governments may find costlier and more ineffectual to deliver themselves';[52: 114]
- as a vehicle to revive democratic engagement;[53 54]
- and finally as a mechanism to combat social exclusion.[55]

That VCOs have moved from 'the official wilderness to the political agenda'[56: 392] can be illustrated by their income stream: 40% of the average human services charity's annual income now derives from government sources.[57] They are also much more involved in new interventions. For example the POPP Programme found that of the 522 organisations involved within and across the initiative, 347 (66%) were VCOs.[44]

Over the last two decades, local authority social services departments (latterly, adult services departments) have moved from service provider to purchaser and, in recent years, to facilitator and enabler of personalised social care or individualisation, thereby radically changing the nature of the local government role.[58-63] Perhaps the first step (nationally, at least) towards initiating personalised social care, the *Community Care (Direct Payments) Act 1996*, enabled local authorities to make direct cash payments to those individuals assessed as needing social care or support and aged 18 to 65. Nevertheless, tight constraints were placed around the type of care individuals could procure, not allowing the 'purchase of health care, local authority services or [the support of] a close co-resident relative'.[64 p 2]

Subsequent statutes and activities[65 66] opened up the access to direct payments for the wider social care user population,[67] while a mandatory requirement to offer direct payments was placed on local authorities in the *Health and Social Care Act 2001*. The slow and uneven take-up of such payments led to further government recommendations to progress self-directed support, including experimentation with individual budgets. Piloted from 2005 across 13 local authorities, individual budgets were subsequently described in 2006 by central Government as the 'future direction of social care'.[64 (p 34)]

3.3 Incentives or targets?

Public consultation, citizen participation, collaboration and partnership were key elements of most Labour government policies from 1997 onwards.[68-71]

Such approaches perhaps sit uneasily with the more centralised managerialist focus of national targets.[15 30 72]

> *There are clear tensions within the Labour government's agenda for central-local government relations – between a drive for national standards and the encouragement of local learning and innovation; and between strengthening executive leadership and enhancing public participation.*
>
> 73 (p 9)

Performance measurement was emphasised through 'explicit, quantitative, time-limited targets',[26 (p 3)] In 1998, Public Service Agreements (PSAs) were introduced, setting a series of objectives with associated performance targets. A target that emerged in 2005, following the early stages of implementation of IFOP, was: 'Objective II, Improving health outcomes for people with long-term health conditions', with the cross-organisational target to 'reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions'.[74 (p 6)] By meeting these 'quasi-contracts' local government and NHS organisations could exchange 'performance' for resources.[15 75 76] In short, through demonstrating appropriate or improved performance, organisations would receive rewards, either financial or organisational (such as greater autonomy).

A further national target put in place concerned delayed discharges from hospital, introduced through the *Community Care (Delayed Discharges) Act 2003*, and implemented in the first year of IFOP. As we noted earlier, there has been a long-term policy commitment to reducing use of hospital bed days by older people. In exploring delayed discharge, or 'bed-blocking', the DH argued that there was remarkable consistency across thirty years of research findings:

> *In particular, older people make up a disproportionate number of those whose discharge from hospital is delayed and who are waiting for other services.*
>
> 66 (p 1)

A number of policy responses concentrating on improving cross-boundary working had previously been put in place, 'enabling health and social care to work as one care system not two'.[77 (p 593)] Nevertheless, the estimated number of delayed discharges, 'equating to more than 4100 older patients on any given day',[78 (p 1)] was felt by government to require its further intervention due to the seemingly slow pace of change achieved through models of partnership working or joint commissioning. The government argued that the embedded and systemic problems in discharging older people would only be addressed through an incentive model – a monetary incentive that would strongly encourage effective joint working to find innovative solutions to prevent delays in the first instance. Under the *Community Care (Delayed Discharges) Act*, social services departments would be 'fined' by hospital trusts for patients who remained in hospital when they had been adjudged clinically fit to leave, but who were unable to move because of a lack of adequate or appropriate care packages (which were the responsibility of local authorities). Hospital trusts could however seek to reach agreements with social services departments (SSDs) to avoid such cross-charging. The delayed discharges legislation took precedence over any local agreements entered into through IFOP and the sites were monitored against its targets.

Along with such cross-organisational incentives or targets, single organisational measures were also put in place. Star ratings were introduced for NHS organisations in 2000 that gave a 'score' for all organisations between 0 ('poor') and 3 ('excellent').[30 79] The ratings were based on performance against up to 50 targets, whether 'key targets' or those that needed to be included within a 'balanced score card'.[26 30 79] Within social care, the Performance Assessment Framework (PAF) introduced in 1999 set a number of performance indicators, and star ratings followed in 2002, with the outcomes feeding into the Comprehensive Performance Assessment of each local authority. As with NHS organisations, those councils deemed 'excellent' enjoyed certain advantages:

> *[They] will have available to them a series of freedoms. For example, three star councils will have access to their share of the social services Performance Fund by right ... [and] will need to provide fewer details to the Department of Health on how they are planning to spend grants if they have two or three stars.*
>
> 80 (p 2)

This centralised 'incentive' system controlled through targets has been criticised on many fronts. Targets were said to be too rigid, undermining staff morale; failures of performance outside target areas were treated as if they did not matter; some targets were not measurable or built on unreliable data; and the degree of sanction or reward was not clearly related to the success or failure of the organisation.[26 30 71 79 81]

For the purposes of the present study, however, it is perhaps the 'weighting' of the targets and their importance in central-local organisational assessment that matters most. The various organisations that were party to IFOP were working to different central governmental targets – or at least to different local contexts and priorities. Consequently, the implications of agreeing the vehicle of partnership to deliver a joint output (in this case a 20% reduction in bed days) through local partnership working would have to be implemented against a background of potentially contradictory central/local objectives and accountabilities. This difficulty affected all services but was perhaps most strongly evident in an NHS managed as a national service.

3.4 Partnership and mandated collaboration

In implementing and embedding the 'new governance', a key vehicle during the study period was that of partnership and/or networks; seen as 'the answer to a number of endemic problems within health and social care'.[82: 1] Partnership working was generally seen as 'a good thing' in moving from outputs to outcomes:

> *If organisations move away from the presumption that there must, necessarily, be a particular set of services, towards the idea that a certain policy outcome is being sought, then they might arrive at the conclusion that that outcome could be delivered in a radically different way.*

[16 (p 201)]

The Labour government had initially placed partnership working at the centre of policy development. An early example was the White Paper *Saving Lives: Our Healthier Nation*,[83] which advocated a 'joined-up' approach across central government and locally through partnerships between social and health care agencies. Subsequent policy documents and statutes reinforced the point, extending the partnership requirement to a wider range of statutory organisations (district councils, police, fire departments and so on), voluntary and community organisations, private sector bodies, and services users and citizens.[47 84-86]

One initiative that was intended to be influential in building central-local relationships, as well as partnerships within localities, was the Local Area Agreement (LAA). Launched by the Office of the Deputy Prime Minister (ODPM) and piloted in April 2005, LAAs were rolled out to all local authorities by 2007. They required local authorities and their key partners to improve public sector services and the health and well-being of older people. It was hoped that the LAAs would 'provide local authorities and partners with the flexibility and capacity to deliver the best solutions for their areas through a reformed relationship between central and local government'.[87 (p 5)] LAAs have become an increasingly important mechanism of central government influence in delivery of the modernisation agenda – key targets, funding streams and central departmental priorities.[85 88-90] Local authorities had slightly different perceptions of the scope and function of the LAAs, seeing them as a mechanism to achieve greater local autonomy in determining their own priorities. The early implementation process was not without difficulties. As the Local Government Association commented: 'As a form of radical devolution and joined up governance for localities, original ambitions have proved unfulfilled'.[91 (p 7)] Nevertheless, there was also evidence to suggest that the early LAAs changed local approaches to joint problems and priorities, developing 'new decision-making bodies with "teeth", thus enabling more robust governance arrangements'.[89 (p 756)]

Joint planning, commissioning and delivery of services demand appropriate flexibility in funding arrangements. The *Health Act 1999* contained three sections to enable partnership working. Section 29 expanded funding transfers from the NHS to local authorities, Section 30 permitted local authorities to transfer funds to health authorities and Section 31 introduced the new flexibilities of pooled budgets, lead-commissioning and integrated provision. In short, the *Health Act* removed what were seen to be significant legal obstacles to joint working between the NHS and local government. In addition, PBC and PbR were intended to provide opportunities to shift the balance of expenditure from acute hospital care to prevention and community-based care.

Such initiatives were of substantial potential significance for the implementation of IFOP. As we have noted above, its purpose was not only to prevent unnecessary admissions and lengths of stay: it sought to develop appropriate partnership and financial models to facilitate this shift in the balance of services.

3.5 Underpinning constructs for change

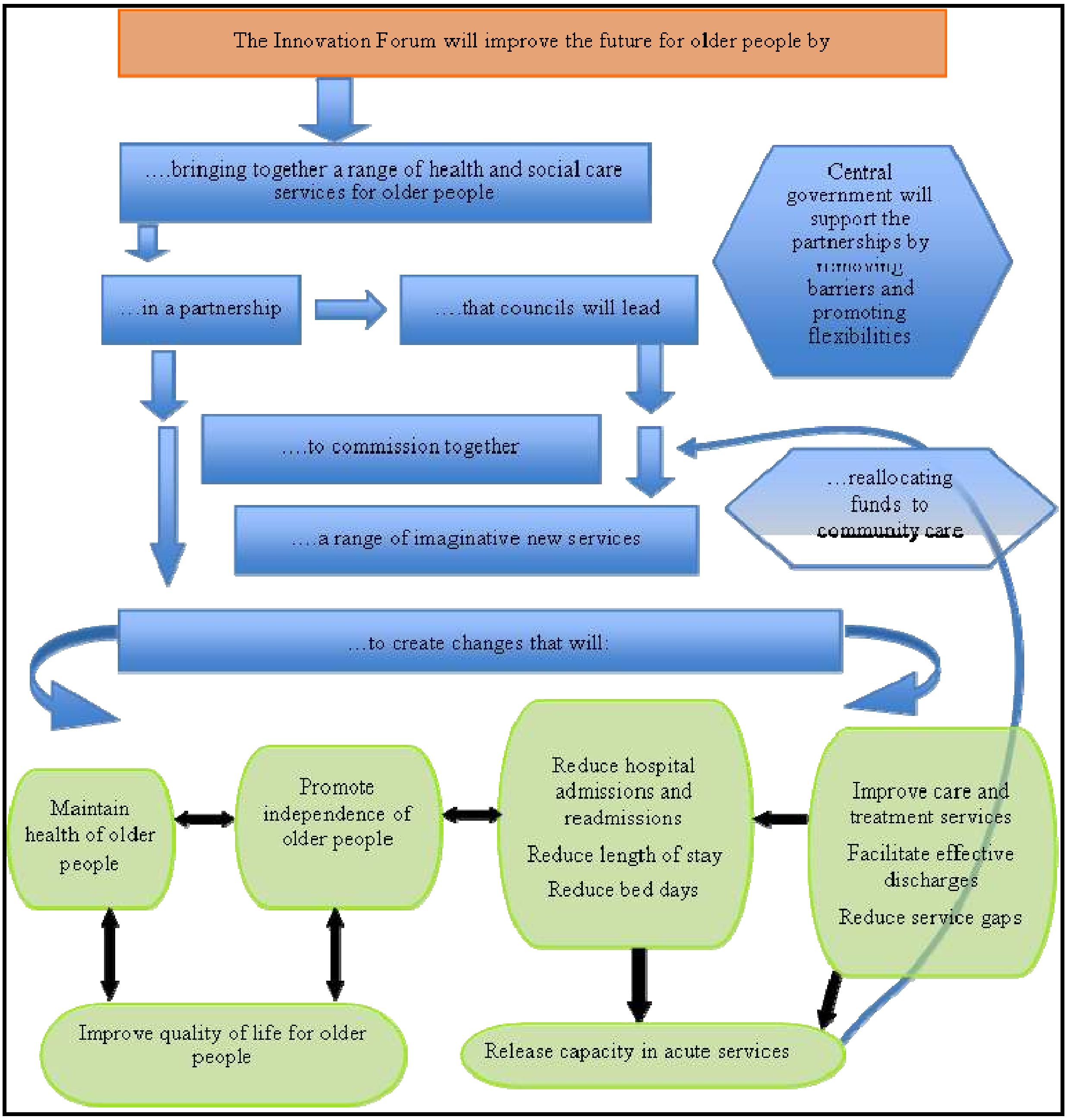
It is clear from this brief description of the policy context that the IFOP was operating in a constantly changing arena: required to respond to the command and control nature of central government targets, while negotiating and building partnerships across numerous organisational boundaries. Nevertheless, as we have also outlined, the pilot programme was based on a number of (more or less explicit) agreed and linked constructs as to what change was necessary to achieve the headline target (of reduced bed days) and associated core outcome (improving the quality of life of older people):

- The IFOP programme partners argued that improvements in the quality of life for older people could be achieved by a focus on preventing dependence and promoting independence through the combined contribution of a wide range of community-based services and other resources mobilised through the structures and processes of whole systems commissioning.
- A reduction in hospital admissions and lengths of stay would also contribute to a better quality of life for older people because of the risks to health and independence associated with hospital care and the environment in which it was provided.
- From a service development and delivery perspective, improvements in the quality of life for older people could be secured through a range of interventions which aimed to: maintain the health of older people in the community, prevent avoidable hospital admissions by meeting their care needs in alternative ways, reduce lengths of stay when they were admitted to hospital, and facilitate effective discharge arrangements to reduce the possibility of readmission.
- Local authorities could adopt and operationalise a community leadership role to establish effective local partnerships capable of delivering a different balance of services and an improved quality of life for older people.
- These partnerships would effectively take the form of managed networks based on stronger horizontal connections at local levels of governance, organised around a single point of commissioning.
- A single measure would be adopted for the project: the realisation of a 20% reduction in the use of emergency bed days by older people aged 75 and over across the three years of 2004-07. The target was voluntary, negotiated and applied by the network of local councils and their local partners.
- The single headline target would be measured on a collective rather than individual authority basis to encourage collaboration and learning across a national network of nine councils and their partners, thereby avoiding some of the dysfunctional effects of national target setting.

- This national network and the local, council-led networks would be supported by central government acting to remove barriers and promote flexibilities in recognition that ‘excellent’ councils had earned the right to innovate and exercise a higher degree of autonomy.
- Vertical and horizontal networks tightly focussed on outcomes for particular populations but operating flexibly on the basis of shared objectives and mutual trust would provide an organisational environment that could deliver holistic care overcome historical disconnections between services.

These elements can be summarised diagrammatically in Figure 2.

Figure 2 Underpinning constructs for change in the IFOP programme



In view of the significance of these issues, the DH and ODPM agreed to support an evaluation of the IFOP programme. In addition, individual councils and their local partners commissioned evaluations of their local programmes. The available funding and time-frame were very limited, and meant that the initial piece of research was constrained to monitoring of overall progress towards the 20% 'headline target' and the production of limited locality-based studies exploring the implementation processes and progress in each locality. Consequently, the researchers formed a consortium to bid for funds to undertake a rigorous and valid evaluation of the organisational and personal outcomes associated with the implementation of IFOP. This SDO-funded project was the result of that collaboration.

4 Methods

4.1 Introduction: evaluation schema

The overarching aim of the study was to compare and critically analyse the impact of different governance models as local health and social care economies sought to reduce utilisation of unplanned inpatient bed days by older people aged 75 years and over. In pursuit of this aim and the six constituent objectives (see Section 2), a multi-method approach was adopted, grounded within the framework of 'realistic evaluation'.[92]

Relating our research objective to the overall schema of realistic evaluation, it is the local initiatives to reduce unplanned hospital stays by older people that introduce the mechanisms of interest. Our underpinning assumption is that professionals' responses to these initiatives will largely determine what practical and policy outcomes will be developed. How professionals experience the different governance models is a core component of a realistic evaluation. As such, the mechanisms of interest extend beyond the operational – clinical or therapeutic – to the specific models of governance employed to reduce the use of unplanned bed days by older people, while also attending to quality and equity. In the case of this research, these governance mechanisms are the local partnerships or network structures operating within central/local hierarchical structures and their associated targets or incentives. Policy makers' programme theory assumes that incentives, particularly economic incentives, reinforced by hierarchy, are a main component of these governance mechanisms.

We have also assumed that, if they work as anticipated, these mechanisms are likely to produce substantial reductions in hospital bed-day use by older people who have one of three illustrative needs: those associated with falls, chronic obstructive pulmonary disease (COPD) and stroke.

A further critical dependency in achieving NHS targets in relation to hospital bed use is that non-NHS agencies can provide resources to prevent such admissions and shorten those which do occur: for instance by substituting for hospital beds. In realist terms, these non-NHS agencies are part of the critical context on which the mechanisms depend. Lastly, the local initiatives and the wide set of national targets and policies in which they are situated define the intended outcomes by which the IFOP local initiatives (or mechanisms) are to be evaluated.

National and local policy-makers' assumptions about how these mechanisms and context combine to reduce the use of bed days by older people constitute the 'programme theory' of the IFOP. A summary of the six research objectives and evaluation schema is given in Table 1. Methods related to the performance of the sites against the 20% target are set out in detail in chapter 9.

Table 1 Research schema

Study objective	Research schema
1. Explore the changes in emergency bed days (EBDs) within each of the nine participating sites before and after the IFOP project.	Analysis of EBDS used by older people of 75 years and over, in the 9 sites, measuring yearly outturns against the projected use of EBDs at the end of the IFOP period.
2. To identify, measure and profile local initiatives to reduce unplanned hospital stays by older people.	Description of each local initiative by means of a set of triangulated case studies, taking each IFOP site as the unit of analysis and assembled from surveys and content analysis of documents. Each case study is structured and reported following a common framework based upon the realistic evaluation schema outlined above, applying the conceptual framework outlined above paying particular attention to the role of incentives in each IFOP initiative.
3. To examine roles played by non-NHS agencies in achieving NHS targets in relation to hospital bed use	From each case, describe those non-NHS resources required, those available and their level of contribution, according to the local programme theory for each local IFOP initiative. Explore the part which incentives (or their absence) played. Comparison of the latter with the local programme theory.
4. To explore professionals' experiences of different governance models	Inductive analysis of professionals' accounts of their experience of each governance model; how they understood the linkages between models, incentives and changes in bed-day use for individuals aged 75 or over.
5. To compare and contrast the user/patient experience within three key conditions: falls, chronic obstructive pulmonary disease (COPD) and stroke	Inductive analysis of users / patients' experience of the services created by each local IFOP initiative, comparing their experience with the programme theory and policy aims for the relevant local initiatives.
6. To identify the characteristics and mechanisms of governance arrangements that are both effective in reducing utilisation of unplanned bed days by older people whilst ensuring quality and equity.	Framework analysis applying the realistic evaluation categories of policy (including programme theory), context, mechanism and outcome, with particular emphasis on the forms of incentive applied and their effects.

This realistic evaluation design included two phases – exploratory and explanatory.[51] The exploratory stage incorporated all nine sites and involved preliminary theoretical development through two specific methods: documentary analysis and structured questionnaires. Within the explanatory stage, three of the nine sites were selected to ensure the initial descriptive outputs could be appropriately tested and understood. Three methods were used: semi-structured interviews with key informants, non-participant observation and individual patient journeys through the health and social care system. (A detailed proposal for the second phase of research can be found in Appendix A.) The following subsections discuss the sampling, data collection tools, analyses and necessary ethical permissions. The on-going challenges to the research are drawn out in each case.

The final phase of the research was to hold two stakeholder consensus workshops. Working with participants from across the nine study sites, we were to explore further the more 'successful' governance models identified through the theoretical and empirical work. We hoped to make recommendations as to specific strategies that would ensure successful networks could be put in place. These networks would implement cross-organisational plans for older people's services and would have as their outcome the reduction in unscheduled acute bed days. We had identified the relevant governance models and carried out analysis at two levels (the strategic and managerial practices level, and the operational practice or patient level) by spring 2009. By this time, the IFOP had formally been completed for almost two years. All strategic and managerial staff were struggling with new priorities, and all had moved onto new roles or indeed new jobs. It was simply not possible to bring this group together. The research team discussed whether a generic group of managers and practitioners could be bought together to inform this final part of the research programme. We rejected this idea because the nine sites had formed a particular 'network of networks'. Bringing individuals from outside the IFOP programme would not necessarily progress the work. Consequently, in agreement with SDO, the research team decided that this stage of the research would be omitted. Rather, guidelines emerging from other programmes (such as Partnerships for Older People Projects, the Individual Budgets pilots), were explored for relevance to the IFOP programme and have been referenced where possible (see Sections 3, 4, 10 and 11).

4.2 Sampling

4.2.1 Selection of phase 1 sites

Nine councils rated as 'excellent', their health and third sector partners responded to the invitation by the Innovation Forum. By necessity a self-selected sample, the authorities and their partners nevertheless demonstrated a wide range of characteristics (see Section 5).

4.2.2 Questionnaire for phase 1 sites

The key informant self-completion questionnaire was used across the nine sites. To ensure the activities of the IFOP programme across the different organisations could be captured, purposive sampling was undertaken. Individuals within organisations were identified by the researchers because of the information and insights they can bring to the research.[93] Project managers within each site were asked to compile a list of potential respondents in the relevant strategic and policy divisions (health and social care) who had been a part of implementing the IFOP initiative locally, or were other individuals involved in running or planning older people's services, particularly those involved in efforts to decrease the use of unscheduled admissions and bed days. There were wide variations in the number of listed individuals provided to the research team, ranging from 11 in one site to 37 in another. An 80% sample was taken from each provided list.

Difficulties arose in regard to this sampling strategy, in particular the formal completion of the IFOP initiative in March 2007. There were concerns that some potential respondents would not be aware of IFOP, given that this programme and any initiatives set up may well have been mainstreamed, subsumed into other programmes (such as LinkAge Plus or POPP) or indeed had ceased to operate by 2007/08. To reduce this risk, two actions were undertaken. Firstly, individuals other than the local IFOP project manager were asked to pass on names to the research team if the project manager felt that another contact would be more likely to name key informants. Secondly, the questionnaires were directed to a wider group of staff: those individuals involved in the overall management, planning or commissioning of services for older people.

4.2.3 Selection of phase 2 sites

The phase 2 sites were selected in May 2007. The decision grid for selection had six dimensions:

a. The outcomes from the documentary analysis.
b. The extent to which the site had met the Innovation Forum 'headline' target for reducing unscheduled bed days in 2005/06 (since HES data for 2006/07 were not available at that time).
c. The organisational and demographic characteristics of the local authorities including administrative type, geographical location and levels of deprivation (this last measured through the Index of Multiple Deprivation (IMD 2004).[94]
d. The number of Foundation Hospitals in place in each location by 2006 (http://www.monitor-nhsft.gov.uk/).
e. The rate of receipt of direct payments by older people per 1000 population 65 or over as a proportion of the rate of those helped to live at home in that age group.[95]
f. The proportion of home care contracts that were in-house.[95]

The last three items were included to ensure an indication of the degree to which market-like arrangements had been established in the local social care or health care systems.

The sites selected had different IFOP governance configurations and use of market mechanisms, different performance in relation to unscheduled bed use by older people, and different levels of deprivation. The governance features are described for these sites, as well as the other six sites, in Section 6.4; other features of the selected sites are displayed in Table 2. Site 3 had not only met but overshot its 20% IFOP target in the year. It was in the most deprived quartile of English local authorities according to the IMD 2004, and in the top quartile of authorities for direct payments take-up by older people. It was in the bottom quartile of councils for the proportion of home care contracts held in-house. Site 5 had not met the IF target, having reduced projected emergency bed day use by older people aged over 75 by less than 15% during the second year of the IFOP. The council was within the (least deprived) top quartile of authorities on the IMD 2004. Unlike sites 3 and 8, the council was in the top quartile of authorities in terms of the proportion of home care contracts held in-house. There was an acute foundation trust within the area. Site 8 had similarly not yet met the IFOP target, also being within minus 15% of the target. The local authority was likewise in the least deprived quartile on the IMD 2004. It was in the second quartile of authorities in the proportion of older people taking up direct payments. Like Site 3, the council was in the bottom quartile of authorities for the proportion of home care contracts kept in-house. The three sites also differed by geographical location and administrative type, but we have chosen not to disclose these details in order to preserve the anonymity of the sites' participants.

Table 2 Features of selected Phase 2 sites

Site 3	Site 5	Site 8
Extent to which site has met target		
Fully met target in year 2	Within 15% of target in year 2	Within 15% of target in year 2
Index of Multiple Deprivation 2004		
Lower quartile (most deprived)	Top quartile (least deprived)	Top quartile (least deprived)
Direct Payments 2005/6		
Top quartile (highest proportion)	Second quartile	Second quartile
Homecare in-house contracts 2005/6		
Lower quartile (lowest proportion)	Top quartile (highest proportion)	Lower quartile (lowest proportion)
Foundation Hospitals within participating PCTs		
0	1	0

4.2.4 Identification and recruitment of the patient sample

Patients were tracked with one of three conditions: falls, chronic obstructive pulmonary disease (COPD), and stroke. These conditions are highly prevalent among older people who present at A&E departments.[96 97] In each site we recruited and followed six patients with one of these presenting conditions (Table 3).

Table 3 Patient diagnosis at each site

Patient condition	Site 3	Site 5	Site 8
COPD	2	2	0
Stroke	0	0	1
Falls	4	4	5
Total	**6**	**6**	**6**

By necessity, identification of the sample was purposive: individuals were selected who had specific experiences of the health and social care systems. Patients were identified through three routes: an inappropriate or avoidable hospital admission, repeated admissions, and/or participation in an intervention badged as part of the local IFOP initiative. Owing to concerns around recruitment, we did not restrict inclusion to people aged 75 and over.

The hospital sample focused on those patients whose admission was defined as inappropriate and could therefore have been avoided. *The Modified AEP (Appropriateness Evaluation Protocol) Criteria* tool was used as a guide[98] (see Appendix A). Assistance from hospital, community and or social care staff was needed to identify those patients whose admission was defined as avoidable and to complete the modified AEP criteria. Initially it was intended to recruit patients from both hospital and community settings. However, this proved impossible in all sites. For example, in site 8, delays in gaining R&D approval from the NHS Trust forced a pragmatic decision to recruit only in the community setting. Similarly, where patients could have accessed the services of more than one acute trust in the area, only one acute trust per site was included owing to the potential delays and time likely to be incurred if all additional NHS R&D applications were to be completed.

Older patients experiencing health or social care interventions resulting from an emergency admission are particularly vulnerable. Particular care was taken with their recruitment into the study. Staff working with the patients were requested to make the initial approach, provide and discuss the study information (see Appendix B). If those patients were interested in taking part, researchers followed up this initial approach, giving further information about the study and gaining informed consent from the patient and any participating carer.

Within such a recruitment model, staff took on the gate-keeping role. To ensure the inclusion criteria could be met and the numbers of patients recruited, the research team spent time gaining the trust of staff. The process was facilitated by attending the necessary staff team meetings to explain the study and provide additional support through written information and guidance. Approaches were made to a number of teams, not all of which eventually yielded potential participants for recruitment.

The challenges of recruiting patients included patient frailty, limitations of the AEP and restructuring within the locality. Staff identified difficulties in recruiting patients who matched the eligibility criteria. For example, staff in hospital settings found it difficult to identify patients who had received an avoidable unscheduled hospital admission, but who were also able to participate fully in the study and had the capacity to consent. This may explain why staff members identified very few potential participants with stroke. The use of the modified AEP was not entirely successful in two sites, due to the changing circumstances of patients, the complexity of their presentation, and differing staff views and understandings of patients' health at admission. Finally, in one of the sites, some stroke rehabilitation services had recently been tendered to an acute trust outside the IFOP programme. As R&D permission had not been sought from this acute trust we could not make an approach to either employees or patients.

4.3 Data collection

Five data collection methods were used. Within the exploratory phase, documentary analysis and a structured questionnaire were carried out. Within the explanatory stage, key informant interviews, non-participant observation and the patient journey were used to explore the dominance of governance models or incentives.

4.3.1 Exploratory phase documentary analysis

Documentary data collection focused on three areas: data that could support the building of site demography, national strategy documents that could provide appropriate context around governance and emergency bed days, and local documents focused on the IFOP partnership structures and interventions.

To build the site profiles, routine administrative data were accessed on population demographics, performance indicators, hospital bed availability and unplanned hospital activity (lengths of stay, admissions and bed days). The data were either drawn from existing databases or a direct request was made to the organisation concerned: the DH, NHS Information Centre for Health and Social Care, the Office of National Statistics (ONS), the Healthcare Commission and the (then) Commission for Social Care Inspection (CSCI). Contextual information was also drawn from CSCI and the Audit Commission.

In collecting the data within each locality, a data collection form was circulated among the members of the research team in order to collect consistent information across the sites (Appendix C). Such documents facilitated the development of a picture of each local IFOP programme and the information obtained fed into subsequent stages of the evaluation process, ensuring the formation of 'important questions [pursued] through more direct observations and interviewing'.[99: 233] The latter was supported by the self-completion questionnaire and topic guide for the follow-up key informant interviews. Comprehensive data were received from certain sites, including electronic copies of strategic and operational documents and links to publicly available resources. In a few sites, however, delays were experienced in obtaining replies from project leads on those documents that had not been made publicly available but had been central to the locality's IFOP strategy. In the first year of the IFOP programme (2004/05), project leads from each site had provided information on the project aims, funding and delivery as well as short descriptions of the various projects or interventions associated with IFOP. In the initial year, 88 projects were associated with IFOP; these have previously been described by Wistow and King[22] (and see section 7 below). This information was recorded in an Access database, which expanded over the course of the evaluation as new initiatives came on-stream. In 2007, the project leads and other local contacts were also asked to provide information on the sustainability of the projects to the end of March 2007. This information was gathered in tandem with an ongoing collection of documents for analysis.

4.3.2 Exploratory phase structured questionnaire

The self-completion structured questionnaire (see Appendix D) consisted mainly of tick-box questions, with a few open-ended questions. Consisting of eight sections, the questionnaire began with an instrument for describing organisational culture based on the competing values framework of Quinn and Kimberly,[100] as used by Shortell et al.[101] It then covered the following topic areas:

- the organisational priority to reducing acute bed days;
- the number and inclusion of planning meetings related to reducing acute bed days;
- the perceived impact of performance indicators on reducing bed days;
- perceptions of integration mechanisms (such as joint appointments, pooled budgets and lead commissioning);
- local attitudes to multi-agency contracts and agreements to mechanisms for care closer to home; and
- local attitudes to public and user involvement.

Difficulties were encountered in collecting the questionnaire data. Minor delays were experienced with the NHS Research Ethics application process. Very significant delays were experienced in obtaining both local NHS research and development (R&D) and local authority research management and governance permissions. Similarly, the PCT reconfiguration had a substantial impact on identifying key informants, as all positions were in a state of flux. Five months elapsed before lists were obtained from all sites.

The questionnaire was sent to 139 people working in the NHS, local authority social care and voluntary sectors. From the initial mail-outs and reminders to 9 sites, 38 questionnaires were returned (see Table 3). The highest response rate (at a site level) was 55%, and the lowest 0%. The overall response rate was 27%; excluding the site where no questionnaires were returned, the response rate was 31%. It is possible that because of the newly reconfigured PCTs, the time available to PCT respondents might have been limited by the effects of organisational 'churn'. Also, at the request of the ethics committee, we had agreed to enclose an information sheet about the planned follow up telephone interview with the invitation letters for the questionnaire: potential respondents might have felt reluctant to commit to an interview, which in turn may have affected the response rate. Further details on the composition of the sample are given in Box 1, Section 8.1.

Table 4 Questionnaire response rates

Site Number	Questionnaires received	Questionnaire sent	Response rate
1	3	11	27%
2	0	18	0%
3	6	11	55%
4	6	19	32%
5	2	10	20%
6	5	11	45%
7	3	9	33%
8	6	28	21%
9	7	22	32%
Total	**38**	**139**	**27%**
Total excluding site 2	***38***	***121***	***31%***

4.3.3 Explanatory phase interviews with strategic managers

Within each of the three sites we carried out a number of semi-structured interviews with a purposive sample of key informants. Participants included health and social care managers responsible for the implementation of the IFOP strategic plans or for the development of IFOP initiatives, or for the wider strategic or operational direction of older people's health and social care services in their localities. A total of 21 interviews were carried out: 7 in site 3, 6 in site 5, and 8 in site 8. The participants represented local authorities (3), PCTs (8), NHS trusts (5), mental health trusts (1) and voluntary organisations (1). Four participants held joint posts across health organisations or across health and social care. The interview schedule was informed by and built on the data collection and analysis carried out in the exploratory phase (see Appendix E). The topic guide covered the partnership arrangements and initiatives aimed at reducing the use of unplanned hospital bed days by older people. Participants were asked to comment on the implementation of such projects and strategies, barriers and facilitators to their development and to identify key players involved. They were asked to describe the objectives of the strategies or projects, the extent to which objectives had been met, the benefits for service users, and the impact on joint working between the health, social care and voluntary and private sectors locally. They were also asked to comment on the sustainability of and development plans for projects or strategies. Depending on the extent of their involvement with IFOP initiatives and partnership arrangements, participants were asked to reflect on these initiatives and arrangements in particular.

4.3.4 Explanatory phase non-participant observation

Non-participant observation was carried out across a range of multi-professional forums responsible for monitoring and evaluating unscheduled bed days and designing or implementing specific service initiatives. In all, 30 meetings were attended. This phase of the data collection was focused on the professionals operating 'nearer' to the patient, i.e. at a more operational level that those participating in phase 1 of the study. The types of meeting observed took place in both primary/community care settings and acute hospital settings. The specific meetings varied across the sites.

Researchers were invited to attend the meetings as non-participant observers by the staff they came into contact with as a result of the patient journey – or tracking (see below). These included:

- meetings operating at a strategic level, where managers from the different organisations discussed initiation, implementation and commissioning of services, making direct financial commitments;
- operational meetings carrying out performance monitoring and on-going service planning (numbers of staff, necessary personnel training etc);
- front-line team meetings concerned with specific interventions, such as intermediate care and bedded multidisciplinary rehabilitation team meetings.

Data were recorded as field notes and were used to assist in the exploration and understanding of both patient and senior manager interview data. Such observation was invaluable, supporting research around the patient journey (see below), enabling the researchers to set the patient journeys within the broader context of the local health and social care economies.

4.3.5 Explanatory phase patient journeys

Semi-structured interviews with patients were conducted with the aid of a topic guide (see Appendix F) developed following the Phase 1 data collection and taking into consideration the research literature on governance and incentive arrangements. The guide focused on eliciting the patient experience rather than asking specific questions about patients' views of the role of incentives and local health and social care governance structures. We consulted the public involvement advisory group of one of the research partners (CRIPACC) to ensure that the topic guide was relevant and understandable to an older population, making some changes to the wording and sequence of the questions.

User interviews: Interviews were arranged at a date and time convenient to participants. For those in hospital the initial interview was conducted in a private area of the ward. For bed-based intermediate care, interviews took place in the participant's room. Otherwise the interviews took place in the patient's residence (either home, sheltered accommodation or nursing home). Interviews were undertaken by members of the research team and took around one hour each. Written informed consent was obtained prior to the initial interviews being undertaken. As many of the participants were frail and vulnerable, we paid attention during the interviews to non-verbal cues from patients such as signs of tiredness or anxiety. Consent was considered throughout the research process and viewed as an ongoing process throughout the study.

Staff interviews: Brief semi-structured interviews were also undertaken with a range of key staff involved in the care of the tracked patients at the identified points in their journey (snowballing out from the patient). Staff were identified from the patient experience. For example, in the hospital setting, members of the nursing, allied health professionals or medical staff were asked to participate. Within community settings, interviews were carried out with staff from intermediate or rehabilitation teams, for example. All staff approached in sites 1 and 3 agreed to participate, while in site 2, we approached 17 staff and 14 agreed to participate. These interviews were either face-to-face or by telephone, and were tape-recorded with the participant's consent. The numbers of interviews are displayed in Table 5.

Table 5 Number of 'Tracking Interviews by site'

Site	**Patient Interviews** **(6 patients per site recruited)**	**Carer Interviews**	**Frontline Staff Interviews**
3	18	5	14
5	16*	4	24
8	12**	5	14
Total	**46**	**14**	**52**

4.4 Data analyses

4.4.1 Content analysis of documents

A content analysis[102] of the collated documents was undertaken and key areas coded and compared. For example, the structures of the IFOP partnerships were unpicked, and work was carried out to place these into the four developed 'governance' categories. Other data were collated into specific tables to provide underpinning information around the implementation of interventions and their sustainability.

4.4.2 Questionnaire analyses

Given the relatively small sample size, descriptive analyses were carried out, using Stata 10.[103] Exact tests were used where necessary. Relationships between variables measuring multi-agency process were explored through exact logistic regressions,[103 104] clustering on sites. Although the conditional maximum likelihood estimator used to fit an exact logistic regression is intended for small samples,[105] these analyses must be considered exploratory. Analysis of the questionnaires mostly focused on the individual level as there were too few responses per site or per organisation to permit analysis at these levels. Unfortunately, this also precluded any future work to link the questionnaire responses to the site-level outcome data, such as bed-day use, admissions and lengths of stay.

4.4.3 Patient, carer and staff interviews

Tape-recorded interviews were transcribed and anonymised. The processes of identification of themes, developing categories, determining connections and refining categories were carried out in an inductive way following the constant comparative method of grounded theory[106]. This involved reading of field notes and listening to interviews in order to gain a 'general sense' of the data, followed by detailed coding. This process enabled themes to emerge inductively from the interviews.

These themes described the journey of the patients through the health and social care system and from secondary care to their home or care home setting, enabling the process to be described and understood from the patient's perspective. Coding was facilitated through the use of N6 and NVivo. The researcher at each site explored and coded the data for their site, and through discussion agreed a coding frame, which was then used across all three sites. Findings from each site were then brought together and compared for similarities and differences.

4.5 Ethics and research governance

Permission for all Phase 1 research activities (documentary analysis, questionnaire and telephone interviews) was granted by the Eastern MREC (later Cambridgeshire 4 MREC) at the end of July 2006. A substantial amendment was made to cover the developed questionnaire survey, with approval received in February 2007. Ethics approval for all activities of Phase 2 was granted by the same committee in October 2007. A further substantial amendment for permission to move the senior manager interviews into Phase 2 was approved in April 2008.

Significant delays were experienced in obtaining R&D (NHS) and research governance (local authority) permissions for Phase 1. We initiated applications prior to the completion of PCT reconfigurations, although ultimately the questionnaires were sent out after the start-up of the newly configured trusts in some sites. This necessitated a total of twenty-seven applications to NHS Research Management and Governance units and R&D departments to cover the primary, acute and mental health trusts, plus a further nine applications to local authority research departments. We did not obtain permissions for two acute trust R&D departments because of difficulties in getting any reply to emails or meaningful response to telephone calls. In one case, we obtained an initial response fully one year after our enquiry as to their R&D process. For the Phase 2 research activities (patient journeys, frontline staff and senior manager interviews in three sites), we sought R&D approval from the relevant PCTs as well as research governance approval from the relevant local authorities. We sought and gained R&D approval from an acute trust that had participated in the IFOP programme in each of sites 3 and 5. As described in section 4.2.4, in site 8, the acute trust's R&D approval was so delayed that the research team decided to limit recruitment to the community setting.

5 Site characteristics

To set the local context for the empirical part of the study it is helpful to describe the key characteristics of the local authorities and their NHS partners. We remove some *precise* details to preserve site anonymity.

5.1 Demographic characteristics

The local authorities involved in IFOP shared a number of common characteristics. In a number of respects, they were not typical of the national picture (Table 6). They tended to be above the median in their scores on the Index of Multiple Deprivation (i.e. they were not generally deprived areas); they tended to be rural; and most had relatively low proportions of 'non-white British residents' (with the exception of sites 3 and 8). Of the nine councils, seven had a Conservative majority at the outset of IFOP, one was controlled by Labour and the other by the Liberal Democrats.

5.2 Social care performance

Despite these differences from many other authorities, the proportion of personal social services (PSS) expenditure dedicated to older people (age 65 and over) was similar to the national average, ranging from 34% to 51% of all personal social services gross expenditure in 2006-07, compared to an average of 43% across England. Nonetheless, it is notable that there was a spread of approximately £1000 pounds in PSS expenditure per older person per annum between the lowest spending council (site 7) and the highest (site 3).

The authorities taking part in IFOP were also atypical in their performance (Table 7). In one respect, this was by design since one of the conditions for authorities to join the Innovation Forum was that they were deemed to be 'excellent' in the three-star CPA rating in 2004. By 2006, although the CPA had changed to a so-called 'harder test' with a maximum of four stars, six of the Innovation Forum councils had the highest rating and the remainder had the second highest. However, this corporate 'excellence' masked considerable variation in their adult services departments, as assessed by the former Commission for Social Care Inspection (CSCI). Only two councils had gained the highest three-star rating in 2006, six were awarded two stars, and one (site 7) was awarded one star. Moreover, it is striking that, in 2006/07, most of the nine had higher rates of delayed discharges from hospital compared to the median for England, and lower rates of intensive home care receipt among older people compared to the national median. Only three sites (3, 4 and 5) exceeded the national median for intensive home care as a proportion of the older people being supported by social services at home or in residential care. Yet most sites had neither high rates of residential care nor high rates of intensive home care receipt by their older populations, compared to other English councils.

5.3 NHS performance

Unlike their local authority counterparts, few of the PCTs within IFOP sites were rated as high-performing, as measured by the (former) Healthcare Commission's (HCC) Health Check (see Table 8); the exceptions were in sites 3 and 6. It should be noted that the HCC figures were released under the new PCT configurations, so there were only twelve rather than 25 PCTs at the time we conducted our study. It is interesting that the two better performing PCTs had not been subject to boundary reconfiguration.

Of all twelve PCTs post-reconfiguration, only one (in site 6) had achieved the long-term care target (which largely measures the implementation of case management, e.g. community matrons).[3] On the delayed transfers of care indicator, PCTs in four sites (1, 2, 4 and 5) did not achieve their target. On the other hand, all had met the emergency bed-day indicator (one component of the LTC target), in contrast to the more challenging IFOP target (see section 6), and all but two had achieved the 4-hour A&E wait target (sites 4 and 7 being the exceptions). The performance ratings of acute trusts in these sites (Table 9) were also highly varied and, although measuring differently managed services, it was notable that with HCC quality indicators for acute and primary care trusts suggested variations in the quality of different health services within PCT areas.

---

[3] Part of the New National Targets, the LTC target consisted of three indicators:

- Emergency bed days: reduce by 3% in 2006-7 (and 5% in 2008)
- Very high intensity users: Number of very high intensity users (VHIUs) under the case management of a Community Matron
- Community matrons and additional case managers: Number of staff in the community matron role providing case-management in primary and community settings for VHIU

Table 6 Local authority area profiles

Local Authority	Population size 2006[1]	%65+ 2006	% 75+ 2006	Ethnicity: percentage non-white British (total population), 2006	Quartiles of IMD 2004[2]	Rural/Urban Local Authority Classification[3]	Geographical region (North/ South)
1	>1 million	17%	8%	9%	Third Quartile	Significant Rural	South
2	>1 million	15%	8%	7%	Upper Quartile	Significant Rural	South
3	<0.5 million	11%	5%	51%	Lower Quartile	Predominantly Urban	South
4	1–0.5 million	20%	11%	9%	Upper Quartile	Significant Rural	South
5	1–0.5 million	17%	8%	6%	Upper Quartile	Significant Rural	North
6	<0.5 million	15%	6%	4%	Second Quartile	Predominantly Urban	North
7	0.5 million	20%	10%	5%	Second Quartile	Predominantly Rural	South
8	>1million	17%	8%	15%	Upper Quartile	Predominantly Urban	South
9	<0.5 million	24%	12%	6%	Upper Quartile	Predominantly Rural	South

1 Rounded to nearest 10,000

2 Lower quartile = at or below lower quartile

Second quartile = between lower quartile and median

Third quartile = between median and upper quartile

Upper quartile = at or above upper quartile

3 Three category classification, based on 2001 census population

Table 7 Performance: star ratings, delays and balance of community care

Local Authority	Star ratings		Delays	Balance of Care		
	Star rating CPA 2006	CSCI Star Ratings 2006	Delayed transfers of care (all delays, medically fit to discharge) per 100,000 2006/07– quartiles[1], England	AO/B11: Intensive home care as a percentage of intensive home and residential care 2006-7	C72: Admissions of supported residents aged 65 or over to residential/nursing care per 10,000 65+ quartile	C28: Households receiving Intensive home care per 1000 65+
1	4 star	3	Upper Quartile	Second Quartile	Lower Quartile	Lower Quartile
2	4 star	2	Upper Quartile	Second Quartile	Second Quartile	Lower Quartile
3	4 star	3	Median	Third Quartile	Median	Upper Quartile
4	4 star	2	Third Quartile	Third Quartile	Lower Quartile	Lower Quartile
5	4 star	2	Third Quartile	Third Quartile	Second Quartile	Second Quartile
6	4 star	2	Third Quartile	Second Quartile	Upper Quartile	Median
7	3 star	1	Upper Quartile	Lower Quartile	Lower Quartile	Lower Quartile
8	3 star	2	Upper Quartile	Second Quartile	Lower Quartile	Second Quartile
9	3 star	2	Median	Lower Quartile	Lower Quartile	Lower Quartile

[1] Lower quartile = at or below lower quartile

Second quartile = between lower quartile and median

Third quartile = between median and upper quartile

Upper quartile = at or above upper quartile

5.4 Market-like approaches

We also identified some indicators of the extent to which market-like approaches were present in the nine sites (Table 10). There were marked differences in the degree of contracting-out of home care services. Three sites (1, 3 and 8) were below the lower quartile for England in 2006/07 in the percentage of home care contracts that were in-house (one site reported no in-house contracts), while three others (5, 6 and 9) were above the upper quartile.

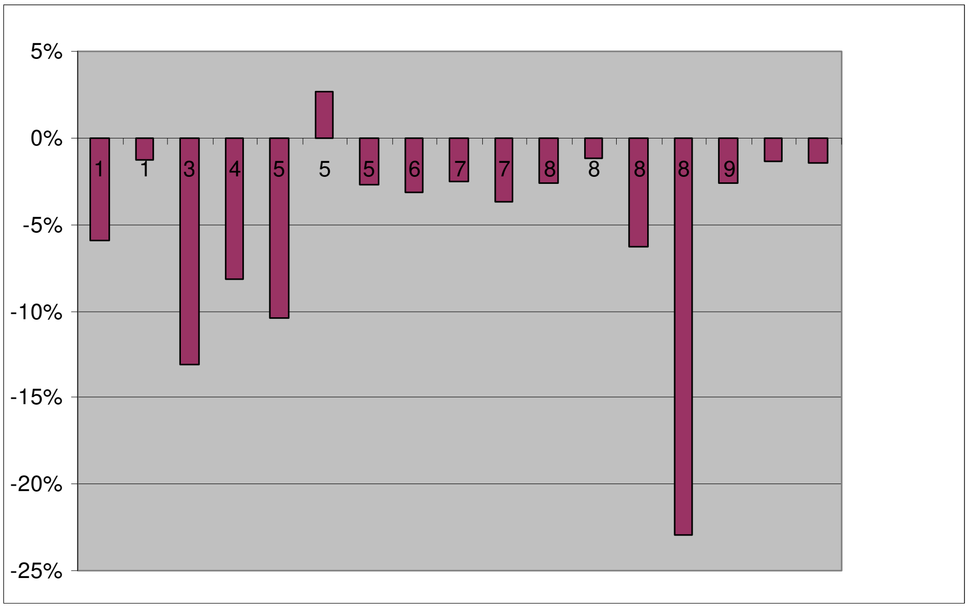
The use of direct payments can also be seen as an indicator of a market-like approach to care, requiring as it does the transfer of commissioning responsibility to individual users. In six sites, higher-than-median rates of older people receiving direct payments (per 100,000 population aged 65 years and over) were accompanied by lower-than-median rates of weekly spend on direct payments to those older people receiving them (one site's spend was the lowest for England). In contrast, site 3 had high rates of both receipt of direct payments by older people and weekly spend on them. Site 1 made little use of direct payments, being in the lower quartile in the rate of older people receiving them and the amount spent on each.

On the NHS side, only two sites had a foundation trust within their borders in early 2006, and only one had a foundation trust within the boundaries of a participating PCT. There were a few instances of such trusts being located near but not in the site (not reflected in the table).

5.5 Supply of hospital beds

Although an imperfect indicator, Figure 3 shows the average daily availability of acute and general beds per acute trust, within the borders of the IFOP PCTs. (There were no acute trusts located within the boundaries of the participating PCTs in site 2.) Along with national trends, almost all of the 17 acute trusts within the participating PCTs decreased the number of their acute and general beds between 2005 and 2007 by between 1% and 23% (an average of 5%), with the exception of site 5, where there was a 3% increase. It must be added that only a few trusts (in sites 3, 5 and 8) had reduced their beds by more than 10%. Although most trusts had decreased the numbers of acute beds, four of them (in sites 1, 5, 6 and 7) had increased the numbers of geriatric beds available. The decreases were in sites with very different levels of reductions in emergency bed days for older people as measured by the headline target (see Table 24). This is not to say that bed supply had no impact. In site 8, one of our in-depth case sites, we encountered instances of patients who had been moved rapidly into the community via an intermediate care team. Patients and carers attributed the rapidity of such moves to the pressure to free acute hospital beds, and senior manager interviews in the same site suggested that one acute trust in particular tended to declare a high state of bed capacity alerts quite frequently.

Figure 3 Percentage change in available general and acute beds within NHS trusts in IFOP PCTs between 2005/06 and 2006/07, by site [1] [2]



[1] Note that no acute hospitals were located within the PCTs participating in the IFOP in site 2

[2] Source of data: Bed availability and occupancy, NHS Organisations in England, for 2005-06 and 2006-07. Based on KH03 returns. Available at: http://www.performance.doh.gov.uk/hospitalactivity/data_requests/beds_open_overnight.htm

5.6 Partnership arrangements: the local context

In addition to the specific networks set up as part of the Innovation Forum in the nine sites (see Section 6), there were also a number of other local governance arrangements. These included partnership structures for managing health and social care services for older people, which could be part of the IFOP programme or independent of it. They also included local networks tasked with devising structures and processes to achieve the same aim. Lastly, they included joint commissioning and funding structures in each site.

Our documentary analysis (described in Section 4) generated more information about the partnership structures than their processes, power relationships, or how ‘central’ the local IFOP was within local decision-making.[107] Some patterns did emerge, however, such as variation in the complexity of partnership arrangements; some movement over time in the relevant partnership structures in all sites; and variation in relationships between health and social care partnerships and the LSPs. Some sites showed a high level of integration between their health and social care planning structures and LSP arrangements. In contrast, others – at least according to their documentation – appeared to spread strategic responsibilities across several structures.

Table 8 PCT performance

		Primary Care Trust		**Target achievement[1]: Delayed transfers of care 2006-7**	**LTC target[2] 2006-7**
		Healthcare Commission Annual Health Check[1]	Healthcare Commission Annual Health Check[1]:		
Local Authority	**PCT (New)**	Use of resources score 2006	Quality of services score 2006		
1	PCT A	Weak	Fair	Underachieved	Failed
1	PCT B	Fair	Weak	Underachieved	Failed
2	Single PCT	Fair	Fair	Underachieved	Failed
3	Single PCT	Good	Fair	Achieved	Under achieved
4	Single PCT	Weak	Fair	Underachieved	Failed
5	PCT A	Fair	Fair	Failed	Failed
5	PCT B	Fair	Weak	Achieved	Failed
6	Single PCT	Excellent	Fair	Achieved	Achieved
7	Single PCT	Fair	Fair	Achieved	Under achieved
8	PCT A	Weak	Weak	Achieved	Failed
8	PCT B	Weak	Weak	Achieved	Failed
9	Single PCT	Fair	Fair	Achieved	Failed

1 Source: Healthcare Commission, New national targets 2006/2007

2 LTC target consists of 3 Long term conditions indicators: 4219 (Emergency bed days), 4220 (Community matrons and additional case managers) and 4221 (Very high intensity users)

Table 9 Acute trusts within PCTs participating in the Innovation Forum: performance

Site	**PCT (new configuration)**	**Healthcare Commission Annual Health Check**†	**Healthcare Commission Annual Health Check**†
		Use of resources score 2006	Quality of services score 2006
1	PCT A	Weak	Weak
1	PCT B	Weak	Fair
2	Single PCT	(1) Good (2) Fair	(1) Good (2) Good
3	Single PCT	Good	Good
4	Single PCT	Weak	Good
5	PCT A	(A1)Excellent (AB1)Weak	(A1) Fair (AB1) Fair
5	PCT B	(AB1)Weak (B3) Good	(AB1) Fair (B3) Good
6	Single PCT	Good	Fair
7	Single PCT	(1) Good (2) Weak	(1) Fair (2) Weak
8	PCT A	Good	Weak
8	PCT B	(B1) good (B2) fair (B3) Weak	(B1) Fair (B2) Weak (B3) Weak
9	Single PCT	(1) Fair (2) good (3) good	(1) good (2) excellent (3) good

Table 10 Indicators of market-like approaches

Local Authority	DIS3326: Use of Block, Spot or "In house" Contracts – Adults in Domiciliary Care: Percentage In-house, 2006 quartiles[1], England	PAF C51.17: Number of OP receiving Direct Payment per 100,000 65+ 2006-7	Average gross weekly expenditure on direct payments per older person receiving direct payments at 31 March 2007 Quartiles	Number of Acute foundation trusts within LA area (within PCTs participating in IF) at 4/2006
1	Lower Quartile	Lower Quartile	Lower Quartile	0 (0)
2	Second Quartile	Second Quartile	Upper Quartile	0 (0)
3	Lower Quartile	Upper Quartile	Upper Quartile	0 (0)
4	Second Quartile	Lower Quartile	Upper Quartile	1 (0)
5	Upper Quartile	Lower Quartile	Third Quartile	1 (1)
6	Upper Quartile	Lower Quartile	Upper Quartile	0 (0)
7	Third Quartile	Upper Quartile	Lower Quartile	0 (0)
8	Lower Quartile	Upper Quartile	Second Quartile	0 (0)
9	Upper Quartile	Lower Quartile	Second Quartile	0 (0)

[1] Lower quartile = at or below lower quartile

Second quartile = between lower quartile and median

Third quartile = between median and upper quartile

Upper quartile = at or above upper quartile

5.7 Types of social partnerships

The IFOP programme brief proposed that new services should be planned by a group of partners forming a horizontal network (see Section 3). These networks were to be established within what could be quite a crowded field of existing related networks. From documents collected in our research, we identified 187 partnerships across the nine sites. In some cases, it was difficult to determine whether or to what extent these were focused on older people; for instance, some were learning disability partnership boards which could address the needs of people aged over 65, but did not appear to be *primarily* concerned with older people. Similarly, the extent of focus of Supporting People partnerships on older people was difficult to gauge, appearing to vary from site to site. Early analysis suggested that most of the partnerships identified were initiated in response to statutory guidance.

Building on the classifications of Seddon et al[108] of social partnerships, and later modifications to their classification by Billett et al,[109] a number of partnership arrangements were identified, with relatively little variation across sites. These included *community partnerships* (e.g. older people's forums or carers' forums), *negotiated partnerships* (groups implementing strategies for intermediate care redesign, joint commissioning boards for older people's services and older people's Partnership Boards), *directed social partnerships* (e.g. groups involved in Local Strategic Partnerships, Local Area Agreement thematic block, or Supporting People governance) and *enacted social partnerships* (e.g. partnerships involved in the governance of the Innovation Forum or of Invest to Save funded projects or Integrated Service Improvement Plan boards). (We discuss social partnerships and the broader categorisation of governance types in Section 6 below.)

We display these partnerships by type and site in Table 11. Most (87) were of the 'directed' type. For example, each site had a local strategic partnership, as expected by central government. Not all sites had a local area agreement in 2005 but all did by 2007, as these had been imposed by guidance although not (yet) imposed by law. About half as many (46) were classed as 'enacted' and we found 39 community partnerships (39). We found very few 'negotiated' partnerships, and even these could also be seen as having been formed in reaction to government policy, albeit in a less focused way than the directed or enacted partnerships. Some older people's forums appear to have been initiated by councils, in response to central government expectations or requirements of local involvement, with councils for instance seeking volunteers to join the group, and offering to facilitate and support their work. In contrast, some of these forums appeared to be more independent, sustaining their activities through subscriptions and fundraisers, and acting as pressure groups to defend or advocate increasing local services.

Although each partnership was assigned to one category, which masks the fact that in some cases different types of groups are related by risk-monitoring and reporting arrangements. For instance, an 'enacted' IFOP group might be 'overseen' or 'linked' to a 'directed' LSP/LAA thematic block group. Such linkages could place partnerships within more than one governance structure. Certainly, lines of responsibility and accountability could appear to be somewhat blurred when seen through the lens of a desk-based enquiry. It is therefore important to be cautious in interpretation of the data. However, it is clear that the majority of partnerships identified were organised in response to central government statute, guidance, or time-limited 'pilot' funding calls. This finding does suggest that local programme networks may face considerable constraints on their ability to innovate in local service planning structures in accordance with purely local circumstances.

Table 11 Partnership arrangements related wholly or partly to the local planning and delivery of older people's services (2005-2007), by site

Partnership types	**Total**	**Numbers of partnerships (%) by site**								
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Civic partnership	39 (21)	3 (13)	13 (59)	2 (14)	3 (11)	1 (8)	1 (5)	3 (13)	1 (8)	12 (39)
Negotiated partnership	15 (8)	4 (17)	0 (0)	1 (7)	1 (4)	4 (31)	3 (14)	1 (4)	0 (0)	1 (3)
Directed social partnership	87 (46)	10 (42)	7 (32)	10 (71)	11 (41)	6 (46)	5 (24)	15 (63)	10 (83)	13 (42)
Enacted social partnership	47 (25)	7 (29)	2 (9)	1 (7)	12 (44)	2 (15)	12 (57)	5 (21)	1 (8)	5 (16)
Total	**188 (100)**	**24 (100)**	**22 (100)**	**14 (100)**	**27 (100)**	**13 (100)**	**21 (100)**	**24 (100)**	**12 (100)**	**31 (100)**

5.8 Local strategic partnerships and Local Area Agreements

At a national level, LAAs and LSPs became more central to partnership working at a strategic level between 2005 and 2007, moving onto a statutory footing in the new LAAs in 2008. One third of the IFOP sites had taken part in the first wave of LAA pilots of 2005; four were also 'single pot' LAA pilots, where central monies were not ring-fenced by thematic block. All sites had partnership arrangements relating to the LAA in place by 2007.

The Local Strategic Partnership governance structures in most of the sites were complex. Some sites had up to five layers of management (sites 1, 2, 8), the rest had four (4, 7, 9) or three (3, 5, 6). In many sites, there were subgroups tasked with delivering the LAA outcomes or sub-outcomes. Not surprisingly, the number of layers of management and the number of steering or working subgroups increased with the number of smaller organisational units (district councils, PCTs) within the sites. All sites had some form of thematic block group related to population health, wellbeing and older people's services – often labelled as *Healthy Communities and*

Older People (HCOP). There was a trend over the period from 2005 to 2007 to develop such subgroups, and to divide the tasks between public health-related outcomes and older people-specific outcomes (site 8, 3 and 9), or to subdivide groups into 'reference' and 'business' or 'delivery' groups (sites 2 and 5). However site 9's LAA took a different approach, extending public involvement in the planning and delivery of the initiatives associated with the thematic block. The partnership monitoring the HCOP thematic block outcomes was said to be seeking to widen its membership, while a separate community involvement partnership was formed to further older people's involvement in planning and commissioning, and to align with the district councils. As will be discussed in the next sections, there could be considerable overlap and interaction, or even apparent competition, between LAA networks and IFOP networks.

Although there were many similarities across the sites' LAAs, there were certainly differences of focus in relation to outcomes specific to older people. Some LAAs (in sites 1 to 4) did not have any 'outcomes' related to older people, although they all had indicators or targets. This might be seen as an indication of a corporate focus, although site 2 had a strong focus via their LAA initiative for older people, in spite of having no 'outcome' for older people in their agreement. If the *number* of outcomes was seen as an indication that older people featured within the top local priorities, then sites 5 to 9 seemed to have greater focus on older people, as judged by their LAA. Within the HCOP thematic blocks, there were again differences of focus between councils. For instance, an agreement in site 3 had 'stretch targets' for the measurement of wellbeing and quality of life of the 'younger' old; and site 8 had an extremely strong focus on the development of a model of intermediate care. The role of Supporting People (SP) and its integration into the LAA was variable, so that some sites (e.g. site 1) pooled the SP grant, whereas in site 4, for example, the grant was only aligned with the LAA.

5.9 Other partnership arrangements, joint posts and joint commissioning

The IFOP programme brief envisaged that partners in each site would work together through the creation of a 'single point of commissioning'. We looked at the data on joint commissioning and on joint appointments to understand both structures in place and the processes and national contextual factors affecting joint commissioning and joint planning. From the documentary analysis we had identified a number of related partnership structures, including joint commissioning boards (which can be seen as networks), joint commissioning teams (including joint commissioners for older people and other related senior joint appointments (which can be seen as hybrid hierarchies) and pooled funding arrangements.

In addition to the LSP structures, most sites had multiple other partnership or commissioning boards/committees in place, usually covering mental health (sites 3, 4, 5, 6, 7, 8), learning disability (all sites), and drug and alcohol teams (DAAT) (sites 1, 3, 8). These were often in charge of directing joint commissioning teams based in the statutory agencies. Some of these groups also fed into the LAA outcomes and fed back to the LSP boards via explicit reporting links, for instance through PCT or local authority senior managers who were LSP board representatives. In certain sites these partnership boards were particularly numerous or had numerous subgroups. For instance:

- Site 4 had a board supervising learning disabilities, mental health, community equipment, and older people’s services. This board changed to a commissioning board later in 2007 after the end of the IFOP, and an adults’ trust board was also added. There was a joint commissioning team for learning disabilities and DAAT.
- Site 6 had a joint commissioning team (across the PCT and LA) for learning disabilities, older people, physical and sensory disabilities, mental health, young people; a commissioning agency to oversee these services was planned but not implemented in 2007.
- Site 8 had a commissioning board covering mental health services for older people, learning disabilities, DAAT, and some children’s services. This board was responsible for overseeing a joint commissioning team for the same services. However, neither the commissioning board nor the team covered non-mental health older people’s services.
- Site 3 had a joint commissioning committee overseeing a joint commissioning team for learning disabilities, DAAT, and mental health services. The commissioning committee and team’s remit were expanded later in 2007 to include older people’s services, but after the IFOP programme period.
- Sites 1 and 9 had joint commissioning teams for mental health.
- Site 7 had plans for a commissioning unit for learning disabilities and for older people with dementia and Site 9 had plans for a joint commissioning board, but neither were implemented within the IFOP period (or within 2007).

In terms of joint senior managerial posts, site 6 had a joint assistant director for older people across the council and PCT. Both sites 3 and 5 had directors of joint commissioning, across part of the local authority and one of two PCTs in site 5, and across the local authority and PCT in site 3. Both sites were later to establish joint commissioner posts for older people’s services after the end of IFOP in 2007.

Finally, ambitions to integrate commissioning across health and social care were expressed within some LAAs, particularly in sites 5, 6, 8 and 9:

- Site 8’s partners expressed a wish to employ their agreement as a means to develop integrated commissioning.
- Site 9’s thematic partnership group was said in contemporary plans to aspire to develop joint commissioning and joint service delivery.

- Sites 5 and 6 emphasised the establishment of a single point of commissioning within their LAAs; for instance, site 6 noted that their partners had 'committed themselves' to establishing this.

The degree to which adult services had been integrated with the local NHS varied quite considerably between sites, as measured by the development of partnership boards, joint commissioning boards, and joint commissioning teams across sites:

- Sites 1 and 9 had fewer board and joint commissioning arrangements in place.
- Sites 8 and 4 had large-scale partnership or commissioning boards.
- Sites 3 and 5 put structures in place during the IFOP for establishing joint commissioners for older people later on, whereas such joint posts were more difficult to set up in, or were not an ambition for, others, such as sites 8 and 9.

Finally, the extent to which partnership arrangements were underpinned by section 31 (later Section 75) agreements aimed to pool budgets, establish lead commissioning or provide integrated provision also varied. It was certainly simpler to align rather than pool funds. However, most sites had some section 31 agreements (under the *Health Act 1999*) and later S75 agreements (under the *NHS Act 2006*). There were pooled budgets in all sites between local authorities and PCTs for integrated equipment services.

- Sites 1, 6 and 7 had S31 agreements for intermediate care services, sometimes in the form of a private finance initiative (site 1).
- Site 6 was unusual in having a pooled budget between the council, strategic health authority (SHA) and local acute trust for these services.
- Site 8 also had pooled funds between local acute trusts, the council and PCTs to reduce levels of delayed transfers of care.
- Site 3 had Section 31 agreements between the PCT and council for long-term care of older people.
- In site 2, the council, all PCTs and the SHA pooled funds to purchase additional nursing beds.
- Sites 4, 5 and 9 pooled funds for learning difficulties; in sites 4 and 9, the council acted as lead commissioner as well.

It emerged from this analysis that, overall, sites were either moving – or aspiring to move – towards an increasingly 'joined-up' approach to commissioning. LSPs moved towards more elaborate management structures for public health and older people's services, separating the 'delivery' partnerships from their more general strategic partnership forums, which had much larger memberships and were less suited to implementing specific work-streams. In order to deliver on both cross-sectoral and organisational plans, health and social care partners looked at progressively more joint planning, and, more crucially, joint means of purchasing and contracting for services. However, these trends were most apparent at the end of, or after, the IFOP period. The push towards purchaser-provider splits in community health care, advocated in *Our Health Our Care Our Say* in 2006, not surprisingly took shape after the reconfiguration of PCTs was complete in April 2007. The 'world class commissioning' agenda[110] and the 'transforming community services' agenda,[111-113] would take the purchaser-provider division much further, ultimately necessitating new governance structures across health and social care economies.

6 Governance structures

6.1 Introduction

Our aims of identifying the governance arrangements that are effective in reducing utilisation of unplanned bed days by older people (while ensuring quality and equity) and of exploring professionals' experiences of different governance models requires an account of the structures present in the IFOP sites, and of the extent to which these structures produced or constrained the adoption and implementation of the interventions ('projects', 'mechanisms') that the study sites used in their attempt to reduce hospital bed-day use by older people. We first set out in section 6.2 what we understand by the governance structure of a 'partnership' and its points of similarity and difference with the governance of networks more generally. Sections 6.3 and 6.4 then report and compare what governance structures were found in the different study sites. In section 6.5 we consider how, given the local health economy context, these governance structures influenced the sites' adoption of intervention projects intended to reduce unplanned hospital bed-day use by older people.

6.2 Governance through networks and partnerships

Wherever the state does not directly control areas of social life, policy makers face the questions of how far they wish to govern these activities and through what means. In many developed capitalist societies, including Britain, policy makers have since 1991 increasingly attempted to dismantle direct state control over large parts of the provision of health and social care, with the 'hollowing-out' of the state leading to 'governing without government'.[16] The move from 'old government' to 'new governance' has been discussed at great length in the literature[16 35 51 114 115] but in brief the three main governance structures available in modern capitalist societies are usually held to be markets, hierarchies and networks.[116] Leaving aside that these three categories do not exhaust the list of possible governance structures, there are two important empirical qualifications to that simple trichotomy.

Within the public sector, sub-sectors such as health care, social care and education are hybrid structures.[117] In each of them, hierarchies, networks and markets coexist and interact in different combinations and patterns. Concomitantly, the governance of a network such as those that implemented IFOP policies may include 'potential disjunctures between different models of governance' detected through the identification of where the power and authority lies in any activity or decision making. Whilst markets, networks and hierarchies may be analytically distinct, they co-exist in the day-to-day world of public policy implementation, producing hybrid governance structures.

Furthermore, in the English public sector, attenuated forms of these governance structures are mainly found. Exworthy et al.[118] coined the terms 'quasi-hierarchy' and 'quasi-network' to supplement the established term 'quasi-market'. Exworthy and colleagues focused on arguing that the NHS always combined network, hierarchy and market structures. Even when hierarchical governance was most pervasive, the NHS could never be described as, say, a pure hierarchy, but only as a 'quasi-hierarchy' (and analogously when health policy became more market-oriented and more network-oriented). We add that specific structural characteristics differentiate markets, networks and hierarchies in the English public sector from the pure 'ideal' types:

- In quasi-markets, the state replaces the individual service user as purchaser of services. Optionally, public bodies use their market power to determine what kinds of services are provided (a 'planned market' in the terminology of Saltman and von Otter[119]). Another policy option is for a professional agent to represent the service user as proxy purchaser (as in some instances of direct payments for social care and practice-based commissioning).
- In quasi-hierarchies, instead of a unified line-management structure, there exists a system in which a set of regulatory bodies, themselves to greater or lesser extent at arms-length from the state, and other arrangements (e.g. one public body appoints the managers of another) hold other public bodies (e.g. 'public firms' such as NHS Trusts) accountable to central government.[120]
- Quasi-networks consist of networks, firstly, of organisations as much as of individuals. Optionally, a central body may be established (or an existing network member be chosen) to coordinate and exercise governance over the network as a whole. Policy makers also have the option to mandate existing (or create new) networks to act as implementation structures for central policies.[121] Networks with both these characteristics are sometimes described as 'top-down' networks, even as 'hierarchic'.[122] Both 'pure' and 'quasi-networks' often have over-lapping membership (links) with other external networks. Internally, they often have sub-networks, including implementation groups that specialise in coordinating or carrying out a specific part of the network's activity.

Within each of these three categories, further sub-categories of variants are found.

Two ways of categorising the sub-variants of networks and quasi-networks are relevant to the present study. One way is according to the network's origins. Modifying the classification developed by Seddon et al.,[108] Billett et al.[109] differentiate 'social partnerships' according to how they originate, distinguishing:

1. *Negotiated partnerships* are formed between organisations to secure a service, and requiring negotiation between various interests and agendas.

2. *Community partnerships* are localised networks based in combination of local community groups, providers and local authority. Bottom-up, they may be regionally focused or centre on particular issues

3. *Enacted social partnerships* are constructed by sponsors external to the community to realise particular goals through direct or indirect funding.

A subset of enacted partnerships, *directed social partnerships* are established and sponsored by government to achieve specific policy goals by bringing community, industry and providers together and shaping their activity in relatively direct ways.

Hence, as Leach[16 (p 31)], summarising Taylor[123 (p 51)], have argued, networks do not emerge 'fully formed', and governments may 'dominate networks by determining their operational parameters and objectives, imposing their own value preferences through control of financial resources, legislative powers and political legitimacy (Taylor, 2000)'.

A network's origins determine its objectives and hence what function it serves (what it attempts to contribute to its health and social care economy). Among other functions, Southon et al.[124] therefore distinguish:

- *referral networks*, which are provider-side networks directly making and coordinating existing systems of referrals of (in the present case) older people so as to avoid unnecessary unplanned hospitalisation;
- *programme networks*, focusing on introducing a specific model of clinical care, of care organisation (such as a single point of access to complex services, or case management) or of inter-organisational patient flows so as (in the present case) to reduce such hospitalisations;
- *project networks*, which make single but large infrastructural changes such as installing new management information systems or a major capital scheme.

The study networks ('partnerships') in IFOP sites were hybrid governance structures. They contained quasi-market (contractual and commissioning) elements and quasi-hierarchical elements (some member-organisations were accountable to others), but the fundamental form of governance structure was partnership. Although some, such as Lowndes and Skelcher,[125] might disagree, we understand these partnerships as essentially networks of (mainly) organisations collaborating in the attempt to reduce unplanned hospital admissions for older people. Policy-makers' metaphors of partnership suggest a broad equality of contribution (inputs), power, responsibility and benefit; a putatively different model to the 'centred' networks found in, say, the US health system[126] and commercial 'alliances'.[127] We therefore conceptualise partnerships of the kinds promoted by New Labour as a specific type of network, one in which a range of mutually interdependent organisations (mainly public sector) collaborate on more-or-less equal terms.

While in some cases (see below) they incorporated pre-existing networks, the IFOP partnerships were what Billett et al.[109] would classify as enacted rather than negotiated or community partnerships. The complex of policies described earlier (Section 3) gave the study networks a combination of functions: those of programme networks (service redesign, joint commissioning), of project networks (undertaking capital projects) and of referral networks (coordinating existing inter-organisational service provision). In this case a 20% reduction in bed days is an activity demanding a 'whole-systems' focus. Nevertheless each member-organisation in these networks had different central government targets and thus priorities, with the implication that any local, inter-organisationally negotiated objective or target might become subordinated to other objects or simply not pursued. Consequently, the study networks required governance arrangements, including incentives that aligned these diverse organisations' discrepant objectives and activities towards the common end of reducing unplanned hospitalisation of older people.

Policy makers who wish to maintain, or extend, the 'hollowed-out' character of the state therefore face the problem of deciding which variants and combination of quasi-hierarchies, quasi-markets and quasi-networks to institute and use as governance structures in pursuit of a specific policy such as that of reducing unplanned in-patient bed use by older people. Jessop[19] uses the term 'meta governance' to describe the task of promoting coordination to achieve greater efficiency and accountability across different governing structures. Literature reviews conducted for the SDO programme suggest that a 'contingency' approach to this problem should be adopted.[128] [129]. It is probably futile to seek to identify 'the one best way' of shaping and combining governance structures and processes for the care of older people at risk of hospital admission. Rather the problem is to discover, in relation to this common policy objective, which governance arrangements appear better adapted to which local circumstances and why.

A 'model' of governance thus comprises a specific combination of governance structures, an activity over which governance is exercised, and the actors (both organisations and individuals) who jointly undertake that activity. Depending on circumstances, the governance model may also include a designated body which exercises that governance and a specific set of incentives. Each Innovation Forum partnership represents a specific model of governance. Indeed, the 'innovation' in question in each is, in part, an innovation in governance besides an innovation in models of service delivery. That is, it sets up inter-organisational structures (a network structure) by which the network members jointly coordinate and manage hospital referrals for older people (network 'core process'), including measures to reduce unnecessary referrals.

To achieve such ends, a network requires a membership (who supply the resources needed as inputs to the network's activity) and a structure through which the members can decide what they will collectively do and how. The IFOP networks also required structures for user involvement because that was a current policy priority. A network also needs a structure for carrying out (implementing) the agreed activities. By 'structure' is meant a set of stable links between members. What these links transmit is outlined below. We next report what membership and governance structures the IFOP networks assembled.

6.3 Governance structures found in IFOP sites

6.3.1 Membership

Representatives of the network's member-organisations constituted the raw material of an IFOP network's governance structure. The core membership was stipulated by IF decisions and policy (see sections 3.2.1 and 3.5) and comprised statutory bodies: local government, PCTs and NHS trusts. A few of the study networks included representation from third sector organisations, though very much in a minority. Only one network involved a commercial firm, and that as a sub-contractor rather than as a network member contributing to strategic decisions. Network 2 had four general practices (group practices) as members.[4]

These members entered the networks with unequal power, reflecting the member-organisations' sizes, resources and fragmentation, and not all member-organisations were equally willing or able to engage in network activity. Some examples can be given:

- In network 3, the local authority found it harder to engage with the NHS Trust than with the PCT, but the latter had leverage over the former through joint appointments and commissioning arrangements. Member-organisations in the network anticipated that large-scale transfers of budgets or resources to the network would internally be seen as too great a concession. Though the local authority and PCT had plans for establishing a joint commissioner for older people in 2005, it was 2007 before these plans came to fruition.
- The governance structures in network 5 were dominated by NHS bodies and interests, especially the Professional Executive Committee (PEC) and the local NHS trust.
- In contrast, in network 7 the core group and the organisations it represented dominated network activity, and the council appeared the most influential (indeed it appeared to exercise some influence over the PCTs).
- In network 1 the council exercised more power than the relatively small, fragmented PCTs that were participating in the network.
- In network 8 the PCTs were the most active member-organisations, dominating the networks because of their preponderant practical contribution to the work of the network.
- The PCTs were also most powerful in network 9.

---

[4] From now on, when we use the term 'network 1' we are referring to the IFOP network in site 1, etc.

- Site 2 (which consisted of projects in a small number of GP practices) initially had a small project management team based in the local authority, with no senior-level management forum across the authority or PCTs.

In all the study networks, PCTs appeared to have only limited influence on the acute trusts.

We outline the number and types of partners involved in the IFOP initiatives in Table 12. The composition of the IFOP partnerships: some sites (e.g. 4, 5, 9) had rather large and, in terms of the range of participants, inclusive forums, reaching beyond health and social services into other local and regional agencies from the public and third sectors. In other sites, IFOP management arrangements were focused on a core of senior health and social services representatives (e.g. sites 3 and 7), with information cascaded to other relevant groups.

It is also worth noticing what membership was not included in the IFOP networks. Apart from network 4, general practices were not involved. Only sites 4, 8 and 9 had third sector (voluntary organisation) representation. No large corporate providers, or smaller local private providers, were involved.

Networks whose remit and tasks were related to those of the IFOP networks existed in the study sites as described in section 5.7. In sites 1, 3, 7 and 8, however, these related networks appeared substantially to duplicate part or all of the remit of the IFOP network.

Governance of each IFOP network involved three main structures:

- A decision-making structure, through which the networks' member-organisations decided what actions the network would undertake, in particular what projects it would adopt with the aim of reducing unplanned use of hospital bed days by older people.
- A structure for feeding users' experiences into network decision-making, since this was an important policy aim at the time of the study and an important part of the rationale for organising the IFOP programme through local government.
- Structures for implementing IFOP decisions, above all through structures linking the decision-making body to front-line clinical and social care staff.

The following sections report in turn the structures found in the study sites for these three purposes.

Table 12 IFOP: member-organisations of the networks 2004–2007

Site	NHS organisations					Voluntary organisations (number)	Others (number)
	PCT partners (number) at start of pilot (2004)	PCT partners (number) following reorganisation (2006)	Secondary care trusts (number)	Mental health trusts	Ambulance trusts (number)		
1	3	2	2	1	1		
2	4	1					
3	1	1	1				
4	1	1	1	1	1	3	District Councils (2) Strategic Health Authority PBC Cluster Partners (1)
5	3	2	3	1			District Councils (6) Police and Fire Authorities
6	1	1	1	1			Leisure services
7	3	1					
8	5	2	2	1	1	1	District Council
9	3	1	3			6	District Councils

6.3.2 Decision-making structures

For making strategic decisions, each of the networks created a steering group consisting of the chief executives, or their nominees, from the main member-organisations. These were invariably the statutory organisations. Some examples can be given:

- Site 7 arrived at an essentially similar structure by making the pre-existing Chief Executives' Core Group become (also) the core group of the IFOP project.
- In site 1 the IFOP project consisted in effect of two largely separate networks linked by a project lead and an executive steering group meeting once a year, but each with its separate steering group (and in PCT1 also a 'core group') who nominated projects.
- In site 8, there was one IFOP steering group, representatives from the council adult services department, multiple PCTs, a district council and a voluntary organisation, with a project manager jointly appointed between the council and the PCTs. Groups other than the IFOP were named as having established the LAA targets.
- In site 6, in contrast, there was an executive team of very senior managers from the (one) PCT and council.
- Site 2 initially had a small project management team based in the local authority, with no senior-level management forum across the authority or PCTs. These arrangements changed with the introduction of the LAA, discussed below, when the (extended and reconfigured) projects came to be overseen by the LAA executive board.
- Sites 2, 5, 8 and 9 used the LAA as a key document and the associated thematic groups as an advisory planning forum for their older people's services from the inception of the LAA.

Table 13 shows the designated strategic decision-making body for each network.

Table 13 IFOP programme strategic decision-making bodies

Site	2005	2006	2007
1	Innovation Forum Executive Steering Group (until 04/2007)		
2	Innovation Forum project management team (until 04/2006)	LAA Executive	
3	Innovation Forum steering group (until 04/2007)		
4	Innovation Forum Steering group (until 04/2007)		
5	Innovation Forum Services to Older People Group		
6	Innovation Forum Executive group (until 4/2007)		
7	Chief Executives' Core Group (until 04/2007)		
8	Innovation Forum Steering group (until 4/2007)		
9	Innovation Forum Leads Group (until 04/2007)		

Although all the partnerships had a designated coordinating body, two main variants were apparent. Either coordination of the network was allocated to an existing managerial group or body (sites 1, 7, 9) or a dedicated managing group was created (elsewhere).

Although the overall structures of decision-making bodies were similar across the networks, decision-making practices within these structures were not. In site 2 there was little tradition of previous collaboration between the four PCTs and the local authority. Although the meetings were reported to be consensual, they were supportive information-sharing events rather than meetings for planning joint activities. Its coordinating group was formed mainly of those delivering the projects and the council's project management team, and the network was managed from the local authority Chief Executive's office. The fragmented, diverse membership of the network, and tensions between organisations limited the scope for setting up an integrated governance structure. In networks 1 and 3, a collegial, informal network of senior strategic and operational NHST, PCT and council managers oversaw the network, but only met on a formal basis annually.

Four characteristics of the IFOP networks appeared to determine how far the steering groups were able to take meaningful strategic decisions about the coordination of services for older people. One was the extent to which top-level, or at least senior, managers were regular participants. Where less senior managers were delegated to attend instead (networks 4 and 5) they were not always sufficiently confident (or indeed authorised) to commit their superiors or their organisation's resources to implementing steering group decisions. This was especially so when the member-organisations were struggling to deal with budget deficits, and the network lacked members with commissioning roles or powers. These less senior managers were also the 'boundary-spanners' who transmitted network decisions and links into the rest of their member-organisations.[130] [131]

In network 8 too, although the steering group had a wide membership, met frequently and its meetings were positive and friendly, at the same time it had relatively little influence over the objectives or set-up of the projects, and so little influence over project outcomes. Here too the people who came to the steering groups had to check back with their organisation before making decisions, except for the local authority representative who was senior enough to take decisions, including financial ones. Where the main member-organisations were conservative in delegating funds or decisions to the network, the network steering group was not able to gather much power or resources or to become an effective and empowered decision-making body. In particular, these steering groups were unable to reach decisions about 'whole-budget' (cross-organisational) release and reallocation of funds. Instead these steering groups acted as information exchanges and, in network 4, paid more attention to operational than strategic issues.

6.3.3 Structures for user involvement

According to policy-makers the purpose of the structures for user involvement was to make the IFOP partnerships aware of users' and carers' priorities and preferences for the development and management of services, so that decisions about service development will be influenced by them. Structures for user involvement varied across the networks.

At one end of the spectrum were networks which used multiple methods for finding out user opinions of the services (see table 10). In network 3 users were represented through membership on steering groups (e.g. for case management), consultation events (for some projects), user groups for specific services (e.g. for people with diabetes, nursing home residents) and surveys. In the middle of the spectrum was network 7, where IFOP projects were not chosen by users, although user satisfaction surveys and other methods of user involvement occured post-facto in several projects. Paradoxically, the relatively constrained role of the steering group in network 4 left space for user involvement 'cafes' to develop later on in the study period. Most of the networks were, however, nearer the end of the spectrum with few structures for systematic user involvement. For most of the study period, there was little user involvement in networks, although later there was some user involvement in the design of one project (preventive care provision for nursing homes) and in POPP. User involvement was also patchy and unsystematic in network 8, which did not have its own user-involvement structures but instead used feedback from existing structures outside the network (PPI forums, PALS). Site 9's LAA centred on extending public involvement in the planning and delivery of the initiatives associated with the thematic block. A separate community involvement partnership was formed to further older people's involvement in planning and commissioning, and to align with the district councils.

Table 14 Methods for ascertaining user views

Site	User representation
1	Evaluations including user perspectives; consultations
2	User satisfaction surveys.
3	User consultation events
4	User consultation events
5	User group, PPI forum
6	User consultation events; user group
7	None
8	User consultation events, representation via Age Concern representative
9	Representative in IFOP meetings

Notwithstanding the differences in structures for user involvement, each of the networks was predominantly reliant on 'voice' mechanisms – forums, networks and group and similar meetings. None used any choice-based ('exit-based') mechanisms, despite moves towards client-based commissioning in both the NHS ('patient choice' and Payment by Results policies) and in social care (individual budgets, direct payments) during the study period. These 'voice' mechanisms were usually arranged through local government rather than NHS structures. A recurrent problem with using consultation about pilot projects was inevitably tight timescales, particularly where the users involved were elderly and frail. In general the study networks were about half way up Arnstein's[132] 'ladder of participation'. Their structures for user involvement were not controlling or manipulative of users, but equally the predominantly 'consult and survey' approach fell short of user control of the networks, or even of users negotiating with the network steering groups from a position of approximately equal power or representation.

6.3.4 Structures for implementation

Having decided which projects to adopt, which user preferences to act upon and which other activities to undertake, the networks' leading bodies then faced the task of implementing these decisions. This was to be achieved mainly through the front-line staff working for their member organisations. These implementation mechanisms differed considerably in character and extent across sites.

- Starting with the more elaborate structures for implementing steering group decisions, network 1 had dedicated implementation teams, but one team per member PCT, not one team for the whole network. In one of its member-PCTs, the implementation team role was fulfilled by a sub-group of a regional implementation team (for services for older people). The project manager, a health professional, was employed full-time and jointly funded by the local authority and the PCT. The local implementation team was primarily used for reporting performance on projects, but it ceased to meet after the second year (as did the steering group) due to health and social care reorganisations.
- In network 3, several members of the PCT were joint appointments with the NHS trust, which also involved the acute trust in managing these projects. A project to establish a single point of access to older people's services involved a private company to expand a previous project to develop a new 'front end' for local authority services.
- A more horizontal implementation structure developed in network 5, where the steering group established strong links between LAA, LSP and Services to Older People Group, and relied partly on these for its project implementation.
- In site 8, there was just the one IFOP steering group and a joint manager.
- In site 6, in contrast, an executive team of very senior managers from the (one) PCT and council supervised an operational team attended by members from the independent and voluntary sector and the statutory agencies, sub-teams of which led a number of work-streams. In early descriptions of the IFOP project from site 6, plans were set out to create a single point of commissioning at the macro level with a multi-agency strategic planning group, and at a micro level through integrated health and social care teams, for instance providing intermediate care.

- Site 2 (which consisted of projects in a small number of GP practices) initially had a small project management team based in the local authority, which each month met the projects' frontline workers. (These arrangements changed with the introduction of the LAA, discussed below.)
- Similarly there was little practical distinction between the steering group and the implementation group in network 4 because the two had a somewhat overlapping membership who tended to focus on similar outputs. Network 4 also had a jointly-appointed project manager seconded from the LA. Their IF projects each had a collective management group with the local authority included in all six, the PCT in all but one, and the local NHS trust in all but two.
- Below its Core Group of chief executives, network 7 had no fixed structure for implementing decisions, but instead a shifting pattern of ad hoc and more-or-less localised working groups at care team manager level. Nevertheless, implementation mainly occurred through the exploitation of existing hierarchies in the member-organisations rather than creation of new network-based entities. In this network, network 8 and others, implementation of most projects remained the responsibility of the member-organisation which had originally developed it or proposed it for recognition as in IFOP project.

Table 15 reports the implementation mechanisms found, classifying them according to the classification of governance structures found in NHS-like health systems – quasi-hierarchy (QH), quasi-market (QM), quasi-network (QN) – reflecting the hybrid character of these governance structures.[118]

Table 15 How IFOP sites implemented their decisions

Site	Governance structure(s) linking coordinating body to service providers	Governance structure type(s)
1	Through PCT line-management and monitoring of CHS. Each PCT had its own implementation team. In PCT 1, the operational group were operational managers of relevant services (e.g. nursing, rehabilitation). In PCT2, the IF project manager was a council employee working in an acute trust setting, giving a line of informal influence on joint working with hospital staff.	QH, QN
2	Through two local authority managers meeting front-line staff directly. These managers did not, generally, line-manage service delivery staff.	QN
3	Discussion in and implementation by other existing relevant partnership groups such as the PEC and an intermediate care steering group involving senior managers, including commissioners.	QN
4	Subordinate project group initially, then District implementation group (from Sep 2006).	QN
5	Implementation via discussion with other forums and organisations viz. LPSA2 board; Services to Older People Group (Innovation Forum Project Board/ Older People's Partnership Board). Also subordinate Project team.	QN
6	Implementation via discussion with other forums and organisations viz. local Health and social care partnership (of the LSP) /LAA. Forums were	QN,QH,QM

	Older People steering group (Joint Commissioning) (merged with NSF LIT Group and subordinate to IF networks); and subordinate work-streams including: • Prevention Forum (also merged with NSF LIT sub-group) • Primary care/integrated services group • Intermediate Care Steering Group • Integrated Falls Services Group (NSF) • Older Peoples Engagement Forum Main organisations were local authority and PCT.	
7	Implementation mainly through the existing hierarchies of the statutory member-organisations, but also small-scale ad hoc local implementation networks.	QH, QN
8	Implementation mainly through the existing hierarchies of the statutory member-organisations	QH
9	Through: Multi-agency Steering groups (link to the LSP HWP) District Community Commissioning Steering Group	QN,QM

Table 15 shows the hybrid character of the IFOP governance structures (also reported in other health networks, and not only in the UK[133-135]), and how much the mixture varied site by site. In summary, four main patterns emerge here:

- The steering groups in networks 2, 4, 5, 6 and 9 set up sub-groups to undertake more concrete tasks arising from its decisions. Such sub-groups appeared more spontaneously in network 7. These were operational-level bodies of professionals.
- Sites 1, 2, 5 and 6 relied upon other external pre-existing partnerships, and therefore on the existing inter-agency relationships, to implement their coordinating body's decisions. In sites 2, 5 and 9 the Innovation Forum was involved in formulating the (wider) LAA targets relating to older people, and IFOP projects were put to service in meeting these targets.
- Sites 6 and 9 used a commissioning body, subordinate to the network coordinating body, to contract for services. Network 5 also made commissioning recommendations to its local commissioning bodies.
- In sites 1, 7 and 8 especially, decisions were implemented through the line-management hierarchies of the network's member-organisations; that is, through quasi-hierarchical structures whose apex was (in theory) *within* the network, to which was subtended the conventional hierarchy within the relevant member-organisation(s).

The fourth of these structures was the most prevalent. It applied whenever the management of a project had originated within one organisation and was subsequently transferred to (or was re-badged as) an IFOP project. That member-organisation often chose to 'own' and retain control of the project even though the project had, so to speak, been contributed to the network and counted as an IF activity. Furthermore, most of the front-line staff who were expected to implement IFOP network decisions were employed by the networks' member-organisations.

Whilst all the networks' decision-making bodies had some form of managerial infrastructure (budgets, management information systems, support staff, etc.), in some the infrastructure was so limited as to constrain what projects the networks could select or implement. For instance, a network might lack the capacity to collect audit data or to review research. Some examples can be given:

- In site 1, for example, support was limited to two staff, with different employers and different working styles. One of the PCTs identified barriers to project development as including a lack of capacity for data analysis, an absence of performance data in some areas, and problems drawing up a data-sharing agreement between health and social care organisations, although some analysis of admission activity was carried out for the IFOP project by a network member. Two of the PCTs in this site carried out a large-scale audit of appropriateness of location of care and bed use in NHS trust- and PCT-owned hospitals. Nevertheless, all of this was insufficient infrastructural support to allow evidence-based reviews to be made as a basis for project selection.
- Network 5 had some budgets that could be used for IFOP-related project development, a similar position to network 8, and both had a project lead or project manager. However, network 5 still lacked managerial infrastructure resources, especially management information systems. Different models of service delivery were developed in response to local needs in geographically distinct areas of this site, and evaluations in sites 5 and 8 of specific IFOP projects, for instance fall services, provided further information to support service design.
- Network 7 had resources available for cost modelling, routine data collection and public involvement. Although not extensive, this infrastructure was greater than in some other study sites.
- Site 6 used statistical modelling of intermediate care and case management.
- Site 3 commissioned research on admission rates and average length of stay and multiple admissions at ward level.

Network governance structures are often argued (see above) to be constituted of non-contractual and non-hierarchical links between network member organisations. Here we list these types of links and report the extent to which each was found in the study networks.

- One approach is persuasive appeal to shared values or culture, above all the imperatives of current policy (e.g. targets), or to an organisation's status as legitimate authority (democratic mandate), or to occupational 'disciplines' of the clinical professions[136] [137] and managers.[138] Appeals to the necessity of satisfying policy mandates and targets were pervasive through the study networks, but the steering groups made little appeal to disciplinary ('professional') values. Local authorities could in principle have exploited their local democratic mandate and a mandate as user representatives, but we found little evidence that they did. Trust is often mentioned[139] as a concomitant of value-convergence and a factor assisting governance within networks, but in network 5 it appeared weak. That network had a bipartite governance structure with formalised managerial practices. Letters of agreement were frequently used to formalise decisions and implementation arrangements (an approach which might be interpreted as symptomatic of lack of trust between the member-organisations). In network 2, one PCT set up a rival project in competition with, and tending to undermine, the local IFOP project. The council in network 7 set up discharge management arrangements of its own when it felt that the NHS arrangements were at capacity or not dealing with the case mix that the council wanted to prioritise. In contrast, networks 1, 7 and 9 assimilated an existing body as network steering group. The longer-standing such a body is, the more likely that trust has developed among its members.

- Technical (evidence-based) guidance was conspicuous by its absence, compared with other health networks,[140] [141] except in network 6, where clinical providers were among the active members and produced some evidence reviews, and network 8 which commissioned the local university to produce some evidence reviews (which were then shared with IF partners).
- Practical help in kind (reciprocated or gift) – such as deployment of staff, equipment, information, premises and expertise – was also not overtly used by the steering groups at whole-network level, although at more local level (e.g. in networks 1 and 7) there was evidence of this kind of link between network members. A more important instance was that member-organisations used their internal hierarchical structures to implement steering-group decisions.
- Referral routes were, for the purposes of the IFOP networks, a crucial link between network members. In health care networks (see Southon et al.[124]) referrals can be managed by the body controlling the network. But the present networks were not able to do so; in terms of the Southon et al. classifications of health networks, the IFOP networks are programme networks rather than care networks. Referral decisions were made deep within the networks' member-organisations, and even managers of the latter can be expected to have difficulty influencing them.
- Finance, whether grants, budgets or contracts, were used in a number of networks, either in the form of pump-priming grants and project budgets, or indirectly through the steering group issuing advice to commissioning bodies.
- Another approach was to use information and monitoring systems within the networks to create transparency, hence power-knowledge.[137] Whilst service reviews and audit data were available to the networks, only network 7 got as far as modelling these data. So, data-based links were widely present but not a powerful means of governance. As reported

above, some of the networks had sub-groups to collect and disseminate information about network activities.

- Pre-existing networks drawing informal links such as shared political allegiances, religion and ethnicity are mentioned as means of influence within networks in other studies[142-144] but were not found in our study networks. What we did find was the co-optation for IFOP purposes of older networks of referral links or for the representation of particular care groups or professional bodies, especially for the purpose of helping implement steering group decisions (see above).

Even when present, some of the above links were at times weak. In network 2 the links between the four member-PCTs and council were undocumented and informal. In many sites, initiatives were not 'badged' as IF activities.

Table 16 Governance links between network decision-makers and other network members

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9
Shared values	√	X	X	X	X	X	√	√	X
EBM/EBP	X	X	X	X	X	√	X	√	X
Help in kind	√	√	√	√	√	√	√	√	√
Referral	X	X	X	X	X	X	X	X	X
Finance (All projects funded by several member-organisations)	X	√	√	√	X	X	X	X	X
Information	√	X	√	√	√	√	√	√	√
Affiliation with other networks	√	√	√	X	√	√	√	√	√

Reading Table 16 column-wise it appears that the widest range of linkages for governance purposes existed in networks 8 (five media of linkage), followed jointly by networks 1, 3, 6, and 7; with networks 2, 4, and 5 and 9 having fewest. On that basis, one would predict that network 8 stood the best chance of implementing whatever IFOP projects they adopted.

6.4 Differences in governance structure between the networks

In summary, governance structures in the IFOP networks were essentially similar in the following respects. The main decision-making body was a steering group of senior, if not chief, managers. Statutory bodies were much more strongly represented than other organisations, or users. The networks all operated in environments where other networks with closely-related remits were also operating. All the networks inherited and re-badged at least a large minority of their projects for reducing unplanned bed-day use by older people from their member-organisations or from earlier networks. Consequently all the networks had, to some extent, to implement their decisions through the existing managerial hierarchies of their member-organisations. Each network had some structures for involving users, but these structures were in every case somewhat marginal to the networks. Every network felt the need, above all, to respond to a complex of policy mandates that bore more heavily upon their health than upon their local government member-organisations.

The main differences of governance structures are summarised in Table 17. The row labels are formulated so that a tick (√) indicates the presence of an attribute likely to strengthen the network's governance structures. 'User representation had influence' is interpreted generously; the presence of just one project where that occurred is shown with a tick.

Table 17 Governance structures and managerial practices

	Site								
Structure or managerial practice	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Pre-existing body becomes steering group	√	X	X	X	X	√	√	X	√
Member-organisations delegate control of decisions and resources to IFOP network rather than retain them.	√	X	√	X	√	√	√	X	√
Network-based implementation group(s)	√	√	√	√	√	√	√	X	√
Member-organisations delegate control of project implementation to IFOP network rather than retain it.	X	√	X	X	X	√	X	X	√
Network infrastructure sufficient for project selection	X	√	√	√	√	√	√	√	X
Absence of non-IFOP network with similar remit	√	X	X	√	√	X	√	X	√
Approximately equal power of health and local government member-organisations (health not dominant)	√	√	√	√	√	√	√	X	√
Extensive adoption and re-badging of pre-network projects	√	√	√	√	√	√	√	√	√
User representation structure(s)	√	√	√	√	√	√	X	X	√
At least five types of governance link between steering group and member-organisations (see Table 16)	X	X	X	X	X	X	X	√	X
Input to commissioning	X	X	X	X	√	√	X	X	√

A crude way of comparing the *prima facie* strength of governance structures in the networks is to read the table column-wise, noting which of these factors tending to promote strong network governance are present in each site. On that basis, networks 9 and 6, and then network 5, would appear to have had the most developed network governance structures and the most favourable context for network-based collaboration, with network 8 in the least promising position.

Table 16 and Table 17 suggest that two main models of governance were found in the study networks:

- A 'joined-at-the-top' model, where the member organisations' senior or chief managers met ('networked') to coordinate projects which remained owned, managed and implemented by IFOP member-organisations severally and independently. In this model of governance, the network was a network of hierarchies. Taken as a whole, the network appears as a quasi-hierarchy with the steering body at its apex. (Social network analysis would be required to establish if these networks were hierarchical in the more formal sense defined by Krackhardt.[145] Networks 1, 7, 8 and 9 were essentially 'joined-at-the-top' networks.

- A horizontal 'network-of-networks' model, where the IFOP network substantially relied on other external networks both to help implement the IFOP steering committee's decisions and for critical inputs, such as user views or evidence reviews, to those decisions. Network-level implementation groups within the IFOP network supplemented these external networks. Networks 2, 3, 4 and 5 came closest to the network-of-networks model.

Some IFOP sites (above all network 6; and to a small extent network 7) combined these models, and two sites supplemented them with use of local commissioning structures. However, both these governance models were clearly quasi-networks. Despite the emphasis given in policy documents and IFOP objectives, commissioning-based (i.e. quasi-market) models of governance were not found in the IFOP sites we studied. The networks that did produce commissioning proposals used this as one means among others of implementing their decisions.

6.5 Governance structure and the selection of intervention projects

What matters in terms of our research questions is how these governance structures constrained or facilitated the networks in developing or inventing activities ('projects') intended to reduce bed-day use through unplanned admissions of frail older people. The following patterns emerged regarding the relationship between network governance projects and the ways in which they selected projects, whether in the sense of positively selecting or inventing projects or the sense of adopting a certain range of projects in default of alternatives.

The presence of numerous network member-organisations with disparate interests was an obstacle to adopting large-scale integrated projects. In the absence of agreement at steering-group level, the alternative was for network 2 to assemble projects proposed 'bottom-up' from front-line staff, or to re-badge existing projects as IFOP projects.

Member-organisations were reluctant to delegate decision-making powers and resources to networks 3, 5, 7 and 8. Individuals participating in some of these networks were not powerful enough to commit their own organisations to decisions or to bring resources to the projects. This constrained the selection of projects to be conservative, i.e. conforming to existing resourcing, staffing and managerial arrangements. In these cases, IFOP steering groups did not so much design new projects as collate existing projects from the member-organisations. The IFOP networks were limited to the adoption of small-scale projects originating 'from below' from service staff, or to the re-badging of existing projects as IFOP network projects (networks 1, 4, 5, 8, 9). Adoption 'from below' favoured projects supported by the larger or more powerful occupational groups (doctors and nurses) (networks 2, 6).

Many member-organisations retained control of their own pre-existing projects, with the IFOP network acting mainly as an information exchange. Retention of projects and resources meant that member-organisations could if they thought necessary set up parallel projects of the own to supplement or replace network projects (networks 2, 7). In part of network 1, IFOP proposals were not integrated into other mainstream clinical plans, or even viewed as being in possible conflict with them, resulting in slow progress for some projects. One of the member-PCTs used 'disinvested' funds, freed after the first year from the acute hospitals to fund some acute services, without consulting the IF network.

Reconfiguration of member-organisations also constrained what projects could be adopted in networks 1 and 4, and so (in network 1) the development of projects was constrained by financial problems in two of its member-PCTs, and by staff changes there due to reorganisations. Thus network 4 could in 2006 only adopt one project and so the network decided to concentrate on one local area where an IF project was perceived as having been successful, and to develop the local intermediate care service in a whole systems way there. Hence financial circumstances in the member organisations also constrained what projects the networks could adopt.

Membership of the networks was predominantly of statutory organisations. In many IFOP networks users had little voice and neither did the third sector. There was little participation by commercial providers. Where these participants were absent, projects originating from them could not generally be considered nor selected for network-wide implementation. Only three isolated projects originated from these sources.

Policy imperatives had a triple influence on project selection. By virtue of their own prior quasi-hierarchical relationships to central government, IFOP member-organisations faced similar or parallel policy imperatives bearing upon them outside the networks. Largely, these mandates were convergent (e.g. supporting case management, deficit reduction, substitution of community for hospital care) and constrained the network members' collective selection of projects. The remaining space for local initiatives was limited to adapting or nuancing these national mandates. In selecting projects, each IFOP network was thus constrained by the superset of targets facing all its member-organisations collectively. This set of imperatives framed negotiations and decisions about network activity. NHS bodies generally were reported as facing more numerous and more closely binding central targets than local government, so in practice NHS targets tended to predominate when the networks selected practical projects. An immediate way for networks and their member-organisations to demonstrate compliance with, or at least the active pursuit of, central targets was to adopt and re-badge existing projects that they believed served that purpose. At least half the networks' projects were in this category in all the study sites, with the exception of network 5.

Network steering groups tended to be 'realistic' about adopting projects, tacitly constraining their choice of projects in light of their perceptions of the limitations of the resources and powers available to the steering groups, including the network's capacity to implement their decisions. Power to extract cost savings from member-organisations and redistribute these savings was particularly important for IFOP (e.g. network 5). Lack of finance also necessitated a conservative approach (see above) to project adoption (network 4), but left open the option of making commissioning proposals (which cost the network little to produce) to local commissioners (e.g. network 5). The requisite resources included resources outside the network's membership, including residential care capacity (in networks 1, 2, 7 and 9). Conversely, the presence of developed, network-wide means of implementing their decisions (e.g. network 3) favoured the adoption of more ambitious and more collective projects.

The power and resources which member-organisations brought to the network influenced the choice of projects. This balance of power depended, in the IFOP sites, upon whether the health organisations were numerous and fragmented (e.g. network 8) or in financial difficulties (e.g. network 4, 8). Where available (networks 6, 8), clinician (GP and NHS trust clinician) input to the networks facilitated the use of evidence-based reviewing to find and select projects.

In the next section we report what intervention projects these governance structures actually produced, including the ways in which the projects were selected or devised through these governance structures within the IFOP networks.

7 Local initiatives to reduce unplanned hospital stays

7.1 Introduction

What new services were associated with the IFOP initiative, and to what extent were they likely to affect the use of emergency beds? We draw here on the documentary evidence collected and some findings from the questionnaire sent out at the outset of the study to 139 people working in the NHS, social care and voluntary sectors in the IFOP sites. It must be remembered, as we noted in Section 4, that there was a low response rate: only 38 people (27%) returned questionnaires despite reminders. The responses are nonetheless useful. Tables reporting the *detailed* results of this survey can be found in Appendix G.

7.2 Innovation Forum projects

Projects launched as part of the IFOP initiatives in each site were identified by the research team, and a database of projects was set up and updated until the end of the programme. (The 88 projects in the initial year were described previously by Wistow and King.[22]) Tracking the projects over the period presented a considerable challenge. In some sites, information was received on initiatives covering the whole council area across multiple PCTs. In others, projects with the same or similar titles were presented as a single project. Moreover, as some IFOP activities focused on a strategy or service redesign, it was difficult to compare the number of projects across different sites.

By the end of 2006/07, the research team had received data on 128 IFOP initiatives. As can be seen from Our interest lay in the project aims and the extent to which they were achieved. The aim of reducing hospital bed use can be achieved in a number of ways. Projects can be established to try to prevent the need for an emergency attendance at a hospital in the first place (for instance, by addressing factors that might lead to a crisis). They can divert emergency attenders at the point that they might have been admitted to care in a hospital bed (for instance, by referral to intermediate care teams). They can seek to reduce lengths of stay (LOS) and they can improve discharge arrangements.

The ways in which the projects in each IF site aimed to reduce bed use are summarised in **Error! Not a valid bookmark self-reference.** (information was missing in four cases). Note that projects could have more than one aim: indeed three sites reported that all their projects addressed all four strategies for reducing bed use. As can be seen, the great majority of projects included the aim of preventing admissions.

Table 18, there was a wide disparity in the number of projects per site (for instance, three in site 3, and 38 in site 1). The number of projects per PCT varied six-fold.

Our interest lay in the project aims and the extent to which they were achieved. The aim of reducing hospital bed use can be achieved in a number of ways. Projects can be established to try to prevent the need for an emergency attendance at a hospital in the first place (for instance, by addressing factors that might lead to a crisis). They can divert emergency attenders at the point that they might have been admitted to care in a hospital bed (for instance, by referral to intermediate care teams). They can seek to reduce lengths of stay (LOS) and they can improve discharge arrangements.

The ways in which the projects in each IF site aimed to reduce bed use are summarised in **Error! Not a valid bookmark self-reference.** (information was missing in four cases). Note that projects could have more than one aim: indeed three sites reported that all their projects addressed all four strategies for reducing bed use. As can be seen, the great majority of projects included the aim of preventing admissions.

Table 18 Diversity of aims of the IFOP projects

Site number	**Number of projects N**	**Prevent an emergency attendance N (% of projects)***	**Divert emergency attenders from admission to hospital, N (% of projects)***	**Reduce length of stay following emergency admission, N (% of projects)***	**Improve discharge arrangements N (% of projects)***
1	38	29 (83)	23 (65.7)	26 (74.3)	26 (74.3)
2	4	4 (100)	4 (100.0)	4 (100)	4 (100.0)
3	3	3 (100)	3 (100.0)	2 (66.7)	2 (66.7)
4	6	6 (100)	6 (100.0)	6 (100.0)	6 (100.0)
5	25	23 (92)	11 (44.0)	13 (52.0)	16 (64.0)
6	6	4 (66.7)	4 (66.7)	5 (83.3)	4 (66.7)
7	4	3 (75.0)	3 (75.0)	4 (100)	4 (100.0)
8	28	22 (81.4)	18 (66.7)	17 (63.0)	13 (48.1)
9	14	11 (78.6)	9 (64.3)	10 (71.4)	11 (78.6)
Total (col %)	**128 (100)**	**105 (84.7)**	**81 (65.3)**	**87 (70.2)**	**86 (69.4)**

*excludes cases that were missing data on aims

Most initiatives were set up by local authorities or PCTs (see Table 19) and most were managed by them. Almost three-quarters of the projects were managed wholly or partly by a PCT, while more than half were wholly or partly managed by a local authority social services department. In addition, 36 (28%) were jointly managed by both agencies.

Table 19 Organisations involved in managing the projects

	N*	%
Primary Care Trust	93	72.7
Local authority	71	55.5
NHST	22	17.2
Voluntary	15	11.7
Private/independent	3	2.3

* Excludes cases where information was unavailable.

In contrast, less than one-fifth (22 projects) were managed by an acute trust. At first sight, this apparent lack of involvement of acute trusts seems surprising given that a high number (86) of projects were intended to improve hospital discharge arrangements, although it may simply reflect the limited managerial responsibility of hospital trusts for providing services in the community. Most projects (86%) had no voluntary or private sector partners involved in their management. Of the very few projects managed by organisations other than PCTs or councils, five (4%) were managed jointly by a PCT and an acute trust, four (3%) by a council and a voluntary organisation, and two (2%), by an acute trust and a council.

Initiatives that were similar in terms of approach, location, staffing and function were organised into a set of specific categories, set out in Table 20. The diversity of projects is particularly striking.

Table 20 Types of IFOP initiatives

Description	**N***	**%**
Expanding community Intermediate Care services	27	22%
Case management of those with chronic conditions at risk of hospitalisation	16	13%
Introducing or expanding falls prevention services	10	8%
Improving (diagnosis-specific) care pathways hospital to community	8	7%
Supporting care homes with health staff	8	7%
New hospital discharge planning arrangements and services	6	5%
Expanding access to voluntary sector support services	6	5%
Providing rapid-access, short-stay rehabilitation beds outside of an acute hospital (includes intermediate care beds)	5	4%
Single point of access to community health services as alternative to hospital care	5	4%
Providing alternative health care services at the point of contact with emergency services	3	2%
Using new technologies to monitor service user’s health or safety at home (telehealth and telecare)	3	2%
Integrating community based health and social care teams	3	2%
Provision of minor injuries unit or walk-in centre located within a hospital	2	2%
Housing-based support	2	2%
Improving physical well-being in the community, e.g. fitness/exercise groups	2	2%
Expand existing community rehabilitation teams	2	2%
Improving information for patients and service users	2	2%

Acute care at home (IV antibiotic therapy)	2	2%
Home improvement service	2	2%
Providing rapid-access step-down (non-rehab) beds outside of an acute hospital	2	2%
Redesign or refocusing of existing service	2	2%
Community screening of at-risk older people	1	1%
Improving community equipment services (including rapid access)	1	1%
Expanding or Improving palliative care	1	1%
Expanding acute hospital therapy staff	1	1%
Expanding or improving community comprehensive geriatric assessment and treatment (medical day units)	1	1%
TOTAL*	**123**	**100**

*5 projects not classifiable on the basis of available information

Five categories account for more than half of the total: an expansion of intermediate care services (22%), case management of chronic conditions (13%), falls prevention (8%), improving (diagnosis-specific) care pathways from hospital to community (7%) and supporting care homes with health staff (7%). Many projects shared an element of rehabilitation, with 40 projects involving therapy staff in delivery. It is important to recognise that some projects could be classified under more than one category, particularly those with a particularly broad remit.

Notwithstanding such classification difficulties, some general themes can be noted within particular sites. From an analysis of the types of initiatives featured within each site, it was evident that sites 1, 5, 8 and 9 had a relatively strong focus on the expansion or development of intermediate care services and on case management; sites 1, 5 and 8 had relatively large proportions of projects concerned to redesign care pathways between acute hospital and the community and to support care homes with health staff (therapy or nursing staff). Both sites 3 and 5 had projects involving the creation of a single point of access for the public to community health and social services. Site 4 had an emphasis on integrating community based health and social care teams.

An important aspect of the programme is the extent to which initiatives were sustained following the end of the IFOP. This information is set out in Table 21. By the end of March 2007, of the 128 identified projects, nine (7%) could not be accounted for. (There were considerable difficulties in tracking the projects over the three-year period of the IFOP as they inevitably changed over that period, and because senior link staff at the start of IFOP also moved to other responsibilities.) Of the remainder, the great majority (101) were still active, with only 18 having definitely ceased (of which four were said never to have started).

Table 21 IFOP programme projects: sustainability over three years

Whether operational at the end of March 2007	**N**	**%**
Information not available	9	7
Yes	101	79

No	18	14
Total	**128**	**100**

From the information received, it is clear that in some cases projects had undergone major changes in size or personnel. Some initiatives involving service redesign had given way to related initiatives, with different tasks, but similar aims. At a site level, the proportion of projects not sustained or (more rarely) not having started at all during the period of the IFOP programme varied between zero (sites 3 and 6) and 33% (sites 4 and 9) (see Table 22). (In site 5, those that had not started were however planned to start after the formal end of the IFOP programme.) There was no single characteristic that distinguished projects that were not continued, although certain types fared poorly. For instance, two of the six initiatives for new hospital discharge planning arrangements and services were not sustained.

Table 22 Innovation Forum projects: sustainability over three years, by site

Site	**Yes (%*)**	**No (%*)**	**Information not available**	**Total**
1	28 (93)	2 (7)	8	38
2	3 (75)	1 (25)		4
3	3 (100)	0 (0)		3
4	4 (67)	2 (33)		6
5	21 (88)	3 (12)	1	25
6	6 (100)	0 (0)		6
8	21(75)	7 (25)		28
9	9 (90)	1 (10)		10

* Excludes cases where information was unavailable

7.3 Funding arrangements

As shown in Table 23, the funding of IFOP projects took different forms. We were unable to get information from all sites, but where the information was available it showed that about a quarter of projects were funded by a PCT or a group of PCTs, and about a sixth by the council only. Most were funded jointly in various combinations: about a third by the council and the PCT, and a few by the council with other NHS organisations, such as acute and mental health trusts. Very few were funded by another source or combination of sources, generally a voluntary sector organisation.

Table 23 IFOP initiatives: Sources of funding in 2006

	PCT	**Social**	**Combination of**	**Combination of**	**Other sources or**	**Data**

		Services	NHS organisations and Social Services	PCTs and Social Services	other combinations of funders	missing
1	10	5	6	7	3	7
2				4		
3				3		
4				5	1	
5	12	4		7	1	1
6	1	2		2	1	
7	1	1		2		1
8	12	1	2	6	1	6
9		7	2	2	3	
Total	36	20	10	38	10	14

The IFOP commissioning brief recommended that the council-led partnerships should appraise local strengths and weaknesses, and then make timely investments of resources. A number of councils appeared to have followed this process, being involved in substantial pump-priming of new projects and developments, some at the beginning and some towards the middle of the IFOP period. For instance, social services funding in site 1 had served to get an early project started, involving the ambulance service routing 'Category C' callers to alternative care arrangements, and this project later obtained funding from health organisations across the region.

Local authorities could also commission services on a scale not always feasible for a single PCT in the face of budget constraints, or where services spanned a number of PCTs. For example, site 1 was able to fund an assistive technology pilot covering the populations of several PCTs, which needed funding of nearly £1 million, but involving substantial returns to scale. Other examples included a council investment of mainstream funding in creating a 'single point of access' for care management, rehabilitation and signposting/information provision. In site 7, more than £1 million was invested in the second year of the IFOP to pay for a community matron service across three PCTs, using reimbursement funding.

Several councils were involved in large-scale capital projects in partnerships with PCTs and independent providers. In site 1 there was a PFI arrangement to build an intermediate care facility on former community hospital grounds, managed by a private company, pooling health and social services revenues and covered by a Section 31 agreement. Faced with a PCT-owned outdated nursing facility, the council in site 8 sold some land to enable the building of a care home that included intermediate care and dementia care facilities. These were to be run by a private provider, with the council leasing beds on a long-term block contract and the PCT providing therapy staff, and the arrangement opened up the potential for further capital projects based on the sale of the PCT land. In site 9 the council spent several million pounds in the first two years on similar capital projects involving major intermediate care components, with contributions of over £1 million from the PCTs involved, as well as substantial involvement of private building companies and housing associations.

Many of the IFOP projects and initiatives were funded on an invest–to-save basis. For instance, in site 3, intermediate care modernisation work had been undertaken in part to release funds tied up in a community hospital to enable reinvestment in modern community and bed-based services in the area. The modernisation programme was funded by the PCT, but with the strategic input of the council, and PCT involvement in both the strategic steering group and all the operational subgroups.

One danger with the invest-to-save model could be that only projects thought likely to generate savings in the short term would be funded. This, in turn, could mean that council partnership funding became vital to funding the development of services with preventive aims over the long term. It is also notable that projects in sites 1, 3, 4 and 6 four involved networks of voluntary organisations and older people's groups, attracting large-scale grant funding to the local authorities from central government. In all, however, the pilot nature of much of the partnership work meant that services were potentially unsustainable and, indeed, a few did not last to the end of the third year.

As presented in the introductory sections of this report, the IFOP was an entirely voluntary arrangement between the sites' partners, and received no dedicated, ring-fenced funding. Therefore, unlike projects that received ring-fenced external grants (such as POPP or the Individual Budgets Pilots), the funding boundaries around the projects were not necessarily rigid, or indeed explicit. The sites tended to use existing structures to meet this target: 're-badging' projects was costless. Thus the initiative was more a galvanising of existing resources and commitments, and more an over-arching broad ambition than a specific 'contract' as might be the case in grant-funded pilots. The absence of ring-fenced funds, the tendency in some sites to pump-prime projects that were not 'badged' as IFOP alongside specific projects, and the large differences between sites in size and scope of IFOP projects, makes it difficult – and more importantly, potentially misleading – to calculate and compare levels of project-specific funding.

7.4 Comments on the IFOP projects from the initial questionnaire

We refer again to some of the tables in Appendix G. We asked those people completing questionnaires to indicate the priority given by their organisation when planning service development to unscheduled hospital service use by older people (Table G3). They were much more likely to prioritise the reduction of unscheduled admissions of this group, compared to such admissions of people with chronic conditions or others under age 65. This same emphasis on older people was seen with bed days and lengths of stay. Some differences between sites were statistically significant (on Fisher's exact test): admissions and LOS of older people; and admissions, bed days and LOS of those with chronic conditions. Given the sample size, little further information on differences between sites is available.

We also asked respondents to assess the potential of various interventions to decrease hospital bed use by older people. From their responses, we classified these as potentially high, medium and low-to-no impact (in Table G4). Three-quarters or more of the sample noted that the following four types of intervention were likely to have a high impact:

- increasing rapid-access home-based care and support services (87%)
- expanding intermediate care services (82%)
- case management of those with chronic conditions at risk of hospitalisation (76%)
- improving discharge planning arrangements within the acute hospital (76%).

Three types of intervention were anticipated to have low or no potential in the opinion of a substantial minority of respondents:

- provision of minor injuries unit or walk-in centre located within the acute hospital (45%)
- introducing a single assessment process (34%)
- expanding access to voluntary support systems (21%)
- expanding access to statutory home-care services (21%).

Finally, some respondents noted other types of intervention which they thought might decrease bed use, but without indicating their view of strength of the potential impact, most of which could be described as 'low-level' or 'upstream':

- signposting to other services (2 respondents)
- better access to and provision of mental health services to older people (2)
- preventive hospital aftercare (1)
- development of the Advanced Practitioner role specifically for nursing homes (1)
- collaboration or co-location of GP services and A&E departments (1)
- supporting carers more proactively (1)
- increasing access to respite services (1)
- developing preventive/wellbeing and mental wellbeing services (2)
- exploring/supporting social enterprise (1)
- low level help on immediate hospital discharge (1).

Although the interventions thought likely to have a high impact on reducing emergency bed use were reflected in the types of initiatives introduced, the relative emphasis across interventions is perhaps not what might be expected. In particular, most of those completing the questionnaire expected discharge planning to have a high impact, yet improvements or expansions to such services had made up a only small proportion of the IFOP initiatives. In addition, despite considerable interest in improving access to services and developing low-level and preventive services, home-based care and support services did not feature highly in the actual IFOP projects. This may reflect the learning that had occurred since the beginning of the IFOP programme, or the impact of a shift in central government policy towards third-sector service delivery models. On the other hand, a fifth of respondents did not think that voluntary support services per se had much potential to decrease hospital bed use by older people.

7.4.1 Local structures and initiatives, outside of the IFOP programmes, to reduce the use of EBDs

IFOP groups were subject to change over time, and did not operate in isolation from other management forums responsible for older people's services. Key to the IFOP's 'programme theory' was the leadership role that councils were to take up within local partnerships to 'improve the future' for older people. The same leadership role has also been progressively emphasised in central guidance and legislation governing the LSPs and their local area agreements; the IF and LAA structures might be anticipated to become intertwined in at least some sites and the subsequent discussions covers how this was in fact the case.

There was some variation in the extent to which the LSP/LAA groups had developed clear governance arrangements to delineate 'advisory' and 'delivery' functions. As described in section 5, in most sites, there appeared to be other 'delivery partnerships' that might be responsible for commissioning, sometimes functioning outside the auspices of the LSP and LAA theme groups. These were focused on a particular set of services, such as intermediate care or care closer to home, or the development of a joint commissioning board for adult services. Over time, IFOP-specific meetings and other delivery partnerships were merged into or subsumed by other planning structures, such as the LSPs. For instance, site 2's IFOP projects led to an LAA Older People's Demonstrator project and eventually became part of a thematic block's governance structures. Our in-depth case study interviews with senior managers provided insights into this process of adaptation: for instance, a key informant in site 8 indicated that the IFOP group became, first, part of a separate, long-standing strategic planning group for older people's services, and then part of the LAA thematic group.

In site 3, one strand of the IFOP strategy had been to expand intermediate care. Over the later period of the IFOP, the modernisation of intermediate care services in the local area became a major focus of interagency planning and networking. These activities involved many of the same senior strategic managers from the council, local acute trust and PCT meeting as were involved in the IFOP group, overseeing a number of subgroups of operational managers and senior clinicians tasked with implementing the strategic plan.

In site 5, the IFOP group had begun with less formal governance structures, relying on individuals in the group reporting back to their own organisations; later it became part of more formal arrangements, through the LSP and LAA. The (LAA) HCOP thematic block group was supported by an executive commissioning group for older people, which also oversaw the IFOP project. The IFOP was seen as having influenced subsequent arrangements made by that commissioning group, for example in that the group was using a joint outcomes framework; and investments by partners had been aligned to target reductions in long-term and acute care, with released funds to be directed towards low-level support and community health alternatives (for instance extra care housing and intermediate care).

Sites 1, 3, 4, 5 and 9 had major change programmes other than the IFOP, involving older people's health and care, most linked to short-term funding or pilot demonstrator projects. Sites 6 and 9, both of which had some small-scale projects involving voluntary sector partners in preventive projects, participated in a national demonstrator project of prevention partnerships (POPP) during the course of the IFOP programme. In many of these cases, experience gained in establishing IFOP had been instrumental in enabling the development of subsequent initiatives.

Thus the IFOP appears to have had considerable influence in shaping local policies on the reduction of emergency bed use by older people, even where its activities were not specifically named as contributing to the delivery of a target. A number of LAAs contained mentions of the benefits of having the experience of participation in the IFOP behind their submissions. Sites 5 and 6, as noted in Section 5, put an emphasis on the establishment of a single point of commissioning within their LAAs. Site 5's LAA emphasised that integrated commissioning arrangements were to be taken forward using the IF approach as a basis; this point also arose during senior manager interviews in that site.

In some sites, the LAA included a 'stretch' or LPSA2 (Local Public Service Agreement, round 2) target that was said to be either the IFOP target (a 20% reduction in use of emergency bed days by those aged 75 years and over) (as in sites 1, 7 and 9), or calculated using the IFOP methodology for projecting the number of bed days that were to be saved, but applying this to different populations, for instance people aged 50 years and over (as in site 6). Other sites that had a stretch target for emergency bed use by older people used the long-term conditions (NHS) target and/or methods for calculating this (sites 2 and 8). Three sites named the projects carried out under the auspices of the IFOP as contributing to the delivery of bed-day reduction targets (sites 6, 5 and 9, the last listing some individual IFOP projects in the LAA submission).

The arrangements for delivering LAA targets were reliant on pre-existing partnerships, and therefore on the existing inter-agency relationships and key planning and delivery personnel in the areas. In sites 2, 5 and 9 the Innovation Forum networks were said to be involved in the creation of LAA targets relating to older people, and IFOP projects were put to service in meeting these targets. In site 8, networks outside of the IFOP were named as having established the LAA targets. Sites 2, 5, 8 and 9 used the LAA as a key document and the associated thematic groups as advisory planning fora for their older people's services from the inception of the LAA. As previously mentioned, site 2's LAA included a demonstrator initiative that built on the work of the IFOP projects, but extended the pilots to other neighbourhood areas.

7.5 Conclusions

The IFOP sites shared a common starting point in that all the local authorities involved were among the 29 councils rated as excellent in the first CPA exercise. As we have previously noted, they were operating according to a number of 'constructs of change' that underpinned the IFOP programme and provided a framework of more or less well-evidenced beliefs about the nature and mix of change in service models, organisational structures and behaviours necessary to enable this target to be achieved.

The majority of the service models and initiatives that sites introduced to address IFOP targets seemed to have the multiple aims that included: preventing acute events and patients needing an emergency attendance at a hospital; diverting emergency attendees to services that provided community-based care; facilitating the timely hospital discharge of those patients that did need urgent care in a hospital bed. The observation that schemes had multiple aims is not unanticipated as an expansion of community-based services for intermediate care was the main strategy that sites used to address IFOP targets. Such services have a role in preventing acute hospital admissions (following acute events) and in facilitating acute hospital discharge.

However, although respondents to the questionnaire thought that intermediate care services would have most impact on IFOP targets, sites also embraced the preventative agenda when developing new services. The introduction of services for case-managing patients with long-term conditions and for increasing access to falls prevention schemes was common.

Finally, most IFOP schemes were funded and managed by PCTs and/or local authorities. Although some IFOP schemes were initially funded on a pump-priming basis, the vast majority were sustained at the end of the project.

8 Roles of non-NHS agencies

8.1 Introduction

One of the objectives of the IFOP programme was to encourage councils to form effective partnerships with the NHS and other agencies and to direct investment into social and health care. A variety of mechanisms were employed across the sites to build links between different parts of the NHS, local councils and other non-NHS agencies. The sites shared a common and voluntary willingness to adopt a collective headline target for helping the NHS to reduce the number of EBDs used by people aged 75 and over. It can therefore be assumed that the IFOP councils believed that their community leadership role and NHS commissioning partnerships were either already sufficiently well developed to secure this target or could be sufficiently developed to deliver it over a three-year period. These partnerships included clinical partnerships, joint working and joint commissioning. In this section we describe those various partnership arrangements and how they performed, drawing our evidence from responses to the 'governance questionnaire', and from data collected through interview, non-participant observation and documentary analysis in the three case study sites. Section 4.3.3 gives more details on the people interviewed in the three sites. It should be remembered that the latter were undertaken in early 2008, nine months after the official finish of the IFOP, with a range of professionals providing health and social care to 18 users (six in each site) as well as with users themselves and their carers. More details on the questionnaire and the interviews can be found in Section 4.

As will be seen, it emerged that it would be accurate to describe our results from the questionnaire and the key informant interviews as shedding light on the roles of non-acute care services. Acute providers, as described in Section 4, were not well represented among the pool of potential questionnaire respondents and it would follow that they were in the minority of respondents as well; indeed we had only one questionnaire back from acute trust employees.

8.2 Multi-agency forums

Most (33 of 38) of the senior managers completing the questionnaire reported being part of (or attending) a multi-agency group one of whose concerns – and often the primary concern – was to reduce emergency bed use by older people (see Table G2 in Appendix G). We asked for some details about these groups, asking them to describe the one with which they were most familiar in the event of there being more than one such group. (We did not ask for the groups' titles in the hope that this anonymity would encourage people to respond openly.) Ten of these respondents belonged to groups that were part of the IFOP.

Box 1 Questionnaire respondents' backgrounds

Respondent background details are given in Table G1.

The sample was almost evenly split between respondents in purely strategic and combined strategic and operational posts (50% and 45% respectively). Two respondents described their responsibilities as purely operational; for the purposes of analysis these were categorised into the combined strategic and operational group. The great majority (85%, or 32 people) were from councils or PCTs, with this number evenly split between the two organisational types. There was one respondent from an NHS trust (5%), 2 (9%) from mental health trusts and 3 from (14%) voluntary sector organisations.

Forty percent of sample respondents were from the top three tiers of their organisation. Respondents had been in post for an average of 3 years. Respondents working in local authorities had been in their posts significantly longer than those working in PCTs (on average 20 months longer); however it is possible that the shorter time in post was an artefact of the reconfiguration of PCTs. The total length of time worked within the organisation (8.3 and 9.9 years for PCT and LA respondents respectively) was not significantly different between these groups. The proportions of the total sample in strategic positions did not differ significantly by organisational type, nor did the proportions vary by level of seniority within the organisation.

Of the groups thus described, two-fifths had been meeting for at least two to three years. More than half met on a monthly basis. The responsibilities of about half the groups were described as both operational and strategic, with another quarter being purely strategic. PCTs and local authorities had the largest presence in these groups, each representing (on average) about a quarter of all the participating organisations. Acute trusts represented the next largest group (on average, 15%). About a quarter of the groups involved service users.

The arrangements for chairing these meetings varied considerably. In about half, the chair was a PCT employee; in slightly fewer the chair was from the local authority. The chairs of other groups came from acute trusts, mental health trusts and voluntary organisations. In about a third of the groups, the role of chair rotated, mostly between the PCT and council, but in three cases involving the acute trust as well.

About two-thirds of the groups controlled access to funding. Not surprisingly, this factor was closely related to the post of the person responding: 88% of those in strategic posts reported attending a group with access to funding, compared to only 37% of those with operational or combined responsibilities (with this difference being statistically significant). There were relatively few funding sources reported, such as the PCT Local Development Plan (LDP) and reimbursement funds, and other central government grants (see Table G5 in Appendix G). Funds accessed by the groups tended to be combined from more than one source: most usually these consisted of LDP and reimbursement funding, together or in combination with other grants (62% of combined funds reported). This appears quite consistent with the funding of the IFOP projects: as discussed in Section 7.3, many projects were funded jointly, more frequently by the council and the PCT (30%), and much less often by the council with other NHS organisations (8%).

We asked about group processes and interactions. Responses were generally very positive (Table G8 in Appendix G): for instance, both frequent cancellation of meetings and poor attendance were reported as uncommon. There was, however, variation in the way groups worked. In most groups, one particular organisation tended to dominate (only one-quarter of our respondents suggested otherwise) and it was not uncommon for issues to be resolved without repeated discussion (about one-third felt this to be the case). Indeed, in only one-third of the meetings was it thought that there had been disagreements between organisations in the previous year. About one-third felt that people came to meetings with their own agendas.

Two elements of meeting processes appeared to be related: whether one organisation dominated the meeting and whether issues were usually resolved without repeated discussion (see Table G9 in Appendix G). The proportion of people indicating that issues were resolved without repeated discussion differed significantly by their response to whether one organisation dominated. Just over half of those indicating that issues were not resolved also reported that one organisation tended to dominate the meeting; put another way, 90% of those disagreeing that one organisation tended to dominate the meeting also agreed that issues were speedily resolved.

When we used statistical analyses to test for association, we found a possible relationship between these variables and another item from the questionnaire: whether or not the respondent was replying with reference to an IFOP-specific meeting. These relationships were explored through exact logistic regressions clustering on sites, reported in Appendix H. The analysis suggested that the perception that issues are resolved without repeated discussion in the group may be associated with the perception that the group was dominated by the members of one organisation; if the group was IFOP-related, however, this non-significantly decreased the likelihood of perceiving that issues were resolved speedily (see Table G11 in Appendix G). The IFOP-specific meeting variable appears to 'suppress' the negative relationship between being dominated by one organisation and the speedy resolution of issues within the meeting (see Table G10). One interpretation of these findings could be that participating in the IFOP may have positively affected the perceptions of group dynamics.

This interpretation is supported by our in-depth interviews with senior managers. In one site, the IFOP project structure was said to be in the form of informal matrix management, including health and social care commissioners, public health and performance leads. 'Goodwill' and 'relationships' were said to be important, allowing the partnership to function well from the beginning. Such partnerships relied on members going back to their own organisations to try to influence decisions. As time went on, it became more important to develop more formal structures, with clear lines of accountability and reporting, and governance arrangements that were recognised by all the partner organisations. This meant building the partnership into the LAA, and thereby aligning previously separate performance and accounting systems.

Likewise, an association appeared to exist between the perception of disagreements between member organisations and the frequency of meetings (see Tables G12 and G13). Those attending meetings less frequently (tri-monthly vs. monthly) were less likely to perceive disagreements between member organisations. Again, interviews in the case study sites gave further insights. It was clear that relationships took time to build, but proved highly important for joint working because they enabled people to develop a sense of trust in each other. They could then work more effectively together, with better understanding of each other's roles and each other's services. As one interviewee commented:

> *That took a long time, it took a year – first of all, we looked at what we did now, this is way back, and what was astounding was our lack of knowledge of each other, and also our lack of knowledge of what was available, both ways.*

Managers spoke of the benefits in the long term of knowing key individuals in other organisations, enabling creative thinking about future developments. One manager reflected that perhaps what was needed in order to evolve together was some 'scheduled time to do some strategic thinking together', because strategic meetings were very pressured:

> *We don't develop our thinking – it's all very business-orientated, with an agenda and you quickly go through with the time allocation. It doesn't lend itself to promoting partnership arrangements.*

A manager in one site noted that the partners working on the steering group for the modernisation of an intermediate care project had already been working together closely; it had been a joint decision to set up the project and agree the work-streams because it affected both health and social care. This raises the question of whether the exact focus of a meeting was not as important as the continuity of the personnel and of having *some* regular meetings between partners. As one person said, 'as far as I'm concerned, I've had five years of close working.'

Another person concisely described the effort involved in managing multi-agency meetings:

> *You get so many different views and agendas brought to the table – the skill really is to end up with something that everyone can sign up to, no matter which direction they're coming from.*

The role of non-NHS agencies and resources in reducing the use of emergency bed days is important, but their influence can be difficult to gauge and is sometimes discounted by those working in the NHS. In the questionnaire, we asked which organisation had taken the lead in decreasing local emergency bed days locally. Almost half of those responding identified the PCT and a third identified the local authority; only very small numbers noted that an acute trust or mental health trust had taken the lead. Conversely, very few respondents noted that councils had played a *small* part in decreasing bed days and none that the PCT had played a *small* part (see Tables G6 and G7).

As shown by the questionnaire findings, acute trusts were seldom perceived to take the lead in reducing acute bed use by older people. Staff from acute trusts also generally made up a small proportion of the membership of such groups. Given the pivotal position of acute hospitals in effecting change, this could be a cause for concern. There were, however, exceptions: the steering group of the intermediate care modernisation programme in one site, referred to above, had senior acute trust manager representation, most work-stream subgroups included hospital consultants among their members, and new services had hospital consultant representation within their multi-disciplinary teams.

8.3 Joint working

The IFOP seems to have had the effect of helping to progress plans and resolve issues. For instance, meetings in one site were said to have been very well attended, with participants very involved, and in another it was said that the IFOP had:

> *… got people talking to each other and people understanding each other's ways of working, each other's roles and looking at new ways of working.*

In another site, meetings to move care closer to home were seen as having been very effective in gradually changing relationships so that key people, particularly clinicians, had begun working in a more joined-up way. Over the three sites, joint working was viewed positively by the majority of key informants. But some concerns were also expressed about the effectiveness of partnership working. Some noted their hope that when people did meet and talk, it was more than just 'lip service' and that joint working would continue. Examples were also given where multi-agency group recommendations were not adopted by member organisations which could lead to frustrations for the group. As previously described, budget constraints were a source of tension in many of the IFOP sites. Senior managers interviewed felt that in retrospect deficits incurred by some PCTs during the IFOP programme period had been an impediment to joint working, as PCTs were unable to provide their share of the money and this made them a weaker partner. In turn it became difficult for the local authority to keep up the momentum during the latter half of the IFOP initiative, as NHS priorities were diverted to 'financial recovery' schemes.

Across sites, several managers pointed out a relationship between a lack of inter-organisational communication and service duplication. Examples included a situation where the council had commissioned a voluntary organisation to provide a service, which in fact overlapped with services provided by the PCT's intermediate care teams; this was attributed to a lack of consultation between partners. Similarly, examples from two sites were offered of overlap between acute and PCT services. In one case, it was noted that this duplication had not been noted until PCT and acute trust managers had had some ‘conversations’.

Interestingly, it was noted that instances of service overlap could prove productive in aiding discussion between teams and, ultimately, promoting understanding of each other’s services. The need for discussions between partners cropped up again and again in interviews across sites, organisations and people in various positions. Several participants described the process of engaging in constructive debate, with disagreements being eventually resolved through continued and open discussion. Indeed, some had visions of a seamless service, including a departure from turf wars. One participant described service objectives thus:

> *We have integrated services and it doesn’t matter who owns them, who manages them – they flow across both acute and secondary care and social care, because sometimes you don’t need secondary care, you need social care – and making sure it’s all joined up.*

As might be expected, however, managers did not always find partnership working easy. Both PCT and council managers described instances of ‘us-and-them’ attitudes in working with the acute trust at both operational and strategic level, despite their wish to avoid such conflicts. For example, problems were noted arising from a lack of trust and respect for community health staff from acute trust staff. At a more strategic level, an example was given of acute trust staff repeatedly declaring beds to be ‘emergency beds’ to elicit more strenuous efforts from the council to hasten discharges, but at the same time damaging inter-organisational trust.

But these issues were not one-way. Managers in acute trusts also gave examples of distrust shown by PCT staff. For instance, in one site, it was noted that community health staff had been invited to base themselves in A&E, but had been hesitant to agree. Another example was a service, planned and funded by the acute hospital, needing community staff that the local PCT had been unable to provide, yet which the same PCT wanted to have moved to community premises once it had been set up at the acute hospital. Both examples were given as antithetical to a good service, affecting patient access and choice.

Further examples were offered of difficulties in the relationship between new PCT services and acute trusts. In one site, PCT rapid-response nurses had been allocated to work within the A&E department to increase acute referrals to their service, but when such referrals did not happen, the nurses were withdrawn, a decision described as ‘very disappointing’ by PCT managers. A rapid-response team in another site, initially located within the acute trust, was relocated to a PCT building, and said by acute trust managers to be less visible, less flexible and less busy as a result. A number of problems centred on hospital discharge. For instance, rehabilitation staff in one PCT were said to be unwilling to assure hospital staff that they would see discharged patients right away, on the grounds that this would be unnecessary; however, this resulted in patients being kept in hospital for longer, because of staff concerns for these patients.

National policy appeared to have an impact on local joint working processes. Opinions differed on whether the impact of reconfiguration was positive. One PCT manager thought that it had made possible more effective and faster communication between the council and PCT management, as there was a single management team. In contrast, another found it to be much harder to work closely with the council after the PCT merger; it was more difficult to make links with new local authority staff because they were geographically further removed. The restructuring of adult services had contributed to this sense of distance. The result was poorer partnership working because of fewer joint meetings and discussions.

8.4 Perceptions of integration mechanisms

In the questionnaire, respondents were asked to consider, on the basis of their experience, the impact of four potential mechanisms for integration: pooled budgets, lead commissioning, joint commissioning and joint appointments. Comments on the first three were generally very positive, particularly in enabling them to commission more efficient and user-focused services (see Tables G14, G15 and G16).

With respect to joint appointments the responses were more complex (details in Table G17 in Appendix G). Nearly three-quarters of those responding disagreed with the proposition that good local working relationships made joint appointments unnecessary, suggesting that most felt they were useful. There was a high level of agreement that joint appointments were most effective at the senior commissioner level and also that they were most effective at the senior operational level.

In terms of commissioning and funding strategies, almost all respondents thought that lead commissioning would make services more user-focused and improve both the commissioning and delivery of services. Only two respondents described lead commissioning as unsuitable for their local situation.

The responses indicate considerable variation in senior managers' perceptions of the effect of integration mechanisms on the distribution of financial risk. While only a third agreed that the pooling of funds distributed risks unequally between the partners, about a half agreed that this was true of lead commissioning. Only about a third agreed that both pooled funding and lead commissioning were not necessary where partners already had a good relationship. Two-thirds agreed that joint commissioners were likely to be effective only if there was a pooled budget in place.

Senior managers' interviews reflected similar positive views of the potential benefits of joint commissioning. Instances of efficiencies were given, such as economies of scale and decreased costs of administration, setting up and monitoring only one instead of two contracts, with two separate monitoring timetables.

8.5 Contracts and commissioning

The questionnaire explored the types of contracts and agreements likely to be used in multi-agency approaches to decreasing unscheduled bed use by older people (see Table G18 in Appendix G). When providing services jointly, a large majority of those responding (78%) indicated that they would use partnership agreements using section 31 (now section 75) agreements; almost all would use a service-level agreement; but two-thirds would contemplate using a verbal agreement between senior managers. One respondent added that they would use a 'joint agreement: roles and responsibilities'.

Asked about how they would expect to monitor a jointly provided service, most respondents indicated that they would expect both that each agency would share its monitoring report on a regular basis with other partners and that they would request information from other partners on a 'need to know' basis. A somewhat smaller majority – about two-thirds – thought they might examine joint monitoring reports constructed by one partner on the basis of data provided by all partners. Half thought it somewhat or very likely that they would use information from an integrated performance database held by one partner on behalf of other partners.

The in-depth interviews threw some light on the development of the joint commissioning function. In one site, progress was described in moving towards a model of formalised joint commissioning across the council and PCT, with joint posts such as a joint director of adult health and social care, and a joint commissioner for older people across the council and one PCT. The IFOP programme was seen to have helped to influence these formal arrangements. Another site had a joint commissioning team across the council and the PCT, which was responsible for older people's services (among other responsibilities). The team was overseen by a joint commissioning committee. Contracts involving older people's services were being reviewed and decisions were being made regarding future joint and lead commissioning arrangements, from a pooled budget. In the third site, a joint commissioning team structure did not cover older people. Managers described their aspirations for more formal structures for this group, suggesting that the organisation was keen to continue with integration work:

I think everybody's now of the mindset that health and social care have to work hand in glove – really, we want to progress that to the more formal joint partnership around commissioning for older people. But we're not at that sort of formal point yet, we've aligned what we do, and we have joint meetings, but we don't have a formal Board and we don't put all the funds in one pot yet, but I'm sure that will come.

This joint board structure would, it was said, be very helpful in allowing decisions to be taken without reference back to other boards. There were perhaps some hurdles left to overcome before this could be achieved:

> But it might take a bit of a relationship leap to get to that for older people as well – there has to be that trust on both sides really, of all the partners involved. But for us that would be the next step for older people.

Although managers were keen not to focus excessively on the structural aspects of partnership, they saw formalities such as terms of reference to be important, enabling each agency's representatives to understand the remit, purpose and intentions of those from other organisations.

The broader government 'choice agenda' affected all the sites. Progress on implementing the local development of Intermediate Care and on bringing 'care closer to home' in one site had coincided with central government drives to create a more contestable primary health care market and to create GP commissioning clusters. The thrust of these new policies was seen by both strategic and operational managers as something of a threat to the continued development of 'seamless' local services, for instance in developing integrated working across community health care. A great deal of work already put into building relationships and building up a knowledge base of services across the health care economy was thought to be in danger from GPs 'going off in their own directions'. There was a sense that the decision-making of GP clusters was somewhat opaque to other parts of the primary care trust. In the words of one manager, this could lead to a 'difficult balance' for the PCT in offering services that might not then be purchased by the clusters. But others saw the potential benefits of practice-based commissioning for prevention. A manager in one site, for instance, argued that the cost of the tariff was saved to the GP if an admission was prevented, so that money would be freed for investment in preventive work.

One effect of the interaction between the central government's emphasis on improving PCT commissioning and local strategic planning was a narrowing focus on the contracting aspects of the commissioning process. Those in PCT commissioning emphasised that they had to be 'business-orientated', and needed to be able to show that services commissioned were cost-effective and achieved what they were intended to do for patients.

The purchaser-provider split could make commissioning more difficult in a number of ways. Commissioners noted, for instance, that they had to rely on senior managers in the provider trusts to direct them to appropriate clinicians, because relationships with the providers' frontline staff groups had became more arms-length. Problems could also arise where those commissioning new services sought to address entrenched provider practices that hindered patient flows between the acute hospital and the community, through the contracting process. For instance, contract specifications could be written to deter providers from rigidly enforcing service eligibility criteria. But this in turn could have mixed effects, such as duplication of services and also the creation of incentives for provider services to 'cream-skim'.

Operational managers within local provider services had other problems with commissioning. With the implementation of *Transforming Community Services*, there was a sense that PCT commissioners now had a greater range of choice of services in both acute trusts and the PCT provider units. Several managers remarked on growing tensions between their services and those of the acute providers, as they began to see each other as competitors. At the same time, the PCT needed to pay acute providers, for instance to help them to attain their targets or help them out in a bed crisis. All costs became more noticeable. For example, one community rehabilitation unit was co-located in council offices, which charged the PCT for its office costs, which in turn needed to be taken into account when responding to new tenders. Concerns were expressed that such issues might lead to the withdrawal of the team from those offices in order to save money, despite the fact that such a move might adversely affect joint working.

8.6 Performance indicators

Two-thirds of the questionnaire respondents agreed that central government targets had exerted an impact on bed use by older people (and about a third disagreed). The results did not differ significantly by seniority or by whether the person had a strategic or operational remit. They did differ, however, by respondents' length of time in post; those agreeing had been significantly longer in post. This might suggest that those with more experience had time to witness the impact of performance indicators on bed day use. Half of the respondents agreed that targets agreed locally had exerted an impact on unscheduled bed days.

Respondents were asked to specify the five central performance indicators that had the greatest impact on emergency bed use by older people, listing them in order of impact. Interestingly, some lists contained items that were not performance indicators at all, notably Payment by Results (PbR) and Practice-based Commissioning (PBC). Some respondents did not name specific indicators but named 'the LAA' or 'LAA LPSA2'. The responses that could be categorised (all but 8 of 70 responses) were grouped into a list of 24 items and the top three are presented in Table G19 in Appendix G. It must be noted that only three-fifths of respondents completed this ranking exercise, so our interpretations should be interpreted with caution. Among the most frequently listed indicators were 'delayed transfers of care' (PAF PI D41) and the long-term care Public Service Agreement target 12a (a 5% reduction of emergency bed-day use by people with long-term conditions). We also asked about locally-agreed performance indicators; the responses were broadly similar to those given for the central government indicators and are not presented here.

Our in-depth interviews raised additional issues. Perhaps unsurprisingly, it was noted that targets could get in the way of local priorities. In the case of PCT staff, the community matron service exemplified a target-driven approach, having been put in place partly by re-badging existing activity. For council staff, the pressure could be intense not to 'lose your stars' by delayed discharges, yet the knock-on effect was that patients were discharged to long-term care without sufficient time to consider the alternatives. It was felt that acute hospitals were being assisted by PCTs to meet their targets, through preventive activities. Where there were too many targets, it was felt that the effect could be overwhelming, focusing management energies inwards, instead of towards achieving results through collaboration. As one manager told us:

> *The consensus of opinion in the past was there are too many targets, goalposts were moving all the time, and to achieve one target it had an impact on another service. A&E four-hour wait for example: you needed to get the patients through the system, therefore it had the effect on bed management, discharge planning, access to community hospitals, so it was just a vicious circle all the time.*

8.7 Shifting care closer to home

We asked questionnaire respondents to rate the impact of a number of potential barriers and incentives to shifting resources from secondary health care to community health and social care. Again, we asked them to then rank the top three in importance. We focus here on shifts of resources between secondary and community health care.

A number of barriers to shifting resources away from acute care were identified by more than half of those responding (details in Table G20 in Appendix G). In descending order of identification, those identified by more than half the respondents were:

- lack of commissioning expertise within PCTs
- lack of commissioning capacity within PCTs
- political interventions to protect local hospitals
- the emergence of foundation trusts
- financial constraints on acute trusts
- existing contracts tying up funds that could have been otherwise invested
- the resistance of health staff
- financial constraints on the local authority.

For some of these barriers, however, there was a lack of consensus on the nature of the impact, with a substantial proportion arguing that the shift would be in the direction of community health, or, indeed, that there would be no effect. For instance, in the case of PbR, about two-fifths of respondents thought that funds would shift towards community health, while slightly fewer thought that they would shift towards acute care. Almost a quarter did not know what effect PbR would have. This finding raises an interesting question about the impact of incentives on local decision-making. Another example can be seen in the fact that about a third of respondents thought that resistance among social care staff had the impact of shifting funding towards the acute sector, whereas nearly half thought there was no effect.

Respondents were given the opportunity to identify other barriers or incentives affecting the shift of care closer to home. All factors listed by more than one person were recoded into two new variables (the development of PBC and the emergence of community foundation trusts;

see Table G21 in Appendix G for details). Other factors that were thought to slow the shift to community care or reverse the direction of care back to the acute sector included the following (one respondent in each case):

- lack of investment and skills development in primary care workforce due to financial restraints (slows rate at which shift can safely occur)
- capital required to develop new estate e.g. polyclinic model (slows rate at which shift can occur)
- lack of commissioning capacity in local authority
- a time lag to develop new roles and skills and cost of double running.

A few individuals also noted additional factors promoting the shift of resources to community health care:

- formalised joint commissioning arrangements
- development of community nursing
- shared performance framework where incentives are joint and equally enforced.

Only three-fifths of respondents answered the questions about the most important factors affecting impact, but at least 20% of these respondents ranked the following within their top 3 highest-impact issues locally (full details in Table G22 in Appendix G):

- financial constraints on the PCTs
- Payment by Results
- financial constraints on councils.

A similar question was asked on the factors affecting the shift of resources from secondary health care to social care in the community. The rankings were broadly similar (see Tables G22 and G23) and are not further discussed here. Several respondents named further factors promoting the shift of resources to social care: two, the impact of PBC and of joint commissioning, are included in Table G23. Others mentioned were:

- development of self-directed support
- a shared performance framework.

One of our interviewees added that the

> … shift of acute healthcare to the community is driven by PbR and impact of practice-based commissioning budgets. PBC commissioners only just beginning to get to grips with health commissioning not social care commissioning.

8.8 Public and user involvement

We asked those completing the questionnaire to indicate the importance they attached to a number of mechanisms for public representation (see Table G24 in Appendix G). In many cases, opinions were quite evenly split.

There were only three mechanisms which were generally agreed (by 60% or more of respondents) to be very important or decisive:

- one-off consultations, e.g. hospital redevelopment or closure
- health overview and scrutiny committees
- older people's forums.

Indeed, a number of public involvement mechanisms were seen by about half the sample as having little importance:

- patient choice of hospital
- surveys of user opinions
- intervention by local councillors
- direct payments (social care)
- intervention by MPs.

Although the question was asked in terms of local effectiveness, the proportion of responses in each category of importance did not vary significantly by site for most items. The two exceptions were the importance of 'older people's forums' and 'surveys of user opinions'. The former was seen as decisive or having 'a lot of importance' by all or most of those in two sites (sites 3 and 9), but of little importance in all respondents in a third site (site 8). Similarly, user surveys were seen as decisive or having a lot of importance by all respondents in sites 1 and 7, but as having little importance as a mechanism of public involvement by most or all respondents in sites 3, 6, 8 and 9.

Interviews from the three in-depth case studies shed additional light on this issue. In one site, managers noted that those older people who became involved on Boards tended to have 'an axe to grind', so there could be a reluctance to involve them. At the same time, it was argued that there was sufficient involvement of older people. On user surveys, one manager commented that:

> *We don't do that many of them, but we are developing more of them and trying to get feedback from patients to say what did they think was good, what did they think was bad, is there something we can improve on? But the age-old thing about the only people that fill out the surveys are the ones that have got something to say, quite often not good things, usually bad things so it's difficult to judge that one.*

8.9 Other comments on the questionnaire

Lastly, a few respondents made general comments that echoed many of the themes covered in this and earlier sections. A respondent from site 1 emphasised that while the *council* met with primary and secondary care representatives, what was needed was better working between primary and secondary *healthcare* in the face of different agendas between PCTs and acute trusts, and in particular, in relation to intermediate care funding. From site 7, one person suggested that the role of the private sector should not be underestimated, given how many social care workers were privately employed in care homes and care agencies. A manager from site 6 emphasised the need for national incentives to facilitate change. A manager from site 9 felt that community resources had been underdeveloped for years and that a robust infrastructure needed to be put in place, after which the power of hospital specialists would still need to be overcome in order to shift provision into the community.

8.10 Conclusions

The questionnaire results, though based on a small purposive sample, indicate that acute trusts were seldom perceived to take the lead in reducing acute bed day use by older people by members of multi-agency groups with this objective. Senior managers also indicated that relationships with the acute sector could be difficult. Acute trusts also tended to make up a small proportion of the membership of such groups. Given the pivotal position of acute hospitals in effecting change in terms of care pathways, this must be a concern. It was somewhat surprising that many multi-agency groups had been running over periods of more than two years. Other research has drawn a link between the stability of relationships to partnerships in health and social care.[146] However, the duration of operation of these groups did not appear to be significantly related to the measures of group process and conflict. On the other hand, the frequency of meetings appeared to influence perceptions of local organisational relationships, and again this is supported by the interview data, although it would require further investigation with a larger sample to confirm this. Perhaps the more information that is gained by attending such meetings, the more potential there is for increased awareness of inter-organisational disagreements. It is possible also that those who were part of an IFOP group perceived the relationships between the group’s member organisations more positively than those in other groups.

A lack of commissioning expertise and capacity within PCTs were the barriers most frequently identified as key barriers to ‘shifting the money’ from the acute sector to community health and social care. Yet commissioning-related issues were not as frequently ranked among respondents’ top three factors influencing the balance of care as the financial constraints on PCTs and PbR. Lack of maturity in the NHS commissioning function has been identified as a hindrance to the progress of joint strategic commissioning across health and social care.[147] The underdevelopment of joint commissioning poses a barrier to more integrated working.[146] It appears from our results that joint commissioning was looked upon favourably as an integration mechanism by many senior managers involved in older people’s services. This appears consistent with other partnership studies, where managers in health and social care agencies have seen such integrative mechanisms as useful in promoting, among other benefits, efficiency in commissioning and freeing up management thinking.[148] Yet only two sites had committed to employing joint commissioners for older people’s services in 2007/08, with more interest in joint commissioning boards rather than specific joint commissioner posts. Indeed this is a national issue. Joint commissioning between councils and health has been underdeveloped in areas other than those seen as national priorities, such as intermediate care and integrated equipment services.[54 149]

The qualitative evidence from key informant interviews sheds some light on the reasoning and the context for different stages of development of commissioning: there was a consensus that joint commissioning and pooled budgets were important. This showed a continued trend towards integration, even if some integration was planned or aspired to, rather more than implemented. Levels of trust appeared to be one important factor in integration. Other prerequisites were transparent planning and reporting structures, the infrastructure to gather required information for commissioning, and of course adequate funding levels. Each of these factors would play into the perception of lead commissioning in particular as unequally distributing financial risks. One difficulty that should be further explored is that in the future, with the purchaser-provider split in community health care, it would be harder to gather good quality information from providers informally or through hierarchical reporting structures, with more reliance on contractual means.

It appears that the impact of incentives could vary from the perspective of this group of senior health and social care managers. They did not all hold the same expectations of the direction of outcomes of targets upon the use of bed days by older people. Furthermore, some respondents lumped financial incentives in with targets. In light of recent moves to scrap waiting time targets for acute hospitals, it is worth noting that in fact some targets were seen to have an impact on reducing acute hospital bed day use, particularly the delayed transfers of care and LTC performance indicators.

Lastly, descriptions of multi-agency meetings with senior managers often touched on the planning of some aspect of intermediate care, seen as a high impact factor for decreasing bed days. In Section 10 we discuss patient, carer and professional’s views of local health and social care systems: intermediate care featured greatly in many of the pathways encountered.

9 Reducing emergency bed days

9.1 Meeting targets

In 2003, the nine pilot sites committed themselves to a single 'headline' target of a 20% reduction in the number of emergency bed days (EBDs) used by people aged 75 years and over by 2007. The extent to which the sites were successful in this respect over the three years of the IFOP is explored in this section.

Two aspects of this voluntary target were noted in Section 3. First, the 20% reduction was to be compared with a projection of what the level of bed usage by this group of older people *would have been* without the IFOP programme. Second, the target was a collective rather than an individual one. Although, performance would necessarily be monitored across the individual sites, it was accepted that the success or otherwise of this project would be assessed against the *single* headline target for the sites as a whole. We also recognised that the target was innovative and ambitious: neither local authorities nor the NHS had previously set any kind of numerical targets for reducing the use of acute hospitals, and the 20% level was based on what, if attained, could reasonably be claimed as a significant level of achievement. It was not based on any kind of trend analysis or feasibility study. From this perspective, the single headline target can be seen as both a sharing of the risk and also an incentive, at least to some extent, to work collaboratively rather than competitively.

The voluntary and collective nature of the headline target did, of course, generate a degree of local ownership not associated with national targets. This sense of ownership was reinforced by the role of the sites in developing the formula for calculating the 20% target and thus the level of bed reductions it implied individually and collectively. The methods used to devise the projections, and the challenges faced in calculating them, are described in detail elsewhere as part of the separate monitoring of the IFOP project commissioned from LSE,[150] but are summarised briefly below.

A model was developed to estimate what the bed use would have been in 2007 in each participating local authority if historic trends had continued unchanged, using three age bands: 75-79, 80-84, and 85 years and over. Projections were made up to and including 2006/07 for both demographic and activity levels. The model was built in several stages.

First, population projections were developed for each PCT from 2002 to 2007, based on the projected population growth rate for England using projections from the Government Actuary's Department (2002 base). The anticipated percentage change in the population of England per age band was applied to the age band-specific 2001 Census population data within each PCT. This assumed standard population growth rates for most PCTs. Two sites provided local population projections and, in another, the Census

2001 populations were revised upwards, and the projections altered when these data became available.

Data for emergency admissions, bed days, and length of stay (LOS) were taken from the Hospital Episode Statistics (HES). Admission rates and LOS projections were based on the average rate of change observed over three years, from 2000/01 to 2002/03. Rates of admission per 1000 were projected to 2007 by multiplying the previous year's admissions rate per 1000 persons by the average rate of change in admission per 1000 persons in the period from 2000/01 to 2002/03. As with the admission rates, the average yearly change in LOS 2000/01 and 2002/03 was applied to the previous year's LOS. The product of the projected admissions and projected lengths of stay created the projected number of bed days for 2006/07. (However,actual HES bed-day data may not always reflect an exact relationship between admissions and lengths of stay.[151])

The headline target for reductions in the numbers of emergency bed days was therefore 20% of the total projected. It was, however, more meaningful for annual monitoring purposes to adopt the remaining 80% figure as the ceiling for bed days in 2006/07, and measure performance as distance from that level of bed utilisation. In other words, the sites were operating with this target as the maximum number of EBDs to be used in 2006/07 (the third and final year of the IFOP programme) on the grounds that it represented 80% of the activity that was estimated would have been the position if historic trends had continued unchanged.

Each local authority site's performance figures related to projections of activity and population of the participating PCTs. Where only some of the 'matching' PCTs had agreed to join the project (as was the case in sites 1, 2, 4 and 8), the site's target was the sum of the targets of the *participating* PCTs and not that for all PCTs within the boundaries of the relevant local authority. Moreover, bed days for site 2 were not included in the overall target because the IFOP initiatives there were highly localised at the level of two GP practices rather than across the whole of the participating PCTs. Table 24 sets out the performance of the pilot sites, expressed in several ways. First, the reduction in bed days required to achieve the target (i.e. projected bed days in 2006 less 20%) from baseline is displayed in the second column. The next three columns track the difference in the outturn against projected bed days, less 20% – in other words, they show how much of the 20% reduction was achieved. The final three columns show the actual HES outturn as a proportion of the projection over the three-year period.

For the purposes of comparison, we set out not only the performance of the participating PCTs, but also similar data for non-participating PCTs (applying the above methods to these, using HES data for all English PCTs for the years 2000/01 through 2006/07). In some cases the performance of non-participating PCTs on the bed-reduction measures was better than that of participating PCTs (for instance in site 1). Table 24 shows that overall, the authorities achieved their collective target of a 20% reduction, but that this rested on different levels of performance across the authorities. The targeted reduction was exceeded in three sites (3, 4 and 7); three sites achieved a reduction of at least 10% (9, 8 and 6) and site 5 just missed this reduction. Site 1 achieved only a very minimal reduction, though in this case the council and the NHS disputed the figures in the HES data set and the Department of Communities and Local Government accepted the council's own figures when awarding LAA performance reward monies. In no site was there a higher level of EBDs than the projected 2006/07 figure (i.e. not including the target 20% reduction). It can also be noted that even in those sites where bed-day reductions did not reach the targeted 20%, at least one of the partner PCTs achieved reductions in excess of 20% (8 of 25 IFOP PCTs).

What is less evident in these figures is that because there are substantial variations in the scale of population and provision, some of the percentage changes reflect very different absolute numbers. For instance, two PCTs (1c and 8d) required an 8.4% decrease to achieve the target, but in absolute terms, the decrease required was roughly 9000 and under 7000 bed days respectively.

It can be seen that site 7 had a substantial degree of headroom in that its projection indicated that EBDs could rise by a further 11% before reaching its ceiling. This factor was a substantial contributor to its ability to meet the target but not to exceed it to the degree it did. Instead, its very high rates of delayed transfers of care provided a different incentive to participate. As we described earlier, all their IFOP projects were aimed at improving discharge arrangements.

9.2 Unscheduled acute admissions and average lengths of stay

Between 2003 and 2007, all sites experienced decreases in the average length of stay (weighted by admission) associated with unscheduled acute admissions of people aged 75 years and over (see Table 25). Changes in admissions of this population varied between sites (Table 26); only sites 2 and 8 saw admissions per 1000 decrease consistently year-on-year over the period. It was more common for sites to experience decreases in admissions per 1000 between the baseline and first year of the Innovation Forum, and between the second and third years, than between the first and second years. It may be significant that the second year (2005/06) was the year of maximum reported disruption to working relationships between PCTs and councils due to the coming into effect in October 2005 of the *Commissioning a Patient-Led NHS* reorganisation of PCTS.

Table 24 Performance on headline target 2004 to 2007, by PCT (partners and non-partners)

Site	IF Partner	(Old) PCT	Baseline: % change to achieve target	Change still required (from 2004/5) to meet target in 2006/7	Change still required (from 2005/6) to meet target in 2006/7	Change still required (from 2006/7) to meet target in 2006/7	2004/5 as a % of 2006/7 projection	2005/6 as a % of 2006/7 projection	2006/7 as a % of 2006/7 projection
1	**(3 PCTs)**	**-**	**-19%**	**-9%**	**-24%**	**-20%**	**89%**	**104%**	**100%**
	Yes	a	-27%	-14%	-32%	-35%	94%	112%	115%
	Yes	b	-20%	-5%	-34%	-35%	85%	114%	115%
	Yes	c	-8%	-10%	-3%	14%	90%	83%	67%
	No	d	-22%	-15%	-17%	5%	95%	97%	75%
	No	e	-5%	-9%	4%	9%	89%	76%	71%
	No	f	-6%	-6%	2%	17%	86%	78%	63%
	No	g	1%	-3%	11%	33%	83%	69%	47%
	No	h	-4%	5%	3%	-5%	75%	77%	85%
2	**(4 PCTs)**	**-**	**-11%**	**-15%**	**-6%**	**-5%**	**95%**	**86%**	**85%**
	Yes	a	-32%	-65%	-50%	-55%	145%	130%	135%
	Yes	b	-25%	-20%	-14%	-24%	100%	94%	104%
	Yes	c	-7%	-6%	2%	4%	86%	78%	76%
	Yes	d	4%	-2%	6%	14%	82%	74%	67%
	No	e	2.7	5.8	7.3	9.2	74%	73%	71%
	No	f	13.1	14.9	24.2	29.3	65%	56%	51%
	No	g	-11.1	-6.4	5.1	1.2	86%	75%	79%

Site	IF Partner	(Old) PCT	Baseline: % change to achieve target	Change still required (from 2004/5) to meet target in 2006/7	Change still required (from 2005/6) to meet target in 2006/7	Change still required (from 2006/7) to meet target in 2006/7	2004/5 as a % of 2006/7 projection	2005/6 as a % of 2006/7 projection	2006/7 as a % of 2006/7 projection
3	**(1 PCT)**	**-**	**-4%**	**10%**	**17%**	**16%**	**70%**	**63%**	**64%**
4	**(1 PCT)**	**a**	**0%**	**8%**	**15%**	**24%**	**72%**	**65%**	**56%**
	No	b	-2%	-2%	-3%	9%	82%	83%	71%
	No	c	32%	19%	17%	21%	61%	63%	59%
	No	e	17%	7%	21%	1%	73%	59%	79%
	No	d	-21%	-19%	-24%	-17%	99%	104%	97%
5	**(4 PCTs)**	**-**	**-7%**	**-8%**	**-11%**	**-10%**	**89%**	**91%**	**90%**
	Yes	a	-19%	-32%	-38%	-30%	112%	118%	110%
	Yes	b	-8%	-13%	-13%	-13%	93%	93%	93%
	Yes	c	5%	5%	3%	1%	75%	77%	79%
	Yes	d	-7%	-1%	1%	-4%	81%	79%	84%
6	**(1 PCT)**	**-**	**-15%**	**-9%**	**-3%**	**-6%**	**88%**	**83%**	**86%**
7	**(3 PCTs)**	**-**	**13%**	**17%**	**22%**	**26%**	**63%**	**58%**	**54%**
	Yes	a	18%	16%	23%	30%	64%	57%	50%
	Yes	b	11%	6%	14%	13%	74%	66%	67%
	Yes	c	10%	24%	27%	30%	56%	53%	50%
8	**(5 PCTs)**	**-**	**-19%**	**-13%**	**-11%**	**-4%**	**93%**	**91%**	**84%**

Site	**IF Partner**	**(Old) PCT**	**Baseline: % change to achieve target**	**Change still required (from 2004/5) to meet target in 2006/7**	**Change still required (from 2005/6) to meet target in 2006/7**	**Change still required (from 2006/7) to meet target in 2006/7**	**2004/5 as a % of 2006/7 projection**	**2005/6 as a % of 2006/7 projection**	**2006/7 as a % of 2006/7 projection**
	Yes	a	-28%	-33%	-37%	-28%	113%	117%	108%
	Yes	b	-14%	-8%	-1%	-6%	88%	81%	86%
	Yes	c	-20%	-7%	-4%	3%	87%	84%	77%
	Yes	d	-8%	-10%	-12%	-3%	90%	92%	83%
	Yes	e	-12%	-5%	5%	16%	85%	75%	64%
	No	f	-9%	-14%	5%	2%	94%	75%	78%
	No	i	-10%	0%	5%	3%	80%	75%	77%
	No	g	2%	-7%	1%	9%	87%	79%	71%
9	**(3 PCTs)**	**-**	**-14%**	**-12%**	**-13%**	**-8%**	**92%**	**93%**	**88%**
	Yes	a	-17%	-22%	-32%	-28%	102%	112%	108%
	Yes	b	-27%	-33%	-38%	-34%	113%	118%	114%
	Yes	c	-7%	-1%	3%	9%	81%	77%	71%
TOTAL IF*	**Yes**	**-**	**-8%**	**-2%**	**-2%**	**2%**	**82%**	**82%**	**78%**

The IF sites' performance on EBDs, admissions and lengths of stay by older people (aged 75 years and over) was different from that of all other English PCTs. They had consistently lower EBDs per 1000 (Table 27), lower admissions per 1000 (Table 28) and lower lengths of stay (weighted by admissions) than other English PCTs (Table 25); these figures are based on analyses of the 303 PCTs prior to the 2006 reconfiguration, of which 25 PCTs were involved in the IFOP). Nonetheless, perhaps surprisingly, the IFOP sites experienced consistently higher average levels of delayed discharges per 100,000 population than other English councils.

Table 29 sets out changes in the mean rate of delayed transfers of care from hospital over the same period for IFOP and other English councils. The rate of discharge was declining for both groups until the last year of the IFOP, when the mean rate of delayed discharges across councils increased (before falling by 21% over the following year). Certain IFOP councils experienced very considerable decreases in their rates of delays (particularly sites 2, 3 and 9); in contrast, councils in sites 1, 6 and 7 experienced increases year-on-year throughout the IFOP period (not including the baseline year 2003/4). While these councils experienced either sustained rises or sustained falls in delayed transfers of care, the councils in the remaining sites experienced fluctuations. Council 8's rates rose between years 1 and 2, but declined between years 2 and 3. Rates in councils 4 and 5 fell between years 1 and 2, but rose between years 2 and 3. This latter could perhaps be explained by a change in the definition of SitReps (Situation Reports), the basis of these performance statistics, to include not only acute but also PCT and mental health trust bedded services[152]. That sites 2, 3 and 9 achieved consistent decreases over three years is thus all the more impressive. Over the period of the IFOP programme, delayed discharge rates increased by 55% for site 1 and 65% for site 7, while falling by 53% for site 9, and 44% for site 2. In the year following the end of the IFOP programme, all but sites 3 and 8 saw a fall in the rates of delayed transfers of care; sites 3 had a 15% rise, and site 8 had no change from the previous year.

Table 25 Length of stay weighted by admissions from baseline to final year of the Innovation Forum

	LOS per year (sd)		**% change in weighted means p.a. from previous year**	
	IFOP PCTS	Other English PCTs	IFOP PCTS	Other English PCTs
2003/4	13.9 (3.13)	15.8 (4.55)	-4.9%	-4.7%
2004/5	12.8 (2.72)	14.5 (3.28)	-8.3%	-8.0%
2005/6	11.7 (2.52)	13.4 (2.70)	-7.8%	-8.3%
2006/7	11.3 (2.18)	12.5 (2.68)	-6.2%	-3.2%

Table 26 Percentage change in admissions per 1000 population between 2003 and 2007

Site	2003/4 to 2004/5	2004/5 to 2005/6	2005/6 to 2006/7
1	5.3	36.2	-1.2
2	-2.6	-1.6	-5.3
3	-0.1	-5.7	23.2
4	-3.7	8.6	-9.3
5	-5.4	6.1	4.3
6	-1.3	4.3	5.9
7	1.6	-3.3	-6.1
8	-2.6	-1.6	-5.3
9	-6.2	5.2	-1.4

Table 27 Total bed days per 1000 per year from baseline to final year of the Innovation Forum

	Mean total bed days per 1000 (SD)		**% change in means p.a. from previous year**	
	IFOP PCTS	Other English PCTs	IFOP PCTS	Other English PCTs
2003/4	3967 (873.31)	4728 (1374.06)	-0.5%	3.4%
2004/5	3780 (768.19)	4518 (1045.75)	-4.7%	-4.4%
2005/6	3632 (674.97)	4290 (993.77)	-3.9%	-5.1%
2006/7	3441 (648.88)	4030 (988.81)	-5.2%	-6.1%

Table 28 Admissions per 1000 from baseline to final year of the Innovation Forum

	Total admissions per 1000 per year (sd)		**% change p.a. in means from previous year**	
	IFOP PCTS	Other English PCTs	IFOP PCTS	Other English PCTs
2003/4	276.97 (32.75)	296.91 (45.46)	6.2%	6.9%
2004/5	283.17 (36.07)	309.49 (45.77)	2.2%	4.2%
2005/6	294.38 (31.88)	317.12 (49.9)	4.0%	2.5%
2006/7	292.63 (38.83)	315.56 (50.99)	-0.6%	-0.5%

Table 29 Delayed discharges (all delays, medically fit to discharge) per 100,000 population aged 65 and over,+ from baseline to final year of the Innovation Forum

	Mean delayed transfers of care per 100,000 per year (sd)		**% change in means p.a. from previous year**	
	IFOP Councils	Other English Councils	IFOP Councils	Other English Councils
2003/4	51 (25)	48 (26)	-12%	-21%
2004/5	39 (16)	32 (20)	-24%	-33%
2005/6	33 (7)	28 (18)	-15%	-13%
2006/7	35 (7)	27 (18)	6%	-4%

Table 30 Percentage change in the number of delayed transfers of care per 100,000 population aged 65 or over between 2003 and 2007

Site	**2003/4 to 2004/5**	**2004/5 to 2005/6**	**2005/6 to 2006/7**
1	-37	9	42
2	-14	-39	-8
3	-55	-21	-15
4	-7	-22	6
5	-28	-14	57
6	20	19	18
7	4	29	28
8	-30	13	-5
9	-14	-36	-27

10 Patients', carers' and professionals' experiences of different governance models

10.1 Introduction

At the patient-practitioner interface, adherence to IFOP goals would imply care processes that delivered a number of things. One was patient-centred care. Another was timely access to appropriate preventative, assessment and treatment services, with the goal of reducing avoidable acute bed use. A third requirement was ready access to community and institutional services for supplying rehabilitation and long-term care. There was also a need for integrated working between all relevant service providers and adequate continuity of care.

The patient journeys we followed incorporated experiences of a number of services, with patients frequently accessing a range of services during the care episode. Although the number of patients being 'tracked' was relatively small (n=18), these journeys were able to provide insights into a range of services across the three sites. The journeys experienced by the 18 patients have been summarised in Figure 4 to give a sense of this breadth of service use.

Figure 4 A visual representation summarising the physical movement and transitions made by patients during their journeys

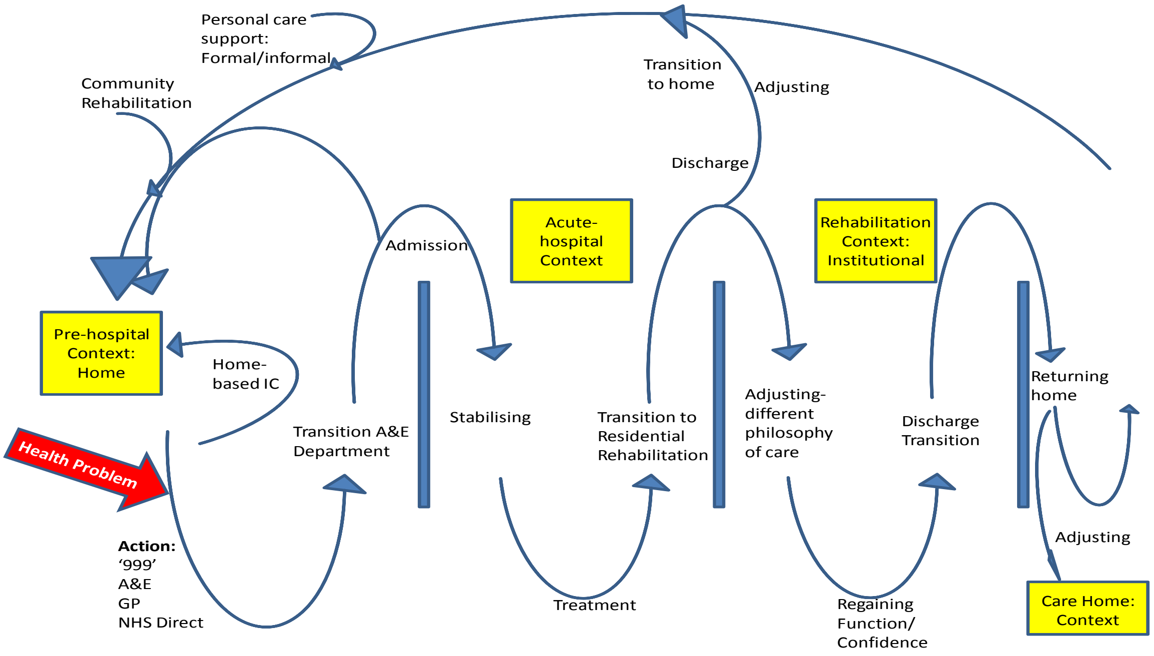
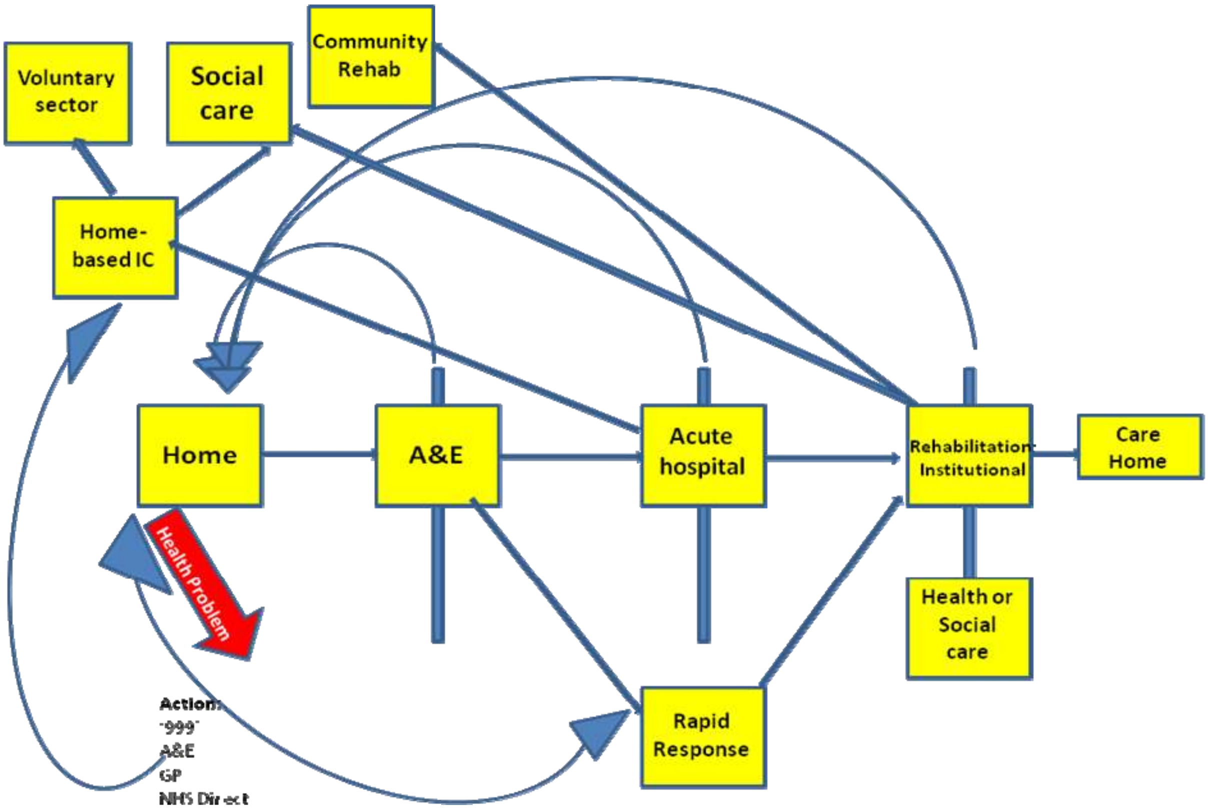


Figure 5 Diagram summarising the services accessed by patients in their journeys through the health and social care system



The use of a range of services across the health and social care systems involved older patients making a range of transitions as they moved between the different services and settings. These have been developed into Figure 5, the arrows indicating movement of patients across boundaries and settings: older people and their family carers have to move between and make sense of a whole range of services with different criteria, goals and staff.

The study of 'patient journeys' allows an exploration of the extent to which the IFOP vision of service delivery processes and patient-centred care was achieved. First, results are presented which capture feedback from patients (and some carers) about the care they received and their assessments of that care. Feedback from professionals and practitioners about service provision and service delivery processes is then provided.

10.2 Feedback from patients

Initial results focus on care delivery processes and the extent to which they appeared to support timely access to appropriate and well-integrated care. Feedback from patients is grouped according to three key phases of their 'journeys': (a) the initial crisis, i.e. their initial engagement with the health service and events leading up to it; (b) the acute phase, i.e. when they received medical interventions, generally in an acute hospital; and (c) the intermediate care or rehabilitation phase when they received care and support following (or possibly instead of) acute care. We then look at the extent to which services might be regarded as patient-centred by presenting patients' experiences and assessments of the care that they received. Again, feedback is grouped according to key phases or situations within their journeys.

10.2.1 Care delivery processes: the initial (and pre-)crisis phase

It is now widely accepted that better 'upstream' work, including greater recognition of the availability of preventive services (and use of these), can reduce the demand for emergency beds for older people. This has been demonstrated in the recent report on the POPP programme [44] as well as other studies. It has been demonstrated, for instance, that early interventions are effective in reducing the burden of recurrent falls[153] and that for patients with COPD, timely treatment of an exacerbation can shorten recovery time, minimise the risk of hospitalisation and improve health-related quality of life.[154] Feedback from the patient journeys indicated ways in which events leading to the crisis might have been prevented by more timely access to preventative services.

First, a number of problems developed because of falls, with 14 of the 18 patients interviewed having had a fall at some point prior to this episode of care. None of the patients indicated that they had attended a falls clinic, although two had received other falls prevention interventions at some point. In many cases, these previous falls had not been reported by patients thus making it impossible to introduce early interventions.

I've had a couple of bad falls. They've maybe put me in bed for a few days, but nothing like this! But it's just one of those things – you trip, or you sort-of stumble.

[Mrs P]

However, this highlights the need for health professionals to be proactive and take opportunities to ask patients about previous falls when they present for other reasons.[155]

Second, a number of patients experienced a period of ill-health before bringing this to the attention of a relevant professional. For example, there was often a reluctance to 'bother' professionals, in particular GPs, although the resulting delays in treatment could be very risky to patients' health and could sometimes lead to a possibly otherwise unneeded readmission to hospital. To give one example, Mrs I, in her mid-60s, suffered from COPD, yet had been working until two months before her first interview, despite four hospital stays in the previous year. However, as well as her reluctance to access care, she also felt that her current crisis was linked to her being discharged from hospital before she felt really well:

I suffer with a breathing problem and I know what I can do on a day to day basis, what stretches me and what I just have to pace myself at. But it wasn't any of that – my whole being felt dreadful. It was an effort to get out of bed to walk to the loo, it was an effort to go back to bed. I had no interest in eating anything, I just felt totally lifeless, drained and that was the way I was when I came out in January.

[Mrs I]

Despite a course of steroids and two of antibiotics, she 'still wasn't right'. A respiratory nurse at a pulmonary rehabilitation class advised that she needed further steroids, but when she arrived at her doctor's surgery, the GP immediately rang for an ambulance. She was re-admitted and treated for severe dehydration and an infective exacerbation of COPD, staying in hospital for three days.

Another woman, Mrs J, in her early 80s and suffering from COPD and heart failure, had a rapid re-admission after four days at home. She felt that she was still sick at the time she was discharged, but her GP did not visit (nor had he visited before her previous admission, although he had prescribed antibiotics for her chest at some point). Her daughter was unhappy about the problems associated with the first admission:

The first time we took her in, it was horrendous waiting eleven hours [in A&E] – and they had to discharge her after three days ... You could see she was ill! And then four days later she's back in again.

[Mrs J (daughter)]

There appeared to be poor knowledge by patients of alternative ways to access treatment. None of the patients had contacted NHS Direct, and there was a strong reliance on dialling 999, even though evidence suggests that up to half of those who fall and are attended by the ambulance service do not need to be taken to hospital.[156] The next case study, however, describes a successful service response.

Mrs N had received services from a community-based intermediate care team for about a year following a fall (later diagnosed as caused by a CVA). At the time of the crisis, she used her community alarm and the call centre contacted the emergency services. When the paramedics examined her, they decided that there was no need for her to go into hospital and instead referred her to intermediate care services. The decision appears to have been aided by patient-held notes kept in her home. She seemed to make fairly regular use of the paramedic service after experiencing a fall as she preferred the service they offered and the rapid response:

If I press that [alarm], then it answers in the hall there. That's how I got the paramedics you see, because – not being unkind – you can be on the phone for hours trying to ring a doctor and you don't get anywhere. So I ring now for the paramedics.

[Mrs N]

10.2.2 Care delivery processes: the acute phase

Some hospital stays can be averted at the point that patients find themselves referred (or refer themselves) to the A&E department. One of the cases studied illustrates an initially successful service response (but see section 10.2.4). Mrs D had a history of CVA and Parkinson's Disease and was living at home with home care visits four times a day. After a fall, she was taken by ambulance to A&E where she was diagnosed with a fractured neck of humerus and pubic rami. Considerable effort appears to have been put into avoiding an admission to the main hospital. She was kept in an observation ward overnight and referred to the rapid response team for an assessment in her own home the following morning. She was anxious to return home, which her niece felt had influenced the decisions made:

> *She said she would do anything to be back home. I don't know….how she presented to – if she did have any assessments at the hospital – how she would have presented there, to try and convince them that she was okay to go home.*
>
> [Mrs D (niece)]

Clearly, it can be difficult for A&E staff to make fairly quick decisions that appropriately balance risk and a patient's preferences; this has been well recognised in other studies.[157] In this case, it seems that the staff coped with this issue by referring on to the rapid response team, with an understanding that she would be visited quickly.

But not all patients are successfully diverted. Four patients in our study were admitted even though health staff thought their admissions could have been prevented. For example, Mrs P fell in the street and a member of the public called 999 to get help, as she seemed unable to get up. As she recounts:

> *I had to go to hospital, really. They asked which one I would prefer to go to and I said [name] because it's easier to get to if I had to go back. But that was all, they took details in the ambulance and passed me over (laughter), as a parcel … I went to the hospital and they x-rayed the hips and my elbow, because I made a mess of the elbow. I had to stay overnight because I couldn't walk. And then they brought me home, because the care team were willing to look after me and see that everything went OK. Otherwise, I'd have probably had to stay in hospital.*
>
> [Mrs P]

Her discharge home was arranged by hospital therapists, as she told them that this was her preference if it was possible; they also arranged intermediate care team support. It may also be that the lack of a bed-based intermediate care facility influenced the decision for her to return home. It is unclear why the referral to the intermediate care team could not have been made earlier, avoiding the need for admission.

Two other patients in this study had their admissions avoided, following falls, by A&E staff, but their problems were not fully resolved because staff did not make any follow-up arrangements for additional services. For example, Mrs R had an accidental fall while on holiday in Spain, and received treatment there. On returning home, she went to her local A&E department, who again x-rayed her arm, left the plaster and sling in place and sent her home. The A&E staff did not discuss with her how she would manage at home with one arm in a cast. Fortunately, she learned about adult care services from a family member and her GP referred her to the intermediate care team (ICT) for assistance and rehabilitation:

> *I got a phone call within 24 hours from adult care [actually ICT] asking me what was wrong and coming along – and maybe two days later I was all set up; they were marvellous.*
>
> [Mrs R]

Mr H, in his 60s, fell in his kitchen one morning. He went to A&E in his local acute hospital and learned that he had fractured his ankle. Because there were no staff to set it, he was urged to go to a different local hospital, which he did the next day. He was sent home with a pair of crutches and told not to put weight on the broken ankle, but without careful attention to his needs:

They got someone to wheel me down to the taxi area, pair of crutches, never even tried me on the crutches, but when I tried to walk I couldn't move my leg.

[Mr H]

Nonetheless, he received home care one hour a day for cleaning, shopping and meal preparation, as well as meals on wheels twice a day and had two visits from his GP. After a week of providing services, the social services department referred him to the community rehabilitation service, treated as a priority because he was not managing at home and was considered at risk of hospital admission. The speed of their response and the care provided by the rehabilitation team appear to have been critical in preventing his admission to hospital.

10.2.3 Care delivery processes: the intermediate care or rehabilitation phase

Decision-making about on-going care in some cases was quick and resulted in patients being very happy with the outcome. One man was offered a six-week package of intensive physiotherapy and transferred to the rehabilitation unit the next day. He was screened in the hospital's observation ward by staff from the intermediate care service:

They came to see if I was a suitable candidate that they could help here, because they can't take everyone … I told them all the circumstances, and they had a discussion, they said I was a suitable candidate and that I could benefit from what they could offer.

[Mr K]

Similarly, another patient had a speedy transition to community treatment, following good communication between hospital and community staff. As she told us:

I just couldn't believe it. It all sort of clicked into place. I thought, this is actually going to happen… I came home and I just couldn't believe it, the phone rang and [they] said 'We'll be here in half an hour' – and they were.

[Mrs I]

Sometimes a patient's choice of destination could clash with intermediate care admission criteria. One patient, for instance, was keen to move to a community hospital for convalescence, as she felt too weak to go home. She did not realise that such a move could only take place if further rehabilitative treatment was needed.

A number of patients felt they were not provided with sufficient information for them to understand what was happening to them. It is known that bottlenecks in services elsewhere can have a major impact on discharge planning, yet these are not always discussed with patients themselves [158]. Some patients expressed some frustration with this situation. One had hoped to go to the local community hospital, which she had heard praised by friends, but eventually went to a rehabilitation unit. She warmed to the idea of the latter, after her son found further information about it through the internet, but still felt she had been given little choice:

I was supposed to be going on the Friday and then one of the family rang up and they said 'She won't be going on Friday, she'll probably go on Monday'. And then later on, my grandson came and [...] asked where I was going and they said [community hospital]. And then the next visitor that came asked and they said 'There's no room at [community hospital], she's going to [rehabilitation unit] on the Monday'.

[Mrs B]

Hospital transport can be key to getting people home successfully. This needs to be handled sensitively. One patient spoke well of the transport team:

They brought me home in the ambulance and they had to physically carry me upstairs (laughter) – it's quite a long way up …

[Mrs P]

But some had encounters with hospital transport that were unpleasant or even distressing. One patient felt that her transport home, which was long and involved stops to pick up other patients, may have contributed to her re-admission. Another was left in the hallway of her home in her wheelchair with no effort to assist her to her armchair or generally settle her in:

They brought me in the front door, he pushed the chair there, said cheerio and off he went… If it wasn't for the fact that I've got a friend who's got my phone number and I managed to wiggle the chair around until I found my phone… I phoned him and I said would he come down and release me from the chair?

[Mrs L]

This treatment presented the risk that she would have yet another fall and crisis re-admission. Fortunately the supported discharge team and the neighbour arrived shortly after she reached home, so they were all able to help her. Indeed, she was able to move around, once given her frame.

10.2.4 Patients' and carers' assessments of services: efforts to avoid admissions

When patients are in crisis, professionals often look to family or other potential carers to help out in the hope of avoiding an admission to hospital. Such requests could put considerable pressure on those who were expected to assist quickly. This can be seen in the case of one woman's niece, who was asked to come at short notice in order to prevent an admission, but was left feeling somewhat guilty at her reluctance to do so:

I got a phone call at about 6 o'clock from one of these OT women saying 'In my opinion [Mrs D] should not have been discharged home on her own – given her fracture in her arm, she can't get up out the chair… Could you come over and stay with her and look after her?' I said: 'Well, you've placed me in a very difficult position. It won't be tonight will it? I'm sorry, I can't'. That made me feel terrible.

[Mrs D (niece)]

Another patient had a network of support, particularly from older neighbours, that enabled her to live in her own home. But she felt they then became imposed upon by local professionals:

She's [neighbour] not a carer, she's not a helper – they started ringing her up 7 o'clock in the morning, so I had to have her name scrubbed off. I never tell anybody her name... The last time I was bad they said they wanted to ring [the neighbour] and I said 'No, I'm not giving you permission' because she'd just had a broken shoulder herself.

[Mrs L]

On the other hand, it was certainly the case that the friends and family of some patients played a key role in providing care. For instance, one woman living on her own needed help over two days until a rehabilitation bed became available and she obtained this from her son and friends.

10.2.5 Patients' and carers' assessments of care in A&E

Some patients had spent considerable periods of time in an A&E department. It was noted that this could be a very stressful period, both for patients and for those concerned about them. One patient's daughter recalled difficulties in obtaining food for her mother, while waiting for her to be admitted:

She didn't get anything until she was on the ward at 1 o'clock in the afternoon – and that's from 7 o'clock the previous night. I was out getting her teas and food, walking in [the street outside the hospital] at 3 o'clock in the morning.

[Mrs J (daughter)]

Another issue was difficulty in obtaining clear information, as described by the niece of another patient:

When I phoned up A&E to find out where she was and what was going to happen to her, I must have spoken to about eight or nine different people and got passed from pillar to post in terms of 'She's on the medical assessment ward', or 'She's in A&E', or 'She's not here, she's in a side ward'. ... I kept getting back to the same person – that didn't instil me with confidence, but I know what it's like in a busy A&E.

[Mrs D (niece)]

10.2.6 Patients' and carers' assessments of hospital environment and staffing

Four participants made extensive comments about the quality of the hospital environment and services. The availability of nursing staff was a particular concern, especially for those who had little contact with anyone else. One woman, recently widowed, noted:

I was in a room on my own at the top of the corridor and it got very, very lonely – sometimes I never saw anybody from breakfast until dinner time. I had no television or radio and it got a bit wearisome. But nurses haven't got a lot of time to come and chat like they used to have years ago. ... I would have liked to have seen them popping in as they went past the corridor, even if they just put their heads round the door and say 'How are you?', but they're so busy.

[Mrs Q]

But it was not solely their availability that was at issue. Nurses' attitudes were also the cause of concern, coupled with constant turnover:

They don't seem to care at all. … You get a nurse one morning, you think, well the next day you're going to go along fine, because she's there. But you don't, you see somebody different.

[Mrs L]

Patients were not always satisfied with the rehabilitation services available in hospital. One noted that very little physiotherapy was provided in one hospital stay, compared to a different hospital on another occasion. In contrast, a patient in another site, with a history of falls, had received regular rehabilitation during both her recent admissions. During her first stay, she had had intensive physiotherapy and OT and attended hospital falls and exercise groups; she had been seen by a nurse specialising in working with people having falls, who gave her advice on preventing urinary infections and recommended medication for osteoporosis.

10.2.7 Patients' and carers' assessments of hospital discharge

Many patients and carers were concerned with the quality of discharge planning, particularly their lack of involvement in this process. Issues underpinning patients' accounts of planning for discharge and post-hospital care included: the need for choice and information, problems of hospital capacity and the admission criteria for alternative services.

Patients clearly sought some sense of choice in whether they were to be discharged, but this was not always offered. Some trusted the hospital team to make the right decision, but others were less sanguine. Two patients with COPD from different sites had an unsuccessful discharge home from hospital, each following their own insistence that they were not feeling well enough to go. As one said, it was difficult to argue with doctors:

I was astonished when the young doctor said 'I think you can go home tomorrow'. I said 'I don't feel fit. … What about me going to the [rehabilitation unit] for a bit?' And he said 'Oh no, you'd be much better at home, get back to normal'. And so it was against my will. I suppose they would say I finally agreed, but there didn't seem any option but to go home – and it was then I found I wasn't able to cope. … With hindsight, I was a bit weak to go with it, but I was so weak.'

[Miss E]

For some, there could be constant battles. In one case, a patient's daughter worried that care staff did not understand her mother's home circumstances and would discharge her without any services put in place.

10.2.8 Patients' and carers' assessments of services following (or instead of) a hospital stay

Community-based rehabilitative services, including intermediate care, were an important feature of Innovation Forum activity. These services were frequently developed to provide alternatives to acute hospital care, given the broad target of reducing hospital bed use. In some cases, they were used to divert patients from entering hospital, but they were also used to reduce lengths of stay of patients who had been admitted.

Patients and their families commented on a number of aspects of these services. With respect to assessment and goal setting, some patients reported being unaware of this process or how decisions had been made about their care (or were unable to remember). Some thought that their families may have been involved, others that staff had made all the decisions for them. But some were very impressed with the process of assessment, seen as a subtle activity:

She would probably be sitting watching me walk out, she probably watched the way they had to help me get my legs up on the bed the first time, so she's assessing me all the time, isn't she? So it's not something you're really aware of, she's just watching what I'm doing and how I'm doing it, that's basically what it comes down to.

[Mrs P]

Others commented on the outcomes they tried to achieve:

They concentrate on getting you walking properly and exercising, walking stairs, because if you're living somewhere that has no lift. … And they want to see how you're coping at home. … Oh yes, and they take you home to your own place. … They've done that. Then once you've gone home, I think within about a week, you're getting ready to go home.

[Mrs G]

A number of patients were pleased with the ways they were treated, in terms of speed, thoroughness and the general approach:

They asked me about medication, any operations, any allergies, all these things – and not only did they ask me everything they should, they were friendly. They were right away my first name which I like. And I called them by their first names.

[Mrs R]

The intensity of rehabilitation varied considerably between services. Community-based rehabilitation teams could see their patients very intensively for short periods, as often as three times a day, although this was generally decreased to a single weekly visit. Some patients and carers were dissatisfied with the pace of rehabilitation, although there could be disagreement between them. One woman felt that too little was provided for her aunt, noting that she spent much of the day sitting in a chair and her mobility was deteriorating (in a bed-based service):

She's gone downhill – not only becoming institutionalised, but she's also not had any supportive rehab in terms of mobility or anything. Not even anybody's said 'Walk up and down the corridor'. Because a lot of the staff there aren't trained to do that anyway, they won't take that responsibility.

[Mrs D (niece)]

The aunt, in contrast, acknowledged that she had been feeling weak and lacking in confidence, which had rightly affected the pace of rehabilitation:

You realise you can't stand falling again, you feel so weak and so shaky. … It is just getting your confidence back and once your confidence is back, you feel part of the way there. … They won't come straightaway, because you are so weak ... I was expecting some today, the physio … I am hoping now, now they've started, they are going to do a bit each day. That's what happened the last time.

[Mrs D]

For those receiving rehabilitative care at home, support with personal care and meal preparation was also a key element. This was of particular importance for those without family or friends to support them and could be varied to some extent according to need. As one patient described:

To start with, it was a three times a day situation, because there was nothing I could do for myself. It was really somebody to help me get washed and dressed in the morning and then somebody to get something lunchtime and an evening meal. And then gradually as I began to get better, the morning one stopped and that's how it went on, so now I just get somebody come in for the mobility. Once I was able to do things for myself, which I've always done, there wasn't any need, they've got plenty to do. They don't need to come round just for the sake of it.

[Mrs P]

Many of the patients receiving rehabilitation services welcomed the fact that they were treated as individuals, with their care tailored to their needs. In other words, the holistic and person-centred approach was highly appreciated. As one daughter put it:

It was a whole package. … It wasn't just my mum, they actually thought about my dad as well, because he's 81 and he's got breathing problems. … They came up with good ideas.

[Mrs M (daughter)]

Those receiving home-based rehabilitation (and their relatives) were very positive about being able to have this care in their own home. Several commented on how well they were attended to, both in the home and rehabilitation taking place in the space they were familiar with, thus preparing them to re-engage with their home environment:

I'm a lot happier at home, because you can be your own person, you can do what you like, as far as you're able to, and there's no restrictions. I can have my meals when I want them and go to bed when I want to and simple things like that. It makes a difference. I don't like being regimented.

[Mrs Q]

10.3 Feedback from professionals

Having described patients' views of the care received in the course of their experience of the care system, from their initial crisis through to rehabilitation, it is now useful to examine the same services from the perspectives of the professionals involved.

10.3.1 Initial crisis

All three sites studied had some form of rapid response service to avert acute emergency admissions. The teams varied in composition, but all had nursing and care support staff and some included allied health professionals, such as physiotherapists and occupational therapists. A key issue for those providing these alternative services was getting their existence known to those who might refer patients to them, as lack of referrals seemed to limit what they were able to provide. This, in turn, meant that patients ended up in hospital when they might have been diverted to alternative care.

Critical players in this system were hospital A&E staff. Lack of referrals from this source was frequently noted with frustration by those providing alternative services. They felt that referrals were also limited from GPs and others working in the community, including ambulance services and particularly out-of-hours services. Providers in all the sites argued that an opportunity was being missed to prevent hospital admissions by not referring people to their service:

> *There are quite a lot of people referred because of falling, but unfortunately a lot of them don't get referred at the time of the fall – they get referred for physio as an afterthought by the GP. You wish sometimes that they'd referred them at the time for a more immediate response.*

Just as patients and their families had a tendency to dial 999 when faced with an emergency, so too do local professionals often see this as the obvious first step to obtaining help. Considerable efforts were being made to publicise the existence of rapid response teams more widely, but it was felt to be difficult to change long-held habits and attitudes. Indeed, this was underlined by one professional care worker interviewed:

> *We're not nurses. We don't know what's wrong with them if they have a fall. We can't say whether they're injured. Most of them do not want to go into hospital. They say 'Please don't ring an ambulance', but in most cases you have to.*

GPs in this study appeared to be influential in steering their patients' care pathways, but generally towards hospital services. On the other hand, recent changes in the GP appointment system had resulted in problems for some patients, as described by this worker concerning patients with respiratory disorders:

> *If you want a home visit, you have to let them know between 8 and 8.30 in the morning, which defeats a lot of our patients. Because they think they're not so good and by lunch time they think 'I'm definitely not so good here'. Well, if they then ring up for a home visit, they can't have one ... So then they've got to wait 'til the next day – often then it's too late.'*

Those teams whose services aimed to reduce both initial admission and length of stay invariably reported that they were used much more commonly for the latter purpose. This appears to reflect a national pattern: Martin et al.,[159] in a survey of intermediate care (IC) co-ordinators, found that the majority of IC services were focused on supported discharge.

The role played by out-of-hours rapid response teams was widely welcomed by those who did use them, and they were said to respond more quickly than out-of-hours GPs. Indeed, where there was a risk of hospital admission, rapid response nurses could carry out assessments and some had the power to prescribe. But it could be difficult to obtain vital health information out-of-hours, with community matrons and a patient's own GP not always available to give key information on a patient's baseline condition, and little or no access to computerised centrally held notes/assessments.

The rapid response teams hoped to expand the range of diagnoses which they could address. For instance, people with cellulitis were seen as potentially divertible at the point of the A&E visit, as patients could be given IV antibiotics in their homes, instead of in a hospital ward.

Patients could also be inappropriately referred to alternative services in a crisis, for instance a bedded rehabilitation service instead of respite, because access was free of charge. Decisions about the level of medical input required by such patients were not always straightforward, necessitating a transfer into hospital. Such units could, in principle, take on patients with a more intensive nursing need, thereby diverting them from hospital, but for some reason they did not. In one rehabilitation unit, while some nursing staff were competent to manage intravenous medications, and the unit's admission criteria did not exclude patients arriving with an intravenous line, one staff member could not recall a single case where they had accepted a patient requiring such an intervention.

10.3.2 Hospital discharge planning

Our discussions with local professionals concerning hospital care focused primarily on discharge planning procedures. There was considerable concern about this process which was seen to extend hospital stays beyond what might otherwise be necessary.

The staff working in acute hospitals that we interviewed outlined their discharge planning processes in ways that seemed orderly and sensitive. In one hospital, there was a clear system for communication through weekly multi-disciplinary ward rounds and discharge planning meetings, so that each patient's needs were discussed twice a week. Staff of one hospital explained that planning started early:

> *As soon as the patient comes to the ward, you can recognise how much they can do for themselves or not, just by asking them general questions and making a judgement based on that. Obviously if the patient's happy for us to refer to 'the Social' then we can do that, if not then you can't. And if a family member comes in, they normally give us feedback as well.*

Yet everyone agreed there were many delays in the discharge process, arising for a number of reasons. Hospital staff noted that acquired infections (such as clostridium difficile, MRSA and pneumonia) were one cause. A lack of suitable placements was another. It could be difficult to obtain important information, especially as few areas had integrated records across health or social care agencies:

> *We have to dig deep to get the information. If they've been involved with community OTs, we've got a good strong link with them so it's just a case of ringing them – sometimes, they fax through information or verbally tell us over the telephone and we just make notes. But a lot of the time, you're just presented with a brand new patient and you don't really know a lot about their background…. Obviously, you get a lot of information through the family, with patient consent we ring family just to ask if they have any concerns on how they were managing – that's where a lot of the social issues come into place, where the family say 'well, actually, mum hasn't been managing for quite a long time'.*

Yet another source of delay was conflict between a patient's preferences concerning the timing and location of discharge and the MDT's duty to make a safe discharge:

> *The patient may have refused to be transferred to a rehab bed or they may have refused a package of care – they may refuse any input when they get home. A lot of falls patients are kind-of in denial that they weren't managing before coming into hospital. … They seem to think that 'Oh, once I get back home. I'll be fine'. But we have to try to get across to them that*

we need to put this support in place to prevent you coming back in again, we need to make sure that it's a robust discharge in that everything's in place for you. That can sometimes delay discharge.

Arranging the necessary case conferences and meetings with family members in order to negotiate discharge arrangements that were acceptable to everyone could often take a week to set up.

Communication between agencies was also said to be an issue. A patient might be ready to go to community rehabilitation, but could be delayed by lack of communication between acute and community staff. This was the case for one patient, according to a member of staff in the rehabilitation unit:

It's difficult to say what prevented her from coming to us earlier. One of the issues for us is the communication between the acute hospital and here. We have information on the computer system, but there isn't any actual verbal communication. … I think there are probably bed pressures from their side and that determines when people get moved on. There isn't any real joint working to say that we're picking people up at the right time.

Community staff noted the need to work with acute colleagues in identifying patients suitable for bedded rehabilitation. Some deplored the duplication of assessments between acute and community therapy. Others gave good reasons for needing to re-assess patients rather than accepting unquestioningly the assessment accompanying an acute referral. There was seen to be a need to address basic issues, such as identifying the therapy required, where a patient ultimately would be discharged to, and whether social services had been notified, before a transfer to rehabilitation could take place. Some community-based rehabilitation services had begun to work more closely with one or two acute hospitals, but it was said to take some time to change the thinking of acute staff, for instance that community intermediate care staff worked extended hours, so that screening on the ward might be carried out after 5pm. Another problem, identified by intermediate care staff in one area, was that high staff turnover in hospitals meant that staff were less skilled in assessing patients' ability to cope at home and they therefore received inappropriate referrals.

Primary care professionals expressed distrust in the discharge summaries they were sent by acute hospitals, choosing to visit patients at home as soon as they became aware of a discharge, or to 'keep tabs' on a patient's progress through other hospital contacts. This was easier when there was a network on which to rely, such as a respiratory service that crossed organisational boundaries.

There could also be delays arising from the need to get equipment or services in place. Although teams generally tried to prioritise obtaining equipment to facilitate discharge, this did not always work. One patient in our study had to wait two days in hospital due to delays in organising a hospital bed for her home. As a member of the intermediate care team explained:

They wanted to discharge her home, but she couldn't do the stairs, and we wanted her to have downstairs living. So we had to supply her with a hospital bed which we got very, very quickly. Obviously, we couldn't get it the same day as they wanted to discharge her, so she *came to the community hospital for a couple of nights and then the hospital bed was delivered and she came to us.*

Yet another reason for delayed discharge was the threshold for admission to other services. Rehabilitation units, for example, required patients to be medically fit at the time of referral. In two sites, there was seen to be a gap in provision, with a need for beds for patients who required time to recover, but not necessarily rehabilitation:

The hospital is for acute patients or an acute episode – when they're deemed fit to be discharged, they're not necessarily fit to actually go home and manage in the circumstances that they left. Sometimes, they need a bit of time to get their confidence back, get a bit better to see if they actually will manage in that same situation or if they need a bit more input. They used to get that years ago, but they don't get it now … which often means that when patients go back home, they fail again and then end up going back in – perhaps they wouldn't have done if they'd had that bit of leeway in between.

A number of issues were raised about the role of hospital rehabilitation in effecting discharges. Sometimes, rehabilitation was seen as a step that had to be gone through only to satisfy social services procedures for approving a care home placement. Sometimes, this simply slowed down the process. In the words of one rehabilitation professional:

Because of the way social services and the systems are set-up, unless they've been through a period of rehabilitation, they won't get the funding. They have to be seen, be given the opportunity to be assessed and rehabbed and to go through the process – and that lengthens the process for a lot of people. Whereas it would be quite clear earlier in the process that these people aren't going to manage, despite coming onto a rehab unit.

Limited staffing meant that patients who were not going home were given low priority, as explained by one hospital therapist:

We try to see patients as much as we can, but obviously our priorities do lie with patients that are being discharged home, for example if they live alone – whereas patients who are listed for rehab, as much as I'd like to get round and see all of them, sometimes it's just not feasible.

Delays also affected patients in other ways. Where there was a substantial delay in locating a rehabilitation bed, some patients who recovered their strength while waiting for a rehabilitation placement were no longer suitable for the rehabilitation placement after all. Staff in community rehabilitation settings nonetheless felt that it was important for acute therapists to continue rehabilitation once a bed in the community had been located:

Once these inpatient teams have identified somebody as coming to rehab, it's almost like their rehab in hospital stops. They just sit and wait for the bed, whereas they should be continuing and then they might not actually have to come to rehab.

In contrast, problems could also arise if patients identified for move to a rehabilitation unit made no progress while awaiting transfer, because they then required more intensive therapy once they had arrived:

The patients that we get from the acute hospital – they could have been sat there for four or five weeks and not done anything and then we've got all the hard work to do when they come to us.

Despite the many problems over delayed discharges, some argued that the assessment process was undertaken too quickly, compared to years ago. Staff of both community and acute services commented on the faster pace of hospital care in recent years, generally arising from the need for more rapid throughput. For instance, it was noted by one social services staff member that there had been a reduction in pre-discharge home visits:

> *You don't tend to get a lot of home visits anymore, especially from the acute hospital. It used to be a standard procedure for a person going home – they would do an access visit, they would look at doing a home visit to assess further risks. Now, assessments are carried out on the ward, which often doesn't give a true picture of that person's ability in their own home.*

Home visits were seen as important to identify hazards in patients' homes, thereby preventing falls and, in turn, future admissions. It was said that there had to be a 'clinical need' to warrant a home visit, so those patients who were assessed as independently mobile on the ward were unlikely to get one.

Some patients were said to be sent to a rehabilitation unit too early, for instance with chest infections or other medical problems, when they might have benefited from remaining in the acute hospital for more intensive medical care. As noted by a staff member of one such unit:

> *Sometimes we get people who had falls at home and gone into hospital – they're not really injured, but they have urine or chest infections that may have been a contributing fact to them falling. They've been ill and weak and not eating and not drinking, so they've fallen. They won't spend any time in hospital, 24-48 hours, and then they're not well enough to go home, but they're not really ill enough to stay in hospital. Some come in here and you find you're ringing the doctor because you're thinking that they're deteriorating and there may be other problems that haven't been investigated fully.*

The inherent conflict between the benefits of early discharge and the potential risks to a person's safety was seen to require a delicate balancing act for hospital staff. While the risk of a failed discharge was taken very seriously, the risks of remaining in hospital were also viewed with concern. A number of staff in both acute and primary care services called attention to the adverse consequences for patients of staying in hospital – both physical, such as infections and pressure sores, and psychosocial, such as institutionalisation:

> *Quite often, patients from an acute hospital have got into that sick role – we spend the first week or so undoing what's happened already and trying to convince people that we are trying to give them back their independence. Some people like that and some people are used to the sick role and they like having things done to them.*

It might be added that some community-based rehabilitation staff were unable to understand the acute rehabilitation decision-making process. Some categories of patient, such as post-surgical orthopaedic patients and those with minor falls-related injuries, appeared to be arbitrarily sent home or into bedded rehabilitation. Rehabilitation staff in bedded settings often had experience of working in patients' homes, and could see little difference between those being sent to their units and those being sent straight home.

10.3.3 Rehabilitation in bedded units

All bedded units had a policy of limiting treatment to a six-week period, but none enforced this limit strictly, according to those interviewed. There appeared to be consensus that if patients were able to make functional gains, this was a good reason to extend the duration of treatment. Depending on the ownership of the unit, it was possible (although rare) for people staying on past the six-week limit to be charged for the rest of their stay.

In line with this time-limited policy, some units did not normally accept patients requiring 'slow-stream' rehabilitation, for instance those with complex care needs, who were expected to take longer than six weeks to recover. One patient was cited, who was deemed to be unable to return home after a spell in the unit, but who needed time to come to terms with entering long-term care. Such long stays in a short-stay model were seen to create 'phenomenal' backlogs in the system, particularly if the number of rehabilitation beds available was quite limited.

A number of staff commented on this issue of time limits. It could be difficult to cater for those who might require a stay longer than six weeks. In a unit with an explicit remit to take patients with complex needs, who might ultimately need to enter a care home, this could create frustrations for rehabilitation staff, if they did not have the capacity to give all patients equal time. A staff member of one residential unit expressed concerns over the time taken in decision-making when it appeared that a patient could not return home, although this was controlled by processes and policies external to the unit.

However, it was not uncommon for delays to occur in discharging people home from a bedded unit. Reasons given included external factors, as well as deterioration in physical health, such as a fall. Unavailable equipment could produce a delay of a couple of days. Moderate delays of up to two weeks could occur if a patient's housing required minor adaptations. More serious delays occurred when a patient's housing was no longer appropriate because of diminished mobility. Once issues with housing were identified with social services, it required a great deal of follow-up and negotiation on the part of staff.

Setting up packages of care arrangements could cause problems, especially with issues arising when the packages required more than three visits a day, involved travelling in rural areas, or required the presence of two carers. Similarly, placements into long-term care could cause long delays, if the referred-to service was unable to find a bed or assessed the patient as unsuitable. 'Going to panel' was seen as part of delays involving placements and care packages. Patient-related factors, such as an unchecked deterioration in a disease process, particularly dementia, and problems with carers coping could also cause delays, as reflected by one staff participant:

> *The problem is not necessarily the injury that we've got, it is that there might be other circumstances that have brought them in, i.e. they can't go back because they haven't been coping before that or there's a relative problem or there are other problems … and they haven't been coping. I think the six week window does work quite well. If it doesn't, it's generally because there are other issues that are involved.*

One therapist commented on the impact that OT and physiotherapy staff shortages had on the ability to provide community rehabilitation and thus on patients:

We have a shortage of staff and so does every NHS hospital, so sometimes people who are waiting – not for intermediate care but for physio, for therapy – if people are on the waiting list, then they keep waiting long. … And that is a crucial time, if they had a fall or something else happens, they go to hospitals with a bigger problem and that cannot be cost effective. It's very important to have a bit more staff and try to avoid the situation.

10.3.4 Community-based rehabilitation

Patients receiving intermediate care in their homes, like those in rehabilitation units, were also monitored to ensure that their needs were checked over time:

We normally try to explain to people what we're about and give them a bit of an idea so we'll come for a couple of weeks and see how you're getting on and then we'll review it. And sometimes you extend over the six weeks period, if the rehab is not complete, but you can see an end point, then you would extend it. So, it is sort of quite patient-centred.

Most community-based teams also had time limits on their service, with duration of treatment as short as two or three weeks in the case of hospital-at-home and supported discharge teams. One community-based intermediate care team had a six-week limit, but it was possible for this to be interpreted flexibly. The focus was on a patient's progress and their presenting condition; those with fractures often needed longer, for example, as full rehabilitation could often not begin until their plaster had been removed. Staff described exceeding the prescribed six-week time limit if the patient was still benefiting from their input:

We wouldn't be doing our job right if we just said 'Right, there's your six weeks, you're going to ongoing care'. I don't think that would be very productive.

Nonetheless, services could not be extended indefinitely and patients were said to be well aware of this.

Perhaps not surprisingly, the views of staff about where rehabilitative care was best provided – a bedded unit or at home – appeared to vary with their place of work. Community rehabilitation staff felt that patients benefited from being in their own environment; in addition, this provided a more realistic challenge, rather than the 'theoretical environment' of an institution:

Rehabilitation in hospital is not the same – it's doing it in a safe environment. To be challenged, they have to go out their front door. … And it can't be just once every morning, it has to be every day if you can.

Moreover, it was argued that for some patients, a long hospital stay might mean they become institutionalised. In their own familiar environment, in contrast, they might retain their abilities better, especially as they could pace themselves. In the end, as one staff member remarked, if patients were in hospital, they still had a settling-in period when they went home.

In contrast, staff in bedded units emphasised the efficiency and cost-effectiveness of providing residential-based care. One key argument here was the savings in staffing, as they could cover many more patients with a small number of care staff relative to the cover required for the same number of community patients. The benefits of proper nutrition and the stimulation arising from the company of staff and other patients were other reasons for favouring bed-based rehabilitation:

For the type of client we get in here, it isn't just the mobilisation and that sort of thing, it's the social side and the nutritional side. You make sure they eat [at home] but you can't be there, here they eat together and it does have an effect, [they] try a little bit more, they don't like to leave an half empty plate. Not only that, we have the social side, we have quizzes, things that they don't do at home.

10.3.5 Other organisational issues

Most of the intermediate care teams encountered during this study had co-located the core team members on the same premises. This appeared to be effective in allowing team members to coordinate their actions. Indeed, we did not note any instances of miscommunication within teams leading to problems with treatment planning, treatment or discharge. Some teams were located in more than one site, however, including teams with 'cover' from some professionals in the same organisation or from other agencies.

In the case of community teams, liaison between team members was affected by the fact that they were dispersed to different patients' homes during the day. Mobile phones were useful to communicate rapidly changing circumstances, to check information or to make referrals across and outside the team. Team members could also be kept informed of each others' activities via a communication book, which staff were required to check frequently throughout the day.

The multi-disciplinary team (MDT) meeting was seen as an important mechanism for good treatment planning and coordination. The importance attached to MDT meetings by team members appeared to vary depending on the size, function and setting of the service, and on the availability of team members. In one team, where staff came from different agencies and located in different settings, the MDT was important in providing opportunities for face-to-face discussions of clinical issues and potential referrals. Other team meetings included large numbers of staff, some from outside the core team, again providing the opportunity for liaison both during meetings and afterwards. On the other hand, it was difficult to hold prolonged discussions about any one patient, because of the number of staff not present and the threat of the meeting running over time.

Most, although not all, intermediate care teams had developed joint recording systems, used routinely by team members to record assessment results, goals, and discharge plans. These were not generally the source of any contention. Different arrangements existed for keeping notes with patients; in some cases, they remained in the patients' home, but in others were removed by each agency following its involvement. One staff member noted one case where patient-held notes had helped the team to divert a patient from admission, because of information available to visiting paramedics. Where teams prepared parallel records, there was concern about the duplication involved.

Joint records were in place in the majority of bedded units and this appeared to be a well-established practice in most places. Goal lists, daily communication notes and discharge summaries were generic, but assessment forms were profession-specific rather than interdisciplinary. One unit had experimented with an interdisciplinary assessment form, but reverted to separate assessments due to problems with layout and some staff resistance. The unit had hoped to put all documentation onto an electronic record, but this had not been implemented, resulting in nursing records kept on a computerised system and therapy notes in paper records. This system was said to lead to duplication of assessments, with patients asked the same questions several times.

Another unit had gone through a period of using integrated records, before being forced by a change in social services' record-keeping procedures. The unit's health service partner had then physically separated patient notes into one set for health and another set for social services employees. This was due to be amended again, however, with social services files being amended to 'fit in with the health principle' to create a unified set of notes.

10.4 Conclusions

At the beginning of this section we argued that adherence to IFOP goals in our research sites would be expected to generate care processes that delivered the following: patient-centred care; timely access to appropriate preventative, assessment and treatment services with the goal of reducing avoidable acute bed use; ready access to community and institutional services for supplying rehabilitation and long-term care; and integrated working between all relevant service providers and adequate continuity of care. The evidence generated by the patient journeys did offer examples of 'good practice' that conformed with this vision. However, the evidence also demonstrated key ways in which current practice falls short of these expectations. The main areas of concern are briefly discussed below.

There was sub-optimal use of services for preventing crises and acute events. In part, this was linked to patients being slow to access health care when feeling unwell. However, health professionals also failed to refer patients to preventative services. For example, frequent fallers were not always directed to or informed about falls prevention activities and services even though evidence suggests that such services are effective in reducing the burden of recurrent falls.[153]

The range of services used in a crisis was narrow: ringing 999, contacting the GP surgery or self-referral to A&E. Both patients (and their carers) and many local professionals lacked knowledge of alternative community services to avoid admission to acute hospital care. New services appeared to be 'invisible' to front-line staff, patients and carers, particularly when they were first set up. Although strategies had been developed to streamline access to care, such as 'single-point-of-access services', these proved to be problematic due to incompatible IT systems.

With respect to care in hospital, some of the patients interviewed expressed considerable distrust of nursing staff, as well as concerns about the lack of communication between staff. This is in line with survey evidence. A number of surveys have provided information on patients' views of hospital care, including concerns about the sufficiency of hospital nurses,[160] as well as some lack of confidence and trust in nursing staff.[161]

Considerable attention was given by those we interviewed to discharge arrangements and the potential for delays in this process. Gathering information on a patient's circumstances and preferences was clearly seen to be important, but often time-consuming. Home visits from hospital did not seem to feature. Family members also felt excluded from discussions about discharge arrangements, again confirming findings from elsewhere.[162] Other researchers have described the difficulties in acquiring and judging information offered by older patients in discharge planning.[158] Reviewing evidence on this issue, Coulter[163: 39] concludes: 'evidence exists that many patients have strong treatment preferences, that these are not always predictable, and that doctors often fail to understand them'.

Carers also expressed concerns about the roles they were expected to play in the care of patients following hospital discharge. They felt that professionals often looked to family or other potential carers to help out in the hope of avoiding an admission to hospital. Such requests could put considerable pressure on those who were expected to assist quickly. This view is also supported by a literature review undertaken for the Audit Commission, which found that the community care reforms have added to carer burden through targeting services towards frail older people with no informal carer, leaving those with a carer to fill the gap.[164] In contrast, a systematic review of patients discharged early from hospital reported that carers did not report additional burden.[165] However, Gunnell et al[166] argue that the effects on carers for hospital at home interventions may differ from other forms of home-based care.

Finally, turning to rehabilitation, both patients and staff spoke positively about this phase of patient care. Patients and staff were also content with the six-week duration of rehabilitation. But such time-limited care was seen to require strong leadership, good assessment, communication, screening and goal setting with patients. It tended to require staff working in other phases of patient care to undertake assessment and referral to appropriate services. This needed to be done in a patient-focused, detailed and timely way, and not based on a need to meet targets relating to delayed discharge.

11 Conclusions: governance through local networks, national targets or financial incentives?

11.1 Introduction

National strategies, local initiatives, cross-agency agreements, various targets and financial incentives have all been deployed in an effort to reverse the growth in emergency bed days (EBDs). Within this rapidly changing context there was another effort underway: the *Improving the Future for Older People* (IFOP) programme of the Innovation Forum. A group of nine English councils created their own network in 2003, with the primary aim of reducing use of emergency bed days. Specifically, they agreed to work in partnership with health and third sector organisations to achieve the ‘headline target’ of a 20% reduction in EBDs for people aged 75 and over, over a three-year period from 2004 to 2007. This target was adopted, moreover, before any specific national ones had been set in relation to reductions in EBD numbers.

The study reported here examined how these nine councils and their partners approached this challenge, the interventions they adopted, the opportunities and difficulties encountered, and the consequences for patients. Did governance through such a partnership (i.e. networks) achieve change in EBD numbers or were centrally articulated incentives or targets stronger influences? The overarching study aim, therefore, was to examine the impact of different governance models as local health and social care economies sought to reduce utilisation of unplanned inpatient bed days by older people.

In drawing together the different and complex strands of the empirical work to suggest overarching conclusions in this final section, we first offer a systematic comparison of the governance models and how far they could be said to have affected achievement of the 20% reduction in EBDs. We then re-visit the contribution of each site to the headline target, and examine the attribution of such changes. Is there a single causal pathway between the activities of the networks and outcomes achieved, or are the observed outcomes produced through a combination of centralised targets, local demands and locally developed working practices? In discussing this question we relate the context, mechanisms ('projects' producing changes in service delivery) and user/individual outcomes in the standard way for realistic evaluation.

11.2 Governance and network effectiveness

In exploring the governance models in place within the nine sites, we outlined a number of taxonomies that could be used to classify the activities of the different IFOP networks. These included the markets-networks-hierarchies taxonomy, as well as the more nuanced taxonomy that distinguishes quasi-markets, quasi-networks and quasi-hierarchies. Billet et al.[109] further differentiated network types according to how they emerged or originated, distinguishing negotiated partnerships, community partnerships or enacted partnerships. Comparing these different taxonomies against IFOP activities, the most appropriate category that best described the initial rationale behind, and the origins of the IFOP programme was that of directed social partnerships. As we described in Section 6, such a network is a subset of enacted social partnerships, but is differentiated by the level of involvement of government, which establishes or sponsors such networks to achieve specific policy goals.

However, we could not use such a broad governance categorization as a 'prediction tool' to explore whether some sites were more likely than others to achieve the headline outcome. All nine of the IFOP study networks conformed to such a governance model. Indeed the focus and objectives of the wider IF programme (within which IFOP was located) were driven by the joint objective of creating a more constructive and productive partnership between central and local government. Similarly, all sites used their directed social partnership to negotiate a combination of functions, but predominately they were programme networks, undertaking service redesign and joint commissioning. It was therefore necessary to analyse, categorise and differentiate the structure of their networks at a more concrete, specific level if we were to begin to draw some inferences about the relationships (or lack of them) between governance structures and the achievement of the headline target.

Building on earlier studies of networks and on the coordination of health with social care for older people (see Section 6), we first identified eleven conditions that would begin to differentiate the strengths of each study network. Such conditions included both governance structures and managerial practices. The rationale behind the inclusion of each has been described previously (Section 6). In discussing whether it was the IFOP networks that enabled change and subsequent achievement of the headline target or other factors including the dictates of centralised targets it is helpful to summarise those findings (Table 31).

If a simple count per column is used, the governance structures and managerial practices *a priori* favourable to effective network governance were most often found (in descending order) in networks 9 and 6 (jointly), then in network 5, then in networks 1 and 7 (jointly), followed by networks 2, 3 and 4. Site 8 had apparently the least favourable structure and managerial practices for building strong networks and thus to affect change across policy, practice and outcomes, but the best structure in terms of range of inter-organisational links.

Table 31 Governance structures and managerial practices

	Site								
Structure or managerial practice	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Pre-existing body becomes steering group	√	X	X	X	X	√	√	X	√
Member-organisations delegate control of decisions and resources to IFOP network rather than retain them.	√	X	√	X	√	√	√	X	√
Network-based implementation group(s)	√	√	√	√	√	√	√	X	√
Member-organisations delegate control of project implementation to IFOP network rather than retain it.	X	√	X	X	X	√	X	X	√
Network infrastructure sufficient for project selection	X	√	√	√	√	√	√	√	X
Absence of non-IFOP network with similar remit	√	X	X	√	√	X	√	X	√
Approximately equal power of health and local government member-organisations (health not dominant)	√	√	√	√	√	√	√	X	√
Extensive adoption and re-badging of pre-network projects	√	√	√	√	√	√	√	√	√
User representation structure(s)	√	√	√	√	√	√	X	X	√
At least five types of governance link between steering group and member-organisations (see Table 32)	X	X	X	X	X	X	X	√	X
Input to commissioning	X	X	X	X	√	√	X	X	√
Count	7	6	6	6	8	9	7	3	9

A network inherently consists of linkages between organisations and/or individuals. It needs appropriate and continuing links with external policy, strategic and practice groups;[143 144 167-169] and sufficient links between its members. We assumed that the wider the range of these links the more likely it would be that the directed social partnership or network would be able to influence other members. Through such influence they would be able to implement and progress those adopted projects likely to make the necessary changes in emergency bed days (see Section 7). Network by network, we summarised the links between the IFOP network and (other) member organisations. In theory, seven kinds of links were available for network coordination and governance. Our findings as to which were present in the IFOP networks are summarised in Table 32. The rationale behind their inclusion was described in Section 6.

Table 32 Governance links between network decision-makers and other network members

	Site								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Shared values or culture	√	X	X	X	X	X	√	√	X
'Technical guidance' EBM/EBP	X	X	X	X	X	√	X	√	X
Help in kind	√	√	√	√	√	√	√	√	√
Management of referral routes	X	X	X	X	X	X	X	X	X
Finance (all projects funded by several member-organisations)	X	√	√	√	X	X	X	X	X
Information and monitoring systems	√	X	√	√	√	√	√	√	√
Affiliation with other networks	√	√	√	X	√	√	√	√	√
Count	4	3	4	3	3	4	4	5	3

The widest range of linkages for governance purposes existed in network 8 (five media of linkage) followed jointly by networks 1, 3, 6, and 7; and with networks 2, 4, 5 and 9 having fewest. If range of links is a predictor of an effective network governance structure, one would expect (predict) network 8 to have a greater prospect of realising the IFOP headline targets than the remaining networks; and networks 4 and 5 to have the least prospect. In all the networks though, multiple kinds of linkages were present.

Taking the above two tables together, it could be argued that networks 6 and 9 stood the best chance of implementing whatever IFOP projects they adopted, closely followed by sites 7, 5 and 1. Network 8 had the least good prospect, scoring lowest on governance structures and managerial practices.

11.3 Key outcomes and governance models

In exploring the outcomes achieved by the sites, the nine study networks agreed that achievement of the headline target would be assessed across the IFOP programme as a whole, rather than at the level of the individual network. As we have reported, the 20% reduction in EBDs between 2004 and 2007 was collectively achieved (see Section 9). We obviously wanted to get to the detail beneath this programme-wide achievement to look at the effectiveness (or otherwise) of the differentiated governance models. In comparing the performance of networks, the measurement of the headline target was included, along with three further outcomes: decreases in emergency admissions, decreases in delayed discharges (see Section 9) and whether those adopted projects were sustained beyond the end of IFOP programme (see Section 7). We argued that these outcomes would be suggestive of each study network enabling change at the level of the local strategic and policy planning process (reduction in bed days, decreases in admissions and delayed discharges), as well as at the operational level (projects sustained). These findings are summarised in Table 33.

Table 33 IFOP site performance against bed usage objectives

	Site								
Criterion	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Reduction in bed days 20% (projected)	X	X	√	√	X	X	√	X	X
Nett fall in admits/1000 pop	X	√	X	X	X	X	√	√	X
Decreased delayed discharges during IFOP programme	X	√	√	√	X	X	X	X	√
All projects sustained after end of IFOP programme	X	X	√	X	X	√	X	X	X
Count	0	2	3	2	0	1	2	1	1

Again, using the somewhat crude basis of counts across the four outcomes, the most 'effective' or 'successful' network (for which we have data) was network 3, achieving three of the four target outcomes. Three other networks (2, 4, 7) achieved two of the outcomes, three (6, 8, 9) achieved one, while the least successful were networks 1 and 5, which did not achieve any. However, if we prioritise the headline target, given that all networks were looking to achieve such an outcome, network 3 shares first place with networks 4 and 7, while surpassing them on at least one ancillary outcome.

When juxtaposing these outcomes alongside the differentiated governance models, we found no simple association between what was predicted and what was found. As we have stated earlier, those networks that had the necessary structure and linkages that would lead us to predict success were networks 6 and 9, closely followed by 1, 5 and 7. Networks 1 and 5 did not achieve the headline target, or indeed any of the other ancillary targets. Only network 7, predicted to be effective because of its governance model, achieved the headline target as well as a fall in admissions.

From these findings there is seemingly no single, simple causal link between the model of governance adopted within the study sites and the outcomes achieved. A number of issues are thus raised. For example, certain nuances of the networks within the sites may not have been appropriately incorporated within previously suggested models of network governance, for example omitting key factors that might explain our findings. Alternatively, those governance models might satisfactorily capture what was going on in the sites, but the on-going demands arising from centralised and local targets or incentives limited what the study networks could achieve. The vertical policy and practice requirements, often instituted at short notice, cut across those actions planned and implemented by the horizontal study networks. Within such an environment, the strength of any network would be crucial. It may be that the networks were not strong enough to affect change at either the level of local authority, PCT and NHST, or at the level of operational and practice within and across the different organisational boundaries.

We now expand on these points. We first deconstruct the shared governance structures of the 'successful' networks. We then explore if the members of the networks perceived the centralised targets as a dominating discourse, limiting possible 'whole-systems' changes. Third, we try to infer the strength of the study networks through a discussion of the selected projects, service delivery and patient experience. Finally, we bring this analysis together to discuss whether managed networks can indeed bring about structural and operational change, or whether they are merely a 'side-show' to central and local demands.

11.4 Attribution: causal linkages

11.4.1 Shared governance characteristics of the 'successful' networks

In exploring the suitability of the differentiated directed social partnership structure, it is helpful to look in more detail at the shared governance characteristics across the successful networks. As discussed, we are identifying 'successful' networks by their achievement of the headline and ancillary targets.

The governance model of the successful study networks (3, 4 and 7) was structured around a network-based implementation group, able directly to control the key project implementation milestones and objectives. In fact, such 'hands-on' involvement in the projects went further, with these networks able to influence operational practice. In contrast, the structure of governance of the other study sites relied on member organisations to continue to manage the adopted projects strategically and operationally. These networks were therefore required to manage, influence or communicate through other linkages. The importance of the need for such a structure (a network-based implementation group) may be illustrated by the experience of site 4, which uniquely lacked dependence on external networks. Similarly, this was one of the few sites that lacked competing networks working to a similar remit as the IFOP programme.

Networks 4 and 7 had a 'joined-at-the-top' model of governance; rather less so in network 3. Similarly, such a structure was not restricted to these two successful networks, as network 8 shared this model. Network 8 achieved one ancillary target (reduction in number of delayed discharges) and was predicted to be the least likely to achieve the outcomes when we operationalised the governance model to incorporate management practices and linkages. Although network 8 did not fully achieve the headline target, it got close (achieving a 16% reduction in EBDs). Thus, a 'joined-at-the-top' network governance structure may have made some contribution to network effectiveness.

Conversely, we can eliminate as potentiating factors the presence of links based on 'help in-kind' (see Section 6) since all the networks had these, and, by the same logic, the practice of adoption and re-badging of pre-network projects. All but one network had information exchange links, and all but one had a roughly equal balance of power between health and local government bodies.

Assuming that not all governance factors are of equal importance, this complex, unclear picture suggests (somewhat equivocally) that the governance structures and practices most likely to reinforce the effectiveness of networks appear to be the combination of:

- network-based implementation group(s);
- a managerial support infrastructure;
- a 'joined-at-the-top' governance structure; and
- the absence of substitute non-IFOP networks with similar remit.

Singly, none of these factors appears decisive. It is more consistent with our data to infer that the combination of them is what helped make networks 3, 4 and 7 relatively successful.

However, this analysis leaves out the external environments faced by networks' member organisations, something that may have had a greater impact than the IFOP networks.

11.4.2 Manager and staff perceptions of the network linkages and effectiveness

We summarised in the tables earlier in this section the selected conditions used to differentiate the IFOP networks. In identifying which network satisfied which conditions we drew on evidence from responses to the 'governance questionnaire' (see Sections 4 and 8) and analysis of the qualitative methods (Section 8). Such an exercise was central to enabling a limited 'prediction' model. This could be argued to be reductive in its use of aggregate data in that it weights assessment toward the majority opinion. Yet minority views or perceptions may also provide insight into those conditions necessary for networks to achieve their stated goals. As already discussed, we may not have fully incorporated the nuances of the networks within our 'predictive tool'.

We focus on two highlighted conditions – *shared values or culture*, and *affiliation with other networks* – to assess whether further sub-division of these conditions is needed. These have been selected because the most successful study networks (3, 4 and 7) had a network-based implementation group. However, as noted previously, such a governance structure was not restricted to these three networks, as the other less successful sites 2, 5, 6 and 9 structured their IFOP network similarly. Thus, the question remains as to whether the links and management practices within networks 3, 4 and 7, assessed through the two conditions of shared values and affiliation, were demonstrably qualitatively different – superior – to those of the other sites.

Within the structured questionnaire, a number of questions explored group processes and interactions analogous to the condition of 'shared values and culture' (see Section 8). Responses to these questions indicated positive relationships within IFOP networks. In other non-IFOP meetings, it would seem that the dominance of one organisation could negate speedy decision-making. It would appear that participating in the IFOP programme positively affected the perception of group dynamics. The limited number of individuals who completed the questionnaire does not allow us to compare responses between the successful networks (3, 4 and 7) and others, making it difficult to ascertain whether the 'group dynamics' were necessarily more positive in the most successful sites. The later key informant interviews indicated that in site 8, although various IFOP members also met in other groups, the IFOP was felt to contribute something different to the way individuals worked together in pursuit of a common target. This was said to be less likely the case in other meetings in reporting the second condition – *affiliation with other networks* – we have already described how eight of the nine sites co-opted particular care groups or professional bodies onto their IFOP network (see Section 6 and Table 31).

However, there were no demonstrable differences across the networks in the extent to which representatives could be relied upon to embed the IFOP agenda and decisions within their own member organisations. All study networks identified difficulties in engaging one or other of the member organisations, whether NHS or local authority. There were examples in the later key informant interviews of 'difficult' relations between the operational managers and clinicians of PCTs and those of the acute trust, and fears that relationships between PCTs and acute trusts could be worsened by the trend towards foundation trusts. There were also examples of distrust between operational local authority managers and acute trusts as a result of acute bed 'crises'.

It seems clear from these data that it is not necessarily appropriate to further sub-divide the selected 'predictive' conditions (Table 31 and Table 32). The managerial practices and linkages of the more successful networks (3, 4 and 7), did not substantially differ from those which were less successful in achieving the headline and ancillary targets. Such a finding suggests the equivocal nature of the presence of network-based implementation groups.

11.4.3 Centralised and local policies, incentives, targets and their perceived importance

The IFOP programme demanded the involvement of multiple individuals and organisations, each working within a set of (possibly different) centralised and local policies, and each pursuing their own service-level targets. These policies, which we highlighted in Section 3, were not all necessarily sympathetic to IFOP aims and objectives. Indeed, it was likely that some would have a perverse or negative impact, creating a 'policy mess'.[170 171] Each of our study networks was obviously required to respond to the same national targets, although there were different local policies in place. This vertical pressure from central, local health and social care organisations was a priority to strategic and managerial staff, not least because future funding for the organisation could depend on appropriate actions and re-actions. Horizontally managed initiatives, such as the IFOP programme, can be derailed by competing policies. Thus, the resulting performance of our network sites may owe more to the national and local focus (and the local response) than to the conditions in place in their networks.

In exploring the perceived impact of national policies and targets, two-thirds of the questionnaire respondents agreed that, overall, central government policies and targets had affected changes in bed use by older people. In particular, 40% of respondents emphasised the impact of the cross-charging incentive (punitive or otherwise) for any delayed discharge (see Table G19 in Appendix G). Our documentary evidence and key informant interviews suggest that reimbursement grants provided the basis for much of the joint funding for IFOP projects, and that LAA/LPSA funding was another important source.

Many of the local priorities and targets to which the study networks were required to respond stemmed from existing or forecast deficits in their local NHST and PCT budgets. In exploring the level of overspend in some of the sites, there are tentative indications that the achievements of the more successful networks (3, 4 and 7) may have been supported, or indeed stimulated, by the actions of their health commissioning bodies, determined to reduce spending within primary and secondary health care. Drawing on the documentary analysis and interviews, it was found that within site 4, the NHST was facing a deficit of £15 million, while their partner PCT had a £20 million overspend. Even in site 3, one of the most ‘successful’ networks, the PCT faced an overspend. Site 7 was facing similar problems in PCT overspending and NHST deficit. This finding is somewhat strengthened when the network conditions are explored (see Table 31). A common, negative pattern was found across these sites. All three of these IFOP networks had no substantial input into commissioning bodies for health care. Thus, it could be argued that it was the actions of these commissioning bodies outside the IFOP networks, rather than the IFOP networks' own activities, that resulted in the achievement of the headline and ancillary targets.

However, care has to be taken in attributing achievement of the targets to the activity around these networks. The size of the deficit and overspend may distinguish site 4 from the other sites, but many reported similar difficulties. For example, two of the PCT partners within site 8 were reporting an overspend of between £1 and £4 million and, as we have seen, this locality only met one of the ancillary targets. Nevertheless, this site did achieve a 16% reduction on their EBDs and in those terms was the best performer after sites 3, 4 and 7. In other words, the overarching local context and the associated priorities contributed to, but were not necessarily the main driver in the reduction in EBDs.

11.4.4 Focus and coverage of adopted services

Across the nine pilot sites, the 'mechanism' to deliver the headline and ancillary targets was that of the 128 adopted interventions or projects (see Section 7). These projects had either been in place prior to the start of the IFOP programme or were in the early planning stages, having already received the necessary funding agreements. As we have discussed, there was no direct programme funding that could support the set-up of new projects or the extension of existing interventions. The pilot sites therefore identified those projects already in place across the health and social care economy that were likely to support changes to EBDs. These projects were then 're-badged' or simply 'annexed' into the local programme. The level of direct control over these projects through delegated decision-making or management was dependent on the governance model adopted by the IFOP networks (see Sections 7, 8 and Table 31).

All of the projects selected by the networks were 'preventative' in that they sought to prevent older people from requiring more intensive and expensive services by intervening at an earlier stage. However, it was left to the pilot networks to decide whether they interpreted 'prevention' as involving primary, secondary or tertiary intervention, and whether the interventions were to be aimed at the most complex needs (hospital avoidance, improved lengths of stay and discharge arrangements) or lower-level needs. Thus, there was huge variability in the foci and numbers of projects adopted across the pilot networks (Section 7).

It is in assessing the number and range of projects selected that we can begin to see why the networks 3, 4 and 7 achieved the headline target, despite the initial prediction that their governance structure would not necessarily support effective outcomes. The first point to note is that these sites identified a small number of projects to bring into their network. Network 3 selected three projects, network 7 brought four interventions into their programme, while network 4 – although discussing an initial six – implemented only four. In contrast, network 1 identified and incorporated a total of 38 different projects, and network 5 included a total of 25 different interventions. Neither networks 1 nor 5 achieved the headline reduction in EBDs or the three further ancillary targets, being the least 'successful' of our study sites by these criteria.

This suggests the small number of projects as a factor in predicting successful outcomes. Rather than focusing on the numbers *per se*, what these may suggest is that the selected projects were able to be brought together in such a way as to form a cross-boundary, cross-cutting programme. If a coherent programme is in place, it is far easier vertically or horizontally to manage and communicate culture and practice. A 'scatter-gun' approach is less successful: if a high number of largely unconnected projects that focus on a range of user pathways are incorporated within networks that are themselves constrained by limited budgets, capacity and time, it would seem unlikely that positive outcomes would be achieved.

The numbers themselves cannot indicate whether networks 3, 4 and 7 did indeed have a coherent programme of projects in place. Rather, it is necessary to look at the focus of those interventions adopted by these networks:

- Network 3 concentrated on managing high-level health or social care need through an enhanced intermediate care service and a further case management project focusing on chronic disease. The network also ensured appropriate management and stream-lining of the user pathway by setting up a single point of access.
- Network 4 similarly focused on higher-level needs, providing an intensive home-based intermediate care team joining up home care and nursing staff, and focused on hospital discharge. It also explored appropriate 'seamless' service delivery through integrated health and social care teams.
- Network 7 reflected the selections of these two networks, adopting a large-scale case management programme and short intense interventions to prevent crises developing into long-term acute problems.

Thus, all three networks focused on the top two tiers of the Kaiser Permanente model of care.[172] Recent research has demonstrated that such services have a positive impact on EBDs, with pro-active case coordination services – similar to those adopted within the IFOP programme – reducing hospital overnight stays by almost a half.[44]

However, these networks were not alone in including secondary and tertiary preventative projects within their IFOP programme. Networks 1, 5, 8 and 9 had a relatively strong focus on the expansion or development of intermediate care services and case management. Other networks similarly concentrated on adopting those projects that would provide appropriate service coordination, managing and thus reducing EBDs. For example, network 5 included a single point of access to community-based health and social care teams, in this respect matching site 3.

There is a further facet of the successful networks (3, 4 and 7) that needs to be included in any analysis. The projects adopted by these networks were *mainstream* interventions. They were recognized 'brands', part of the overall whole of health and social care services, managed and delivered by these statutory organisations. They were thus underpinned by core funding, and on-going and (in the main) trusted relationships with managers and operational staff working in other settings. Perhaps most importantly, the adopted projects operated across the totality of the site area. Thus, individual users had a recognized pathway, they could be referred in, receive the intervention and referred on to other statutory services for further support or treatment. The other pilot sites (1, 2, 5, 6, 8 and 9), although adopting similar projects, often only operated these in specific geographical areas. These locally focused services did not necessarily have high 'market recognition'. They were further limited in the extent of the service that could be delivered, owing to their reliance on short-term funding streams. Both of these factors would impact on the user pathway, negating widespread successful hospital avoidance or reduction in bed days.

While such interventions may be innovative 'boutique projects',[173 (p 464)] successfully diverting a handful of users or patients from intensive services, they do not usually result in the large-scale or long-term changes necessary to tackle rising admissions and bed days.

The best-performing sites (networks 3, 4 and 7) also started the IFOP period with certain advantages. Networks 3 and 4 were already above the median for English local authorities for scale of provision of intensive social care at home. Site 3 also had a high-performing PCT, had a relatively high level of direct payments (alongside a high level of contracted-out home care services) and an NHS trust which was rated 'good' for both quality of care and financial management. Site 7 had already achieved the headline target. It appears reasonable to infer that these sites benefitted from 'path dependency': these networks built upon already-established trends that were favourable to meeting the IFOP targets.

Another common feature of the sites with the greatest reduction in bed days was that at least half of the local IFOP projects were funded from some combination of council and NHS sources. In contrast, in sites 5, 6, 8 and 9, about two-thirds of projects were *separately* funded by the council or NHS, while in site 1 it was three-fifths.

In summary, the model of governance associated with an effective network – effective, that is, in IFOP terms – appears to be the selection of a relatively small number of projects with an established basis in either evidence or policy (preferably both), coordinated by a network-based group, but implemented at operational level through line-management within each member-organisation of the network, especially that of the statutory organisations. What matters is not just the network's governance structure. The characteristics just noted appear necessary but not always sufficient to make that structure work effectively. Equally important is the approach to decision-making which occurs through these structures, especially the approach to decision-making about project selection and adoption.

11.4.5 The patient experience

The strength of any network should lie in its ability to manage vertical and horizontal pressures, communicating culture, values and thus changes in practice, through the network membership or 'boundary-spanners'.[51] Indeed, part of the remit of the IFOP networks was to facilitate changes in existing services that would mirror their governance structure, managerial practices and appropriate communication links between member organisations. From the empirical work described in section 10, it would initially seem that none of the IFOP networks was able to influence and thus change service delivery and operational practice within their adopted projects.

Patients reported a lack of information and signposting as to what actions they could undertake before or at their initial crisis. Only rarely was there timely access to appropriate care – the non-availability of an out-of-hours rapid response team was commented upon, mirroring the work of Boaden et al.[38] – and very little evidence of integrated or seamless service provision across the different organisational boundaries. Horizontally, coordination at clinical or care levels was often missing. Social and health care staff identified an endemic lack of knowledge within the key health professions (A&E, ambulance staff and GPs) as to the availability and referral routes of those services that could be used to reduce EBDs (such as rapid response services). The need for a single point of access and better signposting were often mentioned. Communication between different professions was flagged up as an on-going difficulty. For example, it was said by staff that unless an assessment had been carried out by themselves or a close colleague (i.e. within their own member-organisation), any resulting decisions could not be trusted. The process of assessment was identified by managers and practitioners as the central mechanism for the appropriate management of emerging health or social care crises, and thus for reducing EBDs. Any delay or (un)necessary re-assessment could well result in higher use of secondary care services.

These findings raise a number of questions as to the effectiveness of the pilot networks in achieving the headline target and ancillary outcomes. In particular, whether the positive outcomes found can be attributed to the presence of these directed social partnerships, given the generally negative experience reported by patients and their carers. If people aged 75 and over with long-term conditions are not being successfully diverted or discharged, it seems difficult to see how the networks could have contributed toward the outcome findings. Rather, the changes seen could only be the result of outside contextual factors. Locally agreed ward or hospital closures would reduce EBDs. Similarly, targets or incentives set by local commissioners and contractually enforced through (punitive or positive) incentives may well be more successful in ensuring admission and bed-day reductions.

Nevertheless, the findings given here may well be affected by our choice of Phase 2 ‘explanatory’ sites (see Section 4). Only one of our ‘successful’ localities, network 3, was included within this stage of the research. The ‘good practice’ demonstrated within one of their particular services mitigated some of the more negative findings of the patient journey research. (We should emphasise that there were good practices across all three sites in Phase 2 of the study.) Our choice of sites within this second phase similarly excluded those networks that had taken on delegated control of the projects (networks 2, 6 and 9). Their reported ability to manage the adopted projects’ aims and objectives, as well as directly influencing practice, may well have had a greater effect on improving patient-centred care through timely access to appropriate preventative, assessment and treatment services, appropriate integrated working and adequate continuity of care.

However, the question still remains as to whether we would have found any other patterns if we had looked at the practice within the adopted interventions of networks 2, 6 and 9. Prior research substantiates our findings.[155 157 164 165] Perhaps crucially, none of the sites had set up micro-level practice networks to enable appropriate linkages, one key mechanism in managing cross-boundary working and implementing 'seamless' care.[174] They therefore relied on line-management within their member-organisations to communicate network decisions and innovations to frontline clinical and care staff.

11.5 Network governance or central targets and incentives?

The overarching aim of this study was to examine the impact of different governance models as local health and social care economies sought to reduce utilisation of unplanned inpatient bed-days by older people. In particular, we wanted to explore whether those networks put in place by the pilot sites were responsible for the changes found in the EBD numbers, or whether the centrally articulated incentives or targets were stronger influences. We also wanted to explore the role of choice and voice.

Le Grand[175] has argued that public policies should make use of market-like mechanisms, but be fashioned so that self-interest is not allowed to overwhelm providers' altruistic motivations. In counter-balance to the problems of quasi-markets, the creation of 'robust incentives' should appeal to both the 'knightly' and the 'knavish' motivations of providers. Such incentives 'can be achieved by systems that offer personal (or institutional) rewards for activities that are perceived to benefit users, but for which the rewards are not so great as to eliminate any sense of personal sacrifice that is associated with the activity concerned'.[175 (p 168)] But in our study, this apparently straightforward prescription met with the inevitable complexities of everyday practice. The results of the questionnaire and interviews suggest that managers did not hold unanimous expectations that particular targets would necessarily achieve a particular set of outcomes. The results also exposed examples of a conflicting set of incentives that posed the risk of unintended consequences.

Providers of alternative services, particularly of intermediate care, were entering an era of increasing diversification, as purchaser-provider splits in community health took effect. The trend towards contractual relationships appeared to put pressure on these newly developed services to make difficult choices. On the one hand, the new environment appeared to hold out incentives for providers of the new 'alternative' services to maximise the outcomes of their efforts by choosing patients with the greatest capacity to benefit, in order to both have rewarding work and to satisfy contractual requirements. On the other hand, there were risks for such alternative services, particularly bedded services, in not being selective, as to take too many patients with high needs and uncertain capacity to benefit could create bottlenecks. One unintended consequence was that some patients remained in an acute bed while decisions were made as to their 'suitability' for alternative care services, and these wait times could be significant. Other patients found themselves following pathways out to community alternatives, without much sense of having had a choice in the matter.

In contrast to the strong incentives created by targets and fines to decrease delayed discharges and 4-hour A&E waits, there were only weak incentives for professionals in established services to refer to new alternative services to reduce patient demands for acute beds (for instance, PbC, discussed in Section 11.6.1 below). Certainly potential users of the new services (both patients and professionals) were not always aware of their existence and roles. This meant that patients either did not receive any or timely access to services to avoid crisis situations, prevent acute admissions or facilitate acute discharge.

Thus it appears that the greater the range of incentive structures, the greater the possibility of unanticipated interactions or conflicts between them. In particular, the results generated by the patient journey study identified that the strategic goals of the IFOP were not always translated into operational practice.

In the following sections, we draw links between our findings and the present policy landscape, then turn to consider the relevance of our research to operational practice.

11.6 Relevance to the current policy climate

The enacted social partnerships within IFOP were an attempt to build and sustain vertical and horizontal links during a period of almost permanent policy 'churning'.[30 45 176 177] Diversification of supply (foundation hospitals, commercial providers and the third sector) extended the ‘quasi-markets’ within and across health and social care: supposedly building choice, quality and efficiency.[30 178 179] These market ‘freedoms’, with their apparently increased level of autonomy and the ability to attract new business, were arguably counter-balanced by the (micro) management of the Labour Government. Numerous processes and practices were centrally and vertically imposed.[73 180] We have demonstrated how fragile were the networks in the face of such changes. The reorganisation of secondary and primary care weakened the ability of the networks to maintain horizontal links. Vertically (hierarchically) implemented policies carried greater force, especially with the NHS organisations we studied, to the extent of partly undermining the coordinating work which the study networks were trying to accomplish.

Despite such on-going demands, the networks were established locally in the belief that they would provide an appropriate mechanism for attaining the headline target. That they collectively achieved the necessary reduction could be argued to be in spite of, rather than because of, the 'mess' of conflicting policies introduced under the Labour Government. Nevertheless, such network-based coordinating mechanisms may be unsustainable in the foreseeable future given the early proposals put forward by the new Coalition Government.[181] In discussing where the barriers and facilitators may be to such networks, we are necessarily being speculative. The approach of the recent White Paper mirrors many previous policy pronouncements: whilst the broad outline is present, the details are still to be developed.[182 183] Similarly, the public consultation has yet to be completed and a Departmental response prepared as the basis for subsequent legislation. The relevance of our work is that it provides a framework for analysing the potential impact of the new policy initiatives outlined in the White Paper.

11.6.1 Barriers and facilitators to effective social networks

We anticipate that there will be four main barriers to the horizontal coordination of services through provider networks following the enactment of new legislation: the sheer extent of reorganisation; the risk that the continuing shift towards market-like structures will lead to fragmentation; the shift of commissioning responsibilities from PCTs to GPs; and the focus on outcomes as a governmental mechanism to manage accountability and thus statutory funding.[181 184]

The greatest barrier is the extent of the proposed reorganisation, which parallels that of the 1989 purchaser and provider split: the 'politics of the big bang'.[185 186] No one health or social care sector will remain untouched. All NHS trusts will become or be part of foundation trusts (FTs) and PCTs will be abolished from April 2013. PCT commissioning roles will shift to new GP consortia and their health improvement activities will be undertaken through local authorities. Within this report, we have clearly demonstrated that the previous (2005) reorganisation of PCTs, at least during its transitional phase, affected the focus and effectiveness of our networks, in turn impacting on outcomes (Sections 3 and 8). On a very practical level, it seems unlikely that individuals will be able to maintain the same level of trust, contact or focus whilst the NHS undergoes such drastic changes. Some organisations will be losing staff prior to abolition; others will be recruiting staff, building their skill set and necessarily attending to their own organisational development. In the short term, it may not be possible to maintain appropriate and effective cross-sector collaboration if organisations are beset by 'redisorganisation'.[187] As Thomas et al. argue, 'combined horizontal and vertical integration can happen in a natural evolutionary way when those involved have time to think the issues through'.[188 (p 431)] The extent and timetable of change are unlikely to provide such an evolutionary environment.

The proposed extension of the market could contribute to further fragmentation through its likely impact on the operation of networks as well as their model of implementation. Prior research has demonstrated that foundation trusts are far less likely than their predecessors to form horizontal linkages with their wider community. For example, their vertical focus has led to governors and staff arguing they had little impact on the decisions of their trust.[189 190] Such 'isolationism' may be extended as mental health and community trusts take on foundation status, negating any network model of management or co-production. The operational model for foundation trusts explicitly mimics that of a commercial firm, 'attracting scarce resources in a competitive environment',[191 (p 439)] and may lead to an internal focus on their own production and staffing. The White Paper states 'our ambition is to create the largest and most vibrant social enterprise sector in the world. The Government's intention is to free foundation trusts from the constraints they are under, in line with their original conception'.[181]

(p 36) Specific units of the hospital or the transferred community health providers could set up as social enterprises[192-194] increasing the number of market 'partners' to be included within any strategic and practice-based planning. Against this, however, at least some of these trusts are likely to absorb community, and even some primary medical, care services in their locality. It is also proposed that FTs might be providers of social care services, reinforcing still further the prospects of vertical integration locally while potentially undermining some incentives for horizontal integration. At this time, it is not clear how far collaborative duties or mechanisms will be put in place to mitigate these vertical constraints.

The transfer of health care commissioning to GP consortia will have a further impact on the extent and type of networks that can be implemented. Their policy forerunner, practice-based commissioning (PbC), was not an unqualified success. Slow to implement,[195] indeed described as 'stalled',[196-198] the key weakness of PbC was a lack of effective mechanisms that could allow an 'on-going dialogue between the vertical and horizontal dimensions, to ensure that medical and non-medical care are used to their best advantage'.[188 (p 425)] Prior research has demonstrated that not all GPs are easy to involve in implementing policy and organisational change.[44 195] Similarly, their awareness of local resources may limit how far GPs can be responsive to patient and user needs. In exploring the patient experience (see Section 10), we found that some GPs had poor knowledge of referral routes and availability of services that could be used to reduce EBDs. Our interviews suggested that GP commissioning clusters had mixed impacts. The theoretical benefits of incentivising GPs to prevent admissions were acknowledged. But the existence of two quite different kinds of health commissioning (PCT and PbC) could be an impediment to cross-boundary working, fragmenting the local consensus on what mix of services was right for the local health and social care economy. The White Paper seeks to address such problems by recommending that GP consortia have a duty to work in partnership with local authorities, and by removing the rival PCT commissioning structures (in abolishing PCTs). Nevertheless, there is an apparent contradiction in the White Paper when it says that NHS commissioning will still be the 'sole preserve of the NHS Commissioning Board and GP consortia' despite the 'aim of coherent and coordinated local commissioning strategies'.[181 (p 35)] Setting up and sustaining enacted horizontal partnerships against such a backdrop is likely to be no less a challenge than under the previous arrangements we studied. The case for sensitivity and balance in designing the mix of horizontal forces is well made by this example from the White Paper.

Our research demonstrated that health and social care staff perceived central and local government targets as effecting bed-day reductions. For the most successful networks, this focus supported and stimulated their activity, leading to a greater reduction in EBDs. Where targets were multifarious and their purposes not well understood, the study networks found it far more difficult to maintain the necessary vertical and horizontal linkages. Some managers interpreted incentive structures such as PbR and PbC as targets; they also had contradictory interpretations of the impacts of incentives and targets (cf. Section 8.7). The new Coalition Government has said that it will remove such 'top-down targets',[181 (p 21)] replacing them with outcome measures and quality standards. Such changes may support the formation of networks, allowing a whole-systems response to improving the health and well-being of older people. NICE will be producing a hundred and fifty standards to support different 'disease-pathways'. As yet, we do not know whether these will be broad enough to encompass the multiple needs and morbidities of older people, allowing appropriate cross-boundary involvement.

On the other hand, other forms of incentive are being pursued: for instance, proposed amendments to Payment by Results[199] are expected to incentivise providers to ensure patients are discharged at the right time, with the support they need to reduce inappropriate readmissions. Savings accrued from not paying for readmissions would then be used to support services provided by local authorities and other providers focused on reducing readmissions to hospital and decreasing longer-term dependence on health and social care (such as re-ablement services). This could help to funnel funding to new closer-to-home services, something that a number of sites struggled to achieve within the previous PbR regime. It could also help to avert situations such as those encountered by some of our patient participants who faced re-admissions seen as potentially avoidable by professionals involved in their care.

Despite these barriers, there is one facilitator that may be able to support network development. The 'place-shaping' role of the local authority was one of the key strengths in focusing the enacted social networks in this study. The recent White Paper seeks to strengthen such a leadership role. Local authorities have increasingly taken on some public health and 'well-being' functions in recent years, with a number having jointly appointed Directors of Public Health and multiagency health and well-being boards. Such boards were already being set up as part of the LAA governance arrangements, towards the end of the IFOP period. The proposed transfer of public health functions to local authorities builds on this process. A further mechanism detailed in the White Paper is the role of the local authority in promoting holistic health and well-being, initiating or building on existing partnerships.

> *We will establish new statutory arrangements within local authorities – which will be established as health or well-being boards within existing partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement.*
>
> 181 (p 34)

This focus on 'health and well-being' rather than any disease-specific response might yet ensure a move away from concentration on 'component' reform to that of a whole system focus and would 'represent a major shift to the kind of local authority role in the governance of health envisaged by the Innovation Forum on which IFOP was founded.[200]

11.6.2 The essential and 'model' network?

In codifying the different governance taxonomies and juxtaposing the achievement (or not) of the headline target, we were able to draw some inferences around what network structures were necessary to achieve a reduction in EBDs. If networks are to achieve their objectives, a number of functions needed to be in place: a network-based implementation group, a single network rather than a plurality of competing networks focusing on discrete changes, and a joined-at-the-top model of governance. The question remains: do the radical health and social care proposals negate the recommended focus of change or the recommended network structures?

The first part of the question is easy to answer. A reduction in EBDs is a continuing target, at least in the short term, not least as part of the strategy for meeting the '£15 – £20 billion efficiency challenge',[201 (p 10)] a requirement which similarly will only be achieved if there is continuing investment in preventative resources. The second part of the question, the applicability of the suggested network structures, is harder to answer. We would argue that these structures will need to be established when forming any network, but it is imperative that organisations better understand how to balance vertical and horizontal implementation imperatives. Horizontal partnership commitments need to be given sufficient authority. There is a possibility that through vertical integration locally (the inclusion of community health services) foundation trusts may be able to provide a more comprehensive targeted assault on EBDs, if they do not become too inward facing: they need to 'provide a mass-customized, quality experience, whilst maintaining a stable organizational culture for staff'.[191 (p 13)] Similarly, local vertically integrated systems may enable discharge processes to be controlled whilst reducing the risk of readmission. Nevertheless, it is likely that any network will fail, however good its structures and processes, unless vertical influences are balanced by sufficiently strong horizontal pressures.

To continue to enable individuals to remain in the community, and focus upon a few, well-tested mechanisms for reducing EBDs requires the building of effective alliances between local authorities and voluntary organisations on the one hand, and the new public health and primary care organisations on the other. It is currently unclear whether the mix of incentives in the new proposals will enable such a balance to be struck and local commissioning alliances to be formed.

We have so far discussed the relevance of our work in terms of the interaction of national policy drivers with local strategic planning of services for older people. We turn now to consider what light our findings shed on operational practice.

11.7 Relevance for practitioners, operational managers, commissioners and researchers

The design of our study means that we are not able to offer precise prescriptions about ways of closing this gap between strategic goals and operational practice. However, the study's findings do reinforce a number of messages surrounding the delivery of high quality care that have been emphasised in previous research and policy papers. We summarise the main findings, particularly those in Section 10, to pull out some key messages, first looking at the phases of the 'journey' and then at the overarching systems issues relevant to operational managers, commissioners and planners.

11.7.1 Services to avoid acute admissions

Our interviews indicated that there was sub-optimal use of services for preventing crises and acute events. In part, this was linked to patients being slow to access or having difficulties in accessing health care when feeling unwell. Sometimes patients described difficulties in accessing GP appointments (e.g. having to book an appointment before a certain time). This led to worsening of their condition and led to preventable hospital admissions. Access to same-day care was particularly important for patients with respiratory conditions whose condition could deteriorate rapidly. Health professionals also failed to refer patients to preventative services. For example, patients who had experienced frequent falls were not directed to or informed about falls prevention activities and services even though evidence suggests that they are effective.[147] Local authority care managers appeared to be important in a few instances in initiating and coordinating the care and rehabilitation services that kept people out of hospital. In this study, a very narrow range of services were used in a crisis: ringing 999, contacting the GP surgery or self-referral to A&E. None of the patients in this small sample called NHS Direct.

11.7.2 Hospital care and hospital discharge

We found that front-line acute hospital staff had patchy knowledge of the availability and referral criteria of the services in their locality for reducing patient demands on acute beds. This led to under-utilisation of newer services and a reliance on 'traditional' referral patterns to a limited range of services. With respect to care in hospital, some of the patients interviewed voiced concerns about the availability of nursing staff and a lack of consistency of nursing care, apparently due to shift patterns, as well as concerns about the lack of communication both between staff and between patients, family carers and staff. Some family members also felt excluded from discussions about discharge arrangements. For example, carers spoke of patients being discharged from acute care without hospital staff having an understanding of their home circumstances, while staff also reported that home assessment visits were rarely made. Some carers and patients expressed concerns about the roles they were expected to play in the care of patients following hospital discharge. They felt that professionals often looked to family or other potential carers to help out in the hope of avoiding a hospital admission or facilitating a hospital discharge. Such requests could put considerable pressure on those who were expected to assist quickly.

There were gaps in other key services needed to support successful hospital discharges. Discharges were delayed due to the time needed to access services for supplying equipment and making home modifications. The study raised concerns about the adequacy of services for transporting patients back to their homes following a hospital stay, with instances of rushed patient transfers from hospital to home and prolonged journeys with multiple stop-offs, so that a patient's trip home could be lengthy.

11.7.3 Rehabilitation in community units and at home

Patients and staff were content with the six-week duration of intermediate care, but acknowledged the need to have flexibility in interpretation of this if patients were felt to be continuing to gain benefit. Depending on the needs of the patient, it was also accepted that rehabilitation could be delivered at home or in community beds.

The delivery of time-limited and timely, goal-orientated care that achieves measurable outcomes was seen to require strong leadership, multi-disciplinary teams, good assessment, communication, screening and goal-setting with patients.

11.7.4 Overarching/ systems issues

For the patients included in this study, place of care was often influenced by bed availability rather than clinical need or patient choice. Also, communication between professionals and particularly across organisational boundaries remained problematic in the IFOP sites. We found poor use of processes such as the Single Assessment Process (SAP), or the Common Assessment Framework (CAF). There was a lack of compatible technologies to facilitate information sharing: practitioners continued to use the telephone, letters and fax for making referrals and information sharing. Patients described experiencing multiple assessments. Practitioners described spending a lot of time trying to acquire information about patients and information being difficult to get, especially out of hours. However, attempts to establish 'single-point-of-access services' in some localities have experienced a number of teething problems, such as incompatible IT systems.

Inter-organisational networks were weakest at the practitioner level, particularly in cases where the focus of the service was more generalist. Specialised services (e.g. respiratory) encountered tended to network across inter-organisational boundaries.

11.7.5 Key messages

We were able to draw out the following key messages from the findings, many of which will be familiar to those who have read DH policy and practice guidelines over recent years.[66 202]

Community health and social services

The development of single-point-of-access telephone numbers and signposting is probably the easiest way to address the ingrained habits of professionals, paid carers and the public who use the emergency services as a first port of call. The proposed NHS 111 service provides an opportunity to solve this problem, and in our opinion should be used for that purpose. Better access to same-day appointments with GPs and further development of the community matron role for people with long-term conditions would help to address such issues.

Efforts should be made to increase the uptake of community care and treatment alternatives, a drive that should embrace the need to ensure that these services are available ‘out of hours’ and during weekends.

Hospital services

The findings suggest that decisions about hospital discharge should be supported by all stakeholders having a more complete understanding of the availability and feasibility of different care options. Efforts are needed to increase and facilitate the availability of these services. Patients and carers should be involved in decision-making and choice in regard to their care, particularly in discharge planning.

Investment in technologies for improving communication and information sharing between professionals is required. Priority should be given to establishing the use of SAP/CAF by practitioners to facilitate more efficient information sharing.

Across services

Top level decision-making networks should develop mechanisms to improve opportunities for staff to develop their own networks and share learning across boundaries (e.g. Communities of Practice[203]). These should include staff from the acute sector as well as those working in the community. To further facilitate this process, staff should where possible be co-located as we found that this facilitated multi-disciplinary working and ease of information sharing/referrals and widened networks.

Efforts to close the gap between strategic goals and operational practice that this study exposed should not ignore the potential role of new and improved contracting arrangements between service commissioners and providers. The creation of GP-led commissioning through consortia creates opportunities to strengthen the links at practitioner level between primary, social and domiciliary care, with commissioning budgets being used to reinforce evidence-based recommendations and policy targets. GP responsibility for commissioning also means that contract monitoring/compliance will be brought closer to the patient level. For improvements to occur, the local networks will have to recruit the new consortia as active network members (as PCTs gradually withdraw). Conversely, we suggest, representatives of these networks might also be involved – or even incorporated – in the management of the commissioning consortia.

Finally, the Joint Strategic Needs Assessments (Health Act 2007) undertaken by PCTs and Local Authorities can be used to inform the development of services to promote the health and wellbeing of older people. A review of bed availability could be used to check how far the volume and profile of beds (other than acute hospital beds) matches what is required to reduce unplanned EBDs by older people. Such modelling of bed supply and of other inputs could be supported by new plans to strengthen the role of local authorities to develop more effective NHS, social care and public health commissioning arrangements,[204] for instance by giving Local Authorities more responsibility for leading JSNAs.

11.7.6 Directions for future research

Lastly, our findings have not demonstrated a direct causal relationship between outcomes and individual modes of governance, which might be regarded as a significant finding in itself. The project suggests the relevance of interdependencies between modes of governance and contextual factors to secure the results observed. More speculatively, we would question whether our understanding might be strengthened by considering an approach which is premised on the possibility of multiple causal pathways to a similar set of outcomes based on different configurations of conditions. In this case, it would imply exploring the possibility that different configurations of governance models (including different mixes of governance model) and other conditions may produce desired outcomes rather than seeking the optimal fit between outcomes and causal factors. As Byrne[205] has argued 'Outcomes depend on multiple causes and these causes interact in an unpredictable manner, which leads to non-linear behaviour and self-organizing effects in different directions.'(cited in Buijs et al.[206 (p 37)]). The implications of adopting a perspective of this kind based on an understanding of complexity theory and associated methodologies[207-209] might usefully be explored further by researchers, research commissioners and the policy community.

11.8 Conclusion

From the theoretical arguments and from the empirical data collected, analysed and brought together, it is perhaps not surprising that we can only offer an equivocal response to the question of which was the more powerful influence on changes in the numbers of emergency bed days used by older people: networks or centrally imposed incentives or targets? A number of mechanisms need to be brought together to achieve change and there is not just one governance structure that can be relied upon to produce the stated outcomes. Central targets and financial incentives can focus action, networks are essential to negotiate cross-cutting problems, whilst the mechanisms put in place to meet any targets (i.e. the interventions or projects) need to move away from the usual scatter-gun approach of large numbers of 'boutique' pilot projects to focus on a smaller number of services that can be mainstreamed.

One mechanism that we have identified to combat the threat of increasing service fragmentation is the fostering of trust through strong horizontal networks. As the policy agenda moves to give further emphasis to personalisation, the use of networks in successfully implementing policy goals will become essential. Through further categorisation of published governance models we were able to draw some inferences about the structures necessary (though not always sufficient) for networks to achieve their objectives. These included: the necessity of a network-based implementation group; that localities should set up single networks to focus on specific discrete changes, rather than developing a number of competing networks with a similar remit; and that there should be a 'joined-at-the-top' model of governance.

References

1. Webster C. *The National Health Service : a political history*. 2nd ed ed. Oxford: Oxford University Press, 2002.

2. Hensher M, Edwards N. Hospital provision, activity and productivity in England since the 1980s. *BMJ* 1999;319:911 – 914.

3. Luff D, Nicholl J, O'Cathian A, Munro J, Paisley S. *National Beds Inquiry Report – Supporting Analysis: Review of evidence on patient preferences for different locations and types of care*. Sheffield: Medical Care Research Unit, University of Sheffield, 2000.

4. Marks L, editor. *Hospital Care in the Home: Prospects and pitfalls*. London: King's Fund, 1990.

5. Audit Commission. The way to go home: Rehabilitation and remedial services for older people, 2000.

6. McDonagh MS, Smith D, Goddard M. Measuring appropriate use of acute beds: A systematic review of methods and results. *Health Policy* 2000;53(157–184).

7. Donaldson LJ. Characteristics of elderly people misplaced in hospitals and homes. *Public Health* 1983;97:257–263.

8. Rubin SG, Davies GH. Bed blocking by elderly patients in general hospital wards. *Age and Ageing* 1975;4 142 – 7.

9. Seymour DG, Pringle R. Elderly patients in a general surgical unit: do they block beds? *BMJ* 1982;284:1921–1923.

10. Klein R. *The New Politics of the NHS*. Third ed. London: Longman, 1995.

11. Moran M. Explaining the rise of the market in health care. In: Renade W, editor. *Markets and Health Care: A comparative analysis*. London: Longman, London, 1998.

12. Sibbald B. Skill mix and professional roles in primary care. In: National Primary Care Research and Development Centre, editor. *What is the Future for a Primary Care-led NHS?* . Oxford: Radcliffe Medical Press, 1996.

13. Milne R. Competitive Tendering of Support Services. In: Beck E, Lonsdale S, Newman S, D DP, editors. *In the Best of Health? The status and future of health care in the UK*. London: Chapman & Hall, 1992.

14. Smith P, Goddard M, editors. *Reforming Health Care Markets*. Buckingham: Open University Press, 2000.

15. Marks L, Hunter DJ. Moving upstream or muddying the waters? Incentives for managing for health. *Public Health* 2005;119(11):974-980.

16. Leach R, Percy-Smith J. *Local Governance in Britain*. Hampshire: Palgrave, 2001.

17. Skelcher C. *The New Governance of Communities in British Local Government into the 21st Century*. Hampshire.: Palgrave Macmillan, 2004.

18. Dowling B, Powell M, Glendinning C. Conceptualising successful partnerships. *Health and Social Care in the Community* 2004;12(4):309-17.

19. Jessop B. The Dynamics of Partnership and Governance Failure. In: Stoker G, editor. *The New Politics of Local Governance*. London: Macmillan, 2000.

20. Department of Health. National Service Framework for Older People. London: Department of Health, 2001.

21. Secretary of State for Health. The NHS Plan: a plan for investment, a plan for reform, 2000.

22. Wistow G, King D. Reducing emergency hospital stays for older people: Innovation Forum first year report. London: Innovation Forum, 2006:54p.

23. Kent County Council and Department of Health. Innovation Forum for Older People. Commissioning template, 2003.

24. Glasby J. *Hospital discharge: integrating health and social care*. Oxford: Radcliffe Medical Press Ltd, 2003.

25. Department of Health. Shaping the future NHS: long term planning for hospitals and related services: consultation document on the findings of the National Beds Inquiry. London: Department of Health, 2000.

26. Mays N. Use of Targets to Improve Health System Performance: English NHS Experience and Implications for New Zealand *New Zealand Treasury Working Paper 06/06*, 2006.

27. Lyons SM. Place-shaping: a shared ambition for the future of local government. Final Report. The Lyons Inquiry into Local Government. London, 2007.

28. Clark M, Stewart J. Handling the Wicked Issues: A challenge for Government. Birmingham: Institute of Local Government Studies, 1997.

29. Churchman CW. Guest Editorial: Wicked Problems. *Management Science* 1967;14(4):B141-B142.

30. Stevens S. Reform strategies for the English NHS. *Health Affairs (Millwood)* 2004;23(3):37-44.

31. Ham C. Creative destruction in the NHS. *BMJ* 2006;332(7548):984-985.

32. Department of Health. A Guide to NHS Foundation Trusts. London: Department of Health, 2002.

33. Dean M. Battle over foundation hospitals continues. Downing Street sells one model to managers, another to Labour members of parliament. *Lancet* 2003;362(9383):540-1.

34. Klein R. Governance for NHS Foundation Trusts', British Medical Journal, 326: 174 – 5. *BMJ* 2003;326:174–5.

35. Lewis J. What is New Labour? Can it Deliver on Social Policy? In: Lewis J, Surender R, editors. *Welfare State Change: Towards a Third Way?*

. Oxford: Oxford University Press, 2004.

36. Walsh K. Foundation Hospitals: a new direction for NHS reform? *Journal of the Royal Society of Medicine* 2003;96 106 – 110.

37. Pollock A. *NHS plc: The Privatisation of Our Health Care*. London: Verso, 2004.

38. Boaden R, Dusheiko M, Gravelle H, Parker S, Pickard S, Roland M, et al. Evercare evaluation: final report. Manchester: National Primary Care Research and Development Centre, Manchester University, 2006.

39. Crinson I. The direction of health policy in New Labour's third term. *Critical Social Policy* 2005;25:507–516.

40. Ham C. Lessons from the past decade for future health reforms. *BMJ* 2009;339:b4372.

41. Smith S. Will a market deliver quality and efficiency in health care better than central planning ever could? Yes. *BMJ* 2010;340:c1299.

42. Department of Health. Commissioning a Patient-led NHS. London, 2005.

43. House of Commons Health Committee. *Changes to Primary Care Trusts. Second Report of Session 2005–06*. London: TSO, 2005.

44. Windle K, Wagland R, Forder J, D'Amico F, Janssen D, Wistow G. National Evaluation of Partnerships for Older People Projects: Final Report. Kent: PSSRU, University of Kent., 2009.

45. Department of Health. Creating a Patient led NHS – Delivering the NHS Improvement Plan London: Department of Health, 2005.

46. Checkland C, Coleman A, Hireoh U, Harrison S. Practice Based Commissioning in the National Health Service. Interim Report of a Qualitative Study: National Primary Care Research and Development Centre, University of Manchester, 2008.

47. Department of Health. Our health, our care, our say: a new direction for community services, 2006:1-236.

48. HM Treasury. The cross cutting review of the role of the voluntary sector in public service delivery. London: HM Treasury, 2002.

49. Mulgan G. Government and the Third Sector: Building a more equal partnership. In: Anheier H, editor. *Third Way – Third Sector. Report No 1*. London: Centre for Civil Society, London School of Economics, 2000.

50. Sullivan H. Community Governance and Local Government: A Shoe That Fits or the Emperor's New Clothes? In: Stoker G, Wilson D, editors. *British Local Government into the 21st Century*. Hampshire: Palgrave, 2004.

51. Sullivan H, Skelcher C. *Working across boundaries : collaboration in public services*. Basingstoke: Palgrave, 2002.

52. Anheier H. Third Sector – Third Way: Comparative Perspectives and Policy Reflections. In: Lewis J, Surender R, editors. *Welfare State Change: Towards a Third Way?* Oxford: Oxford University Press, 2004.

53. Goss S. *Making Local Governance Work: Networks, Relationships and the Management of Change*. Hampshire: Palgrave, 2001.

54. Smith G, Stoker G, Maloney W. Building Social Capital in City Politics: Scope and Limitations at the Inter-Organisational Level. *Political Studies* 2004;Vol 52:508 – 530.

55. Miller C. *Producing welfare: a modern agenda*. Hampshire: Palgrave MacMillan, 2004.

56. Crombie IK, Coid DR. Voluntary organisations: from Cinderella to white knight? *BMJ* 2000;320(7232):392-3.

57. Bennett R. Marketing of Voluntary Organizations as Contract Providers of National and Local Government Welfare Services in the UK. *Voluntas* 2008;19:268 – 295.

58. Glendinning C, Kemp P. *Cash and Care: Policy Challenges in the Welfare State*. Bristol: Policy Press, 2006.

59. Kendall J, Knapp M. *The Voluntary Sector in the UK*. Manchester: Manchester University Press, 1996.

60. Knapp M, Hardy B, Forder J. Commissioning for quality: ten years of social care markets in England. *Journal of Social Policy* 2001;30(2):283–306.

61. Langan M. Social Services: Managing the Third Way In: Clarke J, Gewitz S, McLaughlin E, editors. *New Managerialism, New Welfare?* London: The Open University Press in association with Sage Publications, London., 2000.

62. Means R, Morbey H, Smith R. *From community care to market care? : the development of welfare services for older people*. Bristol: Policy, 2002.

63. Wistow G, Knapp M, Hardy B, Forder J, Kendall J, Manning R. *Social Care Markets: Progress and Prospects*. Buckingham: Open University Press, 1996.

64. Glendinning C, Challis D, Fernández J-L, Jacobs S, Jones K, Knapp M, et al. Evaluation of the Individual Budgets Pilot Programme: Final Report, 2008.

65. Davey V, Fernández J-L, Knapp M, Vick N, Jolly D, Swift P, et al. Direct Payments: A National Survey of Direct Payments Policy and Practice. London: PSSRU, London School of Economics, 2007.

66. Department of Health. Discharge from hospital: pathway, process and practice. London: Department of Health, 2003.

67. Fernández J-L, Kendall J, Davey V, Knapp M. Direct Payments in England: Factors linked to variations in local provision. *Journal of Social Policy* 2007;36(1):97–121.

68. Glendinning C. Partnerships between health and social services: developing a framework for evaluation. *Policy and Politics* 2002;30:115 – 127.

69. Goodwin N, Shapiro J. The road to success. *Health Management* 2002;6:20 – 22.

70. Hardy B, Hudson B, Waddington E. What makes a good partnership? Leeds: Nuffield Institute for Health, University of Leeds, 2000.

71. Rouse J. Performance Management Under New Labour: really new or merely more of the same? *Working Paper No. 5*. Birmingham: University of Central England, 2001.

72. Stoker G. *Transforming Local Governance: From Thatcherism to New Labour*. Hampshire: Palgrave, 2004.

73. Wilson D. New Patterns of Central-Local Government Relations In: Stoker G, Wilson D, editors. *British Local Government into the 21st Century*. Hampshire: Palgrave, 2004.

74. Department of Health. Health reform in England: update and commissioning framework, 2006.

75. HM Treasury. *Public Services for the Future: Modernisation, Reform, Accountability*. Cm4148. London: HMSO, 1998.

76. Kelman S. Central Government and Frontline Performance Improvement: The case of 'targets' in the United Kindom: John F Kennedy School of Government, Harvard University.

77. Glasby J. Discharging Responsibilities? Delayed Hospital Discharges and the Health and Social Care Divide. *Journal of Social Policy* 2004;33(4):593 – 604.

78. National Audit Office. Ensuring the effective discharge of older patients from NHS acute hospitals. Report By The Comptroller And Auditor General, 2003.

79. Bevan G. Setting Targets for Health Care Performance: Lessons from a Case Study of the English NHS. *National Institute Economic Review* 2006;197:67 – 79.

80. Department of Health. A guide to social services performance ratings. London: Department of Health, 2002.

81. McCoy D, Pollock A, Bianchessi C, Godden S. Survey on the Implementation of the Community Care (Delayed Discharges) Act (2003). *Discussion Paper Series No. 0702*: The Public Services Programme, Quality, Performance and Delivery, ESRC, 2007.

82. Dickinson H. Factors promoting and hindering partnership working. Birmingham: Health Services Management Centre, University of Birmingham, 2006.

83. Department of Health. *Saving Lives: Our Healthier Nation*. London: HMSO, 1999.

84. Department for Work and Pensions. Opportunity Age – Meeting the Challenges of Ageing in the 21st Century. London: Department for Work and Pensions,, 2005.

85. Department of Health. NHS Improvement Plan. London: Department of Health, 2004.

86. Department of Health. Independence, Well-being and Choice: Our vision for the future of social care for adults in England. London: Department of Health, 2005:1-85.

87. Department for Communities and Local Government. Developing the future arrangements for Local Area Agreements. London, 2007.

88. Department for Communities and Local Government. Strong and prosperous communities: The Local Government White Paper. Making it happen: the Implementation Plan

London: Department for Communities and Local Government,, 2007.

89. Gillanders G, Ahmad S. Win-Win? Early experience from local area agreements. *Local Government Studies* 2007;33(5):743-760.

90. Sullivan H, Gillanders G. Stretched to the limit? The impact of Local Public Service Agreements on service improvement and central-local relations. *Local Government Studies* 2005;31(5):555-574.

91. Local Government Association. A very English revolution. Delivering bolder and better Local Area Agreements. London: Produced jointly by the Local Government Association and the Improvement and Development Agency, 2007.

92. Pawson R, Tilley N. *Realistic evaluation*. London ; Thousand Oaks, Calif.: Sage, 1997.

93. Gobo G. Sampling, representativeness and generalizability. In: C. Seale GG, J.F. Gubrium, and D. Silverman (eds) Qualitative Research Practice, Sage Publications, London., editor. *Qualitative Research Practice*. London: Sage Publications, 2004.

94. Noble M, McLennan D, Wilkinson K, Whitworth A, Barnes H. The English Indices of Multiple Deprivation 2007. London: Communities and Local Government: Social Disadvantage Research Centre, University of Oxford., 2008.

95. Commission for Social Care Inspection. Delivery and Improvement Statements 2006: Commission for Social Care Inspection, 2006.

96. Aminzadeh F, Dalziel WB. Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Ann Emerg Med* 2002;39(3):238-47.

97. Downing A, Wilson R. Older people's use of Accident and Emergency services. *Age Ageing* 2005;34(1):24-30.

98. Bristow A, Hudson M, Beech R. Analysing Acute Inpatient Services: The development and application of Utilisation Review Tools. London.: Report prepared for the NHS Executive South East Thames, 1997.

99. Patton MQ. *Qualitative Evaluation and Research Methods*. London: Sage Publications, 1990.

100. Quinn RE, Kimberly JR. Paradox, Planning, and Perseverance: Guidelines for Managerial Practice. In: Quinn. JRKaRE, editor. *Managing Organization Transitions*. Homewood, IL: Dow Jones-Irwin, 1984:295-313.

101. Shortell SM, Jones RH, Rademaker AW, Gillies RR, Dranove DS, Hughes EF, et al. Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. *Med Care* 2000;38(2):207-17.

102. Scott J. *A Matter of Record*. Cambridge: Polity Press and Basil Blackwell Ltd, 1990.

103. Mehta CR, Patel NR. Exact logistic regression: theory and examples. *Statistics in Medicine* 1995;14:2143–2160.

104. StataCorp. *Stata Statistical Software: Release 10.0*. College Station,Texas: StataCorp LP, 2007.

105. Hosmer DW, Lemeshow S. *Applied logistic regression*. 2nd ed ed. New York, Chichester: Wiley, 2000.

106. Glaser B, Strauss A. *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine, 1967.

107. Mitchell SM, Shortell SM. The governance and management of effective community health partnerships: a typology for research, policy, and practice. *Milbank Q* 2000;78(2):241-89, 151.

108. Seddon T, Billett S, Clemans A. Politics of social partnerships: a framework for theorizing. *Journal of Education Policy* 2004;19(2):123–142.

109. Billett S, Clemans A, Seddon T. Forming, developing and sustaining social partnerships. Adelaide: NCVER, 2005.

110. Department of Health. World class commissioning: Vision, 2007.

111. Department of Health. The NHS in England: The operating framework for 2008/9 Annex D - Principles and rules for co-operation and competition, 2007.

112. Department of Health. Transforming Community Services: Enabling New Patterns of Provision, 2009.

113. Lord Darzi. High Quality Care For All: NHS Next Stage Review Final Report. London, 2008.

114. Denters B, Rose LE. Local Governance in the Third Millennium: a brave new world? . In: Denters B, Rose LE, editors. *Comparing Local Governance. Trends and Developments*. Houndmills: Palgrave, 2005.

115. Newman J. *Modernising governance : New Labour, policy and society*. London: Sage, 2001.

116. Thomson G, Frances J, Levacic R, Mitchell J. *Markets, hierarchies and networks. The coordination of social life*. London: Sage, 1991.

117. Borys B, Jemison DB. Hybrid Arrangements as Strategic Alliances: Theoretical Issues in Organizational Combinations. *The Academy of Management Review* 1989;14(2 (April)):234–249.

118. Exworthy M, Powell M, Mohan J. The NHS: quasi-market, quasi-hierarchy and quasi-network? *Public Money and Management* 1999;14:15–22.

119. Saltman RB, and C. von Otter,C. *Planned Markets and Public Competition.* Buckingham:: Open UP., 1992.

120. Klein R. *The New Politics of Health.* Harlow:: Longman., 1995.

121. Provan KG, Kenis P. Modes of Network Governance: Structure, Management, and Effectiveness. *J Public Adm Res Theory* 2008;18(2):229-252.

122. Addicott R, McGivern G, Ferlie E. The Distortion of a Managerial Technique? The Case of Clinical Networks in UK Health Care. *British Journal of Management* 2007(18):93-105.

123. Taylor AJ. Hollowing Out or Filling In? Task Forces and the Management of Cross-Cutting Issues in British Government. *British Journal of Politics and International Relations* 2000;2(1):46–71.

124. Southon G, Perkins R, Galler D. Networks: a key to the future of health services. *Aust Health Rev* 2005;29(3):317-26.

125. Lowndes V, Skelcher C. The dynamics of multi-organizational partnerships: an analysis of changing modes of governance. *Public Administration* 1998;76(2):313–333.

126. Provan KG, Huang K, Milward HB. The Evolution of Structural Embeddedness and Organizational Social Outcomes in a Centrally Governed Health and Human Services Network. *Journal of Public Administration Research and Theory* 2009;19(4):873-893.

127. Child J, Faulkner D. *Strategies of Cooperation: Managing Alliances, Networks, and Joint Ventures*. Oxford: Oxford University Press, 1998.

128. Goodwin N, 6 P, Peck E, Freeman T, Posaner R. Managing across diverse networks of care: Lessons from other sectors. Report for the

NHS Service Delivery and Organisation R&D Programme. London: National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, 2004.

129. Sheaff R, Dowling B, Marshall M, McNally R, Schofield J, Mannion R. Organisational factors and performance: a review of the literature. London: National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, 2004.

130. Williams P. The Competent Boundary Spanner. *Public Administration* 2002;80(1):103-124.

131. Victor CR, Peacock JL, Chazot C, Walsh S, Holmes D. Who calls 999 and why? A survey of the emergency workload of the London Ambulance Service. *J Accid Emerg Med* 1999;16(3):174-8.

132. Arnstein S. A Ladder of Citizen Participation. . *Journal of the American Institute of Planners* 1969;35(4):216–221.

133. Keast R, M. Mandell, and K.A. Brown. 2006. Mixing State, Market And Network Governance Modes: The Role Of Government In "Crowded" Policy Domains. *International Journal of Organization Theory and Behavior* 2006;9(1):27–50.

134. Koppenjan J, Mandell M, Keast R, Brown K. The Role of Context in Hybrid Governance Arrangements. Washington DC 2009.

135. Powell WW. Hybrid organizational arrangements: New form or a transitional development? *California Management Review* 1987;30(1 (Autumn)):67–87.

136. Flynn R. Clinical governance and governmentality. *Health Risk & Society* 2002;4:155-73

137. Foucault M. *Power/Knowledge*. New York: : Pantheon, 1980.

138. Barratt E. The later Foucault in organization and management studies. . *Human Relations* 2008;61(4):515–537.

139. Mannion R, Davies H, Konteh F, Jung T, Scott T, Bower P, et al. Measuring and assessing organisational culture in the NHS: research report. York: Centre for Health and Public Services Management, University of York., 2007.

140. Addicott R, McGivern G, Ferlie E. Networks, Organizational Learning and Knowledge Management: NHS Cancer Networks. . *Public Money and Management* 2006;26(2):87–94.

141. Sheaff R, Benson L, Farbus L, Schofield J, Mannion R, Reeves D. Network resilience in the face of health system reform. *Social Science & Medicine* 2010;70(5):779-786.

142. Burt RS. A note on social capital and network content. *Social Networks* 1997;19(4 (October)):355-373.

143. Burt RS. Structural Holes and Good Ideas. *The American Journal of Sociology* 2004;110(2):349-399.

144. Granovetter M. The Strength of Weak Ties. *American Journal of Sociology* 1973;78(6):1360 -1380.

145. Krackhardt D. Graph Theoretical Dimensions of Informal Organizations. In: (eds.) CKPM, editor. *Computational Organizational Theory*. Hillsdale:: Lawrence Erlbaum., 1994:89-111.

146. Smith J, Dixon J, Mays N, McLeod H, Goodwin N, McClelland S, et al. Practice based commissioning: applying the research evidence

10.1136/bmj.331.7529.1397. *BMJ* 2005;331(7529):1397-1399.

147. Goodwin N. Developing effective joint commissioning between health and social care: Prospects for the future based on lessons from the past. *Journal of Care Services Management* 2007;1(3):279-293.

148. Glendinning C. Breaking down barriers: integrating health and care services for older people in England. *Health Policy* 2003;65(2):139-151.

149. Phelps K, Regen E. To what extent does the use of Health Act Flexibilities promote effective partnership working and positive outcomes for older people, 2008.

150. Wistow G, King D, Huntingford P. Reducing the use of emergency beds by 20%: Calculating the target. Maidstone: Kent County Council., 2005.

151. Damiani M, Dixon J. COPD medical admissions in the UK 2000/01–2001/02. London: The Kings Fund, 2004.

152. Godden S, McCoy D, Pollock A. Using SitReps performance data to monitor the delayed discharge process. *Health Services Management Research* 2008;21:155 -160.

153. Davison J, Bond J, Dawson P, Steen IN, Kenny RA. Patients with recurrent falls attending Accident & Emergency benefit from multifactorial intervention--a randomised controlled trial. *Age Ageing* 2005;34(2):162-8.

154. Wilkinson TM, Donaldson GC, Hurst JR, Seemungal TA, Wedzicha JA. Early therapy improves outcomes of exacerbations of chronic obstructive pulmonary disease. *Am J Respir Crit Care Med* 2004;169(12):1298-303.

155. Hippisley-Cox J, Bayly J, Potter J, Fenty J, Parker C. Evaluation of standards of care for osteoporosis and falls in primary care: Final report to The Information Centre for Health and Social Care. : QRESEARCH and The Information Centre for Health and Social Care, 2007.

156. Snooks HA, Halter M, Close JC, Cheung WY, Moore F, Roberts SE. Emergency care of older people who fall: a missed opportunity. *Qual Saf Health Care* 2006;15(6):390-2.

157. Poncia HDM, Ryan J, Carver M. Next day telephone follow up of the elderly: a needs assessment and critical incident monitoring tool for the accident and emergency department. *Journal of Accident & Emergency Medicine* 2000;17(5):337-340.

158. Huby G, Stewart J, Tierney A, Rogers W. Planning older people's discharge from acute hospital care: linking risk management and patient participation in decision-making. *Health, risk and society* 2004;6(2):115-132.

159. Martin GP, Hewitt GJ, Faulkner TA, Parker H. The organisation, form and function of intermediate care services and systems in England: results from a national survey. *Health Soc Care Community* 2007;15(2):146-54.

160. Healthcare Commission. Survey of adult inpatients in the NHS 2007: Healthcare Commission, 2007.

161. Richards N, Coulter A. Is the NHS becoming more patient-centred? Trends from the national surveys of NHS patients in England 2002-07. Oxford: Picker Institute, 2007:1-30.

162. The Comptroller and Auditor General. Ensuring the effective discharge of older patients from NHS acute hospitals: National Audit Office, 2003.

163. Coulter A, Nuffield Trust for Research and Policy Studies in Health Services. *The autonomous patient : ending paternalism in medical care*. London: Stationery Office, 2002.

164. Pickard L. The effectiveness and cost effectiveness of support and services to informal carers of older people. A review of the literature prepared for the Audit Commission. London: Audit Commission, 2004.

165. Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, et al. Early discharge hospital at home. *Cochrane Database Syst Rev* 2009(1):CD000356.

166. Gunnell D, Coast J, Richards SH, Peters TJ, Pounsford JC, Darlow MA. How great a burden does early discharge to hospital-at-home impose on carers? A randomized controlled trial. *Age Ageing* 2000;29(2):137-42.

167. Burt RS. The contingent value of social capital. Administrative Science Quarterly 42, no. 2 (June): 339. *42* 1997;2 (June):339.

168. Gittell JH. Organizing work to support relational co-ordination. *International Journal of Human Resource Management* 2000.;11(3 (June)):517–539.

169. Granovetter M. Economic action and social structure: the problem of embeddedness. *American Journal of Sociology* 1983;41:481–510.

170. Rhodes RAW. Continuity and change in British central-local government relations: the "Conservative threat", 1979-83. *British Journal of Political Science* 1984;14:261–283.

171. Winetrobe BK. A tax by any other name; the Poll Tax and the Community Charge. *Parliamentary Affairs* 1992;45(3):420-427.

172. Department of Health. Supporting People with Long Term Conditions. An NHS and Social Care Model to support local innovation and integration, 2005:1-42.

173. Barab SA, Luehmann AL. Building sustainable science curriculum: Acknowledging and accommodating local adaptation. *Sci Ed* 1987;87 454 – 467.

174. Sitzia J, Cotterell P, Richardson A. Formative Evaluation of the Cancer Partnership Project. London: Macmillan Cancer Relief, 2004.

175. Le Grand J. *Motivation, agency, and public policy : of knights and knaves, pawns and queens*. Oxford: Oxford University Press, 2003.

176. Department of Health. Reforming NHS Financial Flows: Introducing payment by results 2002.

177. Department of Health. Health reform in England: update and next steps, 2005.

178. Hunter D. Back to the future (Editorial). *Public Money and Management* 2003;23(4):211-213.

179. Pollock AM, Price D, Talbot-Smith A, Mohan J. NHS and the Health and Social Care Bill: end of Bevan's vision? *BMJ* 2003;327(7421):982-5.

180. McLaughlin E, Gewirtz S, Clarke J. *New managerialism, new welfare?* London: Open University in association with SAGE Publications, 2000.

181. Department of Health. Equity and excellence: Liberating the NHS. London: Department of Health, 2010.

182. Baker M. *Making sense of the NHS White Papers*. Second Edition ed. Oxford: Radcliffe Medical Press, 2000.

183. Paton C. The politics and economics of Health Care Reform: Britain in Comparative Context. In: Altenstetter C, Bjorkman JW, editors. *Health Policy Reform, National Variations and Globalization*. London: Macmillan Press Ltd, 1997.

184. Department of Health. Liberating the NHS: Transparency in outcomes – a framework for the NHS. London: Department of Health, 2010.

185. Department of Health. Health of the Nation: A strategy for health in England. White Paper. London: HMSO, 1989.

186. Klein R. *The new politics of the National Health Service*. 3rd ed. New York: Longman, 1995.

187. Smith J, Walshe K, Hunter DJ. The "redisorganisation" of the NHS. *BMJ* 2001;323(7324):1262-3.

188. Thomas P, Meads G, Moustafa A, Nazareth I, Stange KC, Donnelly Hess G. Combined horizontal and vertical integration of care: a goal of practice-based commissioning. *Qual Prim Care* 2008;16(6):425-32.

189. Dixon A, Storey J, Rosete AA. Accountability of foundation trusts in the English NHS: views of directors and governors. *J Health Serv Res Policy* 2010;15(2):82-9.

190. Lewis R, Hinton L. Citizen and staff involvement in health service decision-making: have National Health Service foundation trusts in England given stakeholders a louder voice? *J Health Serv Res Policy* 2008;13(1):19-25.

191. Newbold D. Foundation Trusts: economics in the 'postmodern hospital'. *J Nurs Manag* 2005;13(5):439-47.

192. Cheater FM. Improving primary and community health services through nurse-led social enterprise. Guest Editorial. *Quality in Primary Care* 2010;18:5-7.

193. Lewis R, Hunt P, Carson D. Social Enterprises and Community-Based Care: Is there a future for mutually owned organisations in community and primary care? London: King’s Fund, 2006.

194. Mayo A, Allen A. Reducing admissions with social enterprises. *Emerg Nurse* 2010;18(4):14-7.

195. Coleman A, Checkland K, Harrison S, Dowswell G. Practice-based Commissioning: theory, implementation and outcome. Final Report. Manchester: National Primary Care Research and Development Centre (NPCRDC), University of Manchester, 2009:1-73.

196. Audit Commission. Putting commissioning into practice: implementing practice based commissioning through good financial management. London: Audit Commission, 2007.

197. Curry N, Goodwin N, Naylor C, Robertson R. Practice-based commissioning. Reinvigorate, replace or abandon? . London: King’s Fund, 2008.

198. Gillam S, Lewis RQ. Practice based commissioning in the UK. *BMJ* 2009;338:b832.

199. Department of Health. Payment by Results in 2011-12. Letter from Office of David Flory, Deputy NHS Chief Executive, 2010.

200. Wistow G, Henderson C. Anticipating the New Health Act: Messages from the Innovation Forum. *Journal of Integrated Care* 2010;18(5):4-14.

201. Department of Health. Revision to the Operating Framework for the NHS in England 2010/11. London: Department of Health, 2010.

202. Department of Health. Our health, our care, our community: investing in the future of community hospitals and services. Health and social care working together in partnership, 2006:i-47.

203. NHS Evidence. What are communities of practice?: NICE., 2010.

204. Department of Health. Liberating the NHS: Increasing democratic legitimacy in health London: Department of Health, 2010.

205. Byrne D. *Complexity theory and the social sciences: an introduction*. London: Routledge, 1998.

206. Buijs J-M, Echuis J, Byrne D. Approaches to Researching Complexity in Public Management. In: Teisman G, Buuren Av, Gerrits L, editors. *Managing complex governance systems: Dynamics, self-organization and coevolution in public investments*. New York/Oxford: Routledge, 2009.

207. Teisman G, Buuren A, Gerrits L. *Managing Complex Governance Networks*: Routledge, 2009.

208. Head BW. Three Lenses of Evidence-Based Policy. *Australian Journal of Public Administration* 2008;67(1):1-11.

209. Rihoux B, Ragin CC. *Configurational comparative methods : qualitative comparative analysis (QCA) and related techniques*. Thousand Oaks: Sage, 2009.

Appendix A Unplanned hospital admissions of older people (75+). The impact of governance and incentives: detailed proposal for Phase 2 of the study

Phase 2: In-depth study of 3 IF localities

The methods of the 3 in-depth case studies of the project have been designed to address the following questions:

1. How have professionals conceptualised changes in governance and incentives?
2. How do professionals interpret and integrate policy concerning governance and incentive arrangements into their daily practice?
3. Are there particular aspects of governance and incentives that are perceived by professionals as more appropriate to the values and culture of their organisation?
4. Do professionals perceive governance and incentive arrangements as driving patient choice and quality of care?
5. What are the perceived facilitators and barriers to reducing unscheduled hospital bed use at each point of the patient journey within the identified conditions (falls, COPD and stroke)?
6. What factors do patients perceive to contribute to preventing unplanned hospital admissions and minimising hospital stay?

Methods are summarised in Figure A1 (Annex A).

Patient Journey

This aspect of the project aims to capture the experience each patient has of the health and social care system over a short time period and to answer the following specific questions.

- What are the perceived facilitators and barriers to reducing unscheduled hospital bed use at each point of the patient journey within the identified conditions (falls, COPD and stroke)?
- What factors do patients perceive to contribute to preventing unplanned hospital admissions and minimising hospital stay?

Patients (and where present, family carers) will be tracked, not only across the boundaries of care but across time.

This journey will capture experience of and understanding of the factors which contribute to either their prevented unscheduled admission/unscheduled admission and subsequent journey through the health and social care system, and of the services falling underneath the umbrella of the Innovation Forum Due to the intensity and work involved, a small number of older people (maximum of 6 per site), with specific conditions which are known to contribute to increased hospital use will be tracked (see table below).

Table A1 Presenting condition and type of service use impacting on bed-day reduction

Type of unplanned service use	Condition
Admission prevented	Falls/COPD
Admission avoidable	Falls/COPD
Delayed discharge	Falls/COPD/Stroke

Details of the sample

This study of the patient journey will track patients with one of three conditions: falls, COPD, stroke (n=18). These conditions have been selected as they are among the most prevalent medical diagnoses of older people in the A&E departments (Downing and Wilson 2005; Aminzadeh and Dalziel 2002). Each site will attempt to recruit and follow patients with each of the presenting conditions (See Table A2).

Table A2 Patient conditions for inclusion in sample

Patient condition	Site A	Site B	Site C
COPD	2	2	2
Stroke	2	2	2
Falls	2	2	2
Total	**6**	**6**	**6**

Identification of sample

Purposive

- Patients will be ID as a result of an inappropriate/avoidable hospital admission/prevented admission, and/or participation in an IF Intervention.
- The hospital sample will focus on those whose admission/and/or/length of hospital stay, is not defined as appropriate and therefore could have been avoided, using the 'modified AEP criteria' tool (Bristow et al 1997) (Annex B).

Assistance from hospital/ community/social care staff will be needed to identify patients who are likely to be within the top 2 segments of the Kaiser Permanente Pyramid, (i.e. Level 2, High risk or Level 3, have highly complex needs) and whose admission/or length of stay, is defined as 'avoidable' and to complete the modified AEP criteria.

Each site will recruit from both the hospital and community setting (where possible).

Staff will make the initial approach to older people, and if they are interesting in taking part, researchers will follow-up this initial approach and gain informed consent (see ethics application for further info).

Recruitment details

- Research team approach community team (e.g. Intermediate care team, community matron) and gerontology clinical area (e.g. medical ward, stroke unit).
- Staff identify patients whose admission has been prevented (community), or who have experienced an admission which could have been avoided/length of stay (Hospital setting- using modified AEP Criteria).
- Staff ask patients if they would be interested in taking part in the study and give information sheet to provide supportive and detailed information.
- If patients agree to participate, then formal approach is made by research team (following explanation of what the study entails)
- Informed written consent taken by researcher.
- First interview.
- Tracking begins (see table below for details).

Table A3 Details of patient tracking process and data collection.

Interview Point	**Number of Interviews**
Interview 1: (During the course of the hospital stay following admission/on entry to IF Intervention) • Patients • Informal/family carers • Staff	• 18 Patients • (Max 18 carers if present) • Max 2 staff/patient (max 36)
Interview 2: On discharge (if were admitted, or following discharge from scheme if in community**) • Patients • Informal/family carers • Staff	• Max 18 Patients • Max 18 • Max 2 Staff/patient
Interview 3: 6 wks – 2 months post-discharge. • Patients • Informal/family carers • Staff	• 18 Patients • Max 18 • Max 2 staff/patient
Total	• **Patients (Max 54)** • **Informal/family carers (Max 54)** • **Staff (Max 108)**

** E.g. discharge from time limited intermediate care intervention/or acute phase of the community-based intervention-e.g. community matron).

The topic guide will be developed following Phase 1, semi-structured interviews with professionals and non-participant observation and the academic literature on governance and incentive arrangements.

Interviews will be undertaken by an experienced researcher and will last no longer than one hour. Interviews will be arranged at a date and time convenient to participants. The initial interview will be conducted in a private area of the ward (a member of the patients' family will be invited to attend if the patient wishes and consents to this) or in the patient's residence (pr preferred venue), if in the community. Where possible informal carers will be interviewed separately. Follow-up interviews will be undertaken in a venue of the patient's choice, but it is anticipated that this will normally be the participant's home or care home residence. Informed consent will be obtained prior to the interviews being undertaken.

Short interviews will be held with a range of key staff involved in the care of the tracked patients at the identified points in their journey (snowballing out from the patient). The staff involved in discharge planning and/or care provided in the community will vary between patients depending on both their requirements and the processes in operation within the acute trusts and their partners. These interviews may be face-to-face or telephone, and will be recorded where possible. When this is not possible, notes of the interview will be made by the researcher.

Staff will be identified from the patient experience. Selection will be made following discussion with the patient/carer and the professional team involved in service/care provision. E.g in the hospital setting, members of the nursing, AHP's or medical staff may be asked to participate. In the community, staff members involved in the intervention, such as staff from the intermediate care team/community matrons/GP may be approached.

Data

Tape-recorded interviews will be transcribed and anonymised.

Analysis

The process of identification of themes, developing categories, determining connections, and refining categories will then be carried out in an inductive way following the constant comparative method of grounded theory (Glaser & Strauss, 1967).

This will involve immersion in the data, i.e. reading fieldnotes, diaries and listening to interviews in order to gain a 'general sense' of the data, followed by detailed coding. This process will enable themes to emerge inductively from the interviews. These themes will describe the journey of the patients through the health and social care system and from secondary care to their home or care home setting enabling the process to be described and understood from the patient's perspective.

Each of the 3 researchers (tba) at the different sites will explore and code the data for their site, and through discussion can agree a coding frame, this can be used by each researcher. The data from each of the sites can then be combined using N6 Merge software.

Similarities and differences between the different models of governance and the different models of service configuration can then be explored. Finally these categories will be compared with existing knowledge and the implications of the findings discussed for policy and practice.

Specific ethics considerations

- Increasing frailty/death of patient during tracking

As the older people we will be recruiting are likely to be frail, they could become ill or die during the tracking phase. In order to reduce any potential distress to either the older person or their family carer, before making contact to arrange interviews 2 and 3, we will contact the GP/Community team involved in their care.

- Disclosure of abuse (by informal carer/family member)

Patients and carers will be interviewed separately unless the patient requests otherwise and chooses to have the carer present.

If family/carer abuse is suspected, then a member of the professional team will be alerted.

- Disclosure of unacceptable practice/abuse (by health/social care professional)

If either of the above are disclosed, then it will be reported to the service manager/GP as appropriate, this is indicated on the information sheet.

- Discussion of specific patient case with staff

Specific consent of the patient will be obtained to enable staff to share information specific to their case.

Non-participant observation

Aims: To explore the nature of decision-making and the impact of organisational (sub) cultures.

Specific questions

- Have professionals conceptualised changes in governance and incentives?
- How do professionals interpret and integrate policy concerning governance and incentive arrangements into their daily practice?
- Are there particular aspects of governance and incentives that are perceived by professionals as more appropriate to the values and culture of their organisation?
- Do professionals perceive governance and incentive arrangements as driving patient choice and quality of care?

Method

Observation of a range of multi-professional forums responsible for monitoring and evaluating unscheduled bed days and designing or implementing specific service initiatives across the 3 selected sites.

This phase of the data collection will focus on the health professionals who are operating 'nearer' to the patient, i.e. at a more operational level that those participating in phase 1 of the study.

Types of meetings

The types of meeting to be observed will vary according to the sites where patients (see above) are to be sampled from, but are likely to include both primary/community and acute settings. This may be e.g. intermediate care teams/ community matrons/ acute settings.

The specific meetings will vary between the sites. The types of meetings may include team/multi-disciplinary and delayed discharge meetings/case conferences that health and social care professionals attend, as well as managerial/monitoring meetings attended by team managers. We will also try to attend meetings which relate to the 3 specific conditions, such as falls service meetings.

Researchers will be invited to attend the meetings as non-participant observers by the staff they come into contact with as a result of the patient tracking

- Meetings operating at a strategic level, where managers from the different organisations discuss development and commissioning of services and financial decisions are made.
- Operational meetings, where operational managers make decisions about service developments etc.
- Meetings where teams at the front-line of service delivery working on the specific interventions aimed at meeting the IF targets plan and discuss how they deliver the interventions.

Data will be recorded as

Field notes, and if possible (if all present agree) tape–recorded.

Analysis

Data will be managed by using NUD-IST and incorporated into the constant comparative analysis.

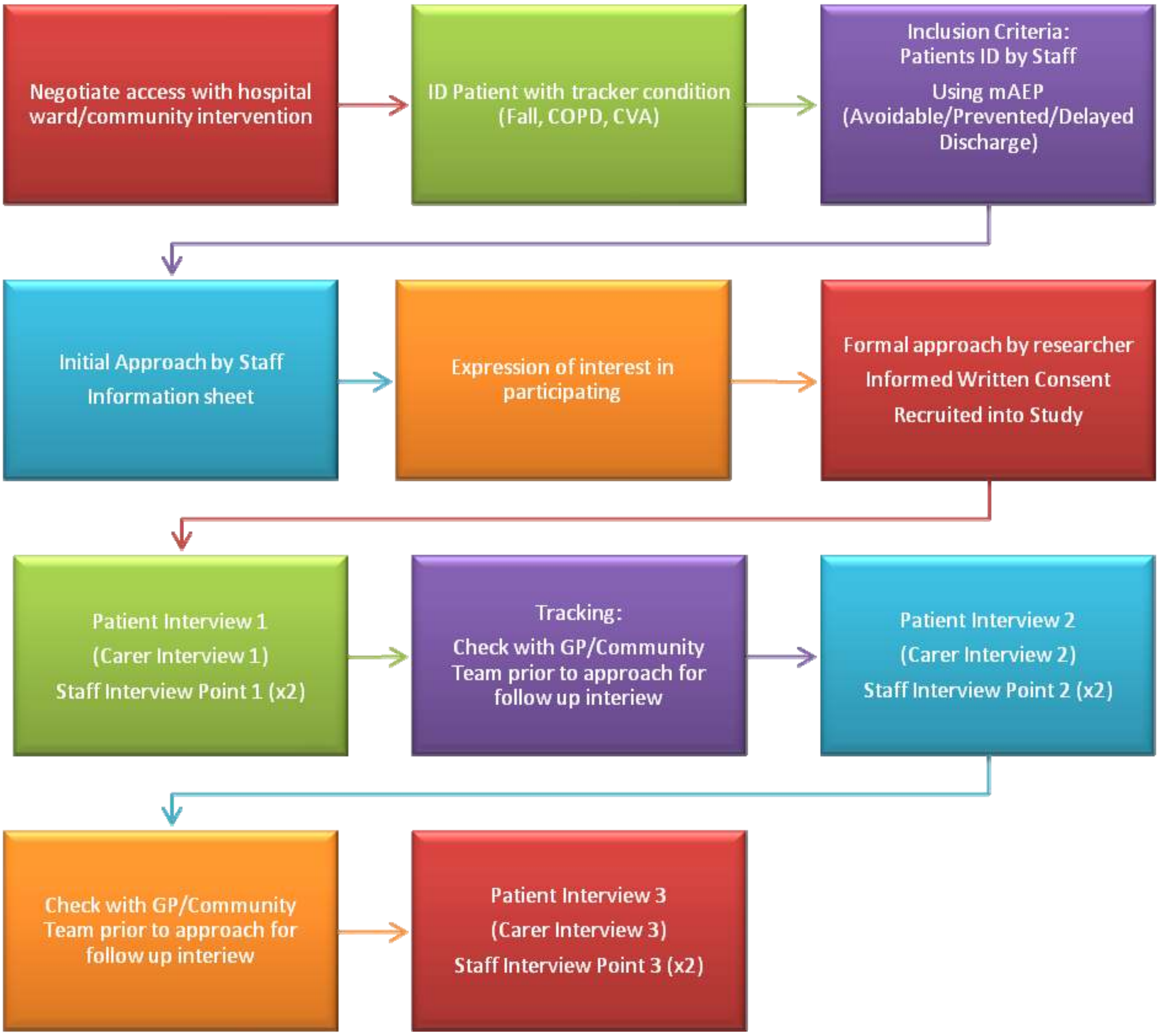
Each of the 3 researchers (tba) at the different sites will explore and code the data for their site, and through discussion can agree a coding frame, this can be used by each researcher. The data from each of the sites can then be combined using N6 Merge software.

Ethics considerations

Information regarding the proposed presence of researchers at meetings will be circulated in advance of the meeting. Participants can then let the research team know in advance if this is not acceptable. Any objections will result in researchers not attending, and objections will remain anonymous.

Annex A: Phase 2 Fieldwork

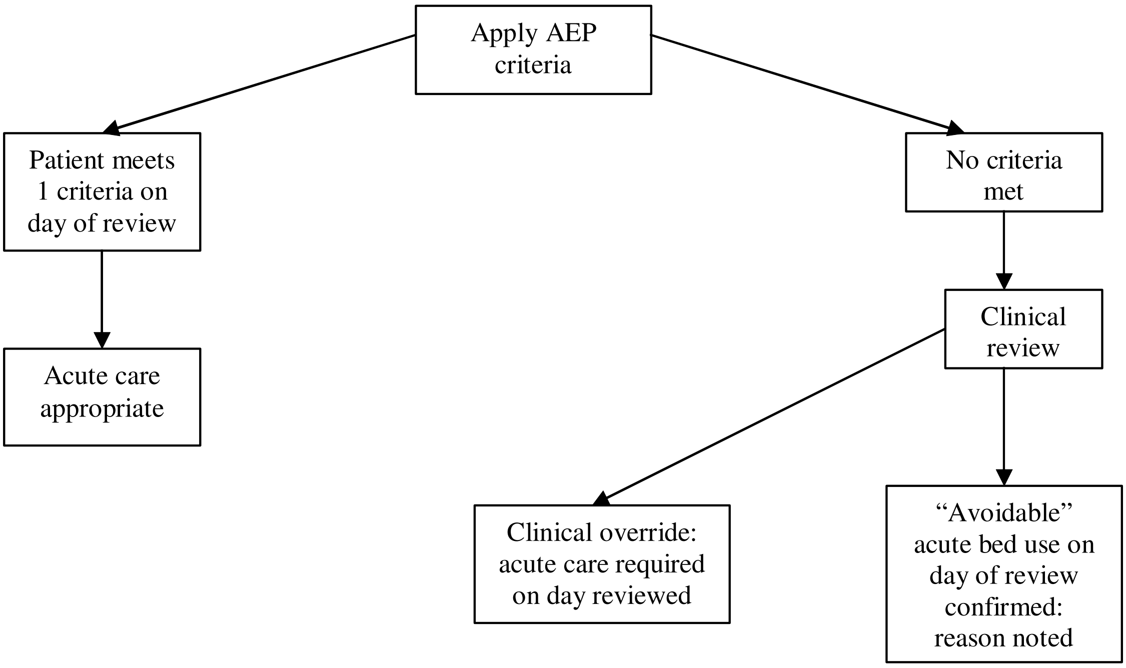
Figure A1 Recruitment and Research Process: Patient Tracking



Annex B

Modified AEP criteria for defining adult care appropriate for an acute inpatient setting (and to determine delays)

Modified AEP review process



Adult day of admission criteria

1. Procedure in theatre within 18 hours;
2. Monitoring of cardiac rhythm, blood pressure, pulse, temperature or respiration every 2 hours for at least 2 observations;
3. Intravenous/subcutaneous/naso-gastric fluid replacement (includes new gastrostomy/does not include access previously established), intravenous/subcutaneous medications;
4. Any form of artificial ventilation or respiratory support (new or changing);
5. Severe electrolyte/acid-base abnormality;
6. Acute loss of ability to move a limb or other body part within 48 hours prior to admission;
7. Acute impairment of sight or hearing within 48 hours prior to admission;

8. Recent acute internal bleeding (except haematuria unless requiring catheterisation);
9. Acute rupture of recent surgical wound;
10. Pulse rate <50 or >140 per minute;
11. Systolic Blood Pressure <90 or >200, diastolic <60 or >120mm Hg;
12. Acute confusional state/coma/unresponsiveness (excluding simple inebriation);
13. Electrocardiogram evidence of acute ischaemia (including unstable angina with suspicion of acute Myocardial Infarction);
14. Overdoses waiting for psychiatric opinion.

APPROPRIATENESS EVALUATION PROTOCOL (AEP) REVIEW

1. PATIENT DETAILS

Survey number ……………………………….

2. ADULT ADMISSION CRITERIA

		Please tick if criteria present
1.	Procedure in theatre within 18 hours: if surgical see sub-criteria	
2.	Monitoring of cardiac rhythm, blood pressure, pulse, temperature or respiration every 2 hours for at least 2 observations	
3.	Intravenous/subcutaneous/naso-gastric fluid replacement (includes new gastrostomy/does not include access previously established), intravenous/subcutaneous medications.	
4.	Any form of artificial ventilation or respiratory support (new or changing)	
5.	Severe electrolyte/acid-base abnormality	
6.	Acute loss of ability to move a limb or other body part within 48 hours prior to admission	

7. Acute impairment or reduction of sight or hearing within 48 hours prior to admission

8. recent acute internal bleeding (except haematuria unless requiring catheterisation).

9. Acute rupture of recent surgical wound

10. Pulse rate <50 or >140 per min.

11. Systolic BP <90 or >200, diastolic <60 or >120mm Hg.

12. Acute confusional state/coma/unresponsiveness (excluding simple inebriation).

13. ECG evidence of acute ischaemia (including unstable angina with suspicion of acute MI).

14. Overdoses waiting for psychiatric opinion.

One or more criteria met - admission day appropriate

No criteria met - admission day not appropriate

Unsure because:

3. DAY OF ADMISSION OVERRIDE INAPPROPRIATENESS/
ASSIGN REASON FOR INAPPROPRIATENESS (to be completed by clinician)

Please tick box

EITHER

No criteria met admission day APPROPRIATE by override

Override reason:

OR

Admission day INAPPROPRIATE

Please tick reason:

1. Any needed diagnostic procedures and/or treatment can be done on an outpatient basis.

2. Patient has been admitted for diagnostic procedure(s) and/or treatment that could/should have been done on an out-patient basis, except that the patient lives too far away from the hospital for it to have been accomplished expeditiously.

3. Patient has been admitted for diagnostic procedure(s) and/or treatment that could/should have been done on an outpatient basis but could not be scheduled expeditiously.

4. Patient needs institutional care, but at a level lower (not otherwise specified) than an acute care hospital.

5. Patient needs care in a chronic disease hospital
6. Patients needs care in a skilled nursing facility.

7. Patient needs care in a non-skilled nursing facility.

8. Premature admission - a day or more before inpatient procedure already scheduled.

9. No documented plan for diagnostic procedure(s)

and/or treatment.

10. Any surgical procedure should be performed on an outpatient/ambulatory basis.

11. Patient needs hospice/terminal care.

12. Actual or suspected elder abuse; patient admitted for protective custody.

13. Non-compliance with necessary outpatient therapeutic regimen

14. Other (specify)

4. DAY OF CARE CRITERIA

Please tick
if criteria
present

1. Any major operative procedure that day: see surgical sub-criteria

2. “Extraordinary” pre-operative consultation/evaluation for theatre the next day: see surgical sub-criteria.

3. On diet for text requiring strict dietary control.

4. New/experimental treatment under MO supervision.

5. Close MO monitoring at least 3 times per day.

6. Any major invasive procedure within past 24 hours.

7. Any form of artificial ventilation or respiratory support (new or changing).

8. Parenteral therapy.

9. Vital sign monitoring <every 30 minutes for at least 4 hours.

10. IM and SC injections > 2 per day (including diabetic newly diagnosed)

11. Input/output measurement and/or daily weighing.

12. Major surgical wound and drainage care.

13. Close nurse monitoring, medically directed, 3+ times per day.

14. Bowel obstruction, ileus and acute retentions (in past 24 hours).

15. Transfusion or serial transfusions for acute conditions in past 48 hours.

16. Dysrythmias causing acute dynamic disturbance or acute ischaemia in past 48 hours.

17. Fever of at least 38° C within past 48 hours.
18. Episode of coma/unresponsiveness in past 24 hours (exclude patients with epilepsy).

19. Acute confusional state in past 48 hours.

20. Acute hematologic disorders with signs and symptoms within past 48 hours.

21. Progressive acute neurological difficulties with past 48 hours.

One of more criteria met - day of care appropriate

No criteria met - day of care inappropriate

Unsure because:

5. DAY OF CARE OVERRIDE INAPPROPRIATENESS/ASSIGN REASON FOR INAPPROPRIATENESS (to be completed by clinician)

EITHER

Please tick box

No criteria met, day or care

APPROPRIATE by override

Override reason:

OR

Day of care inappropriate

Please tick reason:

For cases in which there is a delay in performing the work-up or treatment for which the patient is hospitalized

1. Problem in scheduling surgery.
2. Problem in scheduling diagnostic procedure.
3. Premature admission.
4. Patient scheduled for a diagnostic procedure or treatment (including surgery) is “bumped” from schedule, for any reason (emergency case supersedes elective case, crucial hospital personnel are sick, etc).

5. “Down” days at the hospital : certain procedures are not done on weekends or holidays.

6. Results or diagnostic tests/procedures or consultations needed to guide further diagnostic or therapeutic decisions, have not yet been received.

7. Other (specify)

FOR CASES IN WHICH THE MEDICAL PURPOSE OF HOSPITALISATION HAS BEEN ACCOMPLISHED OR CAN BE ADDRESSED IN A LESS ACUTE SETTING

Physician or hospital responsibility:

8. Discharge planned, but no orders written

9. Failure to initiate/execute timely hospital discharge planning.

10. Inattention to prompt discharge once the purpose of hospitalization has been accomplished: physician keeps patient in hospital beyond time when the patient no longer receives or requires the services/facilities of an acute care hospital.

11. No documented plan for diagnostic procedure(s) and/or treatment.

12. Any needed diagnostic procedure(s) and/or treatment can be done on an outpatient basis.

13. Other (specify)

Patient or family responsibilities:

14. Lack of family for home care.

15. Lack of family preparation for patient's home care.

16. Patient/family rejection of available space at appropriate alternative facility.

17. Other (specify).

Environmental responsibilities:

18. Patient from an unhealthy environment is kept in hospital under either that environment becomes acceptable or an alternative facility is found.

19. patient is convalescing from an illness, and it is anticipated that there would be less than a 72 - hour stay in an alternative facility.

20. Unavailability of alternative facility.

21. Unavailability of alternative non-facility-based treatment such as home health care.

22. Other (specify).

Appendix B Information sheet for patients

INFORMATION SHEET FOR PATIENTS

Improving services for older people to reduce the use of unplanned hospital care

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Within your local area there are initiatives that aim to reduce the unplanned time that older people spend in hospital by providing 'innovative' services that are at least as good and which improve the lives of older people. Most people want to avoid going in to hospital or staying longer than is needed, and efforts are being made to develop new services. Your council is one of nine sites that took part in the Innovation Forum: Reducing Hospital Admissions of Older People (IF), and have been involved in the development and implementation of related initiatives developing these new services over the past four years. Our research looks at the ways in which councils, hospitals and community health services work together to provide and pay for these services. In the first phase of the study we explored how the local health service, the council and other parties, such as voluntary agencies, were working together to plan these such services in these nine areas. We now want to find out how this affects how hospital services are used by people aged 75 or older. We would also like to find out more about patients' views of these services.

What should I expect if I take part?

If you decide to take part, we would like to talk to you three times over a short period of time (2-4 months). The first time, we would like to talk to you about your hospital stay or the services/care you were given to help avoid you going into hospital, as well as the factors that led up to your needing this care/hospital stay. We would also like to discuss any other help or services you are receiving. This will take about an hour. We will arrange the interview at a date and time convenient for you in a private area of the ward, if you are in hospital, or at your home. With your agreement, we would later talk to your family carers about their experience if they are willing to be involved.

We would like to talk to you (and if possible, your carer) again after you leave hospital or the alternative service/care, and again about 2 months later. At these visits, we would like to follow up on your progress and find out your views of the services you have received. We will arrange these visits for a time and place to suit you. If you prefer, we can carry out the second and third interviews by telephone. This will take about half an hour.

If you agree, we would like to tape record the interviews. We will ask you if we can use direct quotes from the interview.

So that we can understand the medical reasons for your admission, we would like to look at the records kept by the ward/__________service. We would like to talk to some of the staff that have been involved in your treatment and care since your admission to hospital/__________service. Lastly, we would notify your GP of your participation in the study. We will then be able to check with them for any changes in your medical circumstances before contacting you for follow-up interviews. Also in the very rare case that the researcher may become aware of risks to your personal safety, the researcher will also need to contact your GP or a staff member involved in your treatment and care, with your permission. Although this is very unlikely to be an issue, the researcher would be obliged to inform a manager of the ward/_________ service in case of adult protection concerns.

Why have I been chosen?

We have asked the staff working within the hospital/__________service to approach some patients who had an unplanned admission/prevented admission and who might benefit from using these new services. We would like to talk to people who have had a recent stroke; have breathing difficulties; or have recently had a fall.

Do I have to take part?

The member of staff who gave you this information sheet will ask if they can give your name and contact details to the research team. It is up to you to decide whether or not to take part. If you do wish to take part or would like to find out more, the researcher will come and see you within the next day or two. We will answer any questions you have and then arrange a time to talk to you if you still want to take part. If you decide to take part you are still free to change your mind at any time and without giving a reason.

What are the possible disadvantages of taking part?

Some people may feel tired during or following an interview. You may also feel that you do not want to answer some questions. You can stop the interview at any time and do not have to answer any questions you do not wish to.

What are the possible benefits of taking part?

You may not benefit directly from the study. However, we hope that finding the best ways for health and social care to work together would help to make sure that in the future older people get the right services provided by the right people in the right place at the right time.

What if something goes wrong?

If you have a complaint about how you feel you have been treated during the course of this study, or how any aspect of it was carried out, then please contact the Chief Investigator, Professor Martin Knapp or alternatively Gus Stewart (Contact details are at the end of this form).

Will my taking part in this study be kept confidential?

What you say in the interviews will remain confidential. We may use direct or "verbatim" quotes from the interview if you agree. Your name will not be used in any publication. The information that we collect (interview recordings (on tapes and CD's), hard copies of interview notes and fieldnotes) will be made anonymous by removing any personal details so that you cannot be recognised from it; and will be stored securely in locked filing cabinets within locked offices. Digital interview recordings and notes and other related electronic data will be stored on computers that are password protected. All data storage and use will comply with the Data Protection Act (1998), and be kept by the Chief Investigator at the London School of Economics for 10 years after the end of the study.

What will happen to the results of the research study?

The results of the research will be used to write a report for the NHS Service Delivery Organisation (who are paying for the research), as well as academic papers and presentations. It will also be fed back to the health and social services in your local area. If you would like a copy of the report or papers, please contact Professor Martin Knapp.

Who is organising and funding the research?

The main researcher organising the research project is Professor Martin Knapp. This research is funded by the NHS Service Delivery Organisation.

Who has reviewed the study?

The study has been reviewed by the Cambridgeshire 4 Research Ethics Committee.

REC Reference Number: 07/H0305/60

Contact for further information:

If you would like further information about the study, then please contact:

The local researcher:
TBC
Address:
Tel:
Email:

Or the Project lead:
Professor Martin Knapp
Address: Personal Social Services Research Unit, LSE Health and Social Care, London School of Economics, Houghton Street, London, WC2A 2AE
Tel: 020 7955 6225
Email: m.knapp@lse.ac.uk

Alternative contact (complaints):

Gus Stewart
Director, Research and Project Development Division
Address: Tower One, London School of Economics,
Houghton Street, London, WC2A 2AE
Tel: 020 7955 7114
Email: g.stewart@lse.ac.uk

Thank you for taking the time to read this, and for considering whether to take part.

You will be given a copy of this information sheet and a signed consent form to keep.

Appendix C Data collection form

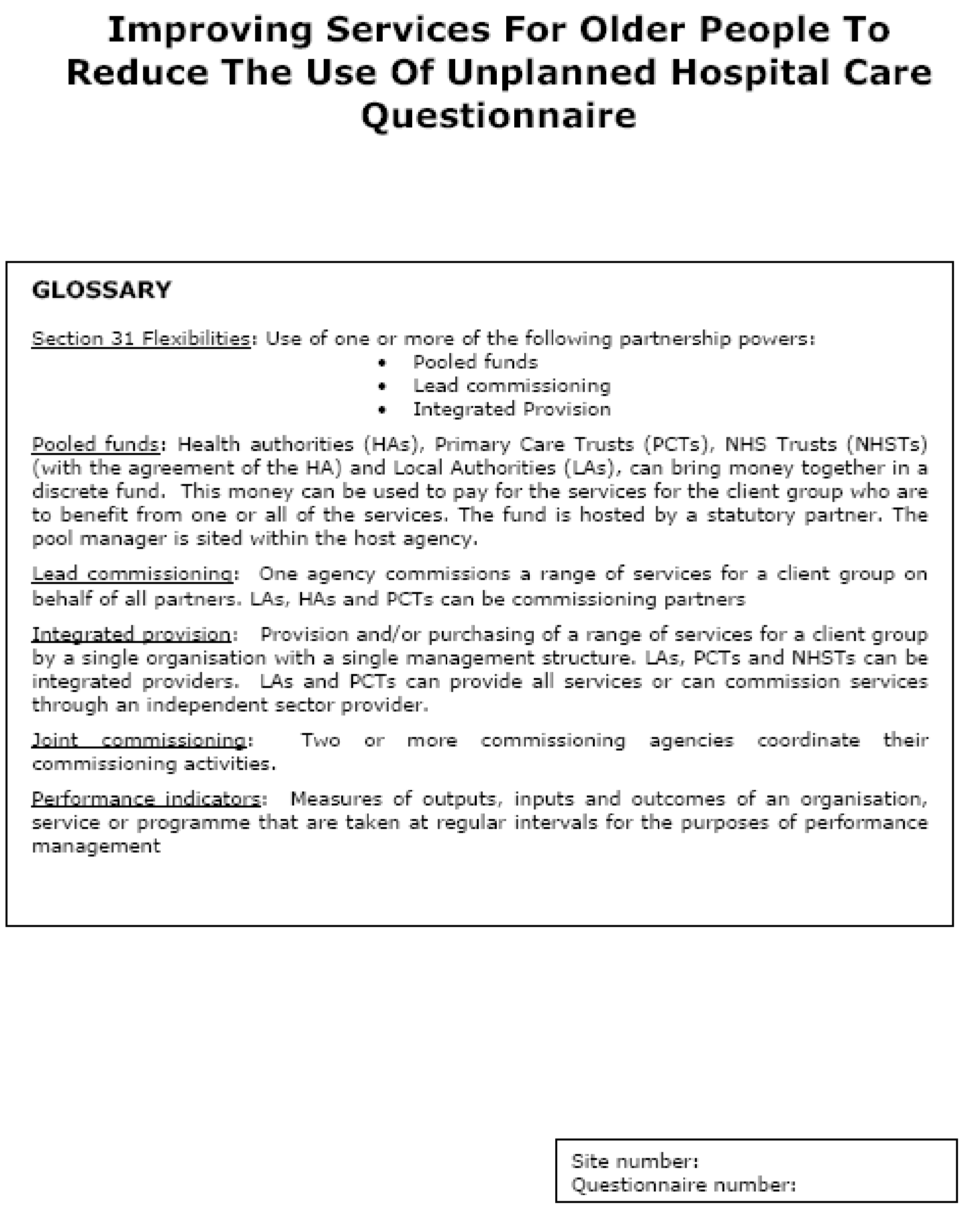
INFORMATION NEEDED	**SUGGESTED SOURCES/WHERE TO LOOK**	**PLEASE ENTER ANSWERS HERE (IN BULLET POINTS)**	**PLEASE NOTE THE SOURCE OF THE INFORMATION. IS INFORMATION ATTACHED**
Overarching locality context			
• Structure of older persons' services	• Adult Care Services Annual Report (Webpages)		
• Accountability/governance structure	• Discuss with PLN		
• Organisational Charts	• Website/or PLN		
Partnership arrangements			
• Working with which partners	• Adult care services annual report (webpages)		
	• Local Strategic Partnerships (Webpages)		
	• Local Area Agreements (Webpages/DCLG website)		
• Evidence of contracts/compacts in place to govern partnerships (including private and voluntary	• Joint commissioning boards - contracts		
	• Adult Care Services Annual Report		

INFORMATION NEEDED	SUGGESTED SOURCES/WHERE TO LOOK	PLEASE ENTER ANSWERS HERE (IN BULLET POINTS)	PLEASE NOTE THE SOURCE OF THE INFORMATION. IS INFORMATION ATTACHED
sector)	(Webpages)		
	• Discuss with PLN or Head of Strategy		
• Commissioning arrangements across partner organisation	• Adult Care Services Annual Report (Webpages)		
	• Annual Reports from Organisations		
	• Section 31 flexibilities; section 28 agreements		
• User and carer representation			
• User and carer meetings across older peoples services	• Adult Care Services Annual Report (Webpages)		
	• Annual Reports from Organisations		
• Evidence involvement in strategic decision making	• Adult Care Services Annual Report (Webpages)		
	• Annual Reports from Organisations (including Public and Patient Involvement Forums)		
	• PLN		

INFORMATION NEEDED	SUGGESTED SOURCES/WHERE TO LOOK	PLEASE ENTER ANSWERS HERE (IN BULLET POINTS)	PLEASE NOTE THE SOURCE OF THE INFORMATION. IS INFORMATION ATTACHED
	• Policy manager for users		
	• One-off consultations (eg PFI, hospital closures)		
• Public representation	• Overview and scrutiny committees		
• Performance management			
• Performance reports on overarching Older Peoples services	• Data monitoring reports		
	• Strategy and Performance officers could tell you this		
• Financial monitoring	• Public Scrutiny committee meetings		
Innovation Forum Projects			
• Membership (to include organisations and level of attendees)	• Case study reports		
	• PLN for update		
	• Minutes in your files		
• Organisational Structure	• Formal meeting minutes		

INFORMATION NEEDED	SUGGESTED SOURCES/WHERE TO LOOK	PLEASE ENTER ANSWERS HERE (IN BULLET POINTS)	PLEASE NOTE THE SOURCE OF THE INFORMATION. IS INFORMATION ATTACHED
	• PID		
	• Terms of Reference		
• Executive decision making (?enabled to make decisions on behalf of the partnership)	• Minutes		
	• Terms of Reference (Ability to release and vire funds)		
• User and carer representation	• Terms of Reference (Ability to release and vire funds)		
	• Meeting minutes		
	• PID		
• Contracts between partners	• Any SLAs, contracts		
• Innovation Forum Services			
• Performance reports on specific IF projects	• Data monitoring reports		
	• Case study reports		

Appendix D Improving Services for Older People to Reduce the Use of Unplanned Hospital Care Questionnaire



Improving Services For Older People To Reduce The Use Of Unplanned Hospital Care Questionnaire

GLOSSARY

Section 31 Flexibilities: Use of one or more of the following partnership powers:

- Pooled funds
- Lead commissioning
- Integrated Provision

Pooled funds: Health authorities (HAs), Primary Care Trusts (PCTs), NHS Trusts (NHSTs) (with the agreement of the HA) and Local Authorities (LAs), can bring money together in a discrete fund. This money can be used to pay for the services for the client group who are to benefit from one or all of the services. The fund is hosted by a statutory partner. The pool manager is sited within the host agency.

Lead commissioning: One agency commissions a range of services for a client group on behalf of all partners. LAs, HAs and PCTs can be commissioning partners

Integrated provision: Provision and/or purchasing of a range of services for a client group by a single organisation with a single management structure. LAs, PCTs and NHSTs can be integrated providers. LAs and PCTs can provide all services or can commission services through an independent sector provider.

Joint commissioning: Two or more commissioning agencies coordinate their commissioning activities.

Performance indicators: Measures of outputs, inputs and outcomes of an organisation, service or programme that are taken at regular intervals for the purposes of performance management

Site number:
Questionnaire number:

Part A. The organisation

ORGANISATIONAL CULTURE

Instructions: These questions relate to the type of Organisation that your institution is most like. Each of these items contains four descriptions of Organisations. Please distribute 100 points among the four descriptions depending on how similar the description is to your Organisation. None of the descriptions is any better than the others; they are just different. For each question, please use all 100 points.

For example: In question 1, if Organisation A seems very similar to mine, B seems somewhat similar, and C and D do not seem similar at all, I might give 70 points to A and the remaining 30 points to B.

Organisation's Character (Please distribute 100 points)

1. _____ Organisation A is a very personal place. It is a lot like an extended family. People seem to share a lot of themselves.

2. _____ Organisation B is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.

3. _____ Organisation C is a very formalized and structured place. Bureaucratic procedures generally govern what people do.

4. _____ Organisation D is very production oriented. A major concern is with getting the job done. People aren't very personally involved.

Organisation's Managers (Please distribute 100 points)

5. _____ Managers in Organisation A are warm and caring. They seek to develop employees' full potential and act as their mentors or guides.

6. _____ Managers in Organisation B are risk-takers. They encourage employees to take risks and be innovative.

7. _____ Managers in Organisation C are rule-enforcers. They expect employees to follow established rules, policies, and procedures.

8. _____ Managers in Organisation D are coordinators and coaches. They help employees meet the Organisation's goals and objectives.

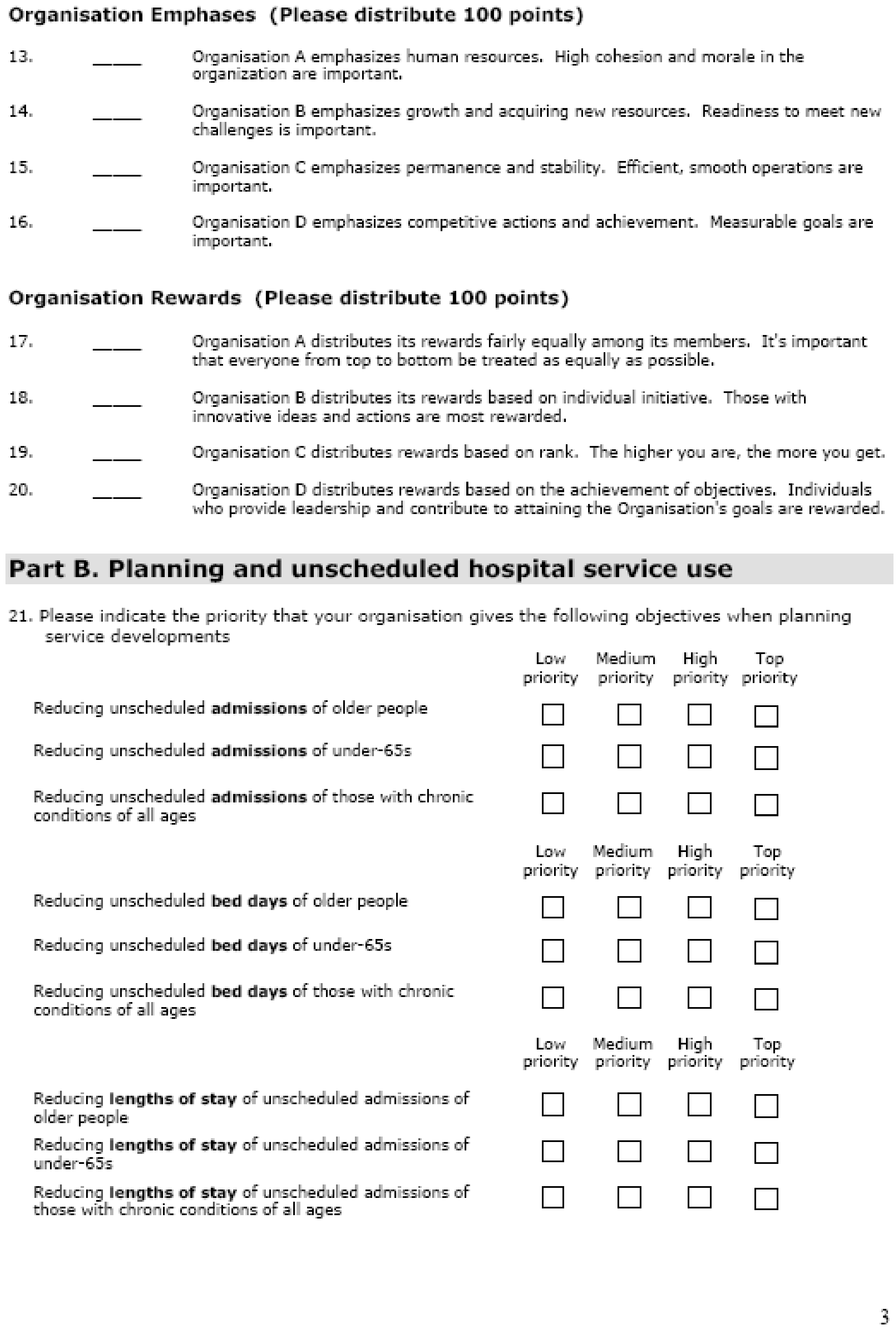
Organisation Cohesion (Please distribute 100 points)

9. _____ The glue that holds Organisation A together is loyalty and tradition. Commitment to this Organisation runs high.

10. _____ The glue that holds Organisation B together is commitment to innovation and development. There is an emphasis on being first.

11. _____ The glue that holds Organisation C together is formal rules and policies. Maintaining a smooth running operation is important here.

12. _____ The glue that holds Organisation D together is the emphasis on tasks and goal accomplishment. A production orientation is commonly shared.



Organisation Emphases (Please distribute 100 points)

13. _____ Organisation A emphasizes human resources. High cohesion and morale in the organization are important.

14. _____ Organisation B emphasizes growth and acquiring new resources. Readiness to meet new challenges is important.

15. _____ Organisation C emphasizes permanence and stability. Efficient, smooth operations are important.

16. _____ Organisation D emphasizes competitive actions and achievement. Measurable goals are important.

Organisation Rewards (Please distribute 100 points)

17. _____ Organisation A distributes its rewards fairly equally among its members. It's important that everyone from top to bottom be treated as equally as possible.

18. _____ Organisation B distributes its rewards based on individual initiative. Those with innovative ideas and actions are most rewarded.

19. _____ Organisation C distributes rewards based on rank. The higher you are, the more you get.

20. _____ Organisation D distributes rewards based on the achievement of objectives. Individuals who provide leadership and contribute to attaining the Organisation's goals are rewarded.

Part B. Planning and unscheduled hospital service use

21. Please indicate the priority that your organisation gives the following objectives when planning service developments

	Low priority	Medium priority	High priority	Top priority
Reducing unscheduled **admissions** of older people	☐	☐	☐	☐
Reducing unscheduled **admissions** of under-65s	☐	☐	☐	☐
Reducing unscheduled **admissions** of those with chronic conditions of all ages	☐	☐	☐	☐

	Low priority	Medium priority	High priority	Top priority
Reducing unscheduled **bed days** of older people	☐	☐	☐	☐
Reducing unscheduled **bed days** of under-65s	☐	☐	☐	☐
Reducing unscheduled **bed days** of those with chronic conditions of all ages	☐	☐	☐	☐

	Low priority	Medium priority	High priority	Top priority
Reducing **lengths of stay** of unscheduled admissions of older people	☐	☐	☐	☐
Reducing **lengths of stay** of unscheduled admissions of under-65s	☐	☐	☐	☐
Reducing **lengths of stay** of unscheduled admissions of those with chronic conditions of all ages	☐	☐	☐	☐

Part C. Multi-agency meetings

	Yes	No
22. Please think of the multi-agency groups/meetings/forums in your local area that have an objective of decreasing the use of unscheduled hospital bed days. Do you attend any of these meetings?	☐	☐

If you answered yes to Q22, please complete questions 23 through 38, below.
If not, please go to question 39, part D of this questionnaire.

23. Of how many such groups, meetings or forums in your local area are you a member? ☐

	Yes	No
24. Are any of these groups/meetings/forums explicitly related to the Innovation Forum?	☐	☐

The following questions are on the subject of groups/meetings/forums in your local area that have an objective of decreasing the use of unscheduled hospital bed days.

25. Please indicate whether you intend to answer these questions with reference to (please tick the appropriate box):

A. An Innovation Forum-specific meeting ☐

B. Any type of meeting/group/forum with an objective of decreasing the use of unscheduled hospital bed days ☐

If you attend more than one such meeting, *think about the one with which you are most familiar.*

26. Is the chair an employee of a

Primary Care Trust ☐
NHS Trust (Acute) ☐
Mental Health NHS Trust ☐
Voluntary Sector Organisation ☐
Local Authority ☐
Private provider ☐
Other (please say which employer) ☐

	Yes	No
27. Does the chair rotate?	☐	☐

4

28. If so, between which organisations *(Please tick all the boxes that apply):*

Primary Care Trust	☐
NHS Trust (Acute)	☐
Mental Health NHS Trust	☐
Voluntary Sector Organisation	☐
Local Authority	☐
Private provider	☐
Other (please say which employer)	☐

29. How would you classify this group/meeting/forum:

	Yes	**No**
Strategic – responsible for planning future service delivery	☐	☐
Operational – responsible for executing strategic plans	☐	☐
Both	☐	☐
Not sure	☐	☐

	Yes	**No**
30. Does this group control access to funding?	☐	☐

31. If yes, do the funds come from: *(tick as many as apply)*

	Yes	**No**
LDP bids	☐	☐
Reimbursement funding	☐	☐
Grants from central government to local authorities other than reimbursement funds,	☐	☐
Lottery monies	☐	☐
Other grants. Please list:		
______________________________	☐	☐
______________________________	☐	☐
______________________________	☐	☐

32. How often does the group meet? *(tick one)*

a.	Weekly	☐
b.	Monthly	☐
c.	Every 2 months	☐
d.	Every 3 months	☐
e.	Every 4 months	☐
f.	Every 6 months	☐
g.	Annually	☐
h.	Less often – please specify	☐

33. Approximately how long has this meeting/group been running? *(tick one)*

a.	2 months or less	☐
b.	6 months or less	☐
c.	6 months to a year	☐
d.	Between 1-2 years	☐
e.	Between 2-3 years	☐
f.	More than 3 years	☐
g.	Longer – please specify	☐

34. Please indicate the number of different organisations that participate in the meeting in the appropriate box. For instance if there are 2 voluntary sector organisations that regularly send representatives, please write 2 in the box

a.	Number of PCTs	☐
b.	Number of (Acute) NHS Trusts	☐
c.	Number of Mental Health NHS Trusts	☐
d.	Number of Local Authorities	☐
e.	Number of Voluntary Sector Organisations	☐
f.	Number of Private providers	☐
g.	Number of Strategic Health Authorities	☐
h.	Number of other organisations (please say which ones)	☐

35. Please answer yes or no to the following: *(if the answer is not yes please remember to tick the "no" box)*

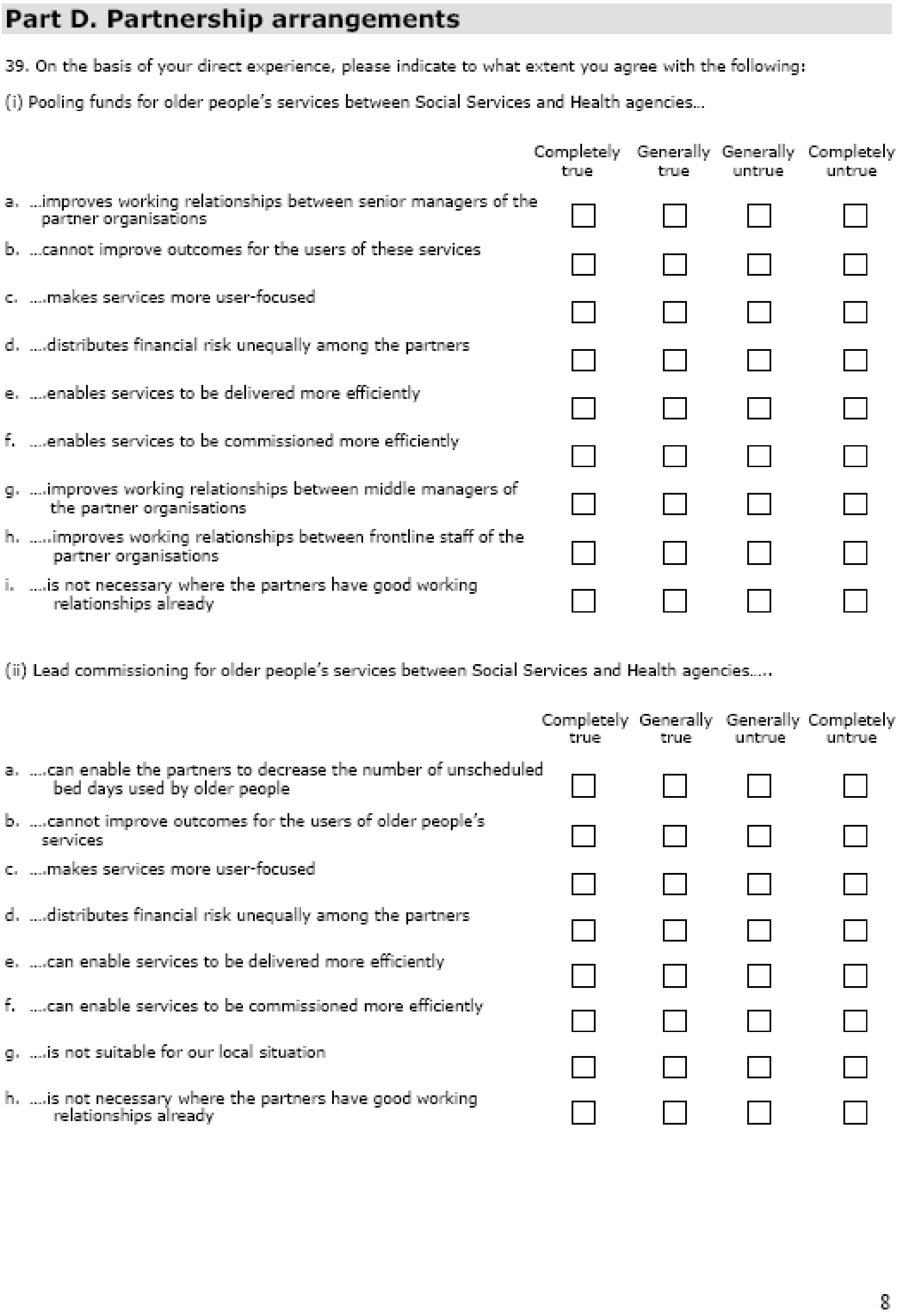
		Yes	**No**
a.	The group has consistently met as scheduled	☐	☐
b.	These meetings have been frequently cancelled	☐	☐
c.	Nominated representatives have attended consistently	☐	☐
d.	Group attendance has been low generally	☐	☐
f.	Representatives come with their own agendas	☐	☐
g.	Issues are usually resolved without repeated discussion	☐	☐
e.	One particular organisation tends to dominate the meeting	☐	☐
f.	During the past year have there been disagreements between the member organisations	☐	☐

36. Are there service user representatives within the group? **Yes** ☐ **No** ☐

37. If yes, how many service user representatives are there within the group? ☐

38. From your perspective, how much of a contribution has each type of organisation made to decreasing the use of emergency bed days locally? *(Please tick one box per organisational type)*

		has played no part	has played a small part	has contributed consistently	has taken the lead
a.	Primary Care Trust	☐	☐	☐	☐
b.	NHS (Acute) Trust	☐	☐	☐	☐
c.	Mental Health NHS Trust	☐	☐	☐	☐
d.	Local Authority	☐	☐	☐	☐
e.	Voluntary Sector	☐	☐	☐	☐
f.	Private Sector	☐	☐	☐	☐
g.	Other organisation(s) (please say which): ________________________	☐	☐	☐	☐



Part D. Partnership arrangements

39. On the basis of your direct experience, please indicate to what extent you agree with the following:

(i) Pooling funds for older people's services between Social Services and Health agencies...

	Completely true	Generally true	Generally untrue	Completely untrue
a. ...improves working relationships between senior managers of the partner organisations	☐	☐	☐	☐
b. ...cannot improve outcomes for the users of these services	☐	☐	☐	☐
c. ....makes services more user-focused	☐	☐	☐	☐
d. ....distributes financial risk unequally among the partners	☐	☐	☐	☐
e. ....enables services to be delivered more efficiently	☐	☐	☐	☐
f. ....enables services to be commissioned more efficiently	☐	☐	☐	☐
g. ....improves working relationships between middle managers of the partner organisations	☐	☐	☐	☐
h. .....improves working relationships between frontline staff of the partner organisations	☐	☐	☐	☐
i. ....is not necessary where the partners have good working relationships already	☐	☐	☐	☐

(ii) Lead commissioning for older people's services between Social Services and Health agencies.....

	Completely true	Generally true	Generally untrue	Completely untrue
a. ....can enable the partners to decrease the number of unscheduled bed days used by older people	☐	☐	☐	☐
b. ....cannot improve outcomes for the users of older people's services	☐	☐	☐	☐
c. ....makes services more user-focused	☐	☐	☐	☐
d. ....distributes financial risk unequally among the partners	☐	☐	☐	☐
e. ....can enable services to be delivered more efficiently	☐	☐	☐	☐
f. ....can enable services to be commissioned more efficiently	☐	☐	☐	☐
g. ....is not suitable for our local situation	☐	☐	☐	☐
h. ....is not necessary where the partners have good working relationships already	☐	☐	☐	☐

Jj

(iii) Joint appointments between Social Services and Health agencies...

	Completely true	Generally true	Generally untrue	Completely untrue
a. ....are most effective when the joint appointment is for a senior operational management role	☐	☐	☐	☐
b. ...are most effective when the joint appointment is for a senior commissioning role	☐	☐	☐	☐
c. ...are most effective when the joint appointment is at a team leader level	☐	☐	☐	☐
d. ...are most effective when the joint appointment is at a frontline level	☐	☐	☐	☐
e. ....are not necessary where the partners have good working relationships already	☐	☐	☐	☐

(iv) Appointing joint commissioners between Social Services and Health agencies...

	Completely true	Generally true	Generally untrue	Completely untrue
a. ,...is only effective if there is also a pooled budget arrangement	☐	☐	☐	☐
b. ....can enable services to be more user-focused	☐	☐	☐	☐
c. ....can enable services to be delivered more efficiently	☐	☐	☐	☐
d. ....can enable services to be commissioned more efficiently	☐	☐	☐	☐
e. ....can be effective without having pooled budget arrangements in place	☐	☐	☐	☐

Part E. Performance indicators

40. From your experience, have performance indicators set by central government had an impact on bed day use by older people?

Yes ☐ No ☐

41. List the 5 performance indicators set by central government that you think have made the greatest impact on bed day use by older people *(Please rank these in order of impact, where 1 is highest)*

1 (higher) ____________________

2 ____________________

3 ____________________

4 ____________________

5 (lower) ____________________

42. From your experience, have performance indicators agreed between local partners had an impact on bed day use by older people?

Yes ☐ No ☐ → Go to Part F, question 44

43. Of performance indicators that have been agreed between local partners, list the 5 have made the greatest impact on bed day use by older people. *(Please rank these in order of impact, where 1 is highest)*

1 (higher) ____________________

2 ____________________

3 ____________________

4 ____________________

5 (lower) ____________________

Part F. Contracts and agreements

44. Based on your experience, of the below multi-agency approaches to decreasing unscheduled bed day use by older people, please rate how likely each is to be used in your local area: *(tick one box in each row)*

	(i) When agencies agree to provide a service jointly, there would be a:	Not at all likely	Not very likely	Some what likely	Very likely	N/A
a.	Verbal agreement between senior management	☐	☐	☐	☐	☐
b.	Partnership agreement using section 31 flexibilities	☐	☐	☐	☐	☐
c.	Service level agreements between agencies	☐	☐	☐	☐	☐
d.	Written memorandum of understanding/intent between chief executives	☐	☐	☐	☐	☐
e.	Other: Please specify ____________________	☐	☐	☐	☐	☐

	(ii) When agencies wish to monitor a jointly provided service they would:	Not at all likely	Not very likely	Some what likely	Very likely	N/A
a.	Examine information recorded in an integrated database of performance measures, held by one partner on behalf of the others	☐	☐	☐	☐	☐
b.	Rely on requesting information on a "need to know" basis from other partners	☐	☐	☐	☐	☐
c.	Expect each agency to share its own monitoring reports on a regular basis with other partners	☐	☐	☐	☐	☐
d.	Examine joint monitoring reports constructed by one partner on the basis of data provided by all partners	☐	☐	☐	☐	☐
e.	Other: Please specify ____________________	☐	☐	☐	☐	☐

	(iii) When agencies jointly provide a service they would staff it by:	Not at all likely	Not very likely	Some what likely	Very likely	N/A
a.	Nominating their own staff to provide the service in cooperation with staff members of partner agencies (through meetings, telephone and email contacts), while remaining within their employer's premises	☐	☐	☐	☐	☐
b.	Co-locating staff members of partner agencies but without changing terms of employment	☐	☐	☐	☐	☐
c.	Formally seconding staff from one organisation to another	☐	☐	☐	☐	☐
d.	Transfering employees from one organisation to another	☐	☐	☐	☐	☐
e.	Other: Please specify ____________________	☐	☐	☐	☐	☐

45. Please indicate how much potential each of the following intervention has to decrease unscheduled bed day use by older people *(tick one box in each row)*

		No potential	Low potential	Medium potential	High potential
a.	Provision of minor injuries unit or walk-in centre located within the acute hospital	☐	☐	☐	☐
b.	Providing alternative health care services at the point of contact with emergency services	☐	☐	☐	☐
c.	Expanding access to community nursing services	☐	☐	☐	☐
d.	Improving discharge planning arrangements within the acute hospital	☐	☐	☐	☐
e.	Case management of those with chronic conditions at risk of hospitalisation	☐	☐	☐	☐
f.	Improving discharge arrangements within a community hospital	☐	☐	☐	☐
g.	Expanding Intermediate care services	☐	☐	☐	☐
h.	Increasing rapid-access home-based care and support services	☐	☐	☐	☐
i.	Introducing or expanding falls prevention services	☐	☐	☐	☐
j.	Introducing a single assessment process	☐	☐	☐	☐
k.	Improving communication between health and social services through use of information technology	☐	☐	☐	☐
l.	Promoting patient self-management of chronic disease or expert patient model	☐	☐	☐	☐
m.	Using new technologies to monitor service user's health or safety at home (telehealth and telecare)	☐	☐	☐	☐
n.	Expanding access to statutory home-care services	☐	☐	☐	☐
o.	Expanding access to voluntary sector support services	☐	☐	☐	☐
p.	Providing rapid-access, short-stay rehabilitation beds outside of an acute hospital	☐	☐	☐	☐
q.	Other method(s) (Please say what)	☐	☐	☐	☐

____

Part G. Shifting Care Closer to Home

46. Please indicate the priority that your organisation gives to the following:

		Low priority	Medium priority	High priority	Top priority
a.	Shifting resources from **secondary** (acute hospital) healthcare to **community health care**	☐	☐	☐	☐
b.	Shifting resources from **secondary** (acute hospital) healthcare to **social care in the community**	☐	☐	☐	☐

47. Please indicate what impact you expect the following to have on the shift of resources from secondary (acute) care into community health care in your local area

		Reverse the shift (i.e. shift resources back into acute care)	No effect	Promote the shift of resources from acute into community health care	Don't know
a.	Payment by Results	☐	☐	☐	☐
b.	User charges for social care services	☐	☐	☐	☐
c.	Resistance of health staff	☐	☐	☐	☐
d.	Resistance of social care staff	☐	☐	☐	☐
e.	Emergence of Foundation Trusts	☐	☐	☐	☐
f.	Financial constraints within the acute trusts	☐	☐	☐	☐
g.	Financial constraints within the PCTs	☐	☐	☐	☐
h.	Financial constraints within the Local Authority	☐	☐	☐	☐
i.	Existing contracts for services "tie up" funds that could otherwise be invested	☐	☐	☐	☐
j.	Lack of commissioning capacity within the PCT	☐	☐	☐	☐
k.	Lack of commissioning expertise within the PCT	☐	☐	☐	☐
l.	SHA, DH or ministerial intervention to prevent 'destabilisation' of acute hospital finances	☐	☐	☐	☐
m.	Other *(Please specify)* ______________________	☐	☐	☐	☐
n.	Other *(Please specify)* ______________________	☐	☐	☐	☐

48. Of the items in the previous question (47), which **3** do you think will have the greatest impact on the shift of resources from secondary (acute) care into community health care in your local area?
(Please rank these in order of impact, where 1 is highest)

1 (higher) ______________________________

2 ______________________________

3 ______________________________

49. Please indicate what impact you expect the following policies to have on the shift of resources from secondary (acute) care into social care in the community in your local area

		Reverse the shift (i.e. shift resources back into acute care)	No effect	Promote the shift of resources from acute into community health care	Don't know
a.	Payment by Results	☐	☐	☐	☐
b.	User charges for social care services	☐	☐	☐	☐
c.	Resistance of health staff	☐	☐	☐	☐
d.	Resistance of social care staff	☐	☐	☐	☐
e.	Emergence of Foundation Trusts	☐	☐	☐	☐
f.	Financial constraints within the acute trusts	☐	☐	☐	☐
g.	Financial constraints within the PCTs	☐	☐	☐	☐
h.	Financial constraints within the Local Authority	☐	☐	☐	☐
i.	Existing contracts for services "tie up" funds that could otherwise be invested	☐	☐	☐	☐
j.	Lack of commissioning capacity within the PCT	☐	☐	☐	☐
k.	Lack of commissioning expertise within the PCT	☐	☐	☐	☐
l.	Other *(Please specify)* ____________________	☐	☐	☐	☐
m.	Other *(Please specify)* ____________________	☐	☐	☐	☐

50. Of the items in the previous question (49), which **3** do you think will have the greatest impact on the shift of resources from secondary (acute) care into social care in the community in your local area?

(Please rank these in order of impact, where 1 is highest)

1 (higher) ____________________________________

2 ____________________________________

3 ____________________________________

Part H. Public and service user involvement

51. Based on your experience, please indicate the importance of the following mechanisms for public representation:

		None	A little	A lot	Decisive	This mechanism doesn't exist
a.	Health Overview and Scrutiny Committees	☐	☐	☐	☐	☐
b.	One-off consultations such as hospital redevelopment or closure	☐	☐	☐	☐	☐
c.	Patient and Public Involvement Forums	☐	☐	☐	☐	☐
d.	Older People's Forums	☐	☐	☐	☐	☐
e.	Partnership Boards	☐	☐	☐	☐	☐
f.	Lay membership of decision-making groups/meetings, forums	☐	☐	☐	☐	☐
g.	Patient choice of hospital	☐	☐	☐	☐	☐
h.	Direct payment of social care provider	☐	☐	☐	☐	☐
i.	Surveys of user opinions	☐	☐	☐	☐	☐
j.	Intervention by MP(s)	☐	☐	☐	☐	☐
k.	Intervention by local councillor(s)	☐	☐	☐	☐	☐
l.	Other *(Please specify)*	☐	☐	☐	☐	☐

____

Part I. Your organisation and position in the organisation

52. Please indicate what type of organisation you work for:

a. Primary Care Trust ☐
b. Local Authority ☐
c. NHS Trust (Acute) ☐
d. Mental Health Trust ☐
e. Strategic Health Authority ☐
f. Other (please say which) ☐

____

53. Please indicate your level of seniority within the organisation: *(Please tick the box that applies to you)*

a. Chief Executive ☐
b. Director ☐
c. Deputy Director ☐
d. Locality manager ☐
e. Other senior manager ☐
f. Other (please say which) ☐

____

54. Tick the adjective that best describes the responsibilities of your post:

a. Operational (if you have general management responsibilities for services ☐
b. Strategic (if you have responsibilities for planning and development of services, e.g. change management, commissioning, strategic development) ☐
c. Combination of operational and strategic responsibilities ☐

55. How long have you been working in your present post? Years: ________ Months: ________

56. How long have you been working in this organisation? Years: ________ Months: ________

57. Have you any other comments about current policies and practices aimed at reducing the use of unplanned hospital care by older people?

Appendix E Topic guide for senior managers interviews

The types of questions asked in the interviews will be informed by the documentary analysis, questionnaires and themes emerging from the patient-tracking interviews with patients and frontline staff as well as researcher observations. However, the following will give an indication of the types of questions we will be asking and areas we will cover.

Respondent Background

Briefly, what is your title and role within your organisation?

Prompts:

- length of time within organisation
- within the department/service

Background to the bed-reducing initiatives or services / Governance arrangements

From the first stage of our research we have put together a list of partnership arrangements and initiatives aimed at reducing the use of unscheduled acute bed days by older people, which are:

Interviewer should first:

1. *send participant a list of the initiatives to reduce use of unscheduled acute bed days by older people that have been documented in Phase 1*
2. *send participant a list of the meetings/partnership arrangements put in place to plan reductions in unscheduled acute bed days by older people that have been documented in Phase 1*

Which initiatives do you oversee/are you involved in?

Who do you report to (title - line manager)?

[If participant has an operational role:] Who works in your team?

Which strategy/plans and associated groups/meetings are you involved in?

Are there other important partnership arrangements (for instance meetings to develop or monitor plans to reduce use of unscheduled acute bed days by older people) I have not listed?

Can you tell me about how the [initiatives, partnerships] that you are involved in came about in [site]?

Prompts:

- how did the decision to develop the [new, if appropriate to context] services or plan come about?

- why were those choices made?
- who was involved in those discussions?
- who was involved in the tendering process?
- how were commissioning decisions made?
- links with other policy initiatives in the organisation or more widely?
- [if unclear from documentation] what is the structure for monitoring progress? (Project board meetings?)
    - Are there subgroups feeding into/reporting back to the project board meetings?
    - have these been working to your satisfaction
- how do the [initiatives, partnerships] tie in to local strategic plans? (relationship with Local Area Agreement for instance)
- How are suggestions for changes/modifications approached?

Assessment of the extent to which initiatives or strategies have met their objectives to date

What is the most important objective for the initiatives you oversee [if applicable]?

What is the most important objective of the strategy/partnership arrangement you are involved in [if applicable]?

What impact do you think that the initiatives/plans might have/ has had on those objectives?

Prompts:

- how will you know this / what has happened
- what data will you have / what data do you have

To what extent and in what ways do you think that users of the initiatives/older people's services will benefit / have benefited?

Prompts:

- how will you know this / what has happened
- what data will you have / what data do you have

What impact do you think that the initiatives/plans will have / has had on joint working between the health, social care and voluntary and private sectors in [site]?

Prompts:

- between whom and for what purposes
- are the [new, if appropriate] services replacing or complementing existing provision?
- has information sharing changed in any way between partners because of the plans/initiatives

- between whom and for what purposes
- how has this been achieved
- How can this be improved?

Progress

If participant has operational role:

How well have the initiatives/plan been going to date?

Prompts:

- who are the significant people in your view to make these services work
- if this initiative has been in place for some time, how has it changed since it started up? (have there been any changes in personnel or organisational structures since the new services started?)
- are there particular problems arising in particular areas/parts of the service
- why might this be / how are the problems being addressed
- which older people to date are using the services
- Are any specific groups of patients being missed?
- have referral channels been as expected
- have communications between staff and between sectors worked well
- any external constraints - organisational / budgetary / political / staff

If participant has a strategic role:

How has the implementation of the strategy/strategies progressed

- What has worked?
- What has been a hindrance?

What are the issues around sustainability of the services/ initiatives?

If participant has operational role:

How do you see the next period for these services?

If participant has a strategic role:

What is the next stage of the strategy/plan?

Prompts:

- what is your overall assessment of the [new, if appropriate] services/plan to date

Appendix F Improving services for older people to reduce the use of unplanned hospital care: topic guide

Introduction

Before we start I would like to thank you for your interest and for taking the time to speak to me. As it says in the information sheet, the research study is exploring your views and experiences of services which are aiming to reduce the use of unplanned hospital services (e.g. intermediate care/other intervention). I hope that you can help by telling me about your experience and views of the services you have used?

I have a few questions to ask which are designed to guide the interview. This is an informal interview and I would like to repeat that everything that is said will be held confidentially and anonymised. This means that no one will be identified in any way.

Before we begin, do you have any questions?

Current events leading up to admission/prevention of admission

Please tell me about how you came to be in hospital/referred to service?

professionals involved in referral, e.g. GP, nurse

How were you coping at home before this? What was happening in your life around that time? Prompts: events related to [condition]; any previous visits to hospital/GP other services due to [condition]. *Explain that there are some questions later on about what services they use so you will come back to this later*

What was your experience of [condition] before this event?

How did you find out about/get referred to the [intervention] (if appropriate)?

Please could you tell me a little about [your admission/the intervention]?

prompt: What happened on day of admission to hospital/service?

Please tell me your thoughts about the process of [admission to hospital/intervention]

(explore satisfaction with what happened; unplanned hospital use/admission e.g prevention of/early discharge (as appropriate)).

If you could change anything about the process of admission [to hospital /intervention] what would it be? Prompts:

If admitted to hospital: Explore whether they feel that coming into hospital could have been avoidable

If admitted to alternative service: explore whether they might have preferred to be in hospital

Interventions

Setting-specific questions:

Hospital (or alternative admission avoidance residential setting):

Describe a typical day in this unit– what do you do?

What staff do you see the most often? Prompt: How often and for how long do you see medical/nursing/therapy/other staff (e.g. physio, OT)

Planning treatment/care: Did staff discuss a plan of treatment with you? What did you want to accomplish? How much were you involved in deciding on the plan and how you would be helping to carry it out?

What have you found helpful?

How have you found it getting around here?

Are there rules you have to observe?

Do you have enough time to discuss any concerns with staff? Prompt: was there enough time to chat/talk. [Emotional support]

In the ward/ or service:

What (if any) benefits have you experienced from this intervention/hospital stay?

e.g. Improved strength/confidence (for community rehab)?

Did they discuss your medications with you?

Any additional thoughts? Prompts: explore experiences with staff if this has not come up

Alternative/admission avoidance service:

Please tell me about any advice/services you were given to help you stay out of hospital?

Prompts:

- What did think the service was for (what were you told was its purpose)?
- Were there a lot of different staff asking you questions, or was there always just one or two people working with you?

Describe what typically happens on the day of a visit.

Planning treatment/care: Did staff discuss a plan of treatment with you? What did you want to accomplish? How much were you involved in deciding on the plan and how you would be helping to carry it out?

What have you found helpful?

How often and for how long do you see medical/nursing/therapy/other staff

Has there been any change in how often you see staff or in how much you have to do for yourself without assistance? (change of pace)

Do you have enough time to discuss any concerns with staff? Prompt: was there enough time to chat/talk. [Emotional support]

How do you think you have done in achieving your goals? How much did the staff help you with this?

Did they discuss your medications with you?

Any additional thoughts? Prompts: explore experiences with staff if this has not come up

The future/ self care/ prevention

Hospital (or alternative admission avoidance residential setting):

Planning for discharge:

Have you had any home visits (taking you home) or visits in the community (e.g. taking you to the shops)?

Have you had any changes made to your home to help you to manage?

What arrangements have they made so far for when you go home?

Do you think you will need any/more help when you go home?

How confident do/did you feel about the preparations for leaving hospital?

Have you been involved in planning for when you leave hospital? And have your [family/friends/carers] been involved? Explore: satisfaction with level of involmement

Have you had any information (for instance leaflets or a talk) about your condition and about services to take home with you?

Alternative/admission avoidance service:

Planning for discharge from service:

What do you feel you can do to prevent yourself from going into hospital?

Do you think you will need any/more help following the intervention?

How do you find out what kind of services are available to help you?

(Ease of finding out, access) How much information did you get from the staff?

Any setting:

Is there anything else you would like to tell me about your experiences?

If using alternative services: do you feel you can ring the staff of [service] if you have any concerns?

Overall, were you satisfied with the service you received? (*Explore reasons for answer*)

Recent service use:

As I mentioned earlier, I would like to make sure that I understand a bit about what services and help you were getting before you came into [hospital/service].

Community

Could you tell me about your use of services based in the community **(over the past three months)**?

Prompts:

Services in your home

- Meals on wheels
- Home/domestic help
- Social worker/care manager
- Nurse
- Saw other staff (e.g. therapist, health visitor) – please specify
- Home library/mobile library
- Do you have a Community alarm/personal alarm?
- Did you use Community alarm/ personal alarm in last 3 months?

When did you last see your GP?

How often do you see your GP?

Where do you see GP (home/Surgery).

Do you phone surgery for advice?

Saw practice nurse?

Repeat prescription (without seeing doctor)?

See other staff (e.g. physiotherapist, counsellor, chiropodist)

Hospital Use

In the last 2 years, have you been to hospital [before this if in hospital now]?

Reasons? Probes:

For physiotherapy or occupational therapy appointment

Accident and emergency (casualty)

Stayed in hospital overnight

Clinic or outpatient appointment

Informal support: Family/Friend

In the last 3 (three) months, have friends and relatives helped you with tasks at home which you had difficulty with or couldn't do (prompt as relevant)?

Personal care (e.g. bathing, dressing)

Housework / laundry

Providing transport / taking you out

Preparing meals

Gardening

Shopping

Looking after pets

Generally providing support

Demographic questions – *as far as possible can be taken from medical notes, if patient has consented, to avoid burden of questions they have been asked already by staff*

1. Name
2. Address
3. Postcode
4. Age
5. Sex
6. D.O.B.
7. Marital status:

Single (never married)

Married

Cohabiting

Separated (but still legally married)

Widowed

Divorced

8. If widowed, how long have they been widowed?

9. What ethnic group do they consider they belong to?

White (British; Irish; Other White Background)

Mixed (White And Black Caribbean; White And Black African; White And Asian; Other Mixed Background)

British Asian (Indian; Pakistani; Bangladeshi; Other Asian Background)
Black British (Caribbean; African; Other Black Background)

Chinese

Other Ethnic Group

10. Which of the following best describes their home? (Please tick box)

- House
- Flat
- Warden-controlled flat
- Nursing Home
- Residential Home
- Other

If Other (details)________________________________

11. What is/was your main occupation when employed?___________

12. What is/was your spouse's main occupation when employed?

13. Living alone?

14. Taking any medicines (prescription or over the counter)?

15. If yes, How many medicines do you take each day? List *(if possible take information from medical notes)*

Appendix G Questionnaire results

Table G1 Responses by site, respondent background

	N=38	
	N	**%**
Site		
1	3	7.9
2	-	-
3	6	15.8
4	6	15.8
5	2	5.3
6	5	13.2
7	3	7.9
8	6	15.8
9	7	18.4
Responsibilities		
Operational	2	5.3
Strategic	19	50
Combination of operational and strategic	17	44.7
Type of organisation		
Primary care trust	16	42.1
Local authority	16	42.1
NHS trust	1	2.6
Mental health trust	2	5.3
Voluntary organisation	3	7.9
Seniority within organisation		
Tiers 1 – 3	16	42.1
Tier 4 and other senior posts	22	57.9
Mean length of time in post [range] (sd) (n=34)	3.1 years [.25-8] (2.13)	
Mean length of time in the organisation [range] (sd) (N=34)	8.6 years [.5-39] (8.99)	
Number of organisations represented in the sample (N=22)		
Primary care trusts	8	36
Local authorities	8	36
NHS trusts	1	5
Mental health trusts	2	9
Voluntary sector organisations	3	14

Table G2 Data on relevant multi-agency groups/ meetings attended by respondent

	N=38	
	N	**%**
Attends a multi-agency group with aim of decreasing EBDs	33	86.8
Mean number of meetings attended by respondents [range] (sd)	3.3 [1-12] (2.3)	
	N	%
Of those attending a multi-agency meeting, those answering with reference to an IF meeting	10	38
Nature of multi-agency group	N	%
Strategic - responsible for planning future service delivery	9	28.1
Operational - responsible for executing strategic plans	4	12.5
Both strategic and operational	19	59.4
Group controls access to funding	21	63.6
Service user representatives attend the group	8	24.2
Frequency of meetings	N	%
Weekly	1	3
Monthly	19	58
every 2 months	7	21
every 3 months	6	18
Meeting/ group operating over	N	%
6 months or less	3	9
6 months to a year	3	9
between 1-2 years	8	24
between 2-3 years	13	39
more than 3 years	6	18
Chaired by representative of	N	%
Primary Care Trust	16	50
NHS Trust (acute)	1	3
Mental Health NHS Trust	1	3
Local Authority	13	41
Other	1	3
Has a rotational chair	10	30
Which rotates between NHS acute trust and PCT	1	3
Which rotates between PCT and Local Authority	6	20
Which rotates between NHS acute trust, PCT and Local Authority	2	7

Table G2 (Continued) Data on relevant multi-agency groups/meetings attended by respondent

	N=38
	Mean [Range] (sd)
Mean number of organisations sending representatives to groups	5.5 [2 -12] (2.7)
Numbers of organisations regularly sending representatives to the group, by organisation (n=33):	
Primary care trust	1.3 [1-4] (.7)
Local authority	1.2 [1-3](.5)
NHS trust	.8 [0-3](.7)
Mental health trust	.6 [0-2](.6)
Voluntary organisation	.7 [0-4](1)
Private providers	.3 [0-3] (.7)
Strategic health authorities	.2 [0-1] (.4)
Other organisations reported	1 [0-4] (.9)
Fire service	0 [0-1](.2)
Older people's forums	.1 [0-1] (.2)
Ambulance service	.1 [0-1] (.3)
District Council	.0 [0-1] (.2)
NHS Direct	.0 [0-1] (.2)
GP practices	.0 [0-1] (.2)
Types of organisations participating as a percentage of all organisations participating per group (n=33)	
Primary care trust	26 [0-67] (16)
Local authority	25 [8-50] (10)
NHS trust	15 [0-33] (11)
Mental health trust	12 [0-50] (12)
Voluntary organisation	9 [0-33] (12)
Private providers	5 [0-43] (10)
Strategic health authorities	2 [0-25] (6)

Table G3 Priority respondent's organisation gives to the following objectives when planning service developments

	Top priority		High priority		Medium priority		Low priority	
	No.	**Col %**	**No.**	**Col %**	**No.**	**Col %**	**No.**	**Col %**
Admissions								
reducing unscheduled admissions of older people (n=38)	10	26.3	24	63.2	3	7.9	1	2.6
reducing unscheduled admissions of those with chronic conditions at all ages (n=38)	7	18.4	23	60.5	6	15.8	2	5.3
reducing unscheduled admissions of under-65s (n=38)	3	7.9	11	28.9	15	39.5	9	23.7
Bed days								
reducing unscheduled bed days of older people (n=37)	13	35.1	20	54.1	3	8.1	1	2.7
reducing unscheduled bed days of those with chronic conditions of all ages (n=37)	8	21.6	21	56.8	8	21.6	-	0
reducing unscheduled bed day of under-65s (n=36)	3	8.3	14	38.9	11	30.6	8	22.2
Lengths of stay								
reducing lengths of stay of unscheduled admissions of older people (n=37)	11	29.7	20	54.1	4	10.8	2	5.4
reducing lengths of stay of unscheduled admissions of those with chronic conditions (n=37)	5	13.5	21	56.8	10	27	1	2.7
reducing lengths of stay of unscheduled admissions of under-65s (n=36)	4	11.1	14	38.9	12	33.3	6	16.7

Table G4 How much potential does respondent think that interventions have on decreasing acute bed day use for older people in their local area

	High potential		**Medium potential**		**Low or no potential**	
	Count	**Row %**	**Count**	**Row %**	**Count**	**Row %**
Increasing rapid-access home-based care and support services	33	87%	5	13%	0	0%
expanding intermediate care services	31	82%	7	18%	0	0%
case management of those with chronic conditions at risk of hospitalisation	29	76%	8	21%	1	3%
improving discharge planning arrangements within the acute hospital	29	76%	9	24%	0	0%
providing rapid-access, short-stay rehabilitation beds outside of an acute hospital	27	71%	10	26%	1	0%
expanding access to community nursing services	24	63%	13	34%	1	3%
providing alternative health care services at the point of contact with emergency services	20	52%	16	42%	2	5%
improving discharge arrangements within community hospital	19	52%	14	39%	2	9%
introducing or expanding falls prevention services	18	47%	18	47%	2	5%
expanding access to voluntary sector support services	15	40%	15	40%	8	21%
expanding access to statutory home-care services**	14	37%	16	42%	8	21%
using new technologies (telehealth/telecare)	13	34%	23	61%	5	5%
promoting patient self-management of chronic disease or expert patient model	12	32%	19	50%	7	18%
improving communication via IT	11	29%	21	55%	6	16%
introducing a single assessment process	10	26%	15	40%	13	34%
provision of minor injuries unit or walk-in centre located within the acute hospital	8	21%	13	34%	17	45%
Other: integrated community nursing & social care teams	1	3%	0	0%	0	0%
Other: more step down facilities to allow for recovery, prevent move to	1	3%	0	0%	0	0%

	High potential		**Medium potential**		**Low or no potential**	
LTC						
Other: acute care at home	1	3%	0	0%	0	0%

Table G5 Source of funding accessed by multiagency groups

	N=21	
Type of funding:	N	%
Mainstream funding only	1	5
Reimbursement funds only	2	10
Local Development Plan funds only	2	10
Other central government grants	3	14
Multiple funding sources	13	62
Of multiple funding sources (n=13):		
LDP and Reimbursement funds and mainstream funding	1	8
LPD and Invest to save funds	1	8
Lottery, LDP funds, reimbursement funds	1	8
Reimbursement and LDP funds	2	15
Reimbursement funds and other central government grants	3	23
LDP and other central government grants	5	39

Table G6 From respondent's perspective, how much of a contribution did each type of organisation make to decreasing emergency bed days locally

	Type of organisation											
Level of contribution	**Primary care trust (n=33)**		**Local authority (n=33)**		**NHS (acute) trust (n=33)**		**Mental health NHS trust (n=31)**		**Voluntary organisations (n=30)**		**Private organisations (n=29)**	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
has taken the lead	15	45	10	30	2	6	1	3	-	-	-	-
has contributed consistently	17	52	20	61	17	52	10	33	12	41	3	11
has played a small part	-	-	3	9	14	42	12	40	11	38	13	46
has played no part	1	3	-	-	-	-	7	23	6	21	12	43
missing/not applicable	3	8	3	8	3	8	7	2	8	21	9	24

Table G7 From respondent's perspective, how much of a contribution did each type of organisation make to decreasing emergency bed days locally – other organisations listed by respondents

	Other organisations									
Level of contribution	Ambulance service (n=3)		NHS Direct (n=1)		Fire Service (n=1)		District councils (n=2)		Carers' organisations (n=1)	
	Count	%	Count	%	Count	%	Count	%	Count	%
has taken the lead	-	-	-	-	-	-	-	-	-	-
has contributed consistently	3	9	1	11	-	-	-	-	-	-
has played a small part	-	-	-	-	1	3	2	6	1	3
has played no part	-	-	-	-	-	-	-	-	-	-
missing/not applicable	33	97	34	97	34	97	33	94	34	97

Table G8 Multi-agency groups/ meetings – processes and interactions

	N=38	
Answered yes (valid n):	N	%
The group has consistently met as scheduled (n=33)	29	87.9
The group's meetings have been cancelled frequently (n=31)	1	3.2
Group attendance has been low generally (n=31)	2	6.5
Representatives come with their own agendas (n=31)	9	29
Issues are usually resolved without repeated discussion (n=31)	20	64.5
There have been disagreements between the member organisations in the past year (n=31)	11	35.5
One particular organisation tends to dominate the meeting (n=31)	8	25.8
Nominated representatives have attended consistently (n=31)	28	90.3

Table G9 Contingency table: Domination of group by one organisation and resolution of issues within the group

	One particular organisation tends to dominate the meeting		
Issues are usually resolved without repeated discussion	No	Yes	Total
No	5 (45%)	6 (55%)	11
Yes	18 (90%)	2 (10%)	20
Total	23	8	31

Table G10 Partial tables: Domination of group by one organisation and resolution of issues within the group, controlling for IF-specific forum

		Answering with reference to IF-specific forum			
		No*		Yes	
One particular organisation tends to dominate the meeting		No	Yes	No	Yes
Issues are usually resolved without repeated discussion	no	2 (29%)	5 (71%)	3 (75%)	1 (25%)
	yes	14 (93%)	1 (7%)	4 (80%)	1 (20%)
Total		16	6	7	2

* Fisher's exact = 0.004

Table G11 Results of exact logistic regression for probability of "issues are resolved without repeated discussion"

MODEL	**Coefficient/ Estimate**	**score**	**Odds ratio**	**CI**	**p-value (of OR)**
Joint exact test for one organisation tends to dominate the group and parameters and answering with reference to IF-specific forum		3.488386			0.0360
One organisation tends to dominate the group	-2.244284*	6.015345	.1060034*	0 - 1.011799	0.0256
Answering with reference to IF-specific forum	-.3465736	.0588235	.7071068	.0084989–58.83146	1.0000
Joint exact test of being in top 3 tiers of organisation and post type		5.812741			0.1630
In top 3 tiers of	.3465736	.0588235	1.414214	.0169977–	1.000

organisation				117.6629	
Post Type	1.511658*	3.164062	4.53424*	.2669337–+Inf	0.1463

*median unbiased estimates

Table G12 Contingency table: Disagreements between the member organisations in the past year and frequency of meetings

Frequency of meetings	**There have been disagreements between the member organisations in the past year**		
	No	**Yes**	**Total**
Monthly or more frequently	8 (44%)	10 (56%)	18
every 2 months	6 (86%)	1 (14%)	7
every 3 months	6 (100%)	0 (0%)	6
Total	6	0	6

Table G13 Results of exact logistic regression for probability of "disagreements between member organisations in the past year", indicator variable approach

Model	**Coefficient**	**score**	**Odds ratio**	**p-value (of OR)**	**CI (OR)**
Joint exact test for In top 3 tiers of organisation and Post Type	-	.1164021		1.0000	-
In top 3 tiers of organisation	-.2350018	.0273556	.7905694	1.0000	.0098028–63.75731
Post Type	-.3465736	.0212766	.7071068	1.0000	.0019718 253.5769
Joint conditional probabilities test for mfdum_1 and mfdum_0	-	9.098697	-	0.0068	-
mfdum_1 (Meeting every two months)	-1.426713	1.748895	.2400969	0.2267	.0039175 * 2.542271
mfdum_0 (Meeting every three months)	-2.278424*	5.798678	.1024455*	0.0176	0–.8699415

*median unbiased estimates

Table G14 To what extent does participant agree on the basis of direct experience – Pooling funds

Pooling funds for older people's services between Social Services and Health agencies…….	**Count**	**%**
cannot improve outcomes for the users of these services		
completely or generally true (n=4)	4	11.1
completely or generally untrue (n=32)	32	88.9
enables services to be delivered more efficiently		
completely or generally true (n=33)	33	91.7
completely or generally untrue (n=3)	3	8.3
makes services more user-focused		
completely or generally true (n=28)	28	77.8
completely or generally untrue (n=8)	8	22.2
distributes financial risk unequally among partners		
completely or generally true (n=11)	11	30.6
completely or generally untrue (n=25)	25	69.4
is not necessary where partners have good working relationships already		
completely or generally true (n=13)	13	36.1
completely or generally untrue (n=23)	23	63.9
enables services to be commissioned more efficiently		
completely or generally true (n=32)	32	88.9
completely or generally untrue (n=4)	4	11.1
improves working relationships between senior managers of the partnership		
completely or generally true (n=32)	32	88.9
completely or generally untrue (n=4)	4	11.1
improves working relationships between middle managers of partnership		
completely or generally true (n=32)	32	88.9
completely or generally untrue (n=4)	4	11.1
improves working relationships between frontline staff of the partnership		
completely or generally true (n=25)	25	69.4
completely or generally untrue (n=11)	11	30.6

Table G15 To what extent does participant agree on the basis of direct experience – Lead commissioning

Lead commissioning for older people's services between Social Services and Health agencies.......	**Count**	**%**
lead commissioning-can enable services to be commissioned more efficiently		
completely or generally true (n=34)	34	91.9
completely or generally untrue (n=3)	3	8.1
lead commissioning-can enable the partners to decrease the number of unscheduled		
completely or generally true (n=31)	31	86.1
completely or generally untrue (n=5)	5	13.9
lead commissioning-cannot improve outcomes for the users of older people's services		
completely or generally true (n=0)	-	-
completely or generally untrue (n=36)	36	100
lead commissioning-is not suitable for our local situation		
completely or generally true (n=2)	2	5.4
completely or generally untrue (n=35)	35	94.6
lead commissioning-can enable services to be delivered more efficiently		
completely or generally true (n=34)	34	91.9
completely or generally untrue (n=3)	3	8.1
lead commissioning-makes services more user-focused		
completely or generally true (n=30)	30	83.3
completely or generally untrue (n=6)	6	16.7
lead commissioning-distributes financial risks unequally among partners		
completely or generally true (n=17)	17	45.9
completely or generally untrue (n=20)	20	54.1
lead commissioning-is not necessary where the partners have good working relationships already		
completely or generally true (n=11)	11	29.7
completely or generally untrue (n=26)	26	70.3

Table G16 To what extent does participant agree on the basis of direct experience – Joint commissioners

Joint commissioners between Social Services and Health agencies are….	**Count**	**%**
is only effective if there is also a pooled budget arrangement		
completely or generally true (n=23)	23	62.2
completely or generally untrue (n=14)	14	37.8
can enable services to be more user-focused*		
completely or generally true (n=30)	30	81.1
completely or generally untrue (n=7)	7	18.9
can enable services to be delivered more efficiently		
completely or generally true (n=33)	33	89.2
completely or generally untrue (n=4)	4	10.8
can enable services to be commissioned more efficiently		
completely or generally true (n=34)	34	91.9
completely or generally untrue (n=3)	3	8.1
can be effective without having pooled budget arrangements in place		
completely or generally true (n=18)	18	48.6
completely or generally untrue (n=19)	19	51.4

Table G17 To what extent does participant agree on the basis of direct experience – Joint appointments

Joint appointments between Social Services and Health agencies are….	**Count**	**%**
most effective when the joint appointment is for a senior commissioning role		
completely or generally true (n=28)	28	80
completely or generally untrue (n=7)	7	20
most effective when the joint appointment is for a senior operational management role		
completely or generally true (n=24)	24	68.6
completely or generally untrue (n=11)	11	31.4
most effective when the joint appointment is at a team leader		
completely or generally true (n=20)	20	57.1
completely or generally untrue (n=15)	15	42.9
most effective when the joint appointment is at a frontline level		
completely or generally true	19	54.3
completely or generally untrue	16	45.7

not necessary where partners have good working relationship already		
completely or generally true	10	27.8
completely or generally untrue	26	72.2

Table G18 How likely the following multiagency approaches are to be used in respondent's local area, based on respondent's experience

	n	%
When agencies agree to provide a service jointly, there would be:		
A verbal agreement between senior management		
not at all or not very likely (n=12)	12	35
somewhat or very likely (n=22)	22	65
partnership agreement using section 31 flexibilities		
not at all or not very likely (n=7)	7	22
somewhat or very likely (n=25)	25	78
service level agreements between agencies		
not at all or not very likely (n=3)	3	9
somewhat or very likely (n=31)	31	91
written memorandum of understanding/ intent between chief executives		
not at all or not very likely (n=9)	9	29
somewhat or very likely (n=22)	22	71
When agencies wish to monitor a jointly provided service they would:		
examine information recorded in an integrated database of performance measures,		
not at all or not very likely (n=16)	16	52
somewhat or very likely (n=15)	15	48
reply on requesting information on a "need to know" basis from other partners		
not at all or not very likely (n=5)	5	17
somewhat or very likely (n=24)	24	83
expect each agency to share its own monitoring reports on a regular basis with other partners		
not at all or not very likely (n=4)	4	13
somewhat or very likely (n=28)	28	88
examine joint monitoring reports constructed by one partner on the basis of data provided by all partners		
not at all or not very likely (n=11)	11	32
somewhat or very likely (n=23)	23	68
When agencies jointly provide a service they would staff it by:		
nominating their own staff to provide the service in cooperation with staff members of partner		

agencies, while remaining in their employer’s premises		
not at all or not very likely (n=8)	8	24
somewhat or very likely (n=26)	26	77
co-locating staff members of partners agencies but without changing terms of employment		
not at all or not very likely (n=4)	4	11
somewhat or very likely (n=32)	32	89
formally seconding staff from one organisation to another		
not at all or not very likely (n=8)	8	23
somewhat or very likely (n=27)	27	77
transferring employees from one organisation to another		
not at all or not very likely (n=22)	22	65
somewhat or very likely (n=12)	12	35
“Other” responses: “joint agreement: roles and responsibilities"		
1 (n=1)	1	100
“Other” responses: “have SLAs with the lead provider giving the info”		
1 (n=1)	1	100
“Other” responses: “transfer staff to specific Mental Health Trust”		
1 (n=1)	1	100

Table G19 The impact of central government performance indicators that have had an impact on bed day use by older people: ranked within respondents’ top three impacts

	N=22	
	n	%
Delayed Transfers Of Care (D41)	9	40%
Community Matron Target (PSA12b)	2	10%
LTC PSA (PSA 12a)	4	16%
PbR	1	5%
C28	3	13%
C32 Helped To Live At Home	2	10%
A&E 4 Hour Targets	2	8%
Practice Based Commissioning	1	3%
PSA Targets Generally	1	3%
Bed-Day Reductions	1	3%

Table G20 Indicate what impact the respondent expects the following to have on the shift of resources from secondary (acute) care into community health care in the local area

	don't know		**promote shift of resources from acute into community health**		**no effect**		**reverse the shift (shift resources back into acute care)**	
	n	%	n	%	n	%	n	%
Payment by results	9	23.7	15	39.5	2	5.3	12	31.6
User charges for social care services	6	16.2	7	18.9	15	40.5	9	24.3
Resistance of health staff	5	13.5	1	2.7	11	32.4	20	51.4
Resistance of social care staff	6	16.2	2	5.4	17	45.9	12	32.4
Emergence of foundation trusts	10	27	5	13.5	2	5.4	20	54.1
Financial constraints within the acute trusts	3	8.1	11	29.7	3	8.1	20	54.1
Financial constraints within the PCT	2	5.4	17	45.9	4	10.8	14	37.8
Financial constraints within the local authority	4	10.8	9	24.3	5	13.5	19	51.4
Existing contracts for services "tie up" funds that could otherwise be invested	12	33.3	2	5.6	3	8.3	19	52.8
Lack of commissioning capacity within the pct	6	16.2	2	5.4	5	13.5	24	64.9
Lack of commissioning expertise within the pct	6	16.2	2	5.4	4	10.8	25	67.6
SHA, DH or ministerial	7	1	5	13.5	2	5	23	62.2

intervention to prevent 'destabilisation' of acute hospital		8.9				.4		
Practice based commissioning*	-	-	3	8.1	-	-	-	-
Community foundation trusts*	-	-	2	5.3	-	-	-	-
Unbundling of PBR tariffs to extend to community services*	-	-	2	5.3	-	-	-	-

*recoded from "other"

Table G21 Indicate what impact the respondent expects the following to have on the shift of resources from secondary (acute) care into social care in the community in the local area

	don't know		promote shift of resources from acute into social care in the community		no effect		reverse the shift (shift resources back into acute care)	
	n	%	n	%	n	%	n	%
Payment by results	5	15	12	37	5	15	11	33
User charges for social care services	5	16	7	22	12	38	8	25
Resistance of health staff	2	6	2	6	13	42	14	45
Resistance of social care staff	6	16	2	5	17	46	12	33
Emergence of foundation trusts	7	21	2	6	6	18	18	55
Financial constraints within the acute trusts	2	6	9	28	3	9	18	56
Financial constraints within the PCT	3	9	14	44	4	13	11	34
Financial constraints within the local authority	3	9	7	22	5	16	17	53
Existing contracts for services "tie up" funds that could otherwise be invested	13	41	3	9	2	6	14	44
Lack of commissioning capacity within the PCT	6	19	0	0	6	19	20	62
Lack of commissioning expertise within the PCT	5	16	1	3	4	13	22	69
Practice based commissioning*	-	-	2	5	-	-	-	-
Joint commissioning between health and social care*	-	-	1	3	-	-	1	3

*recoded from "other"

Table G22 The impact of barriers on the shift of resources from secondary (acute) care into community health care: ranked within respondents' top three impacts

	N	%
PCT financial constraints	12	32
Payment by Results	12	32
Financial constraints within the Local Authority	8	21
Financial constraints within the acute trusts	7	18
Lack of commissioning capacity within the PCT	6	16
Emergence of Foundation Trusts	4	10
SHA, DH or ministerial intervention to prevent 'destabilisation' of acute hospital finances	4	11
Resistance of social care staff	3	8
Lack of commissioning expertise within the PCT	2	5
Resistance of health staff	2	5
Existing contracts for services "tie up" funds that could otherwise be invested	2	5
User charges for social care services	2	5
Community foundation trusts	2	5
Unbundling of PBR tariffs to extend to community services	2	5

Table G23 The impact of barriers on the shift of resources from secondary (acute) care into social care in the community: ranked within respondents' top three impacts

	N	%
PCT financial constraints	12	32
Payment by Results	10	26
Financial constraints within the Local Authority	8	21
Financial constraints within the acute trusts	8	21
Lack of commissioning capacity within the PCT	6	16
Emergence of Foundation Trusts	5	13
Lack of commissioning expertise within the PCT	5	13
Resistance of health staff	2	5
Existing contracts for services "tie up" funds that could otherwise be invested	2	5
User charges for social care services	2	5
Resistance of social care staff	1	3
Practice based commissioning	1	3
Joint commissioning between health and social care	1	3

Table G24 Indicate the importance of the following mechanisms for public representation

	decisive		a lot		a little		this mechanism doesn't exist	
	Count	%	Count	%	Count	%	Count	%
health overview and scrutiny committees (n=36)	7	20%	15	42%	13	37%	1	3%
one-off consultations such as hospital redevelopment or closure (n=37)	6	16%	21	57%	10	27%	0	0%
direct payments (social care) (n=36)	5	14%	10	28%	20	56%	1	3%
patient and public involvement forums (n=37)	3	8%	17	47%	16	45%	0	0%
older people's forums (n=37)	2	5%	20	54%	15	41%	0	0%
partnership boards (n=37)	2	5%	18	49%	15	41%	2	5%
patient choice of hospital (n=37)	2	5%	7	19%	27	73%	1	3%
intervention by local councillor(s) (n=37)	1	3%	15	41%	21	57%	0	0%
intervention by mp(s) (n=37)	1	3%	18	48%	14	49%	0	0%
surveys of user opinions (n=37)	1	3%	12	32%	24	65%	0	0%
lay membership of decision-making groups/meetings/forums (n=36)	0	0%	20	56%	15	42%	1	3%
Use of advocates (n=2)	1	50%	0	0%	1	50%	0	0%

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.