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Integrating Housing into the Whole System of Care for Older People

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By

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Abstract

The ageing population in the UK is placing huge pressure on Health and Social Care, exacerbated by current economic pressures to cut costs. The British Government is politically driving integrated care, to encourage the different services that constitute the whole system of care to work together in order to reduce fragmentation and overlap in the system. However, methods for effective partnership working towards integrated care are not well researched. This thesis details an action research project to virtually integrate Housing into the whole system of care in Conwy in particular, concluding that the methods used provide an appropriate approach for partnership working towards integrated care, thus addressing this gap.

Housing plays an important role in the whole system of care for older people as a person's home environment has a high impact on their wellbeing. Poor quality housing can negatively impact on health, and care can be provided in the home due to the government's emphasis on 'ageing in place'. However, whilst the importance of considering Housing's role in the whole system of care is identified in government policy, efforts towards achieving integrated care do not commonly include Housing departments or providers. The thesis concludes that only types of housing which inherently include care (e.g. extra care, care homes) are integrated into the system, despite the fact that residents can access care in any type of housing.

Soft systems methodology (SSM) is used to identify the whole system of care in Conwy, Wales. A Steering Group was established to develop an Older Persons' Housing Strategy (OPHS) for Conwy, one of the aims of which was to integrate Housing into the whole system of care. The local authority act as the 'strategic enabler' in achieving this. Each Steering Group member was interviewed to establish their role within the system, and their worldviews on it. This enabled the Steering Group to develop a shared vision for the OPHS, which is a key feature of successful partnerships to achieve integrated care. Support is identified as an appropriate integrating function and examined to establish appropriate operations structures.

Through a survey of support services in Wales, it is identified that support, provided by wardens in sheltered housing, is currently going through a transition period, due to changes to funding guidelines for support. Many local authorities in England are now using offsite support, but the impacts of this are not well researched. This research provides an evidence base for practitioners looking to change the structure of their warden service. This is based on a SWOT analysis of onsite and offsite support, conducted from the data gathered during the survey. Local authorities can capitalise on the changes being made to warden services, taking the opportunity to upskill wardens and using support to integrate Housing into the care system by signposting other services. Finally, focus groups were conducted with older people to ensure the OPHS met their needs. This also served to triangulate the findings of the SSM and the survey, demonstrating the effectiveness of combining these methods.

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Acronyms and Abbreviations

A&E	Accident and Emergency
ALMO	Arms Length Management Organisation
AR	Action Research
CCBC	Conwy County Borough Council
CLG	Communities and Local Government
CSSR	Councils with Social Services Responsibility
DFG	Disabled Facilities Grant
ESRC	Economic and Social Research Council
GP	General Practitioner
HM	Her Majesty
JRF	Joseph Rowntree Foundation
NHS	National Health Service
NIACE	National Institute of Adult Continuing Education
OPHS	Older Persons' Housing Strategy
OR	Operations Research
PAR	Participatory Action Research
RSL	Registered Social Landlord
RVS	Royal Voluntary Service
SCIE	Social Care Institute for Excellence
SSIA	Social Services Improvement Agency
SSM	Soft Systems Methodology
SWOT	Strengths, Weaknesses, Opportunities, Threats
WHQS	Welsh Housing Quality Standard
WLGA	Welsh Local Government Associations

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Chapter 1: Introduction

1.1 Introduction

This thesis presents research on integrating Housing into the whole system of care for older people. The aim is to demonstrate the important role that Housing can play in the whole system of care, which housing options are already integrated and how it is possible to integrate the housing options that are not part of this system. The research has been carried out in collaboration with Conwy County Borough Council (CCBC) and several social housing providers in Wales, as part of a wider action research project. During this project, the researcher was commissioned to develop and write Conwy's Older Persons' Housing Strategy (OPHS), which was approved by Cabinet in January 2013 and is included in the Appendix. The research takes a soft systems approach to creating solutions to integrate Housing into the whole system of care, and then uses a survey to examine how these solutions would work in practice. Finally, focus groups were conducted with key stakeholders to ensure that the proposed solutions meet the needs of the target market. The proposed solution was written into the OPHS and is currently being implemented in Conwy, along with the rest of the strategy.

"The UK population is ageing rapidly, but we have concluded that the Government and our society are woefully underprepared" (House of Lords, 2013:7). This is the opening statement to the Select Committee on Public Service and Demographic Change's Report entitled 'Ready for Ageing'. This statement highlights the necessity for research into the improvement and integration of public services in order to meet this demographic change. This thesis aims to contribute to this area of research with a focus on Housing, as more can be done with existing resources. We are living in a period of austerity, so the rising pressure that the ageing population places on public services is exacerbated by the economic pressure to reduce the cost of existing services.

The thesis draws on theory and practice from operations management. Although this area traditionally focuses on manufacturing, many of the theories are still applicable in public sector services. Operations management practices are now commonly being used in the public sector in order to increase productivity and performance of services (Radnor and Noke, 2013). This is necessary due to the increased pressure to cut the costs of services whilst being faced with rising demands. Operations management is "the activity of managing the resources and processes that produce and deliver goods and services" (Slack and Lewis, 2002:5). In manufacturing, organisations develop long-term, collaborative, mutually beneficial relationships in order to meet the needs of their customers and this is what Health and Social Services need to do in order to achieve integrated care. The thesis draws on topics such as supply chain management, operations strategy and performance measurement in the development and analysis of solutions to integrate Housing into the whole system of care for older people (see figure 2 on page 39 to see where each of these topics are covered within the thesis).

Action research was chosen for this project because the funders wanted the researcher to develop and write Conwy's Older Persons' Housing Strategy, which would inevitably result in action leading to change. To do this, the researcher needed to develop a comprehensive picture of the existing system of care in Conwy, to identify what needed to change. Action research provides a richness of insight that cannot be gained by using other methods (Eden and Huxham, 2002). Action research is collaborative and the research objectives for this project were emergent based on the action taking place. The research objectives can be found in Chapter 4 to reflect the fact that this research did not start out with firm objectives. The research aim, to develop a solution to integrate housing into the whole system of care, was clear from the start. However, identifying the specific research objectives too early on in action research process can limit the effectiveness of this approach (Brydon-Miller et al, 2003), by making the research too prescriptive. Emergent objectives are common in action research, as the process of action research follows multiple cycles of Plan, Act, Observe, Reflect (Burns, 2007). This will be explained in more detail in the methodology chapter (Chapter 3).

There is now a widespread acceptance in the public sector that service delivery must be underpinned by a whole systems approach (Hudson, 2006). Terms such as 'whole system of care' or 'a whole systems approach to care' are commonly used in both literature and policy, but remain ill-defined. Theoretically, systems thinking involves 'thinking holistically' i.e. taking into account the whole (Checkland and Scholes, 1990). With this in mind, technically, the 'whole' in the 'whole system of care' should be implied when considering it from a systems perspective (although the term will continue to be used as it is commonly used in policy). In practice, the Department of Health define the whole system of care as "one that recognises the contribution that all partners make to the delivery of high quality care" (Department of Health, 2009). Bringing the theoretical and the practical together, the whole system of care can be simply defined as *a system comprising of all of the organisations directly or indirectly involved in the provision of care for any given individual, and integrated in order to improve the quality of care for that individual.* By this definition, the whole system of care should include health (hospitals, GP's , nurses, physiotherapy etc.), social care (social workers, care providers, etc.), informal carers, housing, transport, pharmacists, voluntary services, support services, etc. This is not an exhaustive list, the organisations involved in the provision of care for older people vary based on the individual's needs, where they live, their income and their family; highlighting the complexity of this system.

The types of issues that the public sector now commonly have to deal with are increasingly complex, meaning that they often cannot be dealt with by a single agency, which has led to a growth in enthusiasm for a whole systems approach (Hudson, 2006). No single agency has the sole responsibility for the care of an older person. Problems caused by a lack of integration between the organisations that make up the whole system of care "typically include difficulties with obtaining needs assessments, putting together comprehensive service packages, co-ordinating multiple providers and services, ensuring continuity, monitoring health and functional status, responding to crises, supporting family carers, and, finally, performing all of these essential activities within existing funding and resource constraints" (Kodner and Spreeuwenberg, 2002:3). This system is huge, and problems within it are messy, ill-defined problems, characterised by multiple stakeholders, confusing boundaries, unclear responsibilities and limited resources for implementing solutions.

Soft systems methodology was developed as a method for dealing with problematic situations that demonstrate these characteristics, so will be utilised in this thesis.

A study which applied 'systems thinking' to healthcare in order to identify the problems in the system, found that staff interviewed considered the hospital system to be one point in a much larger system which also includes transport, local doctors, social services and many other organisations (Rich and Piercy, 2013). However, a lack of understanding about the linkages between these subsystems, and how the 'whole system of care' works, leads to inefficiencies such as bed blocking and patients being inappropriately referred to other services. A better understanding about how each entity links in and contributes to the system is necessary in order to improve. This piece of work primarily focuses on the 'Housing' entity.

"Integration is at the heart of systems theory and, therefore, central to organisational design and performance" (Kodner and Spreeuwenberg, 2002:2). Systems, such as the whole system of care, are made up of interconnected subsystems. Improving the integration between these subsystems enables them to complement one another, helping them to achieve common goals. 'Integrated care' is the term commonly used to describe how a whole system of care can be achieved. Integrated care is defined as "person-centred, co-ordinated care" (Redding, 2013), based on a report that identified "a clear consensus that successful integrated care is primarily about patient experience" (Frontier Economics, 2012:15).

"Person-centred, co-ordinated care" is the definition agreed upon by the National Collaboration for Integrated Care and Support, which comprises of numerous Health and Social Care organisations including NHS England, Department of Health, Social Care Institute for Excellence and the Care Quality Commission (National Collaboration for Integrated Care and Support, 2013). Prior to this, there was no universally accepted definition for integrated care, with one literature review identifying 175 definitions of integrated care (Armitage et al, 2009). A review of research evidence related to integrated care concluded that there was consistently a lack of understanding about the aims and objectives of integration (Cameron et al, 2014). This is not surprising as, when the review was conducted; integrated care did not have an agreed definition.

Integrated care through partnership working between Health and Social Services was introduced by New Labour in 1997, in an effort to address the failure of public services to work together, instead of in competition (Poxton, 2004). More recently, the momentum behind integrated care has been growing, following the appointment of Norman Lamb as Health and Support Minister and the work of the NHS Future Forum (Ham, 2014). However, a literature review on integrated care found that the majority of research in this area focuses on integration between Health and Social Services (Reed et al, 2005). As discussed, there are numerous other entities involved in the whole systems approach to care, highlighting a gap in the current literature. Reed (2005) found that there has not been much research conducted which focuses on integration across the whole system of care, with little attention being paid to all the services that older people require to live independently (Reed, 2005). This thesis bridges this gap, specifically for the Housing entity.

"A distinction can be drawn between 'real' integration, in which organisations merge their services, and 'virtual' integration, in which providers work together through networks and alliances" (Ham and Curry, 2011:2). This research focuses on how Housing can be 'virtually' integrated into the whole system of care for older people. Virtual integration is often seen in supply chain management, where multiple suppliers work together in order to meet the needs of their customers, and is sometimes referred to as contractual integration. 'Real' integration, otherwise referred to as structural integration, would require a drastic overhaul of large, unruly and well established systems, i.e. combining Health and Social Services into one organisation. It thus does not represent an appropriate solution on a local level; it would need to be led by central government. Barriers to structural integration include separate funding streams, conflicting provider and quality regulations, differences in culture, language and service approaches (Kodler and Spreeuwenberg, 2002). The integration of Health and Social Services at an organisational level has been discussed by politicians for years, but without conclusive evidence of how it could be done or whether it actually would save money when accounting for the considerable cost of change. Structural integration is assumed to be the most superior form of integration but this is not necessarily the case for Health and Social Care because the centralisation of administration and power is not sufficient enough to ensure

network efficiency in such large, complex organisations and with such strong variations in local requirements (Goodwin et al, 2004).

Pressures on Health and Social Services budgets have brought virtual integration to the forefront in terms of a feasible solution to reducing the overlap between to two organisations and encouraging joint working. In light of the fact that structural integration is not achievable at a local level, virtual integration is more appropriate for a local project. In a review of the evidence from across the world, Ham and Curry (2011) concluded that projects using virtual integration through joint working across clinics and services often deliver more in terms of outcomes than those just using structural integration, as structural integration is only effective where it promotes virtual integration. For example, if Health and Social Services were to merge but the clinicians did not have an established network to communicate with social workers (virtual integration), then this structural integration would be ineffective. Structural integration would result in a complex hierarchy, which could prove to be overly structural and overly managed, reducing the opportunities to lower costs and innovate (Goodwin et al, 2004). Whilst structural integration will not work with without virtual integration, it is possible to virtually integrate without affecting organisational structures. Structural integration "appears to be neither necessary nor sufficient to deliver the benefits of integrated care" (Ham and Curry, 2011:6). Virtual integration is more achievable and often more effective, and this thesis demonstrates the steps that Conwy took to virtually integrate Housing into the whole system of care in this county.

1.2 Ageing Population in Britain

As the post war baby boomers reach retirement age, our population of older people in the UK is booming. There are currently 7.3 million 'older' households (no one under fifty-five living there) in the UK, excluding care homes (Pannell and Kenway, 2012). The Office for National Statistics (2010) has projected that by 2030, England will have 51% more people aged 65 and over and 101% more people aged 85 and over than it had in 2010 (House of Lords, 2013). Advancements in medicine teamed with improved knowledge about how to live a healthy lifestyle has caused our life expectancy to rise. Therefore, as these baby boomers reach retirement age, their parents are more frequently still alive and well, putting two generations into the 'old

age' category. Some authors refer to these new elderly as 'young old' or the 'third age' (Hale et al, 2010; Tinker 1997). This labels those over the age of 75 as 'old old' or 'fourth generation'. People in this age group may still be active but are more likely to be dependent on others for some aspects of daily life (McNair, 2007).

The term 'older people' is often used to refer to a homogenous group, usually aged over 60. However, the reality of the situation is that this group can include independent older people, older people with disabilities, frail older people, older people who are acting as carers for a spouse, parent or child and working older people; not forgetting that retirement age is moving beyond 65. The list goes on. To approach this group as homogenous, despite their wide ranging variations in need, is inappropriate. People get more diverse the older they get (Age UK, 2013a). Whilst an 80 year old might be living in their own home with no care or support, someone aged 55 might be received daily care due to a disability. BBC News ran a story on a woman who was in her 90's who goes to the gym every week and, in 2012, did a sky dive for charity (BBC News, 2013). A report by Age UK which looked at the oldest old stated that the majority of people over the age of 85 state that their health and quality of life are good; the two most important contributing factors to this are staying active and maintaining friendships (Age UK, 2013a). Therefore, studies looking into this age group need to consider how best to support these factors.

During the last decade, the UK Government have tried to avoid treating older people as a homogenous group by placing an emphasis on personalisation and ensuring that services can be tailor made to meet the needs of the individual. This shift in thinking has led to some well thought out policies and white papers, the most notable one from a housing perspective being 'Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society' (DCLG, 2008; Croucher, 2008). The main theme of this strategy is providing choice for older people. This shows a shift in government thinking, with the ageing process in the UK now being represented in terms of "independence" and "activity" (Hillcoat-Nalletamby et al, 2010). The strategy has been praised for being "ambitious", "broadly focused" and for "making the essential connection between housing, health and wellbeing" (Croucher, 2008). However, this thesis questions the level that Housing is actually integrated with Health and Social Services to improve wellbeing, on a practical level.

Wellbeing can be defined as "a subjective sense of overall contentment, thought to be defined by affective state and life satisfaction" (Christiansen and Baum, 1997:606). The aspects of wellbeing, in line with health, include physical, mental and social wellbeing (Wilcock, 1998). Delivery of wellbeing services to older people is the responsibility of an increasingly complex network of actors. Our global economy has made the world feel smaller, with technology improving communications and relatively low cost of travel, meaning that people no longer necessarily feel the need to live close to their families. The number of people living outside their country of birth today is larger than it ever has been before; if all international migrants lived in one place, then that place would be the fifth most highly populated country in the world (United Nations Population Fund, 2008). Therefore, it is no longer possible for the government to be reliant on families 'looking after their own', which is common in other cultures. Consequently, there is a pressure on the government to provide alternative options for improving the wellbeing of older people in our society.

Future projections of the number of people over the age of sixty have caused the government to raise serious concerns over the future health and care needs of our older population and the significant costs associated with this (Evandrou and Falkingham, 2007). This is because older people account for 52% of current expenditure on Personal Social Services (NHS Information Centre, 2013). The cost of providing Adult Social Care has been steadily rising since 2003, reaching £17.2 billion in 2011-12 (NHS Information Centre, 2013). As the population is ageing, it is becoming increasingly common for an individual to have multiple conditions which results in complex care pathways. The pressure that this places on public services is alarming, so the House of Lords is now suggesting that a "radically different" model of care will be needed to support people in their own homes in order to take some of the pressure off the NHS (House of Lords, 2013). Integration between Health and Social Care services is identified as essential in order to achieve this.

The overall care system needs to be integrated to maximise efficiency and effectiveness, which implicitly leads us to operations management theory and practice. This both enables and requires Housing to be more than just a discrete product. This thesis will focus on housing for older people in order to define in detail the opportunities and wider role for Housing and the Registered Social Landlord

(RSL) within the system of care, thus giving this work a value base. A solution for RSL's to achieve this integration will be developed, designed with both wellbeing and independence in mind, in order to offer service users a much more efficient service that is appropriate to their care needs.

1.3 Background

This research looks at the whole system of care for older people, which is made up of a network of complex subsystems, which interlink in multiple ways. As this overall system is so complex, it is necessary to provide a background to some of the subsystems involved, namely Housing, Social Care and support. This helps to provide context, whilst establishing some of the key issues in, and changes to, these subsystems, such as the development of reablement services and the increased drive for direct payments (introduced later in this chapter). Whilst health is also a key feature of this overall system, the research is primarily concerned with the inputs and outputs of the health subsystem and not the throughput. Health is a complex system in itself and examining it in detail was beyond the scope of this work; this research is concerned with how the health subsystem interlinks with the aforementioned subsystems and not how it operates.

1.3.1 Housing

The term 'Housing' throughout this thesis refers to social housing and specialist housing for older people; housing with associated services i.e. more than just bricks and mortar. People who own their homes, i.e. owner occupiers, are also considered, along with private renters, but privately owned housing does not have the same level of service associated with it. It is these associated services that can be capitalised on in order to integrate Housing into the whole system of care. Social housing is "housing provided by local authorities and housing associations (sometimes known as Registered Social Landlords) and extended to cover housing management by these bodies, regardless of ownership" (Reeves, 2005:2). Government provided social housing began in Britain with the Artisan Act in 1875, which dictated that the local council had the obligation to restore the slums in their locality. The idea was to provide housing at a reasonable rent for the poor who could not afford their own homes. Following this, the Housing of the Working Classes Act in 1890 resulted in local authorities building their own housing stock. After the First World War, pressure

was put on local government to build homes fit for heroes. But perhaps the biggest push in the construction of social housing in the UK was following the Second World War, as so many homes had been damaged in bomb attacks. There was also the issue of the post-war baby boom, leading to a chronic shortage of housing, and therefore the decision was taken to rapidly expand the provision of council housing (King, 2006:56). The New Towns Act (1947) and the Town and County Planning Act (1948) dictated how these houses were to be built. No longer was the stock only designed to meet the needs of the poor, but it was to be 'general needs' housing, designed to meet the needs of the wider society. Advancements in building techniques meant that these houses could be built relatively quickly and to a higher standard.

"Under Thatcher's government, the emphasis was placed on 'owner occupation' as a tenure offering choice and independence from state interference" (King, 2006:60). To this end, the Right to Buy Scheme was introduced in 1980 giving people the right to buy their council house with a one-third discount on the market value if they had lived there over three years, or for half of the market value if they had lived there over 20 years (Housing Act, 1980). The uptake of this scheme led to a huge growth in home ownership, marking the first step of the Thatcher government towards the privatisation of social housing, aiming to reduce the cost to government.

The next step was to transfer the rights and responsibilities of social housing to housing associations in 1988. Whilst some housing associations existed prior to this, this change put them at the centre of housing policy (King, 2006:59). This altered the market orientation of the provision of social housing in the UK, from state to private. Over time, the social housing market has become much more open, with tenants being able to move houses between associations and sit on numerous waiting lists, which emphasises the element of choice with the new 'choice based lettings' system. Whilst the Right to Buy Scheme is still in place, it was reformed in 2005 to place an emphasis on the type of house and alter the discounts and eligibility criteria.

So, whilst traditionally, local authorities were the main providers of social housing for those in need, since 1988, the councils have been transferring their housing stock to housing associations, with the agreement that they will continue to be used for those with a housing need i.e. people in receipt of benefits, who cannot afford other

housing options. To this end, housing associations must charge affordable rents for their properties. The growth of housing associations, and the movement of local authorities away from being social housing providers, is a direct result of changes to government fiscal and monetary policies, in particular the constraints placed on public spending to control inflation (Reeves, 2002:3).

Housing associations in the UK are independent societies, bodies of trustees or companies established for the purpose of providing low-cost social housing for people in housing need on a not-for-profit basis. Communities and Local Government, a ministerial department of the UK government, define registered social landlords as housing associations that are registered with the Tenant Services Authority/Scottish Housing Regulator/Welsh Government (Communities and Local Government, 2011). Housing associations and RSLs are two terms are often used interchangeably to describe companies or charities that provide social housing. Whilst there are subtle differences between the two, these are not relevant for the purpose of this work.

Housing Standards

Another reason for the transfer of stock is that it enables large-scale investment into the improvement of social housing (Pawson et el, 2009). This is because housing associations have 'greater financial freedoms' than local authorities (Reeves, 2002: 190). Therefore housing associations can access funding that councils cannot, in order to improve the quality of the housing they provide. The link between poor quality housing and health issues is well documented (Handy, 2014; Roys et al, 2010; Davidson et al, 2011). For example, damp homes often lead to respiratory problems. Housing also needs to be accessible. The introduction of England's Lifetime Homes standards in 2008 provided guidelines to ensure that newly built homes have a layout that is accessible should the owner develop a disability (Communities and Local Government, 2008). However, older housing stock that was built before these standards were introduced is still problematic, and these standards are not enforced. A lack of accessibility in their current home is one of the main reasons that people have to move to housing dedicated for older people (Communities and Local Government, 2008). The introduction of the Decent Homes Standard in 2000 has encouraged social housing landlords to look at innovative

ways to improve the accessibility of existing housing (Communities and Local Government, 2006).

In England, three options were offered to local authorities in order to bring their homes up to the 'Decent Homes Standard' by 2010. These were to develop a business plan that demonstrates that the standards can be met by keeping stock in house, stock transfer or developing an Arms Length Management Organisation. 'Whole stock transfers' refer to when a local authority transfers all of their housing stock to a housing association or registered social landlord. The organisation the stock is transferred to may be an existing organisation or, more commonly, will be created for this very purpose and will start off with just the local authority's housing stock. Arms Lengths Management Organisations (ALMOs) take over the daily running of the housing management from the council but the council retain ownership of the properties themselves. "This allows the local authority to retain control of its housing stock, with additional funding being provided to the ALMO by central government" as a reward for excellent service delivery (Baxter, 2008).

In 2001, the Welsh Government developed their first formal National Housing Strategy 'Better Homes for People in Wales'. This strategy laid out the 'Welsh Housing Quality Standards', which were to be met by all social housing by 2012. These standards laid out the specifications that housing in Wales must meet in order to ensure it is of good quality; the equivalent to England's Decent Homes Standard. This includes factors such as accessibility, security and energy efficiency (Welsh Assembly Government, 2008). For the majority of Welsh local authorities, this meant a huge amount of investment into their stock. Whole stock transfer was the only option for those local authorities that could not afford the improvements necessary, due to the Welsh government's Treasury rules, which place restrictions on local authorities in order to regulate public sector borrowing (Nadeem, 2007). ALMOs were not offered as an option in Wales as the Welsh Government felt they were not a financially viable option, as the money it would cost the government would reduce the amount of funding available for those local authorities that managed to retain their housing stock (Baxter, 2008).

The first local authority to transfer all of their stock was Bridgend in 2003. Rhondda Cynon Taf then transferred their stock in 2007, followed by Monmouthshire, Conwy,

Newport, Torfaen, Ceredigion, Merthyr Tydfil, Blaenau Gwent, Gwynedd and finally, Neath Port Talbot in 2011 (WLGA, 2012). Cardiff, Carmarthenshire, Denbighshire, Isle of Anglesey, Pembrokeshire and Powys all produced business plans which demonstrated that they were able to meet the standards and maintain them whilst keeping their stock in house. Wrexham, Vale of Glamorgan, Swansea, Caerphilly and Flintshire all needed to transfer their stock to meet the Welsh Housing Quality Standards, however their tenants voted against the transfer. For these authorities, alternatives must be explored further.

It could be argued that stock transfer enables further opportunities, beyond home improvements. The stock transfer organisation becomes an expert, a specialist, which can lead to efficiencies. Whereas local authorities are extremely diverse in the services that they offer, stock transfer organisations only have to focus on housing and associated support. Due to government cuts, council staff are increasingly becoming pressured to expand their work load, diluting the time they can spend on any one area of their job. Therefore, stock transfers commonly lead to a higher level of service, with many stock transfer RSLs demonstrating a higher standard of home improvements than laid out in the Decent Homes Standard/WHQS, and a greater impact on community development than predicted at the time of the transfer (Pawson et al, 2009).

Specialist Housing for Older People

Traditionally, residential homes were the main option for frail older people. These are a residential setting where older people live, usually in single bedrooms, and have access to 24/7, on-site care to help with daily tasks such as washing, dressing and taking medication. This may include nursing care if necessary. Tenants usually have their own room and then they share communal areas. Meals are provided for tenants. However, in the 1960's, sheltered housing was developed as an alternative, following Townsend's 'The Last Refuge' which criticised the standards of residential homes in England (Townsend, 1964). Townsend's study was criticised as it was qualitative in nature, however, he interviewed people at 173 different care homes, giving him a large sample. Many people in residential homes did not require the level of care and support that was provided to them, so sheltered housing became a popular choice for older people (Nocon and Pleace, 1999).

Sheltered housing consists of grouped, self contained accommodation which is fitted with an alarm system for emergencies and is specifically developed to enable older people to reside there safely, with a level of estate management designed to allow for, and encourage, independence. Tenants of sheltered housing are sometimes supported by a warden. The role of the warden is to provide support, advice and guidance to tenants (Milligan, 2009:96). Schemes may also have a community centre, where social activities are encouraged in order to develop a community spirit and prevent isolation.

Traditionally, this warden would live on site so that they were always available in case of an emergency. However, changes to working laws have meant that this is no longer a cost effective option. Now the wardens commonly work from 9am to 5pm on a scheme, assessing for, and fulfilling, support plans with tenants and offering support and advice. If a tenant uses their alarm system, the call will go through to the warden between these hours as they will be on the scheme. If they do this when a warden is not on duty, they will go through to a call centre that will make the decision about the urgency of the issue and contact either a family member or the emergency services. These alarm systems are designed to ensure that tenants of sheltered housing feel secure in the knowledge that if something happens, they will always be able to contact someone who can help. This also gives the tenants' families peace of mind.

Over the last ten years, extra care housing has been a popular option for local authorities. This is a specific model of sheltered housing that provides twenty-four hour, flexible, on-site care to meet tenants changing needs to enable them to live as independently as possible. Tenants have their own flat with a kitchen and bathroom, which they are free to furnish themselves. One meal a day is provided for tenants to encourage them to integrate with neighbours and thus develop a community feel. Communal areas on the schemes also support this. Extra care housing is commonly used by local authorities to replace older models of residential care provision. This is because it was originally thought to be cheaper and it promotes the kind of independence that is not typically associated with care homes and is therefore a much more modern equivalent. However, most extra care housing cannot provide end of life care due to staffing, so care homes are still a vital option.

Whilst residential homes still exist today, people often see them as a last resort. Local authorities have commonly shifted their provision of residential homes into the private sector, as this option is not viewed as one that promotes independence. It is also expensive to provide residential homes, with other options proving to be much more cost effective. The president of the Association of Directors of Adult Social Services stated that it is good practice to support people in the community instead of in care homes as this is both better for them and the evidence suggests it is usually less expensive (Pickup, 2013, cited in Donovan, 2013). However, residential homes still have an important place as a housing option for older people, as many of the other housing types cannot support people who have very high care needs. Whilst it is not cost effective to house someone with moderate care needs in a residential home, it is cost effective as these needs grow and the individual requires around the clock care. More information about the literature around each of these housing options is included in Chapter 2.

1.3.2 Social Care

The National Health Service and Community Care Act (1990) introduced new community care arrangements. Prior to this, the main focus of social care had been the provision of institutions for older people in the form of residential homes. There were also institutions for disabled people. However, in the 1970's, people began campaigning for the rights of those with disabilities to be able to live their lives as independently as possible. This led to a lot of negative media attention towards institutions. In 1986, the government tightened the benefit laws and declared that social care should be more individual and consumer based, as this would cost less than providing everyone with the same high level of care in institutions. In the late 1980's, Thatcher placed an emphasis on the development of private providers so that local authorities no longer had the monopoly on social care provision (SCIE, 2013). This significantly altered the social care market.

The key principle of the Community Care Act (1990) was that social care became needs led and that each client should therefore have an individual, tailored package of care, based on their needs. This also meant that no-one should have to move house in order to receive care and support, with the Act stating that help should be given so that people can live a normal life in their own homes (Community Care Act

1990). The emphasis on keeping people in their own homes wherever possible brought the function of sheltered housing into question. Community Care arrangements often mean that older people are able to live in their own homes, whilst others who may be healthier than them live in sheltered housing. People wishing to avoid residential homes, as their health deteriorates, no longer have to move into sheltered housing to get the help they need, they can be cared for in their own homes.

| Institutionalisation: Pre 1990's | → | Community Care: 1990-2006 | → | Personalisation: 2007-Date |

Figure 1: Timeline of Care Provision Policy

Community care arrangements are still in line with the Government's more recent Personalisation Agenda (2007), which puts a focus on developing the relationship between Health, Social Care and wider community services in order to create a 'truly personalised care system' (HM Government, 2007). The idea is to place the client at the centre of decision making. The position of service users in social care markets has moved from consultation through participation to empowerment. 'Ageing in place' is still viewed as important as it enables the client to maintain their independence in their own home, in a familiar local environment (Hillcoat-Nalletamby et al, 2010). Figure 1 demonstrates the timeline of state care provision.

The Personalisation Agenda brings together four themes:

i.   universal services- focus on advice and advocacy across wider communities

ii.   early intervention and prevention- emphasis on reablement and assistive technology to enable people to stay as independent as possible

iii. social capital- support provided outside of social care, by volunteers, communities, timebanking

iv.   choice and control- emphasis on better housing options, direct payments, person centred support plans and flexible services (SCIE, 2013).

This agenda has consequently led to an emphasis on Health and Social Services working together more closely. However, whilst Housing is mentioned as part on one of the key themes of the agenda, all too often, providers of housing encounter barriers when trying to communicate with Social Services or Health to find out about what they could be doing to make service integration easier. The RSL's are experts at housing related issues and they are keen to keep their tenants happy and independent in their own homes. If a tenant's health deteriorates then they may have to move into more appropriate housing, so it is beneficial to RSL's to provide a good service. More input from Health and Social Services would enable them to do this much more effectively. The emphasis throughout the Personalisation Agenda is on the community and improving links between organisations, so that they can provide a more streamlined service and be more flexible.

In April 2015, The Care Act will become statutory in England, outlining the roles and responsibilities of local authorities in the provision of care and support. The Act outlines the importance of partnership working to provide integrated care. The focus is still on personalisation, but more of an emphasis is placed on prevention and the provision of information, as the responsibilities of local authorities in the role of commissioner's of services (Department of Health, 2014).

Delivery of Care

Care is usually assessed by Social Services, using a unified assessment template. Care can include domestic care such as bathing, washing, dressing and preparing meals. It might also include an element of socialisation, such as taking the client to a day centre so that they aren't alone in their home every day. In extra care housing, the care provided by Social Services may include taking the tenant downstairs for their dinner, if they cannot get there on their own. The majority of local authorities now only provide funding for care if the client is assessed as being in substantial or critical need of it. Those assessed as having a low to moderate need for care will not receive funding towards it from Social Services. That is not to say that some lower level care will not be provided, it may be deemed critical that the client gets taken to a day centre for an hour a week, if their wellbeing is significantly improved as a result of this. This reduction in services is due to spending cuts and it is unfortunate as it means that Social Services is limited in its ability to provide preventative care for

those with lower level needs. Preventative care is targeted at ensuring the client's needs do not increase; without it, the number of people being assessed as having substantial or critical need for care is bound to increase. It is identified in the report by the House of Lords (2013) that England's current model of Health and Social Care is inappropriate, and will not be able to cope with the changing healthcare patterns caused by our ageing population.

Social Services typically outsource care to independent care providers, who can usually provide the services at a much lower cost, freeing up social workers to conduct assessments (Davies and Drake, 2007). One problem with this for the clients is that it widens the pool of potential care workers that will visit them. Therefore, it is not uncommon for a client to be visited by numerous different carers throughout the week, which is not ideal as it limits the opportunity to build relationships with carers. This shift presents a whole new set of supply chain management challenges to local authorities. Challenges include who to outsource from, what type of contract to use and how to maintain control to ensure that regulations are being met. Local authorities cannot outsource responsibility entirely, they still have a duty to ensure that the level of care being given by their contracted providers is consistent with government rules and regulations. Therefore, local authorities are now taking on an enabling role in order to help local providers develop their services to regulations, making them viable external providers. This casts local authorities in a "new role as commissioner of services, where they must identify the most appropriate resource for service delivery, whether it is in-house or outsourced" (Davies and Drake, 2007:500). Although outsourcing is often the 'best value' option, it further fragments the whole system of care.

Another development of care in recent years is the growth of direct payments/personal budgets, introduced in 1996. These were developed as part of the Personalisation Agenda, which states that an individual should have control over the care they receive. Following an assessment from Social Services, the client can opt to receive direct payments instead of Social Services setting up care for them. This means that Social Services will give the client the money to source their own care, under the proviso that they hire the right type of care as laid out in their care plan. This leaves the individual free to conduct interviews and hire an individual or a

company that they are comfortable with to provide their care. In April 2003, it became mandatory rather than discretionary for local authorities to offer direct payments and accompanying guidance (Leece and Leece, 2006). The Coalition Government in its programme for government stated that they would extend the roll-out of direct payments to ensure clients have more control over their care (HM Government, 2010). Therefore, the emphasis on direct payments is set to continue and local authorities need to consider how they can increase the number of people opting for them.

Direct payments were initially for people under 65. However, in 2000 older people were added to the legislation. By 2007, just 13,000 people in England over the age of 65 who received community based care from their local authority were using direct payments, despite being the largest user group of adult social care (Office for National Statistics, 2007). Barriers to the take up with this age group include, "a lack of information for potential users about the potential benefits of direct payments; poor awareness of direct payments among Social Services staff and reluctance to promote the option, particularly to people assumed to be 'unsuitable'; and lack of help with the administrative and other responsibilities of recruiting and employing helpers" (Glendinning, 2008:453). However, since then, organisations and charities have been developed to make direct payments more user friendly by sorting out contracts, holiday cover and even wages if the client wishes. The level of involvement of these organisations is entirely up to the client. This has made direct payments more appealing to older people, as they can take control over their care but without feeling intimidated about the amount of work involved. Consequently, uptake increased and 63,000 older people were in receipt of direct payments by 2012-13 (National Statistics, 2013).

From Social Services perspective, it costs less to provide a client with a direct payment than it does to commission care for them as this method does not involve contracting and administration costs. It is also often better for the carer as they have more consistency in the care they are providing and are better able to build a relationship with the client when employed directly. They may also get paid more as a provider does not 'take a cut'.

Another recent development in care is that of reablement. The term reablement means to provide short term intervention for those with poor physical or mental health in order to improve their independent living skills by helping them to accommodate their illness (Glendinning and Newbronner, 2008). The main focus of this type of service is to help patients to relearn the skills necessary for daily living by helping people to do, rather than doing for people (CSED, 2007). During reablement, a care plan is developed based on the clients assessed needs, with a view to reduce intervention. Care plans often include helping the patient with daily tasks such as dressing, cooking, cleaning, coping with memory problems and outdoor mobility. Treatment lasts for up to six weeks, after which the patient is reassessed to see if they are able to live independently.

Reablement services take referrals from a range of sources. They tend to fall into two categories: Discharge and Intake Services. Discharge Services take those people who are being discharged from hospital and would benefit from intermediate care, often provided in partnership with Health. Intake and Assessment Services work with people who have been referred for home care, through Social Services, to see if they can prolong the time they can live at home. These referrals can be from the community or from hospital discharges, with reablement being offered unless it is deemed inappropriate (Department of Health, 2009).

A study done by De Montfort University found that reablement led to a significant reduction in subsequent commissioned home care hours i.e. the ongoing need for care. 58% of patients required no further home care package following reablement, compared to just 5% in the control group who did not have reablement (CSED, 2000). Newbronner et al (2007) found that between one-third and half of patients, at three of four sites studied, needed no further home care either before or up to twenty-four months after a period of reablement (Glendinning and Newbronner, 2008). Reablement is therefore deemed to be successful at reducing the need for ongoing care, with results often being relatively long-term.

The majority of local authorities throughout the UK now offer, or are developing, a reablement service in a bid to improve patient's lifestyles and prolong the time that they can live independently (Department of Health, 2009). The alternative to living independently is usually a home care package, which costs the council more in the

long run than providing reablement; reablement can lead to "minimised whole life cost of care" (Value Adding, 2010). By asking clients to go through a period of reablement before putting care in place, Social Services ensure that the care package is as cheap as possible, whilst making sure that the individual's independence and wellbeing is maximised i.e. it addresses quality as well as cost.

1.3.3 Housing Related Support

It is necessary here to distinguish between care and housing related support. Housing related support (referred to as support throughout this thesis) is defined as support to "help vulnerable people develop or maintain the skills and confidence necessary to live as independently as possible" (Chartered Institute of Housing, 2013:2). However, this does not include care, such as personal or domestic care, but should instead complement care services. Support can involve checking in on a tenant, ensuring alarms work, signposting services, helping a tenant to claim benefits and encouraging them to integrate into the community. Research has shown that older people want 'help' rather than 'care' in order to retain their independence as this implies that they are in control (Clark et al, 1998:55). Support can be viewed as a preventative and enabling measure and can be used to signpost those services that enable older people to stay in their own home.

Housing related support, provided by a warden in sheltered housing, was originally funded by the local authority's Housing Revenue Account. This account was pooled from all of the rents of people living in council housing in each county. Therefore, anyone who lived in a council property was contributing to the cost of support, regardless of whether they received support or not. The percentage of this money that was spent on support was redirected into the Supporting People funding in 2003, along with the Social Housing Management Grant, Probation Accommodation Grant and unpooled housing revenue monies. Supporting People funding was split into two separate funding streams:

1. **Supporting People Grant-** for sheltered housing and community care adult services. This goes directly to the local authorities, and they pay it directly to the RSLs, based on the number of people they are supporting who are in receipt of housing benefit.

2. **Supporting People Revenue Grant**- for homeless or potentially homeless people. There are many categories including alcoholics and drug abusers. Goes directly to the provider.

In Wales, Supporting People funding is still ring-fenced, meaning that it has to be spent on support. However, it is not in England which puts the funding more at risk in these financially stretched times, as local authorities are able to spend this budget on other things. Support is a preventative measure, i.e. it prevents people from deteriorating due to bad health, poor finances or social isolation. However, due to its preventative nature, it is difficult to quantify the success of support as we cannot accurately predict what would have happened to a person had they not been in receipt of support. Therefore, many local authorities are finding that their Supporting People budgets are being slashed in favour of more easily quantifiable projects (Age UK, 2014a).

The Supporting People Grant is designed to enable vulnerable people to gain and maintain their independence by remaining in their own homes. The support is designed to complement existing care services. Currently, wardens in sheltered housing tend to be partially or wholly funded by Supporting People. This depends on individual housing associations and whether they choose to maximise their intake from the pot of Supporting People funding. Housing associations add a support charge onto the rent of their properties, which covers the cost of the warden. For those tenants who are in receipt of housing benefit, this support charge is subsidised by the Supporting People Grant. The alarm systems in sheltered housing, which provide access to a call centre in case of an emergency, are also funded by Supporting People. Due to government cuts, many housing associations have made the strategic decision not to be too heavily reliant on Supporting People funding to cover the cost of the support they provide, as they feel it is at risk. Many have developed a model where their wardens are paid by a mixture of Supporting People funding, tenant charges and the housing associations themselves.

When Supporting People funding was introduced in 2003, there was a debate in parliament about whether this funding regime should include the support provided in sheltered housing (Wilson, 2012). This was because there was concern that by separating out housing and support services, sheltered housing would become

fragmented and confusing for elderly residents. Fears were justified and in trying to prove that their support service offers good value for money, many housing associations and local authorities have looked at restructuring. This has led to a reduction in the traditional residential warden, and a growth in floating support services. The implications of this will be discussed in Chapter 6 as a major issue.

The 'Supporting People Review (2010)' includes a recommendation "that the eligibility criteria for older people receiving Supporting People funds should be based on need rather than age or tenure" (Welsh Assembly Government, 2010a). Traditionally, tenants of sheltered housing receive support because they live in sheltered housing, i.e. due to their tenure. This could range from one visit from the warden per month to two a day. The warden completes a support plan with individual tenants every six months, in order to assess their needs. The support plan is then sent off to the local authority's Supporting People team to demonstrate that they need support. However, this process has now become stricter. Prior to this, tenants that did not need support would still get one visit per month because they live in sheltered housing. Under the new guidelines, this has to change so that support is tenure-based instead of needs-based. Local authorities were given until April 2014 to implement this change; enabling time for consultation, the development of assessment criteria, etc. This change releases some of the capacity of the warden service, potentially giving them the opportunity to support those in the wider community who are also in need of support. This is also happening in England, with the move towards 'needs-based' support being one of the main drivers for the growth of 'offsite' warden services in England (Oldman, 2008), explored later in the thesis.

1.4 Welsh Policy Context

The action research that this thesis is based on was conducted in Conwy, Wales. It included a survey of fifteen Welsh local authorities, and two in England to provide a comparison. Therefore, this section of the introduction covers relevant Social Care and Housing policy in Wales, in order to provide context to the case study, mainly focusing on policies specifically targeted at older people. However, the UK as a whole is the target for this work so that issues highlighted and solutions found are not intended to be specific to Wales.

The Welsh Government has devolved power over areas such as Housing, Health, and Health Services. Therefore, many policies are different to those in England, for example, medical prescriptions are free for all in Wales. The Welsh Housing Quality Standard in Wales is the equivalent of England's Decent Homes Standard. However, the Welsh version is more wide ranging, including stipulations for outside the home as well as inside (Twinch, 2011).

In 2001, the Welsh Assembly Government developed their first formal national housing strategy 'Better Homes for People in Wales'. As well as laying out the terms for the Welsh Housing Quality Standards, this strategy identified a need for a long term strategy for older people in Wales. Consequently the 'Strategy for Older People in Wales' was developed in 2003. One of its five aims is, "to promote the provision of high quality services and support which enable older people to live as independently as possible in a suitable and safe environment and ensure services are organised around, and responsive to, their needs" (Strategy for Older People in Wales, 2003:9). This aim places an emphasis on personalisation, as it is clearly supporting a person-centred approach to service delivery. Within this aim, the strategic objectives highlighted the need for the development of more housing specifically for older people. The Welsh Assembly Government allocated a budget for the development of extra care housing in order to encourage local authorities to develop this type of dedicated accommodation. Conwy currently has four extra care housing schemes.

The 'Strategy for Older People in Wales' places an emphasis on more unified, person-centred support to enable older people to live independently. It highlights the importance of Housing, Health and Social Care services being delivered in a joint up manner in order to help older people to maintain their independence, mirroring the policy of the central UK government. The Institute of Public Policy Research conducted a study comparing the policy and practice of governments in the UK regarding older people. Whilst England was complemented on their pilots across the country to develop integrated, preventative services, the study identified that "the Welsh approach seems to be the most coherent long term commitment to improving the position of older people of any administration in the UK in the last decade" (McCormick et al, 2009:26). This is because the Strategies for Older People in Wales demonstrate a commitment to ensuring that the consideration of older people

is included across numerous policy areas. The most recent version of the Strategy for Older People in Wales (2013-2023) focuses on older peoples' participation in society, age friendly communities and encouraging future generations of older people to plan ahead for some of the challenges they are likely to face in the future (Welsh Government, 2013). This document highlights that the main success of the previous strategies has been to give older people a voice in the development of policy, both at a local and national level. Whilst England is ahead in terms of actually delivering more joined-up services, Wales has laid the foundations in policy to ensure that the needs of older people are considered across the board (McCormick et al, 2009).

The 'National Service Framework (NSF) for Older People in Wales' was launched by the Welsh Assembly Government in 2006 in order to set national standards for addressing the Health and Social Care needs of older people. These standards aim to ensure that, as people grow older, they are enabled to maintain their health, wellbeing and independence for as long as possible, and receive prompt, seamless, quality treatment and support when required. However, these objectives are limited to Health and Social Care.

'A Strategy for Social Services in Wales over the next decade' (2008-2018)' sets out the strategic direction for Social Services over this ten year period (Welsh Assembly Government, 2007). It emphasises the importance of working closely with partners and developing shared outcome measures, with the vision to support people "to have control over the life they wish to live". People have a right to expect services that enable them to make use of their full potential; protect them from harm and offer a choice about how they are supported. For older people, this means an emphasis on independence, participation, care, self-fulfilment and dignity. 'The Social Services and Wellbeing Act Wales 2014' promotes partnership working, cooperation and integration; placing a statutory emphasis on joint-working and providing a legal framework for improving wellbeing of people who need care and support (Welsh Government, 2014).

The second national housing strategy was produced in April 2010 and is entitled 'Improving Lives and Communities: Homes in Wales' (2011-2016) (Welsh Assembly Government, 2010). This document focuses on a 'whole approach' to improve

people's lives and one of the key elements of this is to "improve housing-related services and support". It emphasises the importance of responding to the needs of our ageing society and encouraging services to become user-led wherever possible. This is a person-centred approach, with the client involved in the decision making regarding service development. In cohesion with the first national housing strategy, the document continues to place an emphasis on the importance of enabling older people to maintain their independence in their own homes through the use of quality care and support. This ensures that this strategy supports the National Service Framework for Older People in Wales. By ensuring that all strategies place the same emphasis on partnership working and independence, the Welsh government is pushing for a more integrated approach between Health, Social Care and Housing. These policies highlight that Housing is at the focal point of service integration in Wales, whereas, in English policy, the importance of integrating Housing into the whole system of care is identified in Housing policy, but is not commonly identified as a key entity in Health and Social Care policies.

In 2011, the Social Services Improvement Agency for Wales (SSIA) produced a report: Better Support at a Lower Cost: Improving Efficiency and Effectiveness in Services for Older People in Wales. This report emphasises that a shift in culture is needed throughout Social Services departments, to ensure that all staff are working towards enabling the client to do tasks for themselves, instead of doing it for them. This is the ethos of reablement, spread across general care services. This creates the independence that is a theme throughout all recent policies relating to older people, in both Wales and England.

1.5 Summary

This chapter has highlighted some of the major issues that we face as a society as our population ages. Our ageing population is putting an increasing amount of pressure on public spending, due to the greater likelihood of an older person needing a hospital visit or developing complex care needs, when compared to a young person. This problem is exacerbated by current pressure to cut the costs of existing services, due to austerity measures caused by the recession. A whole systems approach to care is needed to enable more efficient and effective care provision with reduced overlapping.

A whole systems approach to care is desirable to service users, as it improves the coordination of services, resulting in a smoother system of care. Currently, the system is complex and confusing, due to fragmentation between the organisations providing health, care and support. "There is a need to streamline older person services to ensure that older people are effectively managed to enable them to access appropriate services within the system in a timely manner and maximize opportunities for more proactive care coordination"(McCormack, 2008).

This chapter has provided an introduction to this project, followed by a background into some of the key services discussed throughout the thesis, including Housing, Social Care and support. Finally, some Welsh policy context has been provided as this research was conducted in collaboration with Conwy County Borough Council and some of their partner organisations in Wales.

1.6 Thesis Structure

The rest of this thesis follows the following structure:

Chapter 2 answers the question "Why should housing be integrated into the whole system of care for older people?", by examining both literature and policy in this area. This chapter also summarises the literature around the different types of housing available for older people, identifying which types of housing are already integrated into the whole system of care. Whilst the literature review is embedded throughout this thesis, this chapter draws on the literature to answer a specific question which is grounded in practice as opposed to theory.

Chapter 3 details the research methodology for this thesis. This research was conducted using participatory action research.

Chapter 4 provides an introduction to the case study. It details how the research came about and justifies the case study objectives, demonstrating how they led to the overall research objectives for this thesis.

Chapter 5 utilises soft systems methodology in order to identify potential functions for integrating Housing into the whole system of care for older people in Conwy. It details the process that the action research group took to choosing support as the integrating function. Three options were then developed for how this integration

using support would look at a macro level. The implementation of the chosen option was written into Conwy's Older Persons' Housing Strategy (OPHS), included in the Appendix.

Chapter 6 details the survey that was conducted to examine the current support structures utilised across Wales. Many local authorities were currently reassessing their support services, deciding between onsite or offsite support. A SWOT analysis was conducted on each of these structures to develop an evidence base to help local authorities make this decision. This chapter examines what integrating Housing using support looks like at a micro level.

Chapter 7 discusses the focus groups that were conducted in order to ensure the proposed solutions meet the needs of older people in Conwy. A discussion on conducting focus groups with older people is provided. This consultation exercise was also necessary in order to finalise Conwy's OPHS, as integrated care is 'person-centred' and thus the users should be at the heart of any developed strategy. A focus group with wardens was also conducted as they are central to the solutions provided and thus their views are integral to this research.

Chapter 8 offers a reflection on the approach taken for integrating Housing into the whole system of care in Conwy and the thesis conclusions. Little guidance exists on effective methods for working in partnership to achieve integrated care. This chapter explains how the methods utilised in the action research project addressed some of the common issues faced by local authorities and the health service when trying to achieve integrated care. This chapter also includes the research limitations and suggestions for future research. The conclusions are separated into four categories: conclusions from the literature review, conclusions from the empirical evidence, contribution to theory and contribution to practice.

This structure is summarised diagrammatically in Figure 2 (page 39).

Breakdown of Thesis Structure in terms of Theory

Methods used for Action Research

Chapter 1: Introduction

Introduction to problem:
•Integrated Care (IC)
•Ageing population

Background for:
•Housing
•Social Care
•Support

Welsh Policy Context

Chapter 2: Literature Review

Integrated Care Theory

Operations management for integrated care:
•Service operations
•Supply networks
•Integration

Housing's role in IC

Chapter 3: Methodology

Action Research
•Theory
•Philosophical assumptions

Chapter 4: Case Study and Establishing Objectives

Case study approach

Research objectives defined

Chapter 5: Soft Systems Methodology (SSM)

Scope: Case Study
Theory and critique of SSM
Implementation to case study
Draws on theory from operations strategy and service operations
Solution identification

Chapter 6: Survey
Scope: Wales
Taxonomy of support structures in Wales
SWOT analysis of onsite against offsite support
Draws on strategic operations performance objectives
Solution development

Chapter 7: Focus Groups

Scope: Case Study
Theory and critique of focus groups conducted with older people
Analysis of focus group data
Solution testing

Chapter 8: Reflections and Conclusions

Reflections on methods adopted

Contribution to theory

Contribution to practice

Research limitations

Figure 2: Breakdown of Thesis Structure

Chapter 2: Why should Housing be integrated into the whole system of care for older people?

2.1 Introduction

This chapter aims to address the question, 'Why should housing be integrated into the whole system of care for older people?' The literature is examined in order to discover what work is currently being conducted on integrated care and housing's role within the whole system of care for older people. The chapter will start off by discussing integrated care; the problems organisations face when trying to integrate care and the role of partnership working in its development. The application of operations management to achieve integrated care is also examined.

This chapter then explores the role of housing in caring for older people and why it is so important. There is a current government emphasis on ageing in place (i.e. the home) and personalisation so these concepts are examined in detail. Finally, it looks at different models of housing for older people, including staying at home, sheltered housing, extra care housing and care homes, the ways in which these options are viewed in the literature and how each type of housing contributes to the whole system of care for older people.

2.2 Integrated Care

"Integrated care is a concept that meets the developments towards a growing complexity in care and the needs for better co-ordination and continuity within health care organisations" (Boumans et al, 2008:1134). This inherently implies some level of partnership, whether this is on a structural, organisational or individual level (Glasby, 2003). This work focuses on virtual integration at the organisational level, using partnership working to develop solutions to integrate Housing into the whole system of care for older people. Virtual integration involves providers working together or collaborating, through networks and alliances. However, this partnership

is operating within the constraints of the structural level and suggested solutions need to be disseminated to an individual level. The interconnection between the levels of partnership is demonstrated in Figure 3, demonstrating that "the contribution of individuals, though significant, takes place within an organisational context, which itself is influenced by structural barriers to improved joint working" (Glasby, 2003:130). There are a large number of terms currently used to describe the collaborative approaches necessary to achieve integrated care, with terms such as 'interagency', 'multiagency', 'inter-professional', and 'partnership' being commonly used (Warmington et al, 2004). Whilst the whole system of care includes other agencies, the literature predominantly focuses on the integration of Health and Social Care as these organisations are at the centre of care provision for older people.

I: Individual level

O: Organisational level

S: Structural Level
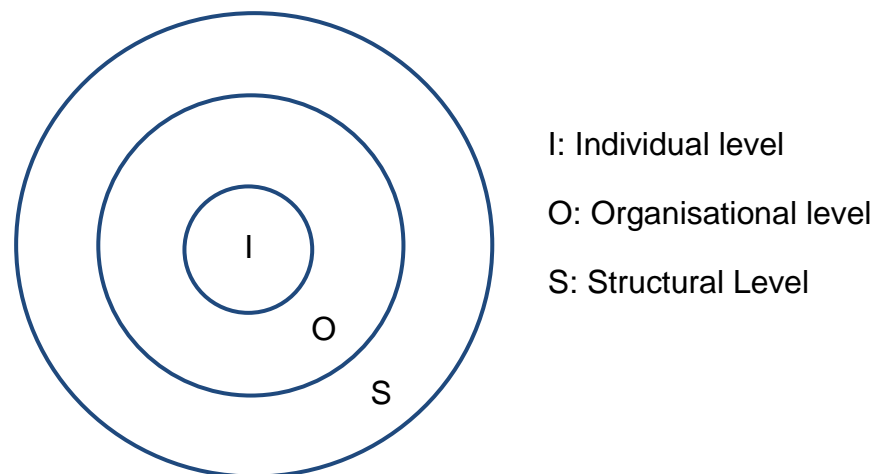
Figure 3: Understanding partnership in Health and Social Care (Glasby, 2003)

Reed et al (2005) conducted a literature review in integrated care, which found that literature published on this topic has moved on from focusing on problems with accessing services to exploring ways in which services could function in an integrated way. There are issues with conducting a literature review into integrated care as the research is spread across multiple service sectors and academic disciplines, resulting in a complex search process (Reed et al, 2005). The authors overcame this by using a thematic content analysis which simply informs the reader what points the literature is currently focused on, instead of an in depth critique of what has been written. From this, they conclude that the majority of attempts to achieve integrated care are modifications of existing services and the development

of services to help older people to navigate what already exists, instead of radical change to the whole system (Reed et al, 2005). This could be due to the long term commitment required to make the necessary changes to the system, which are not possible due to short term policies produced by the government. The review also highlights that housing and transport should also be included in the partnership model; which has since been identified in numerous government policies (discussed later in this chapter). Another issue, identified in a more recent literature review is that "the evidence consistently reports a lack of understanding about the aims and objectives of integration" (Cameron et al, 2014:225).

Leutz (1999; 2005) presents five 'Laws of Integration' based on his extensive experience researching integrated care in both the UK and the US. These are summarised in Figure 4 and explained below.

Leutz' 'Laws of Integration':

1. You can integrate all of the services for some of the people, some of the services for some of the people, but you can't integrate all of the services for all of the people;
2. Integration costs before it pays;
3. Your integration is my fragmentation;
4. You can't integrate a square peg and a round hole;
5. The one who integrates calls the tune.

Leutz (1999; 2005)

Figure 4: Leutz' Laws of Integration

Law 1: You can integrate all of the services for some of the people, some of the services for some of the people, but you can't integrate all of the services for all of the people. This law emphasizes the distinction between narrow and broad integration efforts. One review of the research literature demonstrates that the current focus is on achieving narrow integration, across a range of different services (Cameron et al, 2014). Leutz (1999) emphasizes that not everyone needs integrated care. Research into the development of integrated care should therefore be designed to provide mechanisms for joint working when clients require them, not for all clients.

Law 2: Integration costs before it pays. Currently, the savings from integration are hopes which have not yet been realised, whereas the costs cannot be avoided if we

are going to achieve integrated care (Leutz, 1999). A recent review of the research literature has identified integrated care has not progressed over the last 15 years, in terms of evaluating the costs of integration against savings made (Cameron et al, 2014). One of the major costs of integration is the staff time spent on developing policies and methods for joint working. Complaints about the strain of staff time, caused by projects to integrate care are common in evaluations of integrated care schemes (Glendinning and Lloyd, 1997).

Law 3: Your integration is my fragmentation. This law highlights the conflicts that partnership working, to achieve integrated care, can lead to. The complexity of the organisations making up the whole system of care mean that there are no simple solutions to providing integrated care, either on a structural, organisational or individual level.

Law 4: You can't integrate a square peg into a round hole. This law reflects the fundamental differences between Health and Social Care and the limitations that these differences place on integrated services. Partnerships to achieve integrated care are complex in nature because "medical care and social care contain a series of inherent differences in financing, administration, providers, clinical orientation, access and benefits which make it difficult to integrate these systems" (Leutz, 2005:4). For example, in England and Wales, social care is means tested whereas the NHS means that health care is free to all at the point of contact.

Law 5: The one who integrates calls the tune. People view problems in various different ways, based on their experiences and worldviews. This can lead to multiple different solutions to the same problem, depending on who is developing the solution. The danger with this is that the 'one who integrates' targets their solution at the problem that *they* are experiencing, with little or no regard for the impact this has on the wider system. This does not result in integrated care. Therefore, an emphasis needs to be placed on the importance of the project leaders understanding of the system and the goals of the different organisations that make up that system.

In his reflections on his original five laws, Leutz identifies that perhaps there should have been a sixth: "All integration is local" (Leutz, 2005:9). This supports the idea that government policies should facilitate, rather than dictate, the structure of local

activities. This is because each local system is different based on numerous factors such as political agenda, funding, facilities, population needs, etc.

Methods to implement partnership working should take Leutz' five laws of integration into account and offer the opportunity to explore and develop an understanding of the specific elements of the system the partnership is aiming to address. The existing boundaries cannot be eradicated without a major change in public policy, so what matters are the processes used to effectively overcome and work round these boundaries (Glasby, 2004). A problem solving methodology, such as action research, is therefore an effective approach for developing integrated care initiatives. There are numerous studies that use action research to achieve integrated care focusing on a particular issue at a local level (see Atwal et al, 2002; Watson et al, 2006; Hockley et al, 2005). It is a recognised approach towards integrated care, which "can result in the initiation of change at the level of both individual professional practice and organisational structures and practices" (Hart and Bond, 1995:4).

In developing these laws, Leutz, "clarified thinking about integration in a way that laid the foundation for thinking about integration frameworks" (MacAdam, 2008:16). Whilst the five laws of integration succinctly summarise some of the major issues with attempting to work in partnership to integrate care; they do not provide solutions to these issues. Butler and Jeffery (2004) take the laws to suggest that, when conducting a partnership project to integrate care, the researcher should be cautious in selecting areas for integration, but then rigorously pursue selected areas.

MacAdam (2008) conducted a literature review into integrated care and identified only four frameworks for achieving integrated care, presented by Leutz (1999), Hollander and Prince (2008), Kodner and Spreeuwenberg (2002) and Banks (2004). Whilst these frameworks are primarily targeted at those involved in developing national or regional policy on integrated care, they serve a purpose in providing guidelines for those trying to integrate care on a local level. Whilst some frameworks are more in-depth than others, MacAdam concluded that "there is congruence across the frameworks in most of their key elements" (MacAdam, 2008:24). Therefore, this thesis will present one of the four, the Carmen framework, which was developed by the Care and Management of Services for Older People in Europe Network (CARMEN), and is the most recent framework targeted at European policy

development (whilst Hollander and Price is more recent, this framework is targeted at Canadian policy makers). This framework is also approved by The Kings Fund, who are an independent charity that conduct research into Health and Social Care in the UK, in order to shape government policy and practice. This policy framework (see Table 1, page 46) is not a solution to achieving integrated care, it is designed to act as a checklist for those concerned with developing policy for integrating care services; a tool to review policies against to ensure they take everything into consideration (Banks, 2004). It was developed by collating some of the key themes of integrated care that struck a resonance for each of the countries involved in CARMEN, across practice, managerial and policy levels (Banks, 2004). This research draws on this framework in order to ensure that the integrated care themes are considered in the development of solutions.

Table 1: Carmen Policy Framework for Integrated Care (Banks, 2004 adapted from summary in MacAdam, 2008)

Themes	Clarification
Shared Vision	• Statement that guides principles
Underlying principles and values	Principles include: • Older people are treated as individuals and are in control • Older people's views are central • Access to care must be equitable and according to need • Solutions to integrated care must be sustainable
Criteria for operational success	The integrated system offers: • Flexible and innovative integrated services for older people • Clarity about responsibilities and accountabilities • Appropriately targeted integrated care
Coherence with other policy	• Coherent funding systems • Promotion of independence and well-being • Support to family caregivers • Integrated information
Active promotion and incentives for integrated care	• Allocating sufficient resources • Resourcing integration • Awarding responsibilities to integrate services • Introducing incentives and sanction • Supporting shared learning • Setting standards for joint working and integrated approaches • Providing support to family caregivers
Evaluation and monitoring	• Developing core evaluation requirements such as impact on the lives of older people and caregivers • Changes in services and service outcomes • Cost-effectiveness of whole system approaches and integrated services • Changes in processes and protocols to improve the integration of services
Regulation and inspection	• Coordinate inspection and regulatory processes to avoid duplication.
Support for implementing policy	• Provide support for steps to involving older people • Methods to effect cultural and organizational change • Workforce development • Leadership development • Technology and information system development

The success of integrated care relies heavily on local leadership and partnership working, rather than government structural changes and directives (Hudson and Hardy, 2002). However, central government need to tackle some of the administrative, legal, and bureaucratic barriers to partnership working (Glasby et al, 2011). Partnership working can be defined as, "Joint working arrangements where parties who are otherwise independent bodies agree to co-operate to achieve common goals, create new organizational processes or structures, implement a new organisational process or structures, implement a joint programme and share relevant information, tasks and rewards" (Audit Commission, 1998:8). Local level partnerships are important because of the differences between local authorities in terms of how funding is allocated, population, commissioning practices and political agendas, which means that a 'one-size fits all' solution to integrated care, prescribed by government, would not be effective. Whilst structural changes and government directives do have a place in driving integrated care forwards, local authorities are better placed to identify the boundaries in their own local systems in order to achieve integrated, person-centred care. "Each integration effort has to be implemented locally in a way that is consistent with local systems and personnel... larger policies should facilitate rather than dictate the structure and pace of local action" (Leutz, 2005:9). However, despite the importance of local level integration, little guidance exists about effective methods for achieving this integration that considers all elements of the suggested policy framework. A systematic review of the literature on integrated care in a care home setting concluded that more research is required to enable us to understand how integrated care is achieved and to see the effect of different approaches on cost, staff satisfaction and patient outcomes (Davies et al, 2011).

Due to the Care Act (2015), partnership working in Health and Social Care is soon to become a statutory requirement, once the care and support reforms come into effect in April 2015. In its guidance on the Care Act, the Department of Health states, "local authorities *must* carry out their care and support responsibilities with the aim of promoting greater *integration* with NHS and other health-related services" (Department of Health, 2014). Therefore the emphasis on partnership working and integration is set to increase. However, at an operational level, specific tools for interagency practice and collaboration are lacking (Warmington et al, 2004). More

research needs to be conducted to identify effective methods for conducting work in partnership across these organisations. There are multiple tools and frameworks to evaluate the effectiveness of partnership working (see Ball et al, 2010; Strandberg-Larsen and Krasnik, 2009; Dickenson, 2006; Hudson and Hardy, 2002). But there is little information about the methods employed to make the partnership effective. This thesis presents a combination of methods, utilised as part of an action research project. It will also demonstrate how these methods were effective for achieving the goals established in the early stages of the research.

2.3 Operations Management for Integrated Care

New Public Management (NPM) is a theoretical framework that refers to the growth of a managerial approach to delivering public services, as opposed to the more traditional administrative approach, in order to improve efficiency (Hood, 1991). It encourages the application of theory from areas of management, such as operations management, to the public sector, although it is limited in its assumption of an integrated management theory that has been derived from the private sector (Radnor and Noke, 2013). There is clearly no 'one size fits all solution' within the private sector and this is also true of the public sector. Some theories will be applicable whilst others will not. Operations and supply chain management are commonly being applied to healthcare as a way to reduce costs and improve quality (Dobrzykowski et al, 2014; de Vries, 2011; McCormack et al, 2008). Supply networks commonly found in manufacturing and service operations management share similarities with the supply network for care, as they are built up from numerous organisations who experience common barriers to collaboration. In operations management, there are numerous well established theories and practices about how to overcome these barriers, which can be drawn on to help achieve integrated care. Drawing on supply chain management theory to achieve virtual integration has the potential to be a more effective and achievable alternative to structural integration (Ham and Curry, 2011). One literature review found significant growth in the number of healthcare operations and supply chain management journal papers in leading operations management journals from 1982-2011, which reflects the identified need for more research into this topic area (Dobrzykowski et al, 2014).

So, what are the major differences between public and private sector management? Contrary to the private sector, the public sector is answerable to the general public (and thus has changing goals), it is bureaucratic and authority is frequently shared between managers and professionals (Radnor and Noke, 2013). Different political agendas at different levels of the public sector cause a high level of volatility (Propper and Wilson, 2003). Stakeholders include, but are not limited to, "internal stakeholders such as political leaders, staff, managers, administrators and external stakeholders such as regulatory bodies, citizens, suppliers and neighbouring communities" (Hazlett et al, 2013:990), all of whom often have conflicting goals and requirements (Davis and Martin, 2002). The Personalisation Agenda, introduced in Chapter 1, places an emphasis on the individual in terms of service development, which further complicates the overall system by increasing the relative importance of the client as a stakeholder.

The term 'whole system of care' is used to describe the wide range of services that provide, or are involved in care. Services are a key element to this system; "Service Operations Management, as a discipline, was developed in an attempt to leverage the valuable experience of 'scientific management' in manufacturing companies" (Belvedere, 2012:448). Organisations commonly offer a mix of products and services in order to meet customer needs and create appropriate, internal operating systems (Hill and Hill, 2011). The progression of operations management into services places an emphasis on "a more decentralised but highly collaborative view of value creation, achieved through coordinated approaches such as supply chain management" (Dobrzykowski et al, 2014:514). In the whole system of care, value is considered in terms of each patient's health, but also in terms of the efficiency and effectiveness of the care network. Service operations are commonly dispersed throughout organisations, for example, customer service, contract management, accounting, etc, are all services offered within organisations. Services also need to be established in such a way that they can be responsive to the needs of individual customers/clients/departments. Therefore, interdisciplinary and holistic approaches to service operations management are identified as the most appropriate for achieving understanding (Johnston 2005; Batista et al, 2008; Belvedere, 2012). This was the approach adopted in this thesis.

For the purpose of this thesis, the whole system of care is limited to that which is involved in caring for older people. This is because the growth in numbers of people over the age of 55 is increasingly putting a strain on the Health and Social Care system. The research in this area mainly focuses on how Health can work more closely with Social Services to provide a smoother system of care (McCormack et al, 2008; Reed et al, 2005). For the purpose of this work, the term 'Health' refers to both the National Health Service and private providers of healthcare. Healthcare can be primary or secondary and refers to care given by a GP's surgery or hospital. Social care is the package of care that a person receives at home, either following a period of illness, a setback due to an accident, or a general deterioration in wellbeing. There is not a predictable, linear flow between entities here, as there is in many supply chains, which makes this system complex. Currently, the United Kingdom's care system is fragmented (Ham et al, 2012), which results in patients being moved from one department/organisation to the next in search of the care they need. This is both frustrating and confusing for the patient, with many having very little understanding of how the system works outside of their personal experience (Ipsos MORI 2012; Commission on the Future Health and Care in England, 2014). It is also expensive as each entity has its own assessment processes to conduct when faced with a new patient, resulting in duplication and waste that could be eliminated by sharing patient assessments across Health and Social Care.

The whole system of care is a supply network, which in operations management is defined as "an interconnection of organisations which relate to each other through upstream and downstream linkages between different processes and activities that produce value in the form of products and services to the ultimate consumer" (Christopher, 1992:3). When providing integrated care, organisations such as the NHS and Social Services interconnect in order to provide care services to the ultimate consumer, often referred to as the patient or client. Processes such as diagnosis and treatment are considered 'value-added' activities and those which do not add value, such as queuing for a doctor, waiting to be discharged, or being reassessed by a different organisation should be limited in order to improve the efficiency of the supply chain (Towill, 2003). The purpose of virtually integrated care is to reduce non-value adding activities.

Crucially for the public sector, the lean approach disproves the prevailing view that the trade-offs between public service quality and cost are inevitable (Bhatia and Drew, 2007). In supply chain management it is widely acknowledged that the cost of a service can be reduced, without impacting negatively on the quality, by improving the efficiency and effectiveness of the process. The rising pressure that the ageing population places on public services is exacerbated by the economic pressure to reduce the cost of existing services, so doing more with less, whilst maintaining service quality, becomes essential. This is one of the main drivers for this research, and it pushes it towards supply chain management, where manufacturing companies have become experts at improving the efficiency of their supply chains in order to do more with less.

One way of viewing the healthcare sector from an supply chain management perspective is that, whilst a manufacturing supply chain moves products in order to process them, Health "moves processes to a spot to treat a person who needs them" (Hübner and Elmhorst, 2008:50). This quote is interesting as it helps us to see the supply chain for healthcare from a different perspective, whilst simultaneously reminding us that it is people that we are dealing with here, not products, and thus there is a greater element of unpredictability. This is further exacerbated by the fact that these people are ill and under stress, which has an influence on their behaviour, thus coproduction cannot be assumed (Meijboom et al, 2011). With a manufacturing supply chain, the power broker has a substantial amount of control over the specifications of the final product. However, in healthcare there are numerous other factors to consider, such as the physical and mental health of the patient, whether or not they follow the advice of the hospital and their tolerance to prescribed medication. In service operations management, "the participation of the client in the service production process will influence the whole process of service provision, from specification of the desired services to actual service delivery, e.g. from diagnosis of medical complaints to treatment by physicians and nurses" (Meijboom et al, 2011:168). Two patients could come into hospital with the same disease, be given the same treatment, and one could die whilst the other thrives. This can be outside of the hospital's control. Therefore, whilst there are lessons to be taken from supply chain management for the management of healthcare, some of the analogies are

fairly crude due to the complexities of human nature and the unpredictability of illness.

Nevertheless, integrated care implicitly requires the integration of operations, at structural, organisational and individual levels. Improving performance by coordinating along the supply chain is generally considered as one of the core issues of supply chain management (de Vries and Huijsman, 2011). Figure 5 demonstrates the three phases of supply chain integration. Currently, the whole system of care is at Phase 1, characterised by service fragmentation and local optimisation. However, there are pilots throughout England and Wales where working in partnership on a specific area, such as mental health (Gibb et al, 2002) or end of life care (Hockley et al, 2005), has led to a higher level of integration along the supply chain for care by placing an emphasis on coordination and shared responsibilities (Phase 2). However, very few of these studies provide an evaluation based on patient outcome (Cameron et al, 2014). Therefore, "although the related rhetoric is strong, the literature provides little evidence of the benefits and performance of supply chain initiatives" in healthcare (Lega et al, 2013:931).
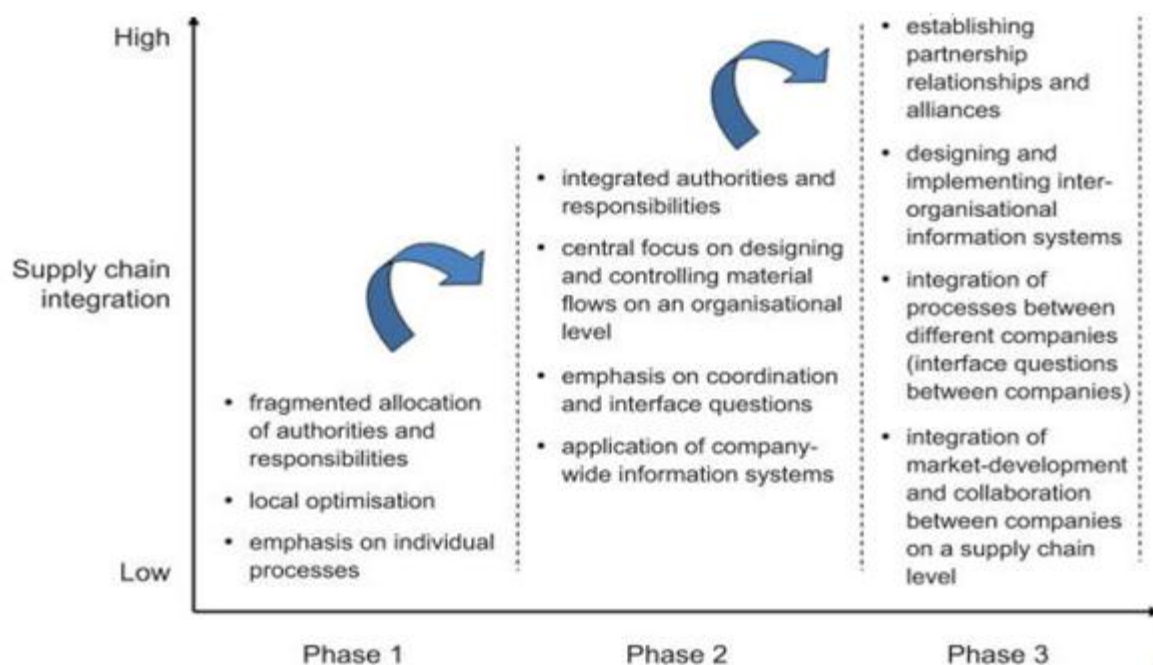
Figure 5: Supply Chain Integration (from de Vries and Huijsman, 2011)

Whilst issues exist within organisational boundaries, "their scale and frequency increase significantly when more care providers are involved" (Meijboom et al, 2011:170). The complexity of the supply network for care creates a barrier to achieving integrated care. Due to the number of organisations involved in the provision of care, the application of supply chain management theory to Health is almost by definition related to organisational aspects like relationship building, allocating responsibilities, and organizing processes (de Vries and Huijsman, 2011). Supply chain management emphasises the importance of frequent formal and informal communication between supply chain partners as an essential element of coordination (Tan et al, 2002). Processes need to be established to enable communication, utilising information technology where possible (Meijboom et al, 2011). This communication provides the basis for integrated services, both in terms of development and implementation.

Local authorities and Health are both huge organisations and, whilst some departments will be collaborating on a particular project, this often does not filter through to the whole organisation. Classical management approaches in Health have separated external partners into different systems, despite them all linking to make up the whole system of care (Rich and Piercy, 2013). Often departments within the health service or local authority will not be aware of the services that other departments are running within their own organisation, let alone others. Here lies the major issue with this type of work. Structural integration between all departments cannot happen without major change in government policy (Oldham, 2014). To achieve structural integration, the government would need to overhaul how Health and Social Care are funded and organised, and how they each conduct assessments and work out entitlements (Commission on the Future Health and Care in England, 2014). However, getting a few key departments to virtually integrate on certain projects could make a real difference to older people's lives. Currently there are no clear methods for developing a project aimed at achieving virtual integration across the whole system of care (Warmington et al, 2004). This research bridges that gap, by demonstrating how a combination of methods as part of an action research project were effective at integrating housing into the whole system of care for older people.

An example of an area where virtual integration across organisations can be beneficial is falls prevention. A third of people aged over 65, and half of those aged over 80, fall at least once a year (Todd and Skelton 2004). Hip fractures from falls cost the NHS an estimated £6m a day and this does not include the costs of other injuries or the cost of any ongoing care (Age UK, 2014b). Falls result in around 700,000 ambulance callouts a year, which is around 10% of all callouts (Department of Health, 2009). By communicating with local authorities and housing providers that falls are a major issue for the health service, these organisations could focus on prevention by informing people how to make their homes safer to avoid falls, drastically reducing costs caused by them. Following a fall, an older person will often lose their confidence and need reablement (provided by Social Services) in order to be able to live independently with minimal care. A study that the Kings Fund conducted in Torbay found that the cost of community care, social care and acute hospital care for someone in the 12 months following a fall rose by 70% when compared to the 12 months before the fall (Tian et al, 2013). Therefore, reducing falls is mutually beneficial to everyone, so numerous services operate in this area causing a large amount of overlap. By collaborating closely the overlap could be reduced and Health and Social Services could utilise housing providers to help inform people on how to reduce the risk of falling in their homes.

However, there are numerous barriers to virtual integration through partnership working across organisations, such as in the example just described. First of all there is the issue with approaching the correct people within the organisation. Spending cuts are making local authorities and the health service fluid in nature, with job losses and people taking on the work of others. Therefore, it can be very difficult to identify the right person to collaborate with, and then retain this relationship if it is not a statutory requirement. Secondly, financing a collaborative service is tricky in these cash strapped times, as organisations are struggling anyway and future savings are very difficult to demonstrate with preventative work. As a result of this, treatment still receives higher priority than prevention (Ham, 2012). Thirdly, the supply chain relationships of the public sector are complex networks, with each organisation having its own systems, enabling legislation, parliamentary portfolio, budget and management systems (Hodge and Coghill, 2007; Callender, 2011). Therefore, no one organisation has control over the whole supply network for the whole system of

care, making the change that is necessary in order to collaborate on a project difficult to orchestrate. This reiterates the barriers to integrated care, from a service operations management perspective. Finally, as previously discussed, there are currently no clear mechanisms or guidelines in place for developing a project into integrated care in terms of what works and what doesn't, putting a team together and ensuring that everyone on that team has a shared goal.

It is not yet possible to propose a supply chain management based framework specifically for integrated care. However, "combining a supply chain perspective with cross-functional and cross-organisational teams, continuous integration practices, lead time control, and appropriate information technology is promising at least conceptually" (Meijboom et al, 2011:171). The rhetoric is strong and lessons can therefore be drawn from operations management literature around these topics, but this area is not yet well established and the complexities of operations management for integrated care are not well understood.

2.4 Housing Policy

This thesis recognises that improving integration between Health and Social Services is essential as these are the entities that have the highest involvement and impact when it comes to providing care for older people. However, it also highlights that there is another essential entity in Housing, as Housing has an impact on a person's health and, due to contemporary community care arrangements, the majority of care currently happens in the home. The Care Act (2014) states, "Housing and the provision of suitable accommodation is an integral element of care and support... Getting housing right and helping people to choose the right housing options for them can help to prevent falls, prevent hospital admissions and readmissions, reduce the need for care and support, improve wellbeing, and help maintain independence at home" (Department of Health, 2014).

The Kings Fund is a charity which conducts research into Health and Social Care in order to inform government policy (The Kings Fund, 2014). The charity has been instrumental in making the case for integrated care, arguing that the current, fragmented system fails to meet the needs of the population and a more integrated approach would improve both patient care and efficiency (Ham and Curry, 2011;

Ham et al, 2011; Goodwin et al, 2012; Ham and Walsh, 2013). One of the key points in their summary of the necessary changes to the delivery system of Health and Social Care states that, the government should be placing greater emphasis on supporting people to maintain their independence in their own homes and offering a wider range of housing options (Ham et al, 2012). This highlights the importance of housing as an element of the whole system of care.

The importance of housing is often overlooked by Health and Social Services (Tinker, 1997; Clapham 1997; Hollywood, 2004). A report by the Housing Corporation recommends the development of flexible housing that is integrated with support and care services in order to meet people's changing needs (Clapham, 1997). Better, more flexible, links are needed between housing, care and support. However, many social service departments are reluctant to allow housing a full role in strategic planning (Clapham 1997). Language barriers between Social Services and housing are a common barrier to integration (Cohen, 2007). For example, the use of acronyms native to the department can make joint meetings quite difficult to follow.

The articles that discuss how Housing is being overlooked in the system tend to be older articles, so is this still the case today? More modern articles refer to Housing as being 'invited in from the cold' in current Social Care and Health policy documents (Tinker, 2004). This is also apparent when looking at government policy. "The 1998 White Paper (HM Government, 1998) identified a need for partnership between Health, Housing and Social Services for the development of successful community care services, and this was reinforced in subsequent policy documents (Office of the Deputy Prime Minister, 2006; Department for Communities and Local Government, 2008; HM Government, 2009) and by the Coalition Government in 2010 (Department of Health, 2010)" (Darton et al, 2012).

Modern housing policies with a focus on ageing do place an emphasis on the important role of Housing within the care system. Engand's 'Lifetime Homes, Lifetime Neighbourhoods' (Communities and Local Government, 2008) is a housing strategy which was developed with the ageing population in mind. As such, it was written in partnership between Communities and Local Government (CLG), the Department of Work and Pensions and the Department of Health. This shows an example of the

type of policy integration which those striving for integrated care are looking for, with the document including a section on how Housing, Health and Social Care should be reconnected (CLG, 2008). However, whilst this is certainly heading in the right direction, it provides a lot of anecdotal evidence about why Housing should be integrated with Health and Social Care, but with only limited practical guidance on how this can be achieved at a local level. Of that practical guidance, there is a focus on what Housing can do, for example, a toolkit for the development of housing with care (CLG, 2008a). Here lies the issue as housing departments can fight to be included in the system, but it is not going to work unless Health and Social Care enable the partnership. This is because Housing is not a powerful player in this supply network and is therefore unable to dictate the terms of integration. Going back to supply chain management, if a large manufacturing organisation such as Toyota wished to develop new tyres, their suppliers would be willing to support them in doing so rather than lose their contract, as not supporting their largest customer would put their business at risk. So power is very important when looking at supply networks. When it comes to the whole system of care, Health and Social Care are both much more powerful players in the supply network than Housing. This is because they are both large organisations whose entire ethos revolves around caring for people, they have a statutory duty to do so. Housing departments, although relevant to this system, also serve other functions, such as planning and development, managing building contracts, community development and improving energy efficiency of stock. Care is not inherently a core competency of housing associations, as it is a small part of what they do. Putting the onus on Housing to develop partnerships with Health and Social Care is therefore ineffective.

The follow up document to 'Lifetime Homes, Lifetime Neighbourhoods' states that the documents success will be dependent on effective planning and commissioning by local authorities and skilled delivery by public, voluntary and private sector organisations, on a local level (CLG, 2009). Whilst the government will support this, it requires a fundamental shift in funding steams and the way in which Health and Social Care work in order to get the most out of this strategy. These elements are currently outside of each local authority's control as Health is controlled by central government. Therefore, placing control with the local authority will only enable the strategy to be taken so far, as it is likely that only the housing department will be

taking notice of it; it is a housing strategy after all. But without the cooperation of Health and Social Care, each local authority has very little chance of achieving the vision set out in the strategy. However, the Department of Health have now identified that, "Housing is an integral part of the health and care system and a local authority's responsibility for care and support. This could be in relation to a local authority's duty on prevention or through the duty to assess an adult or carer's needs for care and support, or in providing advice and information" (Department of Health, 2014). The Care Act 2015 places more pressure on Health and Social Services to acknowledge the role that Housing has to play in the care system, and to work with Housing to improve care services (Department of Health, 2014)

Hillcoat-Nalletamby et al (2010) discuss how housing is already well integrated within the care system in Britain, when compared to France. The paper states that in England, "housing and its role in facilitating independent living and active ageing are explicitly articulated, whilst in France, the housing environment has until recently, been portrayed as one which must accommodate the illness, incapacity and dependency in later life" (Hillcoat-Nalletamby et al, 2010:808). This article concludes that housing is well integrated based on three of the main government policies on population ageing, which make careful use of language following the Personalisation Agenda, and thus place an emphasis on the individual being enabled to retain their independence. The emphasis is placed on the home as somewhere that older people feel comfortable. The home can act as a hub for health offering a safe and familiar environment, that the older people can return to when life outside the home becomes too demanding (Fange and Ivanoff, 2009).

However, whilst the importance of housing being integrated into the whole system of care has been identified in policy, it has so far not filtered down into practice. This can also be seen with integrated care, as a whole. Whilst it has been identified in policy for over 40 years that welfare services could be improved through joint working, there are still numerous barriers to integration, with research evidence failing to demonstrate the impact of joint working (Cameron et al, 2014).There is currently a discrepancy between providers of different types of housing and their relationships with Health and Social Services. Extra care housing, discussed later, is commonly being built in partnership between the local authority and housing

provider. However, other types of housing, such as sheltered housing, do not benefit from the opportunity to collaborate with Health and Social Services over a specific issue. More detail around the various housing types and integration in practice is provided later in this chapter.

On the one hand, it is an ideal time for Housing to integrate with the whole system of care, as the Care Bill and 'Caring for our Future' provide "opportunities and a new context to develop more active cooperation and engagement across Health, Social Care and Housing" (Chartered Institute of Housing, 2013). But on the other hand this is happening alongside "huge changes in the infrastructure, and funding of, health commissioning and delivery; major reforms for housing; challenges from demographic changes - the tsunami of ageing - and during a period of austerity that looks set to continue well into and possibly beyond the next parliament" (Chartered Institute of Housing, 2013). So, although the opportunities for integration are currently there, it is unlikely to be the main priority of Health, Social Care or Housing due to the current turbulence in public policy, resulting in other priorities.

The 'Personalisation Agenda' is an approach to social care, which is described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings" (Department of Health, 2008) . The agenda mentions Housing in one of its four themes, under choice and control (SCIE, 2013). It is for the most part about the integration of community services to improve adult social care, and Housing could have a key role in this as the majority of care happens in the home. Therefore, the Personalisation Agenda offers an excellent platform for integrating Housing and Social Services, as housing departments are also trying to offer personalised services and commonly now consult with tenants over decisions about their housing schemes. However, to date, very little has been written on how this integration is progressing.

The Personalisation Agenda has been developed from a Health and Social Care perspective; only two articles have been located which highlight the difficulties of adopting personalisation from a housing context. One discusses how offering tenants the choice to opt out of services may result in services no longer receiving the funding to be viable, due to a loss of economies of scale (Head, 2009). The other

is an account of personalisation in practice and the difficulties faced in untangling the bureaucracy between organisations, and even departments within organisations (Burton, 2012). Whilst this is very interesting, it concerns a small rural area so it is likely that the problems faced will be exacerbated in larger local authority areas. Burton argues that "the suggestion that care could be truly personal and community based threatens the whole social care structure and system"(Burton, 2012).

2.5 Why is Housing important?

There is currently government emphasis on ageing in place; it is what the majority of older people choose to do, with only 3% of all older person households moving each year (Pannell et al, 2012). This is because it has been recognised that "older people's ability to remain actively engaged in society will be enhanced if they can be helped to live independently in their own homes in familiar local environments" (Hillcoat-Nalletamby et al, 2010:809). Maintaining independence is a major policy driver because as a country, we are increasingly faced with a generation of seniors who have always lived independently and often live very far away from their family members, due to the global economy (Cohen, 2007). This has implications as older people may not have family nearby to help care for them when required, so it will have to come from elsewhere. Safety and security are key aspects when trying to maintain independence (Fonad et al, 2006). It is a person's home that enables them to feel safe and secure.

The push for people to 'age in place' presents a number of issues. Firstly, not all older people will be physically capable of maintaining their home, so will require support in the form of handyman and gardening services. They may also need adaptations to make their home work for their personal requirements. Secondly, older people are statistically more likely to need care. Therefore, enabling older people to live independently in their own homes has huge implications for Social Services. The Personalisation Agenda aims to tailor an individual's care and support to meet their own unique needs (HM Government, 2007). This should be regardless of the type of housing that the person is living in. However, that is not currently the case. For example, tenants of sheltered housing get support in the form of a warden service that people living in their own home cannot access. The carers going into the home depend on the contracts that Social Services have, unless the individual opts

to receive direct payments. Finally, ageing in place puts housing at the heart of welfare for older people, and consequently, housing needs to become a more central part of the broader welfare agenda (Hillcoat-Nalletamby et al, 2010). This supports the argument that housing needs to become part of the whole system of care for older people.

Statistically, older people spend more time in their homes than younger people, with very old people spending an average of 80% of their time at home (Fange and Ivanoff, 2009). Therefore, daily activities that are performed by very old people are predominantly performed in the home (Baltes et al, 1999). As daily activities become more of a struggle, the older person is able to adapt the home to better suit their needs. For example, they might put tea making facilities near to a chair so they can sit down whilst the kettle boils, or have a set cupboard layout so they do not have to waste energy searching for things. Living in their own home gives an older person the comfort and flexibility to make their home more functional as and when their health demands it (Fange and Ivanoff, 2009). This supports the argument for ageing in place, so that the older person can more easily adapt their surroundings as they need to, because their surroundings are familiar. Housing is an integral part of the social and physical environments of older people because it is representative of independent living, physical safety and access to social relationships and neighbourhood resources (Cohen, 2007; Pynoos & Regnier, 1991; Yeates, 1979).

However, for some people ageing in place is not an option. This could be due to their home not being suitable for adaptations, health deterioration resulting in high care needs or the breakdown of their social network, causing them to become isolated. One study which looked at tenants in a retirement home found that the most common reason for moving was accidents that occurred in the home, leading to lost feelings of safety and security (Fonad, et al, 2006). There is also pressure on older people to downsize in order to free up larger family homes for families (Age UK, 2011). So there should also be an element of choice, from smaller housing options such as bungalows, to housing with care or support such as sheltered housing, extra care housing or care homes. Older people should be able to choose between a variety of housing options in their local area, as this is in line with the Personalisation Agenda. Hillcoat-Nalletamby et al (2010) talk about the importance of 'familiar local

environments' for maintaining independence. This could also refer to the neighbourhood as opposed to just the home. If someone makes the decision to move, they still have familiar aspects as they can choose to move somewhere local that better suits their needs.

2.6 How can housing contribute to the whole system of care?

"Commissioners need to be made aware of the crucial role housing plays in the delivery of Health and Social Care services and the benefits and savings it can offer over the longer term" (Age UK, 2014a). When looking at the ways in which Housing can contribute to the whole system of care, it is necessary to look at the different housing options for older people living in the United Kingdom, and the ways in which each of these can, or do, contribute to the system. Popular housing options for older people include their own home, sheltered housing, extra care housing and care homes. This section will look at the current topics that the literature is focusing on for each of these types of housing and identify how they contribute to the whole system of care for older people.

2.6.1 Own Home

The term 'own home' refers to housing that has not been specifically designed for older people, whether the resident owns that house or rents it (privately or from the public sector). The vast majority of older people in England and Wales are owner occupiers, with the most recent census reporting that 75% of households with a Head Reference Person over the age of 65 were owner occupied (ONS, 2013). The census also showed that this age group were statistically the most likely to own their home outright (67% compared to 31% of the total population), as many will have paid off their mortgages whilst still working. This has implications for 'moving on' as the majority of specialist housing for older people does not have the option to buy the unit, so people who make that decision are often forced to go from being a homeowner to a tenant in rented accommodation. This is then a barrier to people moving into this type of housing. Some extra care schemes now offer units to buy, but then there is the issue with selling the unit on once the older person has passed away, as the unit has a much smaller target market and can only be used to house someone of a certain age, and usually with deteriorating health.

It is common to develop a sense of belonging in our homes and the stronger this is, the safer and more comfortable an older person will feel (Rioux, 2005). The Kings Fund's study into securing good care for older people provided multiple sources of research to provide evidence that staying at home in later life is the majority of people's preference (Wanless, 2006). But none of this research is as powerful or hard-hitting as the fact that 89.8% of older people choose to live in non-specialist housing, a significant proportion of the over 65's. This figure can be worked out based on the fact that only 7% of older people in the UK (530,000) live in specialist housing, excluding care homes (Pannell and Kenway, 2012), and the most recent census states that 3.2% of older people in the UK (291,000) live in care homes (Office for National Statistics, 2014). The majority of specialist housing for older people is social housing and 77% is available for rent only, which has implications for an older person's tenure if they opt to move into this type of housing (Pannell and Kenway, 2012).

Whilst research into specialist housing is invaluable, efforts should be focussed on improving preventative measures in order to enable older people to stay independent in their own homes. "Finding reliable help to take care of everyday household needs is all many seniors need to allow them to stay in their own home" (Cronkright, 2007). However, a study by the Royal Voluntary Service, revealed that the fragmented nature of families today, caused by divorce, labour migration, etc, mean that a lot of older people now live a long distance away from their children (Royal Voluntary Service, 2012). This raises concerns about the availability of family support and informal care (Tiomassini et al, 2004). Not living near to relatives can make it very difficult for an older person to access the kind of care Cronkright is talking about.

Funding and installing adaptations to the home are one way in which the government tries to enable people to remain independent. Disabled facilities grants (DFGs) are means-tested grants allocated to those who need adaptations to their home, as assessed by an occupational therapist. In the event of disability, three-quarters of older people would prefer to stay in their homes and have them adapted, instead of moving (Milne 1999). The report *Better outcomes, lower costs: Implications for Health and Social Care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence*, commissioned by the Independent Living

Review, identified that the provision of housing adaptations and equipment for disabled people results in significant savings to Health and Social Care budgets (Communities and Local Government et al, 2008). This is because installing adaptations can also help prevent further injury or disability as the assessors look for potential hazards and try to correct them when installing adaptations. A review by the Welsh Government, which involved interviews with local authorities, RSL's and service users, found that adaptations have a positive impact on the end user, are a cost effective use of public money and deliver on key policy objectives (Jones, 2005). However, on the downside, it is confusing to access DFG's and the process takes a long time (Jones, 2005). Wales has more recently been criticised by the Older Persons' Commissioner for Wales, for taking an average of 326 days to pay out DFGs (BBC News, 2012), demonstrating that obtaining a DFG is still a long process. Heywood (2001) found that minor adaptations had a positive effect on the health of 77% of respondents interviewed, however problems occurred when English local authorities try to use cheaper materials or substitute products as they are under so much pressure to cut costs.

Home care is provided by Social Services for people living in their own home and assessed as having a substantial or critical need for it. However, accessing support in your own home if you have lower level needs can be very tricky for an older person. Those living in their own homes do not have the access to the kind of support offered by a warden to people living in sheltered housing. This is a major inequality that should be addressed as the warden offers a preventative service, access to which could prevent an older person from having to move out of their home due to a deterioration in health.

Technology is also enabling people to stay at home when they might not have otherwise considered doing so. Telecare and other at-home monitoring systems are fitted to suit the lifestyle of the client. If there is a change in behaviour picked up by the monitors then a signal is sent to a call centre, who will phone the home to check the client is okay. If nobody answers, they will phone the client's emergency contact to go and check on them. This provides peace of mind for the older person, as well as for their family. But is support in the form of technology what older people want? Visiting support workers can provide a lifeline for a socially isolated senior

(Cronkright, 2007), but increasingly this type of service is being replaced by the cheaper, more technological option. Installing these technological aids is often presented to older people as 'the right thing to do' if you want to stay in your own home, but there is a paradox here as adding these technologies can change the feel of the home on an emotional, physical and virtual level (Neven, 2014).

Whilst staying in their own homes is clearly the favoured option for older people, there is much more that can be done to ensure that privately owned housing is part of the whole system of care. Currently, it is on the periphery of the system, with owner occupiers only entering the system at times of crisis, such as hospitalisation or following a fall. This leads to a high level of stress, as individuals only learn about the system when something bad has happened, which is far from ideal. Providing support for owner occupiers could offer them a trustworthy link into the system, someone to question about their options before they reach crisis point.

2.6.2 Sheltered Housing

Sheltered housing adds value over and above bricks and mortar as van Bilson et al (2008) found that tenants have a higher perceived sense of security, independence and quality of life when compared to people living in their own homes. Other studies have found that tenants of sheltered housing are overwhelmingly positive about their housing choice and value having an onsite warden (Nocon and Pleace, 1999). Sheltered housing can be viewed as a preventative housing option, as it combines the positive attributes of living in residential care, namely support, alarm system and appropriate accommodation, with the positive attributes of living in the community, such as privacy and independence (Kingston et al, 2001; van Bilson et al, 2008). Therefore, people who would no longer feel confident living in their own home can move into sheltered housing to prevent them from having to move into a residential home, where their independence would be likely to deteriorate.

One of the major issues with sheltered housing is that, due to community care arrangements, people can now receive the same level of care in their own homes as they would in this type of specialist housing. So why move? Cooper (2005) suggests that "people move into sheltered housing for a variety of reasons: to achieve peace of mind; or because of health deterioration, financial reasons, for security or to avoid loneliness" (Cooper, 2005). This quote serves to highlight the importance of the

community as a feature of sheltered housing. Field (2002) found that locally integrated social networks are most common in sheltered housing schemes, with those with private social networks reporting being lonely more frequently. This means that those who engage in the community of the scheme are less likely to suffer from loneliness than those that only socialise outside of the scheme, highlighting the effectiveness of the sheltered housing community. On top of this, sheltered housing is designed with older people in mind, so the housing is appropriate and can usually be adapted easily, making it flexible in order to respond to individual needs. However, some schemes are hard to let, which emphasises the importance of high quality housing and a good location (Nocon and Pleace, 1999). Good access to the local community is also essential to prevent tenants from feeling isolated (Field, 2008). The support that can be accessed in sheltered housing in the form of a warden is also a key defining feature of this housing type, as housing-related support is difficult to access elsewhere. Support could be better utilised to help integrate Housing into the whole system of care, through signposting of services and resources.

One of the main downsides with sheltered housing is the current changes to services that are taking place. Supporting People funding has changed and consequently, many housing associations are removing wardens from schemes and replacing them with floating support. The implications of this are discussed in more detail in Chapter 6. This housing option is not appropriate for everyone, with one study finding that tenants of sheltered housing often have unmet needs, particularly when experiencing psychological and social problems (Field, 2008). These can be caused by depression, activity limitations and dementia. This suggests that people living with a mental or physical disability may require more support than is offered by sheltered housing.

However, there is a high quantity of existing sheltered housing which needs to be utilised, despite it being considered a dated model. Therefore, many Registered Social Landlords with sheltered housing choose to apply some of the more successful traits of extra care housing to their schemes. Options include introducing an element of onsite care, improving lighting in corridors, upgrading facilities which might include adding wet rooms instead of baths, redecorating communal areas and

developing a cafeteria for tenants (Homes and Communities Agency, 2009). RSLs that adopt this approach commonly call updated schemes 'enhanced sheltered housing' or 'extra care light'.

Sheltered housing contributes to the whole system of care by offering a preventative housing option for older people, where they feel safe, secure and supported. It is a flexible option, where care can be bought in as and when it is necessary. Shared community spaces offer an opportunity for providing information to numerous older people at the same time and this is just one of the ways in which integrating Housing could benefit the whole system. This type of housing provides a level of support for tenants, which is difficult to access in other types of housing.

2.6.3 Extra Care Housing

The first thing to note when reading the literature on extra care housing is that there is no clear definition for what it actually is. Different providers place varying emphasis on the housing or care element, depending on what it is they are trying to promote (Croucher et al, 2006). The Department of Health (2004) state that extra care housing is a housing option that falls somewhere between traditional sheltered housing and residential care homes in terms of the levels of care and support available to tenants. There is however a common emphasis on promoting independence in private accommodation within a scheme (Darton et al, 2012). However, this is also true of sheltered housing. Usually, extra care housing has a care team based onsite which acts as a defining feature, and distinguishing it from sheltered housing. Often schemes also provide one meal a day to help integrate the community and keep tenants healthy. However, this is not the case in all extra care schemes, as research has found schemes to be idiosyncratic (Wright et al, 2010).

The lack of definition for extra care housing creates issues for customers, as people do not know what schemes offer which makes it difficult for older people, their relatives and social workers to decide whether extra care is appropriate (Wright et al, 2010) . Older people usually want to stay in their own homes and often only move once they reach crisis point, making it essential that clear guidelines on their housing options are available to them.

It is important to note that without future funding from the governments' Social Housing Grant for further extra care housing schemes; it is likely that the rate of growth of this type of housing will now slow. Between 2004 and 2010, the Department of Health's extra care housing fund provided local authorities, Social Services and housing associations with £227 million of capital funding in order to encourage them to build these innovative schemes in partnership with one another (Department for Communities and Local Government, 2008; Department of Health, 2003, 2005). The fact that this funding stream has now gone limits the amount of extra care housing available in the UK. One study found that for every unit in extra care, there were approximately sixteen units in care homes (Dawson et al, 2006). Therefore, it is not a housing option for all older people whose needs might be met by it.

Extra care housing is interesting because it is an example of a housing option for older people that is already integrated with the whole system of care. "While there are many staff working in housing with care services (extra care housing), there are other practitioners who 'drop in and out', such as visiting NHS practitioners, locum doctors, paramedics or other specialist staff" (Manthorpe and Moriaty, 2011). On top of this, extra care housing usually has an allocations board, where Housing, Health and Social Services are all represented. These boards discuss who will be offered a place in extra care. However, due to the lack of definition, each scheme has different criteria that they use. This can make it very difficult for people to know whether they are eligible for a place (Wright et al, 2009). A common model is to aim to have one-third of tenants with low care needs, one-third with medium care needs and one-third with high care needs to help balance staffing (Wright, et al, 2010). Whilst this is a logical approach, it is not easy to establish what an individual's care needs will be once they move into the scheme. It is common for people's level of care to be reduced once they have moved in due to their improved physical environment (Wright et al, 2010). With changes to older people's health happening frequently, maintaining the balance of individual's care needs in extra care housing is very difficult (Darton, et al, 2012).

However, despite its difficulties, extra care housing is still a good option for older people. One study found that the move to extra care reduced tenant's unmet need,

with them experiencing improved quality of life, better social care outcomes and improved access to healthcare services (Bäumker et al, 2010). The improved access can be attributed to increased staff contact and support, meaning that staff are signposting other services to tenants to help improve their wellbeing. The majority of tenants interviewed in one study stated, "they had not experienced any problems with the services they received within the scheme" (Blood, 2012). Extra care housing contributes to the whole system of care by providing us with the only clear example of how the integration of housing into the system can benefit both tenants and local services. Whilst care homes are integrated into the system, the mechanisms for this integration are not clearly documented in the literature, whereas with extra care, they are. Extra care housing has become the preferred term for integrated housing with care in the UK (Bäumker et al, 2010; Laing & Buisson, 2009).

Health, Social Care and Housing all work together in the development and building of extra care housing (Burlumi and Tuck, 2008). A study in 2006 highlighted that "authority respondents reported that the most influential factor that encouraged and fostered the development of extra care housing was good working partnerships between Social Services and housing departments" (Dawson et al, 2006). The housing department needs to work with Social Services to ensure that the layout of the scheme is appropriate to meet tenants' and staffs requirements flexibly. This can help to prevent costly design mistakes.

Extra care housing contributes to the whole system of care as a housing option that offers a level of support and care between sheltered housing and residential care homes. As schemes are often new builds, and are therefore desirable places to live, they offer an option for the wider population who make a planned move instead of reaching crisis point (Darton et al, 2012). Extra care housing also contributes to the whole system of care on a theoretical level, as it is a model of housing that is already integrated into the system, through clear mechanisms including development and allocation management boards. It is possible to take lessons from the extra care model and apply them to other housing models to aid integration.

2.6.4 Care Homes

The term 'care homes' covers both residential and nursing care homes. In a residential home, the resident usually has their own accommodation and care staff

are on hand 24/7 to offer personal care, such as washing and dressing, whereas in nursing homes there are also qualified nursing staff onsite (Age UK, 2013). If someone requires specialist care in a residential home, the local GP or District Nurse is usually called in. Around 71% of care homes only offer residential care (Goodman and Woolley, 2006).

The contribution of care homes to the whole system of care for older people is important. They offer a place to live for older people who can no longer look after themselves in their own homes, and who need a higher level of personal care than that which can be offered by Social Services. That is to say that they require someone to care for them for more hours than Social Services are able to offer. Whilst extra care also offers round the clock carers onsite, these carers are often not able to offer the high level of personal care that people can access in care homes. This is because extra care housing is not commonly staffed to meet this demand, whereas care homes are. However, very little is known about the specific details of care provided in care homes, such as how much is provided and whether it is effective (Woolley and Goodman, 2001). This is still the case today, and this gap in the research can be attributed to the fact that vulnerable adults are difficult to access for research purposes, with family and carers preventing them from being involved in any research that could prove burdensome or at all detrimental to their health and overall wellbeing (Moore and Hanratty, 2013). Perhaps if this research was conducted, extra care managers could learn from it and establish different care worker patterns to enable a higher level of care and prevent people from having to move on to care homes. Care homes also offer respite which reduces bed blocking in hospitals, as patients can recover in a safe environment somewhere with onsite care.

However, for many people, moving into a care home is not a desirable option. Negative aspects of care home life are often highlighted in the literature, "some would rather die than move to a care home [citing a] lack of privacy and dignity, regimented routines and a feeling of emptiness can affect a person's sense of control" (Bradshaw et al, 2012:429). This is confounded by horror stories of abuse in care homes that are often in the media. One study found that whilst excellence does exist in nursing homes, it is unclear how commonplace this is, which is not

acceptable when we have an evidence-based health service (Turrell, 2001). "Poor housing combined with poor health is cited as a key reason for people moving to care homes prematurely" (Communities and Local Government et al, 2008). This highlights the 'end of the road' view that people have of care homes, as they are somewhere that people move to once their housing can no longer support their needs due to a deterioration in health.

There is very little research that describes the involvement and contribution of primary health care services in care homes, despite policy and research concerns about the necessary improvement of care for vulnerable tenants (Goodman et al, 2003; Szczepura et al, 2008). District nurses and GPs' work very closely with care homes. However the partnership between the organisations is not mapped out, either in the literature or in policy. One study found that district nurses and care workers shared a lack of consensus about their roles, with district nurses often taking much longer on visits to care homes as care staff used the opportunity of them visiting to ask for advice on other residents (Goodman et al, 2003).This suggests that the care staff do need more support, but as this is unscheduled the implications that it has on district nurses' workloads are huge. The Department of Health state that care staff should be supported and trained by nurses, so that they are able to improve the quality of the care being given to older people (Department of Health, 2001). However, this needs to be factored into their workload instead of being included on an ad-hoc basis to ensure quality.

"Although some needs may be met through the care provided within homes themselves, it is recognised that residents will require models of care that can provide contributions from medical, nursing, pharmaceutical and other services" (Szczepura et al, 2008:32). This quote highlights that residential homes are part of the whole system of care, with close links to Health enabling them to offer residents an appropriate level of care. However, this integration is not without its issues. In a series of focus groups conducted by Meehan et al (2002), the groups had a general feeling that hospital staff have a low opinion of care homes and the tasks that can be carried out by staff, resulting in care home nurses feeling like they were operating outside of the nursing profession. Although problems are apparent, Anderson (2004) found that having specialist nurse teams in care homes resulted in better care for

tenants, as they were able to build up relationships with care workers, share their knowledge and identify areas of clinical practice that would benefit tenants.

2.7 Summary

The review of the literature on integrated care has demonstrated that whilst it is widely accepted that both Health and Social Care are in financial trouble if they do not start working together, there are numerous barriers to achieving this. Leutz's 'Laws of integration' summarise these barriers succinctly and ultimately suggest that structural integration is not feasible. It is assumed that structural integration would be the most effective form of integrated care, however, multiple authors are now exploring the virtues of virtual integration as a more feasible and effective approach (Ham and Curry, 2011; Goodwin et al, 2004). Those trying to achieve integrated care should therefore be focusing on virtual integration at a local level. This is the approach taken in this research, whilst drawing ideas from the Carmen framework for integrated care (2004). There is also a gap in the literature on how to achieve effective partnership working for integrated care, which provides a barrier for virtual integration. This thesis bridges that gap.

Operations management theory and practice has a role to play in the development of integrated care, as the necessity for collaboration, relationship management and communication across the care market demonstrates similarities with the more traditional applications of operations management. The supply network for care is a complex network, characterised by large organisations, complicated funding streams and no clear power broker or established strategic direction across the network. Whilst the rhetoric between manufacturing and healthcare is strong, applying operations management theory to integrated care should be approached with caution due to the unpredictable nature of people and disease.

This chapter asked the question 'Why should housing be integrated into the whole system of care for older people?' The answer, as demonstrated throughout the chapter, is that housing has such an essential role to play in older people's health and wellbeing. The current emphasis on 'ageing in place', both through policy and because it is what older people are choosing to do, means that housing has become

the place in which care is carried out. On average, older people spend the majority of their time in their home, so the home environment has a big impact on wellbeing.

However, the review of the literature about the various housing options highlighted that not all housing types are currently integrated into the whole system of care for older people. Housing that has an emphasis on the provision of care, such as extra care housing and care homes, do tend to work closely with Health and Social Services on a variety of issues, such as allocations and tenant care, thus are already integrated into the system. However, housing options that do not have a care element, such as sheltered housing or non specialist housing, are not currently integrated into the system. However, policy does not distinguish between types of housing when discussing the role housing plays in achieving integrated care, as people can receive care in any type of housing and the home environment has an impact on a person's wellbeing. The Older Persons' Commissioner for Wales put it succinctly when she stated:

"Integration is not integration if housing is not included. The places where people live are one of the key deliverables of their overall health and wellbeing. Failure to fully see housing as an equal partner in the integrated care agenda will lead to a failure to deliver integrated care" (Rochira, 2013).

The policy discussed in this chapter has highlighted that government in the UK acknowledges the important role of housing in the whole system of care for older people. However, there are very few practical solutions for how this integration can be achieved. This thesis aims to contribute to this gap in knowledge, by offering a solution to how to integrate Housing into the system. This solution has been implemented through Conwy's Older Persons' Housing Strategy and the rest of this thesis will be looking at the partnership approach taken to arrive at this solution, and explore it further.

Chapter 3: Methodology

3.1 Introduction

This research used participatory action research, working in the county of Conwy to help research and develop their Older Persons' Housing Strategy (OPHS). The local authority initially stipulated that the researcher would need to be responsive to the needs of the developed Steering Group and therefore an emergent; action research approach was adopted, in order to improve flexibility. More details about how the Conwy case study was conducted, case study objectives and Steering Group are detailed in Chapter 4. This chapter introduces some of the key concepts of the action research approach taken, discussing the philosophical assumptions behind action research and seeking to justify the use of this approach in this context.

3.2 Action Research

Action research has been defined as "a participatory, democratic process concerned with developing practical knowledge in the pursuit of worthwhile human purposes, grounded in a participatory worldview" (Reason and Bradbury, 2001:1). This highlights the importance of the involvement of participants and the necessity for the research to be useful from the perspective of social science. From the initial development of this PhD, and the guidance laid out by the funders, it was clear that action research would be appropriate, as the funders wanted to use the research to stimulate change in the county of Conwy. Unlike traditional research which looks for generalisable explanations that are applicable in multiple contexts, action research enables to researcher to develop a localised solution which focuses on a specific situation (Stringer, 2007). For this particular case study, this culminated in the development of the OPHS, which included action plans to stimulate change to the whole system of care in Conwy (see Appendix). Using action research enables the researcher to navigate the complexity of a specific situation, by using a combination of methods appropriate to that situation and triangulating the results to ensure academic rigour.

The classic way to do action research is to collect and analyse data about the nature of the problem, take action to change the situation and observe the effects to inform future actions to improve the situation (Hayes, 2007). So at its most simplistic level, action research involves the four stages demonstrated in Figure 6. It is a cyclical process, designed so that future actions learn from, and potentially build on, past actions.

Plan
Thinking through and developing our intention to act

Act
Intervene in complex social processes

Observe
Finding out what happened as a result of our actions

Reflect
Cognitive, sensual and emotional sense making
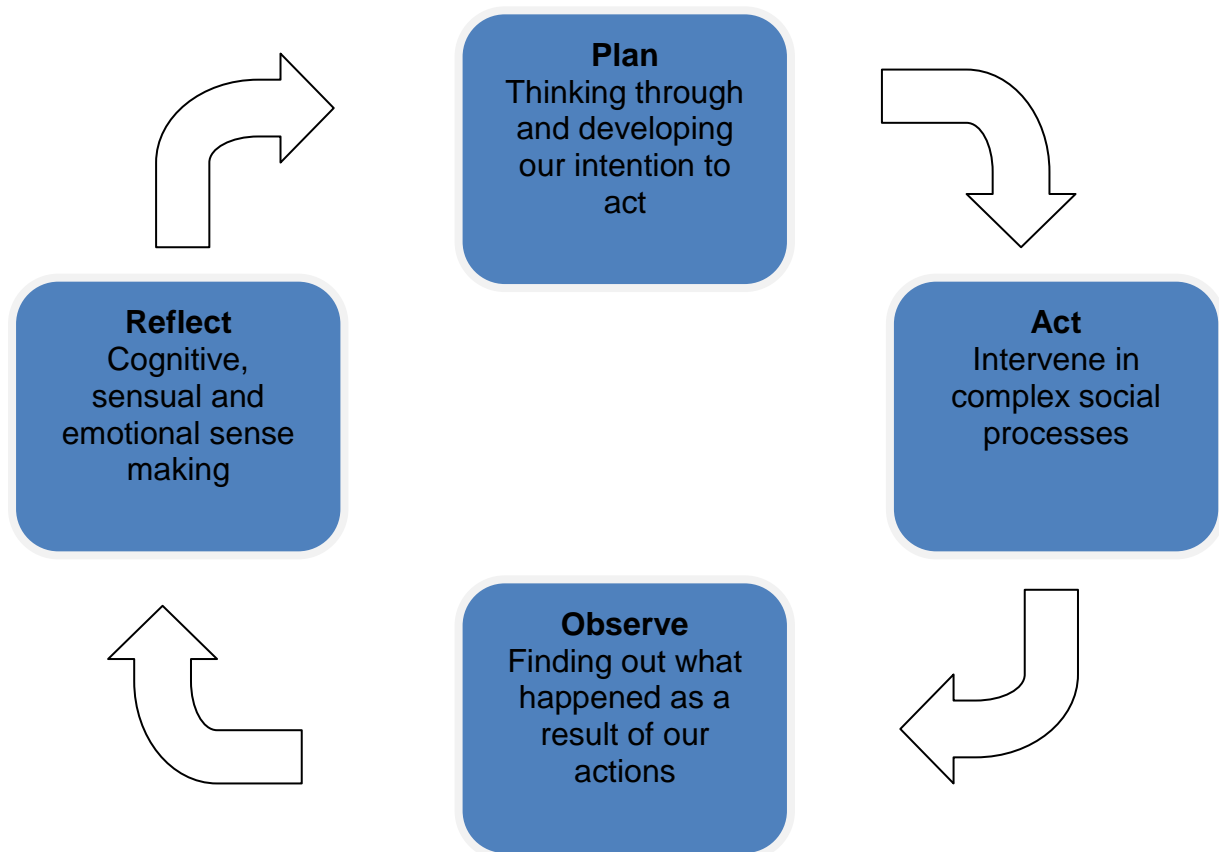
Figure 6: Action research process, adapted from Burns (2007)

Action research is a common choice for research in Health and Social Services, as the four stages commonly "mirror the iterative processes employed by professional staff in assessing the needs of vulnerable people, responding to them and reviewing progress" (Hart and Bond, 1995: 3). Therefore, professional staff are familiar with this approach as they use it daily in practice. Healthcare professionals commonly come across social issues that are beyond the scientific and technical requirements of their roles, for example, patients may seem unconcerned about aspects of their lifestyles that are lowering their life expectancy, such as smoking or not eating a balanced diet (Stringer, 2007). It is not uncommon for health professionals to

conduct their own action research in areas where science gives a limited explanation, as they have access to patients that other researchers struggle to obtain due to data protection. This demonstrates that action research "goes beyond the notion that theory can inform practice, to a recognition that theory can and should be generated through practice" (Brydon-Miller et al, 2003:15).

Action research "combines inquiry with action as a means of stimulating and supporting change and as a way of assessing the impact of that change" (Burns, 2007:11). In that sense, it is not a methodology, but a combination of methods designed to make sense of a situation. This particular case study used soft systems methodology (involving informal interviews and observations), focus groups, and a survey in order to make sense of the current situation in Conwy. Further explanation of these specific methods, and some of the implications of using them, is included in later chapters. The information gathered was then used to develop an Older Persons' Housing Strategy; which would help to move the county towards integrating Housing into the whole system of care for older people. It was participatory action research (PAR) as it involved collaboration with the key stakeholders, who were all made members of the Steering Group. Those using participatory action research believe that research should be done 'with' people instead of 'to' or 'on' people (Reason and Bradbury, 2008; Chevalier and Buckle, 2003; Whyte, 1991; Herr and Anderson, 2005). Action research therefore enables the researcher to work in partnership with the people for or with whom the research is being carried out, sharing the research aims, practices and findings (Wisker, 2001). PAR is a form of knowledge exchange that links participation, action and research, as demonstrated by Figure 7 (page 77).
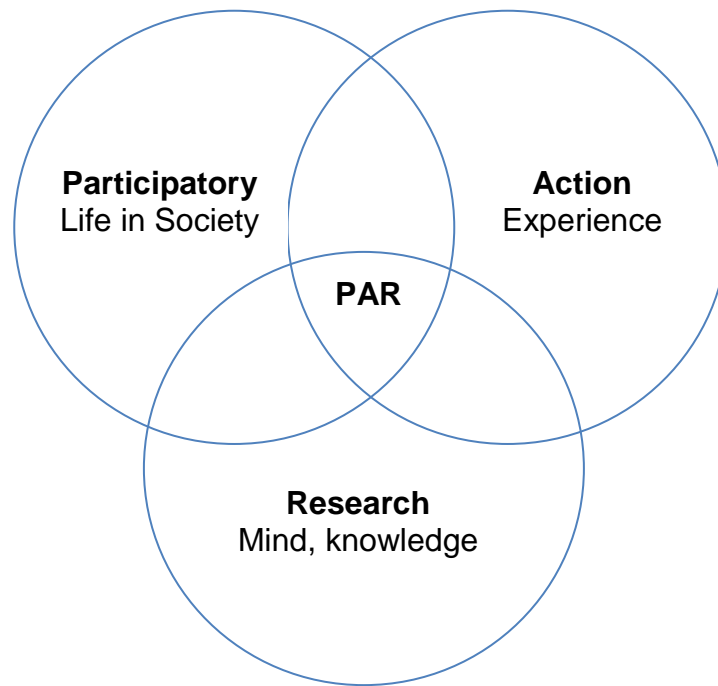
Figure 7: PAR framework, adapted from Chevalier and Buckle (2013:10)

In participatory action research, the enquirers become co-researchers alongside the researcher, in order to add depth to the enquiry through their experiences (Reason, 1998). The stakeholders, who are affected by the problem situation, should participate in the inquiry process by gathering data, reflecting on the information, and ultimately transforming their understanding of the situation (Stringer, 2007). The researcher acts as the facilitator of this progression, by co-ordinating the data collection and collating or analysing the information so it is in a suitable format for the stakeholders to reflect on it. This provides a more comprehensive picture of the topic being studied, by drawing on the experiences of the experts on the topic. One individual may struggle to see a situation from multiple viewpoints so by involving multiple stakeholders, more viewpoints can be considered and a more constructive analysis can be formulated, leading to a comprehensive understanding of that situation.

For example, during the case study, the researcher worked with professionals from Social Services (amongst others). Instead of conducting action research, the researcher could have read about Social Care policies in Conwy to develop an understanding of this aspect of the research. But she had not worked in this complex area and policies and other secondary sources are limited in what they can tell us about what is really going on, on a day-to-day basis. By including people from Social

Services in the Steering Group, these people became co-researchers, resulting in a wealth of in-depth information. With a system as complex as the whole system of care, this was invaluable to developing this research and understanding the system in Conwy. By considering the Social Care teams perception of Housing, Health and vice versa, a picture can be built up of the system that would not have been possible without the involvement of the co-researchers. The approach is effective at making sense of a complex system, such as the one studied in this case study. The organisations involved in this system, including health, the council and numerous registered social landlords (RSLs), all have a complex structure, numerous funding streams and often unclear communication channels. Therefore the researcher needed to adopt a method that would help make sense of this complex system, leading to action research which considers the system holistically and is thus grounded in systemic thinking.

Systemic thinking is a way of thinking about systems by considering and accounting for the whole (Burns, 2007:21). This is key to this case study, where it is necessary to consider the whole system of care for older people as it enables us to make connections that we might otherwise have missed. "A systems approach necessarily underlies action research in all its manifestations. Both rely on an interconnected and holistic view of the world" (Greenwood and Levin, 2007:59). Without considering the system as a whole, it is difficult to identify appropriate integrating functions; it is important to understand the elements of the subsystems that we are trying to integrate before presenting solutions. Systemic thinking is not an approach to action research, but instead a grounding for action research, to help to develop both broader action and deeper research (Flood, 2001).

One way to conduct participatory action research is to adopt a soft systems methodology in order to help make sense of the complex system being studied. This is a systematic approach to understanding a problematic situation, breaking it down and capturing all of the various worldviews of the people involved (Checkland and Poulter, 2006). Soft system methodology (SSM) was used in order to develop a picture of the whole system of care from different members of the Steering Group's perspectives. By looking at the system from the different perspectives of the people

involved, we are able to create a much fuller picture. The SSM approach used is detailed in Chapter 5.

Although other counties were considered during one of the case study objectives, this research mainly focuses on the single case study of Conwy. This is because local authorities vary widely in their housing availability, population, health services, structure of Social Services, and so on. As this research takes a wide view in order to help establish a whole system of care, the case is unique. Yin presents five 'rationales' which justify the use of single-case designs, one of which is that the case is 'unique' (Yin, 2009:47). This is fairly typical of action research as "the bulk of action research takes place on a case by case basis, often doing great good in a local situation but then failing to extend beyond the local context" (Brydon-Miller et al, 2003). This results in difficulties generalising from an action research project.

However, areas where the focus was more narrow, for example, when investigating and analysing different support structures in sheltered housing, the researcher had the opportunity to explore other local authorities, producing some generalisable analysis from the action research by widening the scope of the data collection. It is important to acknowledge that this would not be appropriate with a broad research question as different cases would not be comparable when accounting for the complexity of the whole system of care. But as the question around support structures was narrowly focused, it was appropriate to consider other cases. Widening the scope for data collection ensured that the research had implications beyond the case study, which is identified as an important characteristic of action research (Eden and Huxham, 2002). This is important in ensuring that action research is recognised as a valid and appropriate form of inquiry.

3.3 Philosophical Assumptions

"The social sciences are about people and the relationship between individuals and the social world in which we live" (Woodward, 2003:i). The fluidity and complexity of the social world and its relationship with human behaviour makes it difficult, if not impossible, to study using the same quantitative methods that are applied in the natural sciences. With regards to social science, quantitative researchers focus on measuring behaviour, as opposed to understanding it from a social perspective

(Todd et al, 2004). This limits quantitative research to understanding and measuring the results of behaviour, instead of the causal reasons behind it. This research method is therefore limited in social science by the positivist philosophy that it is built on (Westerman, 2006). Although quantitative methods are often used in social science, such as surveys, questionnaires or structured interviews, the results have a limited amount of depth and usually fail to tell us the reasons behind the participant's response or behaviour.

The alternative is qualitative research which, due to its subjective nature, is often the method of choice when seeking to understand social phenomena within the context of an individual's perspectives and experiences (Silverman, 2006). Qualitative research is based on interpretivism, which assumes that reality is socially constructed and changes over time and therefore results in multiple truths (Sale et al, 2002). This is based on the anti-foundationalist position which argues that our interpretation of social phenomena affects outcomes; social phenomena do not exist independently from our interpretation of them (Furlong and Marsh, 2002). However, the use of qualitative research to aid in the development of social policy has only begun happening recently, as policy-makers have traditionally relied on statistics and numbers to provide evidence and thus always used quantitative research (Richie and Lewis, 2003).

Both quantitative and qualitative methods are commonly used in action research, as this approach "is not so much a methodology as an orientation to inquiry that seeks to create participative communities of inquiry" (Reason and Bradbury, 2001:1). However, mixed methods are problematic from a philosophical perspective. Qualitative and quantitative research methods have evolved from different paradigms and are therefore incompatible as they do not study the same phenomena. Quantitative research is a positivist approach based around the ontology that there is just one truth, an objective reality which is independent of human perception (Sale et al, 2002). Epistemologically, the researcher and their participants are independent of one another and therefore the research remains objective. This means that the phenomena being researched and the researcher have no influence on one another (Guba and Lincoln, 1994). Qualitative research is an interpretivist approach which suggests that there are multiple truths because

reality is socially constructed and changes over time. The epistemology of qualitative research is that there is no reality outside of that created by ourselves, therefore research is highly subjective.

From the literature, there are a number of arguments about mixed method research. The way an individual views mixed methods depends on how they view quantitative and qualitative methods. If the researcher takes a philosophical perspective then it is not appropriate, or even possible, to mix the two due to their opposing ontological positions. This is a purist viewpoint (Doyle et al, 2009). As the methods evolved from different paradigms, they do not study the same phenomena (Sale et al, 2002). The objectivist and interpretivist ontology's underlying each method are commonly presented as incompatible opposites as each position rules out the other (Matthews and Ross, 2010). However, this issue is so deeply rooted in philosophy that it is unlikely to be resolved in the near future (Miles and Huberman, 1984). A more pragmatic approach is required in order to progress the action research agenda and ensure that research has an impact on society.

From a technical perspective, Carey (1993) argues that quantitative and qualitative techniques are just tools and integrating them enables researchers to answer important questions more comprehensively than we could with just one approach. As tools, the quantitative and qualitative methods can work well together and technical issues such as the appropriateness of methods to answer the research question and ensuring the data is compatible should be the focus. People conducting research used for practical purposes, such as action research into Health and Social Care; tend to support this view without considering the philosophical implications. Howe (1988) argues that "truth is what works" and so we should forge ahead with what works. Pragmatists, who are not deeply rooted in either paradigm, move forward with mixed method research on this basis. Bryman (2006) found that there are a rising number of pragmatists in social science research, with only 6% of the 232 mixed method articles he examined raising the epistemological and ontological issues involved in combining qualitative and quantitative research. This suggests that mixed methods are becoming more widely accepted, despite their underlying philosophical issues.

Whilst this particular case study only used qualitative research methods, the debate is still relevant in demonstrating how the participatory worldview has begun to come to the forefront for action research. Participatory action research sits within the participative worldview (Reason and Bradbury, 2001). This worldview is subjective-objective in that it "accepts there is a given cosmos, a primordial reality, and that human presence actively participates with it" (Reason, 1998:4). It is therefore a compromise between the positivist and interpretivist paradigms, accepting that reality exists outside of human perception (objective), but also acknowledging our interaction with reality; our role in shaping, perceiving and researching it (subjective). The participatory worldview highlights that "research into our ways of life cannot be conducted in the same, value-free way as in the natural sciences" (Shotter, cited in Brydon-Miller et al, 2003). Epistemologically, we should seek to understand things through our experiences, and the experiences of those around us. This is arguably better suited to the study of social sciences, where human behaviour inevitably has an impact on both the researcher and the research topic. Our knowledge will be improved and more valid "if our knowing is grounded in our experience, expressed through our stories and images, understood through theories that makes sense to us, and expressed in worthwhile action in our lives" (Reason, 1998:4). This enables the research topic to be considered holistically, commonly using qualitative methods but also drawing on quantitative data to add rigour to the approach and improve generalisability to areas of the research which are narrower in scope.

The primary purpose of action research is to "produce practical knowledge that is useful to people in the everyday conduct of their lives" (Reason and Bradbury, 2001:2). The use of the word 'useful' here has positive implications for using action research to study social science, as 'action' is an inherent part of action research and thus this can be an attractive way of conducting research for funders. Action research gets things done. Reason and Bradbury (2001) go on to argue that the wider purpose of action research is to use the practical knowledge that has been produced to contribute to the wellbeing of humans and communities. The development of the Older Persons' Housing Strategy will mean that Conwy has guidance on how to shape their housing and associated services to better meet the needs of older people, thus improving wellbeing in the local community. Action

research bridges the divide between theoretical management research and the usefulness of that research for organisations (Zhang et al, 2015).

3.4 Summary

This chapter has justified the action research approach taken to complete this research. Participatory action research is research combines inquiry with action, thus making it high impact. Those who funded the case study research were keen for the work to have an impact on the whole system of care in Conwy, initially stipulating the work should have an output of an Older Persons' Housing Strategy for the county.

Action research is grounded in a participatory worldview, which is a compromise between the positivist and interpretivist paradigms. A participatory worldview argues that we should seek to understand through our experiences, and the experiences of others. Participatory action research places an emphasis on the importance of using the stakeholders who are affected by the problematic situation as co-researchers. This is because they have a better understanding of the situation than an external researcher as they are experiencing it on a regular basis. However, one stakeholders perception of the situation may differ from another's, due to their different experiences of that situation. Therefore an effective action research project will involve multiple stakeholders as co-researchers. This is another reason why action research was an appropriate approach for this case study, as the stakeholders were becoming increasingly frustrated with the problematic situation and thus were motivated to engage as co-researchers and provide access to their organisations. Obtaining access in research into Health and Social Services is notoriously difficult, therefore this early and willing engagement was a key factors to the success of this research.

Finally, the complexity of the problematic situation also justified the action research approach taken. As discussed in Chapter 2, the whole system of care is made up of a complex network of subsystems with unclear communication channels. Action research is a process of inquiry that is suitable for complex, 'messy' problems. By involving stakeholders as co-researchers, a more comprehensive picture of these problems can be developed, through their experiences. This can be used to inform action to positively change the situation.

Chapter 4: Case Study and Establishing Objectives

4.1. Introduction

The action research project that this thesis was based on was conducted in Conwy. This chapter provides an introduction to the case study and demonstrates how the research objectives were developed based on the operational case objectives for this work. The aim of the action research was to develop and write Conwy's Older Persons' Housing Strategy by working with the stakeholders to ensure the document was both comprehensive and feasible to implement. During this research, there were three main 'actions', meaning the common action research cycle of plan, act, observe, reflect (see figure 7, page 77) was completed three times:

1. Develop the Older Persons' Housing Strategy for Conwy (Year 1)
2. Take the Older Persons' Housing Strategy through Conwy's consultation process and alter accordingly (Year 2)
3. Implement the Older Persons' Housing Strategy for Conwy (Year 3)

This research took place over a three year period, from February 2011 to January 2014. The project was funded on an annual basis, based on the progression from the previous year.

4.2 Case Study Background

Conwy County Borough Council went through stock transfer in 2008, transferring ownership and management of all of their housing stock to Cartrefi Conwy. Cartrefi Conwy is keen to work closely with the local authority and thus wanted strategic guidance on what to do with its sheltered housing stock, which makes up one-third of its stock profile. With the emergence of two extra care housing developments in Conwy, and two more in the pipeline, Cartrefi Conwy were keen for the council to develop an Older Persons Housing Strategy (OPHS) in order to provide strategic guidance. In particular, they wished to find out if their sheltered housing stock was

still fit for purpose and if so, what lessons could be taken from extra care in order to improve the experience of tenants. Whilst the local authority approved of the idea, they could not find the resources to develop the strategy internally, due to funding cuts. Therefore, Cartrefi Conwy offered to fund a researcher for a year to develop the strategy. This enabled the council to utilise someone who had the time and the resources to spend on the project, something which otherwise would have been an issue in these times of austerity.

The researcher, PhD supervisor, Head of Housing Strategy for CCBC and Operations Manager for Cartrefi Conwy met frequently during the proposal phase, in order to develop case study objectives to be approved by the Steering Group. The researcher highlighted that she was from an operations management background and had an interest in care systems and how to run them efficiently, having previously done research into efficient provision of reablement. The reasons why it is important for housing to be integrated into the whole system of care for older people have been identified in Chapter 2. Early discussion with this project team highlighted that housing providers in Conwy were generally kept out of the loop, despite being well placed to advise tenants on how to access Health and Social Care services. If a tenant received care from Social Services, the housing association would only become aware of it if the tenant told their warden. Housing was not integrated into the whole system of care in Conwy. Therefore permission was granted to look into ways to integrate Housing, alongside developing the strategy.

A Steering Group was established in order to offer a platform from which all key stakeholders could have an input. The group met quarterly so that the researcher could present findings, offering everyone the opportunity to feedback and discuss the direction of the research. Following the initial year, each of the registered social landlords (RSLs) sitting on the Steering Group and CCBC decided to fund the remaining two years of the PhD, enabling the researcher to take the strategy through the consultation phase and start the implementation of the action plans.

This structure for the action research provided the researcher with access that would not have been possible otherwise. The local authority acts as the power broker in this supply chain, so being affiliated with them opened up the fragmented supply chain to the researcher. The stakeholders were involved from the start and all had a

vested interest in the strategy, so wanted to be able to shape it, ensuring cooperation from all relevant parties.

4.3 Case Study Context

Conwy has the largest proportion of people over 65 of any county in Wales. The proportion of older people in Conwy increased from 23.1% in 2001 to 24.4% in the 2011 census (CCBC, 2012). It is important to the local authority and RSLs that sheltered housing offers something different from that of accommodation such as extra care, so that older people have choice with regards to housing options. It is essential that a wide range of housing, with various levels of care, are available to meet the variation in the needs of older people (CLG, 2008), especially in Conwy where there is such a high percentage of over 65's. Over the next decade, the post-war baby boomers will reach retirement age, so the number of people over 65 in Conwy is going to increase by 30% (Statistical Focus Wales, 2008). The number of people over 85 is predicted to increase by 60% by 2025. The Older Persons' Housing Strategy was developed as part of this project, to ensure that CCBC is prepared to meet the housing and support needs of these growing age groups.

The average proportion of over 65's in Wales is 18.4% (CCBC, 2012), meaning Conwy has about a third more older people than the Welsh average. This can be partially attributed to the fact that Conwy is a popular county for people to move to once they retire. Rural migration in early retirement is not uncommon, with "research in different countries indicating high levels of place-based satisfaction, social capital, community inclusion and quality of life amongst older people in rural places" (Milbourne, 2012:315). Whilst there are benefits to migration, moving away can mean leaving friends and family, and therefore support networks, behind. Therefore, as these people become frailer, there is a greater need for support services to prevent ill health and maintain independent living (Conwy Local Service Board, 2011).

Progress has been made in the integration of Health and Social Care services in Conwy following the Health, Social Care and Wellbeing Strategy 2008-2011 (Conwy Local Health Board, 2008). Four Health and Social Care buildings have been developed and occupied to encourage communication and joint working, with a

further one in the pipeline. Representatives from each organisation sit on the allocations board for extra care housing. However, this integration does not involve other types of housing, despite the fact that the majority of care takes place in the home. This is an issue that this thesis addresses.

There are five main Registered Social Landlords (RSLs) in Conwy whose housing stock includes housing specific for older people. These are Cartrefi Conwy, Clwyd Alyn, North Wales Housing, Wales and West Housing and Tai Clwyd, all of whom were involved in the research. In 2011, there were approximately 1,529 units of sheltered housing stock in the county Conwy. Of these units, 972 units had wardens. The rest are defined as sheltered housing as they are linked to Careline and house the over 65's. At the time of the research, there were two extra care housing schemes, with two more being built. The local authority had one in-house residential home, the rest having being outsourced in order to fund the extra care housing.

4.4 Problem Definition

This research aims to identify opportunities for Housing to integrate with and contribute to the whole system of care. However, in terms of the action research project, those involved wanted to identify what should be included in Conwy's Older Persons' Housing Strategy. The problem with this was that no one organisation or individual involved in the action research had an overall view of what the system looks like, how the entities interlink, or what the strategic priorities of all the organisations are. There was a lack of understanding about the system as a whole, due to its complex nature. This chapter aims to detail the action research project designed to help Conwy County Borough Council (CCBC) and the housing associations they work with to address these gaps in knowledge. The case objectives ultimately led to the research objectives for this thesis, as demonstrated later in the chapter.

4.5 Process for Conducting Action Research in Conwy

4.5.1 Establishing a Steering Group

The Steering Group that was established in the early stages approved the case objectives, and then offered advice and guidance throughout the course of the project. The researcher presented findings to the group quarterly, and used their

feedback to help develop the next stage of the project. Within a participatory action research process "communities of inquiry and action evolve and address questions and issues that are significant for those who participate as co-researchers" (Reason and Bradbury, 2008:1). Therefore, the Steering Group (or co-researchers) comprised of representatives from all key stakeholders in the project, including CCBC's housing, social care and provider unit departments, all RSLs with housing for older people in Conwy, Betsi Cadwaladr University Health Board, Conwy Voluntary Services Council, Care and Repair Conwy and local Councillors. The Older Person's Champion also attended in order to share the views of their peers on the research findings and subsequent suggestions. A full list of Steering Group members can be found in the Appendix. Members of the Steering Group were carefully chosen, as Arnesson and Albinsson (2013) identified that for a Steering Group to be effective, each Steering Group member needs "to have a positive approach to the project idea and the set goals, to have knowledge of the assignment, to have a position with the authority to make and carry out strategic decisions of the project, and be able to allocate time for active work and participation in meetings" (Arnesson and Albinsson, 2014:326).

Typically, Steering Group meetings would begin with a presentation from the researcher about the findings from the work conducted during that quarter. The group were then invited to make comments and to feedback on the work conducted. This is an example of member checking, which is a tool commonly used in qualitative research where the researcher will summarise the information they have gathered from the group, and then question them to determine accuracy (Harper and Cole, 2012). Member checking is essential to action research to ensure that the project continues to meet the needs of the participants (Herr and Anderson, 2005). The researcher made brief notes throughout the discussion of actions suggested, in order to move forward, and then compared these to the minutes of the meeting afterwards in order to ensure consistency and completeness. The meetings offered the stakeholders the opportunity to share their 'stories', which is crucial to understanding the complex interrelations between different entities in the system (Burns, 2007:104). The information gathered during Steering Group meetings was therefore invaluable to this research project.

The benefits of having a Steering Group were three-fold. Firstly, it enabled the researcher to have access to a wide range of experts from many different organisations. Whilst each organisation had their own agenda, they were keen to work together towards the common goal of developing an Older Persons' Housing Strategy and offered a wide range of different perspectives on what the document should include. Secondly, offering all stakeholders the opportunity to contribute to, and direct, the project meant that they felt invested in it, making implementation easier. As the people in the Steering Group were senior managers, they were able to make the changes necessary in their own organisations towards an integrated system of care for older people, which is one of the key elements of successful Steering Group projects, identified by Arnesson and Albinsson (2014). Finally, it gave members of the Steering Group the opportunity to find out about other organisations and provided a platform for collaboration, both within the strategy implementation and outside of it.

4.5.2 Case Objectives

This section details the case objectives identified by the researcher, supervisor, Head of Housing Strategy for CCBC and Operations Manager for Cartrefi Conwy and approved by the Steering Group. Briefly, objectives 1-6 were the strategy development phase, with objectives 1-5 being designed to give an in depth knowledge of the current situation in Conwy and elsewhere. Objectives 7 and 8 link to the consultation process, which had to fit with both CCBC's and the University of Liverpool's guidelines. The local authority has guidelines on how to conduct consultations and the university set guidelines during the ethical approval process. One of the issues where the guidelines conflicted involved obtaining informed consent. The university guidelines required written consent, whilst the local authority guidelines stated that the consultation should be informal. The local authority were concerned the obtaining written consent would over-formalise the process. However, they eventually agreed that the researcher should explain why it was necessary, obtain written consent and then run the focus group in an informal manner. The final objective was the implementation of the Older Persons' Housing Strategy. The case objectives were as follows:

1. Identify and assess the current housing and care available for older people in Conwy

The researcher began by doing field research and interviewing all of the members of the Steering Group individually, to develop a picture of the current situation in Conwy, as the Steering Group comprised of many of the key stakeholders for the development of the strategy. Soft System Methodology (SSM) (Checkland and Poulter, 2006) was used in order to develop a picture of current activities and interactions between the three sectors. This technique provided the researcher with a rich picture of the situation in Conwy, because it encourages the practitioner to consider the system from multiple worldviews.

2. Define roles of different housing options in Conwy

Based on the findings from the previous objective, the researcher was able to map out the different routes that people may take through the housing options in Conwy. This gave a better understanding of the roles of each of the housing options and the reasons that older people might choose to move into specialist housing. By combining these findings and looking to the literature for more widely used definitions, the researcher was able to define the role of each housing option. These definitions were presented to the Steering Group for approval, altered slightly in response to feedback and then used in the Older Persons' Housing Strategy (See Appendix).

3. Survey of current Older Persons' Housing Strategies and Trends in Wales (amended to focus on structuring the warden service)

This objective initially began with a literature search for local authorities with Older Persons' Housing Strategies in place in Wales. It was found that Caerphilly and Gwynedd were in the process of developing strategies, and Wrexham, Newport and Neath Port Talbot had all had one in the past but these have expired. However, no local authorities in Wales had a current document under implementation. Therefore, the decision was made to be more focused and ask other local authorities about a different issue, to ensure that the research also had value outside of Conwy. As

support had been identified as an appropriate integrating function, questions arose about how the warden services should be structured, so this became the theme for the survey. Other local authorities in Wales were asked about their warden structures, and any changes they were making as these services were going through a transition phase, from residential to more flexible and cost effective services. Action research is an emergent approach, which should be responsive to the situation (Sankaran et al, 2009). Therefore, changes to initial objectives are common in an action research approach, enabling the researcher to explore new avenues of research as they emerge.

4. Develop a taxonomy of warden support strategies from survey

Investigation into changes in the way wardens work was deemed essential by the Steering Group as local authorities and RSLs across the UK are changing their services in response to looming changes in funding provision and technology. This is a controversial issue, as many people who chose to move into sheltered housing because of the security offered by an onsite wardens, are now having those wardens removed from their schemes (King et al, 2009). A taxonomy was developed from the survey and a SWOT analysis was conducted in order to enable the Steering Group to make an informed decision about how to progress with this issue.

5. Develop a solution to integrate housing into the whole system of care in Conwy

Work from the previous objectives as well as the literature findings were used in order to develop a solution to help integrate Housing into the whole system of care, as discussed in Chapter 2. The Steering Group had concluded that support was the most appropriate integrating function from the previous objectives as wardens are trusted by their tenants and they come into contact with them on a regular basis. The Steering Group were presented with three options for the structure of the new service and chose the most feasible option; which was then written into the OPHS. More information on these options and the way in which the group made their decision is given Chapter 5.

6. Write the pre-consultation draft Older Persons' Housing Strategy for Conwy

This objective synthesized all of the previous work in order to produce a clear strategy document, with action plans, for the local authority to take forward over the next five years. The vast amount of supporting research was written into a Technical Annex, which people are able to access on CCBCs website. This document details how and why each action for each strategic objective was developed. The strategy was then summarised in a smaller document in order to make the strategy accessible to the general public.

7. Take draft OPHS through the council's consultation process

"Soft systems thinking states that an 'authentic' understanding of any action context requires participation of all stakeholders, that is, all people involved in taking action as well as people affected by those actions" (Flood, 2010:277). Therefore, consulting with older people and wardens, as those who would be affected by the actions, was also essential for this research methodology as well as for the local authority. Focus groups were chosen to develop discussion and participants were asked one question about each of the identified strategic outcomes. Each RSL advertised at least one focus group to their tenants and the researcher also conducted focus groups at all local Age Concern forums as they provided a receptive, appropriately aged audience across the county, who lived in various types of housing for older people.

8. Obtain cabinet approval for the implementation of the OPHS

The strategy was presented to CCBC's scrutiny committee and then its cabinet. The researcher answered a few questions from the members during both meetings (reported in Chapter 7) and then the strategy was approved without alterations.

9. Establish and work with subgroups to take the action plans forward

Although the strategy details four strategic objectives, it was decided by the Steering Group that 'Information and Advice' should be built into the other three action plans as it was important for all the strategic objectives. This was because the consultation had highlighted not being able to access information and advice was a key issue for older people. Three subgroups were established in order to implement the strategy.

These were entitled 'Quality Housing Options', 'Restructure Support Service' and 'Assistive Technology and Adaptations'. Each subgroup had an action around ensuring information and advice was available for older people about their subject, i.e. quality housing options, support, assistive technology and adaptations. The chair of each subgroup was actioned to feedback their progression to the Steering Group biannually to ensure that all key stakeholders are aware of the work that is being done.

As support in the home has been a major focus of this research, the Restructure Support Services subgroup had a more substantial action plan and is still continuing to meet regularly. This subgroup is considering changes which would have a large impact, so it is essential that time and care is taken when it comes to implementing their action plan.

4.6 Research Objectives

This chapter has outlined the process used to conduct action research and develop Conwy's Older Persons' Housing Strategy in order to justify the approach. All of the case objectives were deemed necessary and appropriate by the Steering Group in order to achieve the goal of developing and implementing the OPHS. However, the main focus of this thesis is to answer the question, 'How should we integrate Housing into the whole system of care for older people?' Not all of the case objectives are relevant to answering this research question. Eden and Huxham (2002) state the importance of separating research objectives from client requirements in action research, in order to ensure that there is a theoretical element to the research. Four research objectives have been developed in order to develop a solution, based on the case objectives.

Research Objective 1: Explore the current model of Health, Social Care and Housing in Conwy using soft system methodology (SSM) in order to identify potential integrating functions

This research objective combines the case objectives 1, and 2. Adopting a soft systems methodology enabled the researcher to map out the as-is model in Conwy to identify gaps in the system and potential solutions to these gaps. The routes that people may take through the different housing options in Conwy were mapped out in

order to aid understanding. Support, care and reablement were identified as potential integrating functions following this work, with support being identified as the most appropriate. This work is detailed in Chapter 5.

Research Objective 2: Develop conceptual models for integrating Housing into the whole system of care using support

Based on the findings from research objective 1, the researcher developed three conceptual models for integrating Housing into the whole system of care using support. These models focused on who should own the support function. The Steering Group discussed which would be the most appropriate to implement.

Research Objective 3: Explore and analyse existing support structures throughout Wales in order to identify the most effective and efficient way to structure the support service provided by wardens

This research objective combines case objectives 3 and 4. The researcher identified and analysed warden support structures throughout Wales, in light of recent changes to funding. Currently, warden services across the UK are being reduced in order to lower costs, with little considerations being given to the implications of this for older people (King et al, 2009). This objective not only develops a practical solution to structuring the support service to integrate Housing into the whole system of care, but also provides an evidence base for housing associations to use to justify the cost of support. This is detailed in Chapter 6 and this work was also developed into a conference paper which received positive feedback from specialists in housing research.

Research Objective 4: Consult with older people to validate the proposed solutions and ensure they meet the needs of the target market.

Consultation with older people enabled the researcher to test the appropriateness of proposed solutions through a focus group setting. This ensured that both the Older Persons' Housing Strategy, and the solutions suggested in this thesis, met the needs and expectations of the people they are targeted at helping. This is detailed in Chapter 7 and provides a level of justification to the work. A focus group was also conducted with the wardens to ensure that the considerations of those providing

support were also taken into account. This research objective serves to triangulate the results of all the research objectives, an approach commonly used to ensure rigour in action research (Wisker, 2001; Eden and Huxham, 2002).

Table 2 demonstrates how the research objectives and the case objectives interlink, and where they are discussed within the thesis. Whilst some are very closely linked, the Research Objectives focus on integrating Housing into the whole system of care for older people, whilst the Case objectives focus on developing the OPHS for Conwy.

Table 2: Combining Research and Case Objectives

Chapter	Research Objective	Operational Objectives of Case
5	1. Explore the current model of Health, Social Care and Housing in Conwy using soft system methodology (SSM) in order to identify potential integrating functions	1. Identify and assess the current housing and care available for older people in Conwy 2. Define roles of different housing options in Conwy
5	2. Develop conceptual models for integrating Housing into the whole system of care using support	6. Develop a solution to integrate Housing into the whole system of care
6	3. Explore and analyse existing support structures throughout Wales in order to identify the most effective and efficient way to structure the support service provided by wardens	3. Survey of current warden structures in Wales 4. Develop a taxonomy of warden support strategies from survey
7	4. Consult with older people to validate the proposed solutions and ensure they meet the needs of the target market	7. Take draft OPHS through the council's consultation process 8. Obtain cabinet approval for the implementation of the OPHS

4.7 Summary

This chapter has provided an introduction to the Conwy case study and detailed the process for conducting this action research in Conwy. The aim of the work was to research, write, consult with and implement Conwy's Older Persons' Housing Strategy. The instigators of the action research did not know what to include in the strategy document as no one had a comprehensive picture of the whole system of

care in this county, due to the complexity of the system. A single case study design was deemed appropriate due to the differences in local Health and Social Care systems, making the case unique. It was important that the strategic direction of the document complemented the strategic directions of the organisations it would affect, as this would support the implementation process. Three iterations of the standard action research process were completed for this work, the first to develop the strategy, the second to take it through Conwy's consultation process and the third to implement the strategy's action plans.

The Steering Group for this project met quarterly to ensure that the key stakeholders we able to act as co-researchers for this work, an approach common in action research. They approved the case objectives and thus co-created the direction of this project. The Steering Group provided the researcher with access that would not have otherwise been possible, providing the link into the various elements of the system of care in Conwy. This enabled the researcher to develop a comprehensive picture of the whole system of care in Conwy, as detailed in Chapter 5.

The following three chapters will focus on the research objectives, in order to develop and sustain the theory that support is an appropriate integrating function. The Older Persons' Housing Strategy was developed with this theory in mind and so, whilst it is not the main focus of the strategy, it is part of the action plan that is being implemented by the support services subgroup. More details about the Conwy case study are included in Chapter 5.

Chapter 5: Soft Systems Analysis of the Whole System of Care for Older People in Conwy

5.1 Introduction

This chapter examines the work conducted for Research Objective 1: Explore the current model of Health, Social Care and Housing in Conwy using soft system methodology (SSM) in order to identify potential integrating functions. In terms of the Case objectives, this was arguably the most in-depth objective for the development of Conwy's Older Persons' Housing Strategy (OPHS) as it was important to develop a comprehensive picture of the 'as-is', in order to identify the issues that the strategy would have to address. Based on the findings, the researcher then developed conceptual models for integrating Housing into the whole system of care using support, which is Research Objective 2. Three potential options were developed, based on the findings from Objective 1. The Steering Group then discussed these in detail, highlighting the advantages and disadvantages of each before deciding on which option to move forward with. Their choice was written into the OPHS and a subgroup with the task of restructuring support services was established

The Council and Housing both play a role in the development of a whole system of care, as Chapter 2 identified that these are entities within the system. Therefore, it was important to develop an understanding of the relationships between these organisations. Interviews, field work and observations helped the researcher to gather the information but a more structured approach was necessary to conduct the analysis. The researcher used soft systems methodology (SSM) in order to develop a picture of current activities and interactions between Housing, Conwy County Borough Council (CCBC) and Health, as this is a complex situation involving multiple entities. SSM is a systematic approach to taking a problematic situation, breaking it down and capturing all of the various worldviews of the people involved (Checkland and Poulter, 2006). This provides the researcher with a much richer picture of what

is going on. SSM is a form of participatory action research (PAR) (Sanchez and Mejia, 2012), so it fits well with the rest of this research. SSM is an example of a 'soft operations research' methodology, used to tackle the messy, strategic problems in operations research that mathematical methods overlook (Mingers, 2011).

SSM requires the researcher to talk to the various people involved in, or affected by the system being analysed. This also includes the older people that should eventually benefit from the development of the housing strategy. To ensure that the OPHS meets the needs of those it is trying to help, it was necessary to interview current and potential service users in order to find out what they want from their housing, and the aspects of it that they like and those that they feel could be improved. This was done on an informal basis at this early stage of the research, but was formalised later on, when focus groups were conducted with older people (detailed in Chapter 7). Finally, Social Services and Provider Services at CCBC were also interviewed, as they are a prominent part of the system and it was important to look at the types of care that are available for older people in Conwy.

5.2 Introduction to SSM

Soft systems methodology (SSM) is an action-orientated, organised way to tackle complex, problematical situations in order to develop actions to improve them (Checkland and Poulter, 2006:xvi). The way in which humans see a problematic situation is influenced by their worldview. Each individual's worldview "focuses on some aspects of a situation, but ignores others, and in this sense it is partial" (Sanchez and Mejia, 2012:111). This limits how each individual sees the problem, with a partial view implying that no one individual sees the whole of 'the real world' situation. SSM involves considering the problematic situation from multiple worldviews, not only to learn about the system, but also to gain an appreciation of the different perspectives of the actors in that system. Some of the references in this section are relatively dated, as the researcher found that SSM was explained in much more detail in the earlier stages of development as the developers sought to justify it as an effective methodology. The older references are used to add detail to the more modern, step-by-step guides to the methodology.

SSM has evolved over the years, going from blocks and arrows, to seven stages, to two streams and then finally four main activities (Checkland, 2000). The four main activities formed the basis of this research, and the Checkland and Poulter (2006) textbook acted as a guide for implementation. Briefly, these stages are:

Stage 1) Finding out about a problematic situation

Stage 2) Make purposeful activity models based on the information you have found out about the situation, using different worldviews

Stage 3) Use the models to help structure discussion around how to improve the problematic situation

Stage 4) Take action to improve the situation (Checkland and Poulter, 2006:13).

SSM can be conducted internally within an organisation, or by an external researcher as it is a flexible process. Either way, it is important to include key stakeholders as participants as they will have different worldviews, and thus add richness to the enquiry. This was done on an informal basis during this project, with the researcher questioning the Steering Group members (participants) to establish their views throughout the project, and encouraging them to share these views with one another during Steering Group meetings. Due to time constraints on the project, the researcher did not demonstrate the purposeful activity models to the Steering Group, as these are highly conceptual and the Steering Group were interested in practical outcomes. The Steering Group members were busy professionals, so the researcher's time with them was limited and she did not want to lose project momentum by being too abstract during Steering Group meetings. Talking the participant group through the process of moving from 'real-world' thinking to conceptual models requires a certain level of skill which can only be gained through experience of using this methodology (Checkland and Poulter, 2006). As this was the researcher's first time using SSM, she did not want to risk losing the groups interest by involving them in the development of purposeful activity models, so instead developed these herself based on the information gathered during the finding out stage. Discussion about the conceptual models and CATWOE's (explained later) took place between the researcher and her PhD supervisor. From this, three options for the integration of housing into the whole system of care for older people were

developed, and presented to the Steering Group in the form of Venn diagrams for their feedback. Any reference to the 'group' or 'participants' during this chapter is referring to the Steering Group in this particular project.

Stage 1- Finding out

The first stage involves identifying the problematic situation to be researched and finding out about it. Checkland talks in terms of a "problematic situation" in order to emphasize that this is not a problem to be solved, it is a situation to be explored, understood and then improved. Clearly defining the problem at the start can limit the researcher's ability to explore other worldviews (Sanchez and Mejia, 2012) and can lead to prejudices in the enquiry. In order to improve the problematic situation, it is important to inquire about the characteristics of the intervention, such as the culture, social and political aspects, within the overall situation (Checkland and Poulter, 2006: xvi). This enables the researcher to identify potential improvements to the situation that are feasible to implement.

The basic principle behind SSM is that problematic situations exist within a context, which will be perceived differently by different people (Naughton, 1984). The researcher should draw the problematic situation, based upon the multiple worldviews of the actors in the system, identified during the finding out stage. The justification for drawing is that soft problematic situations by their very nature involve multiple interacting relationships and "a picture is a good way to show relationships" (Checkland and Poulter, 2006:25). Pictures enable us to express our views simply and tend to become richer as the inquiry progresses, with the researcher gaining a greater appreciation of other's worldviews. Thus they are termed "rich pictures" in the literature. Questioning these pictures leads to a greater understanding of the problematic situation. It is often said "a picture is worth a thousand words".

Stage 2- Making purposeful activity models

The second stage of SSM involves developing purposeful activity models based on "root definitions" from each of the above worldviews. These are conceptual models, used as "intellectual devices whose role it is to help structure an exploration of the problem situation being addressed" (Checkland, 1990). A root definition is a "statement describing the activity to be modelled" based on a relevant, pure,

declared worldview (Checkland and Poulter, 2006:38). Each root definition is constructed around a statement of a purposeful activity, written in terms of a "transformation process" (T), e.g. housing not integrated into the whole system of care can be transformed to housing integrated into the whole system of care. The PQR formula has been developed for writing root definitions: "do P, by Q, in order to help achieve R, where PQR answers the questions: What? How? and Why?" (Checkland and Poulter, 2006:39). This SSM study enabled the researcher to identify an appropriate 'How?' for this transformation. In order to consider all worldviews identified, the researcher should develop a root definition for each worldview and then construct a purposeful activity model for each root definition.

At "this stage, the methodology moves to the field of systemic thought, applying the concepts of an outstanding system to describe how the system is" (Menezes et al, 2002:57). In order to ensure that the system is considered in its entirety for each root definition, it is necessary to use the mnemonic CATWOE, which is particularly useful in service systems such as the one considered here (Bicheno, 2012). This is because CATWOE helps us to make sense of a complex situation, by ensuring that we consider all stakeholders and other impacting factors when defining the root definitions of the problematic situation. Each element is in relation to the transformation taking place:

- C is the clients who benefit from the transformation;
- A is the actors involved in making the transformation happen;
- T is the transformation itself;
- W is the worldview that adds meaning to the transformation;
- O is the owners who could stop or change the transformation;
- E is factors in the external environment that influence the transformation and which we have no control over (Checkland and Poulter, 2006:42; Staadt, 2012; Bicheno, 2012:103).

Taking all of this into consideration, three groups of activities then need to be identified in order to develop the purposeful activity model (Checkland and Poulter, 2006:45):

i.   activities which concern the thing which gets transformed;

ii.   activities which do the transforming;

iii.   activities concerned with dealing with the transformed entity.

The purposeful activity models are then developed by logically linking together the activities required to complete the transformation identified in each root definition. This requires the researcher to think about the dependencies of each activity on one another. Any monitoring and control activities are written outside of the boundary of the model, as, whilst they are important, they are not operational activities necessary to make the transformation. Each conceptual model is only partial as it considers only one worldview. However, this stage provides the researcher with more detail on each of the worldviews, the activities required to make a transformation and, ultimately, provides models to structure the discussion in Stage 3.

Stage 3- Structuring the discussion

This stage involves "using the models as a source of questions to ask of the real-world situation" (Checkland and Poulter, 2006:xvii). The conceptual models are compared to the real world situation, through the researcher's knowledge obtained in Stage 1, and the rich picture, to identify similarities and differences. Is that activity in the purposeful activity model present in the real world situation, and if it is not, should it be (Naughton, 1984)? Is this activity actually dependent on that one in the real world situation (Checkland and Poulter, 2006)? Where there are differences, why do they exist? Why is that done in that way? What is the reason for that? These are all common questions asked at this stage. By structuring the discussion in terms of questioning the models, the researcher considers the different worldviews they identified as relevant when establishing the root definitions. Discussion is around how the situation can be changed, which will eventually lead to action to improve.

Stage 4- Defining action to improve

The final stage of the SSM process involves taking everything into consideration, in order to identify actions to improve the problematic situation that are not only desirable to the group as a whole, but also culturally feasible. In order to be culturally feasible, the actions to improve must be appropriate to the organisations involved and consider aspects such as organisational change culture, funding, implementation process, etc. This often involves compromise as there is not an

optimal solution in SSM, due to the nature of soft systems (as explained later in this chapter). The researcher encourages the group to consider what changes can be made in the problematic situation, and what would be the consequences of these changes, both positive and negative. Types of change include structural, procedural and attitudinal, but are often a combination of all three (Checkland and Poulter, 2006:58). Finally, the group needs to identify how the effectiveness of the change will be measured and monitored, where possible. In terms of this project, CCBC required that the OPHS be written with measurable results for each action, so monitoring effectiveness was essential.

5.2.1 Soft Systems Methodology for Social Science

Social science is messy (Law, 2004:2). It is complex in nature, due to the unpredictability of human nature. According to the Economic Social Research Council (ESRC) "Social science is, in its broadest sense, the study of society and the way in which people behave and influence the world around us" (ESRC, 2012). Flyvbjerg (2001:9) states that "context is central to understanding what social science is and can be". Flyvbjerg (2001) goes on to argue that this creates a "deadly paradox" for social science as the area of study attempts to combine scientific theory with human activity, which is fluid in nature and dependent on the individual. However, scientific theory is typically associated with words such as explanation, fact and generalisability. There are perceived limitations to using scientific theory to conduct research in social science (Lewis and Richie, 2003:18). The unpredictability of human behaviour is often considered less compatible with scientific theory and the quantitative methodologies employed. That is not to say that quantitative methods are not useful in social science research, they can be very useful in establishing the effects of behaviours, but are limited when it comes to examining the reasons behind them. SSM was developed in the 1970's as the creator, Peter Checkland, tried to apply the well-established, scientific methodology of systems engineering to problematic situations in management. He found the scientific methodology lacking due to the soft nature of social situations, so developed a methodology which was better suited. Thus, "SSM emerged as a total reconceptualisation of systems-thinking-based intervention" (Checkland and Haynes, 1994:192).

The fundamental differences between hard and soft systems thinking are that hard systems thinking is a positivist approach, suggesting that we can accurately represent that which exists and that "people are passive observers of the system" (Johnson, 2008:798). Whereas soft systems thinking is subjective in nature, and this "assumes that people actively construct and interpret elements of the system" (Johnson, 2008:798). The development from hard systems engineering to SSM is a transformation of paradigms (Zhang, 2010). Philosophically, they are fundamentally different ways of looking at the world and developing knowledge, which requires a shift in our underlying assumptions, as explained below.

Hard systems methodology, or systems engineering is built on four principles:

i.   systems exist objectively;
ii.   systems can be well defined through their goals;
iii. every system has an optimal solution;
iv.   logic is the basic dimension behind hard systems engineering (Zhang, 2010; Yan and Yan, 2010).

From the wording of these principles, it is clear that they are developed from the positivist paradigm, thus the researcher has accepted the ontology that there is only one truth, which is therefore objective and independent of human perception (Sale et al, 2002). Epistemologically, the researcher and their participants are independent of one another and therefore the research remains objective, meaning that there can only be one optimal solution. This also means that the research subject and the researcher have no influence on one another (Guba and Lincoln, 1994).

An alternative to this is choosing to take an interpretive approach, where the researcher has accepted the ontology that there are multiple truths because reality is socially constructed and changes over time (Sale et al, 2002). Epistemologically, there is no reality outside of that created by ourselves, therefore research is highly subjective. This fits comfortably with soft systems methodology and other qualitative research methods, and thus SSM sits within this paradigm, with the following key principles:

i.   systems are socially constructed and need to be interpreted;
ii.   systems do not have one clear objective;

iii.   there are no optimal solutions for systems;

iv.   both logical and social-cultural dimensions should be considered in soft systems methodology (Zhang, 2010).

This thesis aims to develop solutions to complex, societal issues, which are ill-defined and, consequently, difficult to deal with from a more traditional scientific approach. "Based on different weltanschauung (worldviews), different cultural backgrounds and different interests, participants involved in the problem situations have their own ambiguous or unambiguous aims for these situations", which are often contradictory (Zhang, 2010:159). SSM has been developed in order to better understand systems, whilst accounting for this. This makes SSM ideal for studying Research Objective 1, as people from numerous organisations are contributing to this work and each of those organisations will have its own aims, objectives and perspectives, some of which will contradict one another.

5.2.2 Critique of SSM

The main criticism of SSM is that, due to its interpretive underpinning, it is not a problem solving methodology (Jackson, 2003; Flood and Jackson, 1991; Mingers 1984). As discussed above, within the interpretivist paradigm there is not one optimal solution. This can make practitioners uneasy and concerned, as the research will only provide 'ideals' that are appropriate to one particular worldview, as opposed to solutions (Rodriguez-Ulloa and Paucar-Caceres, 2005; Lane and Oliva, 1994). The research presented here used SSM as a structure for inquiry and then developed practical solutions from the findings, and whilst the findings informed those solutions, they did not provide them.

Critics of SSM argue that the methodology suffers from "extreme subjectivism", due to its interpretive underpinning, suggesting that it ignores the objective characteristics of social systems such as power and culture (Yan and Yan, 2010). One study reported that, whilst the process of conducting SSM was considered a positive one, the actions to improve were jeopardized by politics and power, minimising the change to the problematic situation (Staadt, 2012). The examination of features such as power and culture is built into the approach during Stage 1, but, whilst they are considered in terms of the problematic situation, the methodology does not consider how they will impact on the participants in the study. Jackson

(2000) highlighted that the imbalance of power between the participants will limit the worldviews considered and the debate around actions to improve, ultimately impacting on the agreed solutions. The composition of the group is important, the members should be diverse, sufficiently managerial to carry out change and willing to collaborate in order to maximise creativity from the SSM process (Molineux and Haslett , 2007)

Mingers and Taylor (1992) conducted a review of SSM in practice across industries, and found that the majority of those that used it found it to be useful, as reflected in 66% of respondents having used the methodology more than once. However, the majority did not use SSM in order to bring about change, but rather to better understand their situation and experiences (Mingers and Taylor, 1992). This places an emphasis on the methodology as an approach to develop an understanding of a complex system. The study also highlights that the methodology is being used by managers from within their own organisations, suggesting that it is of practical value outside of academia.

"SSM studies are not concerned with repeatability criteria" (Gerwel and Bodhanya, 2014:1132). There is clearly an issue with generalising from SSM as the methodology is moulded by the particular problematic situation being studied, as with any single case study. However, although this is a widely understood limitation of research conducted using a single case study, not all academics have an understanding of SSM. Whilst practitioners understand the limitations, other academics may take information that has been published from an SSM study and cite it without having an appreciation of the fact that it is not generalisable, and thus apply the findings to other situations (Checkland and Haynes, 1994). Instead, data from SSM research should be made accessible, with the thought process and activity outlined, so that it may serve as an evidence base to back up conclusions, which outsiders can use to understand how the actions to improve were developed (Gerwel and Bodhanya, 2014).

Researchers are now developing multimethodological approaches for action research, especially in operations research, which has been criticised frequently for failing to tackle complex, messy problems (Mingers, 2000). Combining SSM with other, more quantitative methodologies, such as systems dynamics (Rodriguez-Ulloa

and Paucar-Caceres, 2005), enables researchers to conduct work which both considers the human aspect and is academically defendable. However, this is not appropriate from a philosophical perspective, as positivist and interpretive paradigms contradict one another. Bryman (2006) conducted a review of the literature and found that only 6% of two-hundred and thirty-two mixed method articles examined raised the philosophical issues involved in combining qualitative and quantitative research. Researchers are clearly taking a pragmatic approach and forging ahead with what works on a practical basis instead of focusing on that which is philosophically sound.

The emphasis on hypotheses, generalisability and reliability in the academic world arguably holds social science back as methods of 'proving' work are not appropriate due to the inherently subjective nature of social science. Methods, such as soft systems methodology, have been developed as an alternative to the methods commonly applied to natural science, so that researchers are better able to understand human behaviour and the world in which we live. SSM has been developed as "a rigorous approach to the subjective" (Checkland, 2000: S45), thus providing researchers in social science with a methodology to develop academically defendable work. One of the main benefits of using SSM is that it is an established methodology which provides structure to the inquiry (Mingers and Taylor, 1992).

5.3 Implementing SSM

The SSM was carried out with the Steering Group, as it represents each of the organisations identified as being involved in the problem situation. SSM is not a linear progress, as this methodology is iterative; each stage informs both future and past stages. Therefore, as the researcher goes through the process, the Steering Group may revisit an earlier stage based on new information that has arisen. However, for the purposes of presenting research, it is helpful to consider what work was done for each stage, which is how this section is structured. Whilst the researcher acted as the practitioner and carried out the background research to inform the Steering Group, the group made the final decisions on actions to improve the situation. The researcher presented feedback to the Steering Group at each stage, occasionally revisiting past stages based on new information found, or questions raised by the group. Checkland and Poulter (2006) highlight the

importance of involving the people who are experiencing the problem situation in order to benefit from multiple worldviews. More detail on the use of SSM in this context will be provided below.

The problematic situation in Conwy is that no one individual on the Steering Group understood the whole system of care in Conwy. Their knowledge, built through experience, was naturally focused on their own component part of the system. The group wanted to integrate Housing into the whole system of care, but first needed to improve its understanding of the system by establishing the as-is model. This would enable it to identify potential functions that could help integrate Housing into the whole system of care. Doing this without first identifying the as-is model would potentially lead to inappropriate solutions that cannot be implemented, as barriers would not have been identified and therefore the solutions would account for these barriers. The literature on integrated care highlights the complexity of this area, identifying structural, organisational and individual barriers to achieving integrated care (Glasby, 2003). Proposed solutions must take these into account, for which a clear understanding of the 'as-is' system is essential.

Oldham (2014) argues that although there are issues with the structure of the care system, our current focus should be on the relationships between structures and the people working within them. This is because structural change to fully integrate Health and Social Care is a huge undertaking, whereas making the whole system run more smoothly by improving the relationships between entities is a more achievable goal (Oldham, 2014). Health and Social Care are funded differently and have different eligibility criteria (Goodwin et al, 2014), meaning that the ways in which people access care are different across each organisation. The NHS offers care to all, free at the point of contact, whereas Social Care uses Unified Assessment criteria to identify whether someone is eligible for care, and means testing to identify if they have to pay and how much. These are examples of the barriers to structural integration. However, there are opportunities to improve the relationships between entities by identifying any existing services that go into the homes of older people, and examining whether these services could be expanded, to provide older people with access to services that they might not otherwise have

known about. This would help to develop the relationship between Housing, Health and Social Services.

5.3.1 Mapping the as-is model in Conwy

This "finding out" stage is broken into four sub-stages as suggested by Checkland and Poulter (2006), namely: Analysis One- Intervention, "Rich Pictures", Analysis Two- Social and Analysis Three- Political.

Analysis One: Intervention

This analysis focuses on the intervention itself and involves identifying the practitioner, clients and owners for the purpose of the study. The researcher took the role of practitioner in this SSM project, so that someone worked full-time on achieving the goals laid out by the Steering Group. The clients are the people that caused the intervention to happen. These were the Head of Housing Strategy at CCBC and the Director of Operations at Cartrefi Conwy. They had engaged the University as they wanted to develop an Older Persons' Housing Strategy for Conwy that was well researched and thought out, but they did not have the appropriate resources in-house. The SSM research informed this housing strategy by focusing on building a picture of the whole system of care for older people in Conwy, and how Housing could be integrated into this system

Finally, the 'owners of the issue(s) addressed' are the people who could be concerned with, or affected by, the system and the effort to improve it. The issue owners were invited to sit on the Steering Group so that it consisted of representatives from:

- Local housing associations with housing for older people: Cartrefi Conwy, Clwyd Alyn, North Wales Housing, Wales and West Housing and Tai Clwyd
- Charitable organisations with housing for older people: Abbeyfields
- Council departments with responsibilities in the system: Housing, Social Services, Housing Renewals, Partnerships and Provider Services
- Conwy Care and Repair Agency: offer adaptations for older home-owners and have a handyman service

- Conwy Voluntary Services
- Councillors from the local authority: Housing, Social Care and Health
- Older Persons' Champion for Conwy: able to represent views of older people living in the county
- Betsi Cadwaladr University Health Board

Older people were implicitly represented by these organisations, and explicitly represented by the Older Persons' Champion for Conwy. Having a representative sample of older people included in the Steering Group was not feasible, as it would have made the group too large for in-depth discussion. Older people were engaged during the 'Finding Out' stage on an informal basis (explained below) and then were formally engaged later in the project through focus groups and RSL Board Meetings.

Although Health is a major player in this system, the group struggled to find a representative who could consistently make meetings at this early stage of the research. This was because the Health Service in North Wales had gone through a recent merger (detailed in the political analysis) and so was experiencing a period of turmoil. This left the Steering Group unsure of who to invite from Health, as employees seemed unsure of whose responsibility it was to engage with groups such as this one. The lack of early involvement is reflected in the rich picture, where Health should play a large part, but the group did not understand, or feel able to describe, the complexity of the health system and how it links to the whole system of care. Rich pictures are intended to be a summary of the group's understanding of the system. Therefore, technically, this omission could not negatively impact on the value of the rich picture, as it is only supposed to summarise the group's understanding; the group cannot summarise that which it does not understand. The issue owners all have varying worldviews, which adds 'richness' to the inquiry (Checkland and Poulter, 2006:30).

However, in terms of the overall thesis, a lack of engagement from Health in the early stages of this research is a limitation. The overall thesis is focused on the whole system of care, i.e. how each element of the system interacts. The throughput of the Health subsystem is therefore not relevant to this work. However, the inputs and outputs of this subsystem are, i.e. how older people enter the health subsystem and what happens to them once they leave. Information about this can be obtained

from the other organisations on the Steering Group. However, Health's perspective on it may differ slightly, so its involvement was important. Health representatives began attending Steering Group meetings in the second year, and were able to offer this perspective.

Rich Pictures

In order to find out about the problematic situation, this objective began with field based research focusing on the case of Cartrefi Conwy, to assess its current activities. The researcher spent time immersed in the organisation to gain an appreciation for how a stock transfer housing association runs and the issues it has to deal with regularly. Cartrefi Conwy was seeking the guidance from CCBC that the Older Persons' Housing Strategy would eventually provide. This was because it had a high proportion of sheltered housing amongst its housing stock (one-third) and the executive management team wanted to discover whether this type of housing was still fit for purpose, following the development and growth of extra care housing. To this end, Cartrefi Conwy was extremely helpful in providing the researcher with access to the information required to conduct this work.

Informal interviews were then conducted with each representative on the Steering Group, as they had already been identified as the key stakeholders for this research. Some interviewees recommended that it would be beneficial to the research to interview other people from outside the group, which is an example of snowball sampling. Representatives from the following departments within CCBC, that would be impacted by the strategy, were interviewed: Housing Strategy, Provider Services, Social Services, Housing Renewals, Supporting People, Reablement, Direct Payments and Telecare. The researcher also interviewed representatives from other organisations involved in the whole system of care for older people namely: Care and Repair, Conwy Voluntary Service Council and Betsi Cadwaladr (Health). Brief notes were taken during each of the interviews, which each lasted between 30 and 90 minutes. The researcher then made field notes shortly after each interview to capture detail. The notes were then combined, typed up and sent back to the interviewee for approval to ensure that no mistakes had been made. This was considered necessary due to the complex nature of the organisational structure of

the local authority, its funding streams and cultural norms, such as the extensive use acronyms.

Interviews covered a variety of topics due to the range of organisations and services being questioned. The purpose of these interviews was to enable the researcher to develop a comprehensive picture of the services involved in the whole system of care and establish some of the issues facing these services. Interviewees were asked about their role in the whole system of care for older people in Conwy, and what they thought the Older Persons' Housing Strategy should include. Due to the wide range of services interviewed, the focus of each interview differed widely. However, there were some common themes that emerged across multiple services, including;

i. client dissatisfaction with the number of carers that visit them to fulfil their care plans;

ii. all care packages are outsourced to external providers by CCBC Social Services, except for reablement and care packages for dementia as these are highly specialised;

iii. importance of 'doing with' instead of 'doing for' which reflects changes in policy around effective delivery of care;

iv. concerns over lower budgets for services which meant tighter eligibility criteria and reduced services;

v. high turnover of support services offered by Health and the third sector, as not enough people take up the service so funding is lost;

vi. the role of technology in supporting older people;

vii. contemporary approaches to care such as reablement and direct payments.

Checkland and Poulter (2006) recommend drawing the system in picture form, as a picture can display the system as a whole and show the multiple relationships between the entities, leading to more in-depth discussions in the later stages. The system, as established by the above research, is drawn in Figure 8 (page 113).
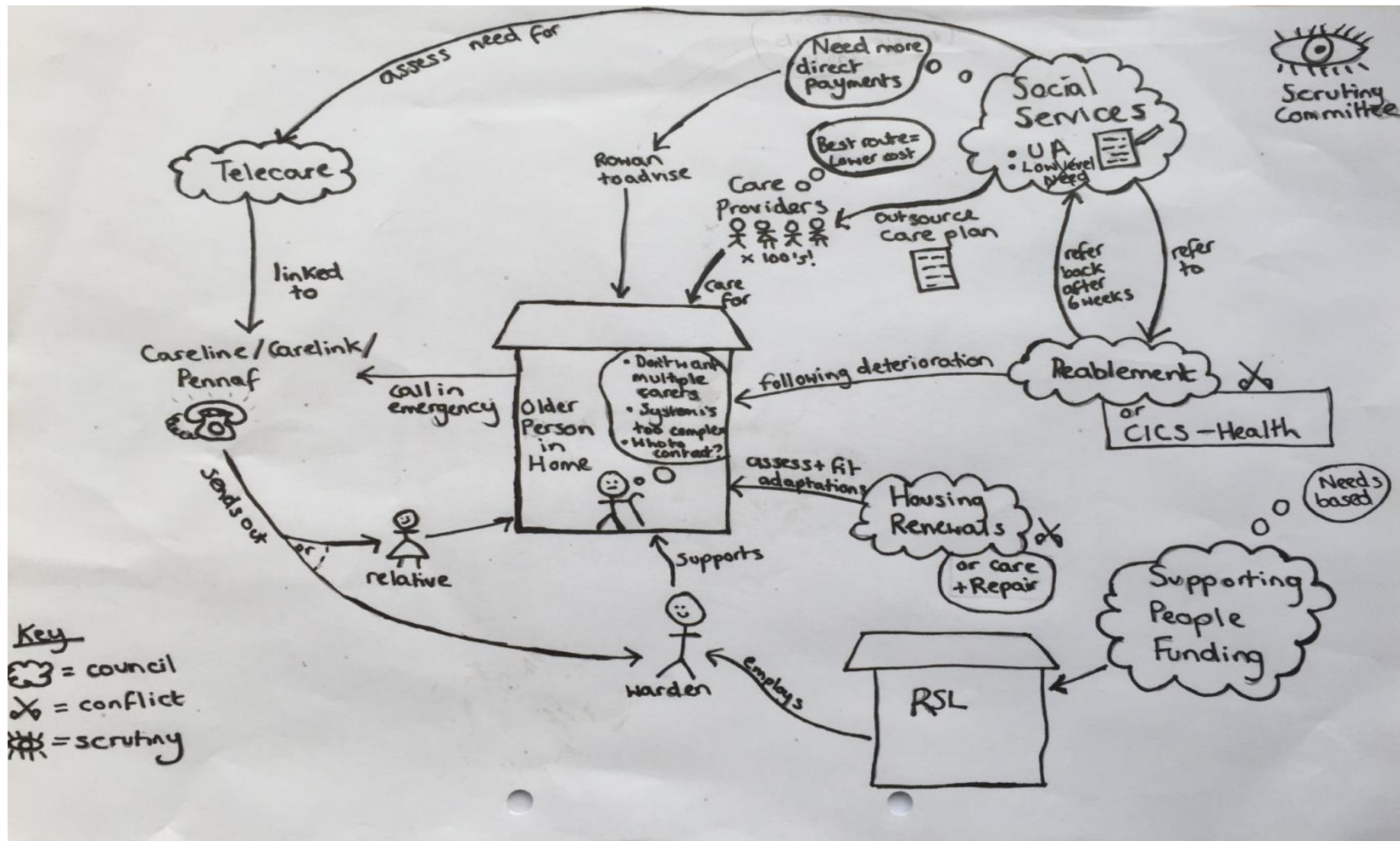
Figure 8: Rich picture of problematic situation from Steering Group's Perspective

Figure 8 highlights that it is common for numerous services to be visiting the client in their home, including carers, housing renewals assessors, support workers, Rowan advisors (for direct payments) and the reablement team. A brief description of these services is given in Table 3.

The Steering Group felt it was important to use an existing service to help integrate Housing into the whole system of care as there was no budget allocated for this purpose, so this would be the most feasible option in practice. Therefore, the five services mentioned above were considered as potential integrating functions. Rowan and Housing Renewals were quickly ruled out as they provide highly specialised information on direct payments and adaptations respectively, and each only intervenes in the short term, usually only visiting the client once or twice. The other three options were examined in more detail.

Table 3: Summary of services visiting the client in their home

Service	Service Provider	Nature of Service
Carers	External care agencies commissioned by Social Services following an Unified Assessment (UA)	Provide care to the client in accordance with their care plan, which is written based on Social Service's assessment
Housing renewals assessors	Assessors for works paid for by the Welsh Government's Disabled Facilities Grant (DFG)	Assess client's home for adaptations, usually with help of occupational therapists who assess client needs
Support workers	Wardens working for client's Registered Social Landlord (RSL)	Provide support for client in accordance with their annual support plan (sheltered housing only)
Rowan advisors	Charitable organisation commissioned by Social Services	Give advice on direct payments and help clients to employ someone if they opt to receive care using direct payments
Reablement team	Joint specialist team with reablement workers from both Health and Social Services	Six weeks reablement to help improve client's health following a hospital stay, or before conducting a Unified Assessment to access care from Social Services

The rich picture (Figure 8, page 113) focuses around the 'client in their home' but does not delve into the different types of housing that this could apply to. As this research is focusing around integrating all types of housing into the whole system of care, it was necessary to obtain more detail about the different types of housing available for older people. As Chapter 2 suggested, some types of housing, such as extra care and care homes, were integrated into the whole system of care and others were not. To this end, the researcher met with a representative from each of the local providers of housing for older people (Cartrefi Conwy, Clwyd Alyn, North Wales Housing and Wales & West Housing) in order to review their housing stock. Abbeyfields schemes and a private residential home, Bryn Eithin in Colwyn Bay, were also visited.

These visits had numerous benefits. First of all, they gave the researcher the opportunity to view the different models of housing for older people, such as sheltered housing and extra care. Secondly, spending a considerable amount of time with the Heads of Service from each of these organisations helped the researcher to develop an appreciation for the different providers' approaches to providing support within their housing stock. This was essential considering the time that the researcher initially spent at Cartrefi Conwy, as major differences between the ways in which the RSL's ran their support services were noted. Finally, it gave the researcher the opportunity to meet some of the wardens/managers and tenants of the different models of housing. Although these meetings were very informal, they highlighted some of the issues with the current system and started to build the picture of tenants' opinions for and against the model of housing they had chosen to live in. For example, many tenants of sheltered housing were unhappy with their care, due to the fact that they see multiple carers on a weekly basis, so there is little opportunity to develop relationships. This was not a problem for tenants of extra care, who had a dedicated team of carers onsite. Again, field notes were taken throughout and the researcher reflected on these and added to them at the end of each day. The researcher also attended five local forums for older people across Conwy to gather the views of older people on an informal basis.

The informal research involving visits to different types of housing, and talking to tenants, enabled the researcher to develop an understanding of the linkages

between housing and tenants. Figure 9 was developed from the findings in this section, in order to help the Steering Group better understand older people's decisions to move between housing types and their accommodation choices.
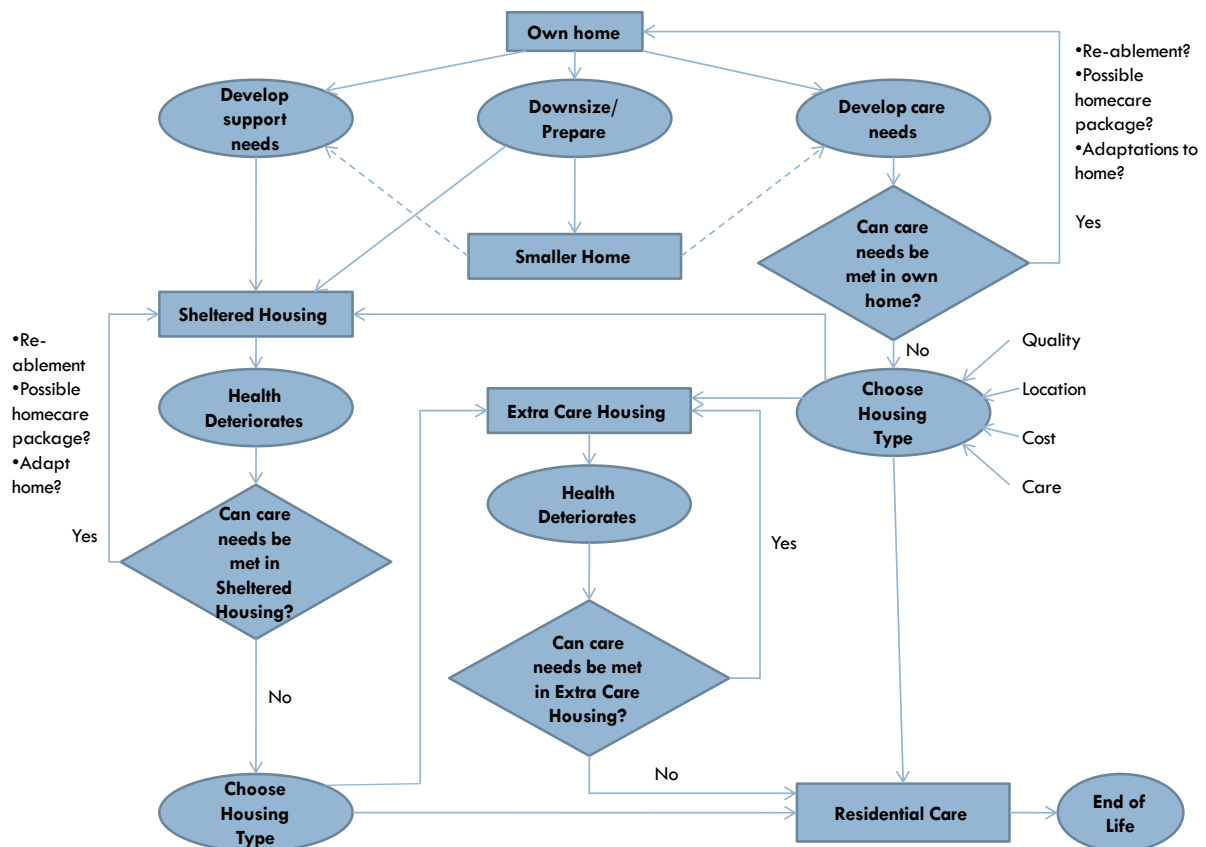
Figure 9: Pathways through Housing

76% of older people in the UK are owner-occupiers and the majority of these people wish to stay in their own homes for as long as possible, with only 3% of all older-person households moving each year (Pannell et al, 2012). The advantages of staying put include familiarity with the home, links to the neighbourhood and a sense of continuity with the past that the home gives (Tinker, 1997). There is also an issue with tenure, as the majority of specialist housing available for older people currently is available to rent but not buy, which presents an issue for those who have previously been owner occupiers. The issue with selling units in specialist housing is that the allocations policy presents complications when the owner passes away, in terms of selling the unit on. Research shows that around three-quarters of older people who do move house, move into one of the same tenure (Pannell et al, 2012).

Therefore, of the 3% of older people that are choosing to move, the majority will not be moving from owning their home to renting specialist housing from a housing association. Following on from this, it is reasonable to assume that the majority of people living in specialist housing are social housing tenants and not owner occupiers.

Figure 9 (page 116) demonstrates that the development of support or care needs are major drivers for moving into housing which is specifically designated for older people. This may be due, for example, to the development of a disability or illness, or the loss of a partner. The Communities and Local Government New Horizons (2008) research found that the most common reason for older people to consider moving is that their house cannot be adapted to meet their mobility health needs. The 'Finding Out' section of the SSM highlighted that quality, cost and location are important factors in choosing where to live and care options may also have an impact on the decision depending on the needs of the individual. Obviously, end of life can happen in any type of housing. However, it is included after residential care to highlight that it is unusual for people to move back from residential homes to another type of housing, because, for example, they have developed dependencies on onsite care, such as the provision of meals, etc. Deciding to move into a care home is commonly an emotionally difficult journey, with new residents commonly feeling sad and anxious about; "leaving a familiar environment to join a new social group, giving up many of their possessions and coming to terms with the loss of independence admission represents" (Rogers, cited in Mulley et al, 2015 :4). It is therefore not a decision that people commonly change their mind about, so once living in residential care the majority of residents stay until they pass away (Naraen, cited in Mulley et al, 2015 :420).

These findings were in support of the literature, as extra care housing and residential homes in Conwy were found to be integrated with the whole system. In terms of extra care, schemes have an allocations board which is responsible for deciding which applicants would benefit the most from moving in, and representatives from both Health and Social Services sit on this board. Social Services also provide the care within the schemes, on a means-tested basis. One extra care scheme had a joint Health and Social Care building next door, as part of the complex. In another

scheme, Health rented an apartment for respite care to avoid long stays in hospital. Residential homes also have their own care teams, who work closely with Social Services to ensure that care plans are carried out effectively.

In 2012, around 10% of specialist dwellings for older people also offered onsite care (Pannell et al, 2012). This leads to the conclusion that the majority of specialist housing is not integrated with the whole system of care for older people, as only housing with care is integrated. The focus therefore needs to shift to how to integrate sheltered housing and people living in their own homes into the system. The 'Finding Out' research highlighted that people living in these types of housing often do not enter into the system until they have reached a crisis point, which is not ideal as this is not a good time to try and navigate this complex system.

Social Analysis

The social analysis focuses on the social aspects of the system, such as the values, norms and both formal and informal roles of people operating within the system. "If we are to learn our way to practical action which will improve a situation under investigation, then changes involved in improvement have to not only be arguably desirable but also culturally feasible" (Checkland and Poulter, 2006:32). The social aspects of the partner organisations were noted and analysed by the researcher from the beginning of the project. Effort was made to integrate into the community by working in both the Cartrefi Conwy office and the Housing Department of CCBC, socialising with staff and talking to people from different departments.

This research spans multiple organisations, so this analysis is multidimensional. It is not limited to the culture of a single organisation, but instead, the culture of numerous organisations and also the ways in which these organisations interact with one another. It would not have been possible to analyse the social aspects of all eleven partner organisations due to time constraints. This is a time consuming process, as the researcher needs to develop trust with staff from each organisation so that they feel comfortable confiding their experiences. Consequently, the Council and the largest housing association, with the most dwellings in Conwy, were targeted for more in-depth analysis. The other nine organisations had a representative on the Steering Group and the researcher made an effort to meet all of these people individually. Over the three year period of the research, relationships were built up

with these individuals and the social aspects of their organisations were discussed on an informal basis. The researcher also waited at the end of meetings, such as Steering Group meetings, so that there was the opportunity for people to come and have an informal, one-to one conversation. This time spent was invaluable for gathering social and cultural information, as some individuals used the opportunity to discuss issues that they did not feel comfortable bringing up during the meetings.

Political Analysis

The political analysis focuses on the distribution of power in the system, be it formal or informal. Like with the social analysis, any information about the balance of power obtained throughout the course of the research was noted by the researcher to reflect on later. It was found that both Health and CCBC exercise power over the whole system of care, but neither organisation has power over the other. This can lead to contradictory control actions and contention. One example of this is hospital discharges, with Health frequently becoming frustrated that the local authority social care team has not established the care plan necessary for the older person to be allowed home. This is usually due to issues with sharing information and is a prime example of one of the reasons that Health and Social Care should work together more closely. Conwy have now developed four Health and Social Care joint working sites to encourage integration. These are buildings in which staff from Health and Social Services work together, using hot desks as and when they need them. Staff are able to consult with one another over patients, and the buildings offer a place for joint meetings to take place.

The health service in Conwy is run by Betsi Cadwaladr University Health Board, which, since 2009, has been responsible for Health in all of the counties in North Wales; following the merger of Wrexham, Flintshire, Denbighshire, Conwy, Gwynedd and Anglesey Health Boards (NHS Wales, 2014). At the time of starting this research (2011), this merger was fairly recent and had thus led to some confusion about job roles and whose responsibility it was to liaise with the Steering Group in the development of the OPHS. This was frustrating for the Steering Group as it left a knowledge gap, during the first year of development, about the way the health system works in the county. However, by the second year the issue had been resolved and a representative from Health was able to contribute to the group.

The local authority also has the feature that there is no formal hierarchy between departments. It therefore became clear early on in the project that there should be input from the Head of Social Services, as well as the Head of Housing. The Head of Social Services was approached and the benefits of a well researched OPHS, for Social Services, were explained in detail by the researcher. The researcher asked her if there were any issues in the department that could perhaps be addressed by the strategy. The take up of direct payments by older people in Conwy was low, so she wanted the Steering Group to look into ways to increase this, as the department's target was to double the number of direct payments that year (2011). This target was identified by the department as achievable, as there had not been a high uptake at this point and older people had not previously been targeted for direct payments. Direct payments are better for Social Services as the hourly cost of providing care for someone is £13.16, whereas the cost of providing them with direct payments is £10.20. This is because the contracts with care agencies also cover the agencies overheads and administrative costs, whereas this is not applicable if the older person is sourcing their own care. The Head of Social Services chose to send along a representative from Social Services to Steering Group meetings with the power to make decisions, so that the department was involved throughout the development of the strategy.

The Registered Social Landlords (RSL's) are answerable to the local authority from a strategic perspective. The local authority provides qualifying tenants with housing benefit and Supporting People funding that pays for the tenants' rent and support. Cartrefi Conwy is a stock transfer organisation and owns the most social housing in Conwy. When the stock was transferred to them in 2008, they inherited a lot of the local authority's housing department staff, which gives them a unique insight into the local authority's culture and mechanisms for decision making. There were initially concerns that transferring the staff in this way would result in Cartrefi Conwy operating in the same way as CCBC, and thus experiencing the same weaknesses, such as adopting a highly risk averse management style or over-complicating the decision making process. This was addressed by bringing in external staff as part of the executive management team, developing new governance models (for example, having tenants on the board) and by putting together a modernisation plan to bring

all of its housing stock up to the Welsh Housing Quality Standards by 2012 (which they achieved).

5.3.2 Making Purposeful Activity Models and Structuring Discussion

CATWOE was applied to the different organisations involved in order to ensure that their subsystems of the whole system of care were considered in their entirety, from multiple worldviews. The root definitions are built from this CATWOE Table (Table 4), which considers the overall focus of each organisation/service. Reablement and care both currently fall under the remit of Social Services in Conwy.

Table 4: CATWOE for organisations involved

CATWOE	Health	Social Services	RSL	Wardens
Clients	People who are ill	People who are assessed as having a substantial/critical need for care	Tenants	His/her wards or charges
Actors	Hospital, Health Boards, GPs, District Nurses	Social workers, care providers, carers, councillors, clients	Board of Directors, staff, Local Authority	Tenants, RSL
Transformation	Good health/no need for healthcare	Independence-client given the care necessary to continue living at home	Quality homes, good communities	Independence-client given the support necessary to continue living at home
Worldview	People get ill and they need to be fixed for discharge	It is best for people to maintain independence as long as possible	Affordable, long-term homes for people with low incomes	It is best for people to maintain independence for as long as possible in their *own* home
Owners	Central and devolved governments	Local Authority	Self	RSL
Environment	NHS, austerity, Social Services integration	Austerity, care provider guidelines, Personalisation agenda, Health integration	Social value, austerity, Government (policy and funding)	Supporting People funding, EU working time directives, austerity

The development of Table 4 highlighted two main issues. Firstly, Health's worldview is short-term and thus has a specific, quantifiable end date i.e. when the patient is discharged. Whereas the other three have long-term worldviews as they are community-based services, distinguishing Health from the rest of the system. It is difficult to measure the impact of preventative, community based services, as it is not possible to say what would have happened without this intervention. Health commonly has established links to community-based services through Social Services and reablement; in Conwy there are multiple joint Health and Social Care buildings to encourage integration. However, Health does not commonly deal with Housing as an entity in Conwy. This is despite the fact that unsuitable housing can be a barrier to discharge, causing an average delay of 27 days and costing an average of £11.2 million a year in England alone (Age UK, 2014; NHS England, 2014).

Secondly, there are numerous similarities between Social Services and wardens in terms of the CATWOE. Their transformations are extremely similar, both focused on maintaining independence in the home, with Social Services using care and wardens, support. Currently, wardens only provide this service to tenants. However, with changes to Supporting People funding, this will no longer be the case in the future and 'clients' will be a more appropriate word to describe the users of support. Therefore, the only significant difference between the transformations is the level of help that they provide. Social Services' and wardens' worldviews are also extremely similar, both focusing on independence. However, the wardens currently have the boundary formed by the specific type of housing. Whilst care provided by Social Services can follow the client to a new home, support provided by a warden cannot. Again, this will change due to the changes in Supporting People funding, further increasing the level of similarity between the two services.

Taking this information into account, the focus of the discussion then shifted from the transformation of housing not being integrated into the whole system of care, to housing being integrated. Root definitions and purposeful activity models were developed by the researcher for this transformation, based on numerous worldviews, following the method described earlier in this chapter. Within the boundary of the models there are the operational activities required to make the transformation;

outside of the boundary are the monitoring activities defined to ensure that the transformation is effective (Checkland and Poulter, 2006:48). These were used as 'sense-making tools' by the researcher, in order to improve her understanding of the whole system of care and develop discussion within the Steering Group meetings.

It was found that the different organisations involved in the integration would all benefit from it, but in different ways. For example, integration would enable Housing to better support their tenants, reducing the possibility that their health would deteriorate to the point that they would have to move into a care home. For Social Services, integration would enable Housing to fill the gap left by tightened Social Services funding, by providing support to people who are not eligible for care under the new criteria. For Health, opening up the lines of communication with housing providers would enable improved flow of older people from hospital discharge to their homes, reducing bed blocking. Figures 10 and 11 (pages 124 and 125) illustrate the differences when integrating from the perspective of Health and Social Services.

Consistently across all purposeful activity models was the issue of *how* to integrate. The rich picture highlighted three feasible integrating functions based on the identification of services that visit the client in the home, namely: support, reablement and carers. Each of these options was examined against the multiple purposeful activity models to see if any raised issues, or fit particularly well.

Using carers as the integrating function created an issue for Social Services, as their Unified Assessment dictates that they are only able to tender for the care of people with substantial or critical care needs following cuts to funding. This means that anyone who is assessed as having low to moderate care needs will not be provided with a social care package. Social Services was clear in its view that the benefit of integrating Housing would be that housing related support could pick up these clients with lower level needs, in order to stop their health from deteriorating further, as demonstrated by Social Service's root definition. However, this benefit could not be achieved if carers were responsible for integration, as they only visit people with high level care needs. There is also the issue that care is outsourced and Social Services do not have the power over the multiple care agencies that they work with to ensure that each individual carer is working to close the gap between Health, Social Services and Housing.

Root Definition for Health
A system that reduces bed blocking in hospitals, by enabling older people to heal in their own homes, through integration with housing, in order to improve efficiency.

CATWOE
C – patients of health
A – steering group
T – housing not integrated with whole system -> housing integrated
W- integration would reduce bed blocking
O – health, social care and housing
E- budget cuts and the ageing population resulting in pressure on health to move people on

Purposeful Activity Model
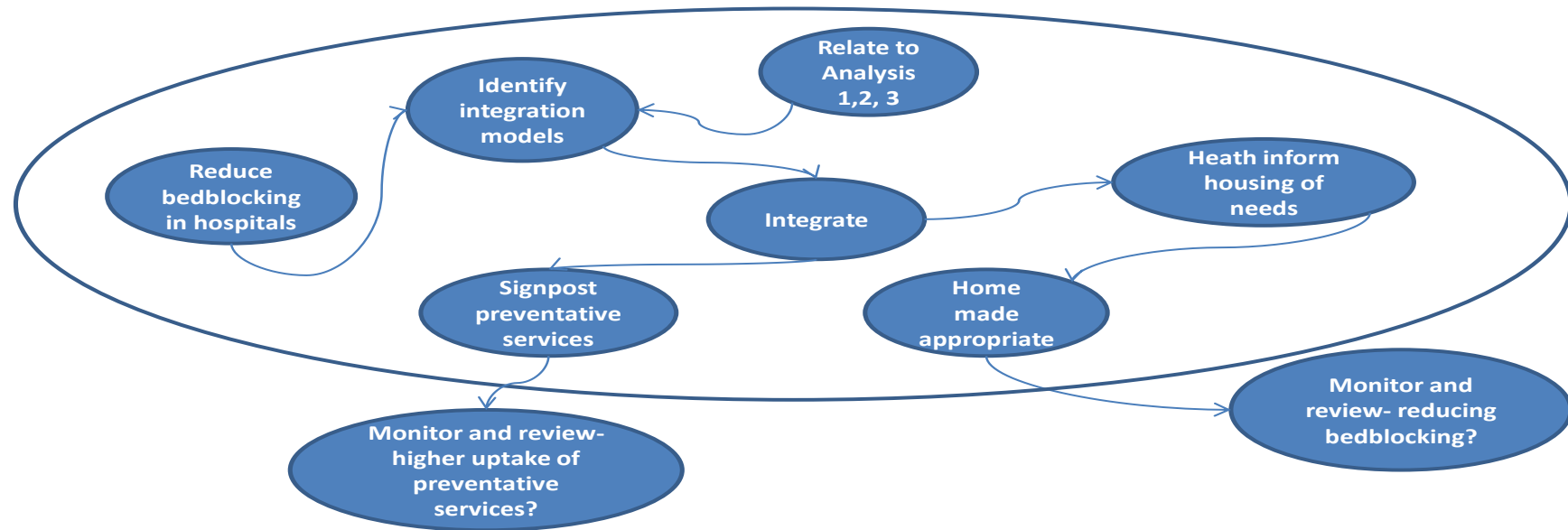
Figure 10: Purposeful Activity Model from Health's perspective

Root Definition for Social Care
A system that improves preventative services, through integration with housing, by spotting deterioration in the home early and addressing it by signposting existing services

CATWOE
C – clients with low to moderate health needs (not met by SS)
A – steering group
T – housing not integrated with whole system -> housing integrated
W- integration would pick up clients not eligible for social care
O – health, social care and housing
E- budget cuts have led to a reduction in preventative services, must have critical or substantial needs to receive care

Purposeful Activity Model
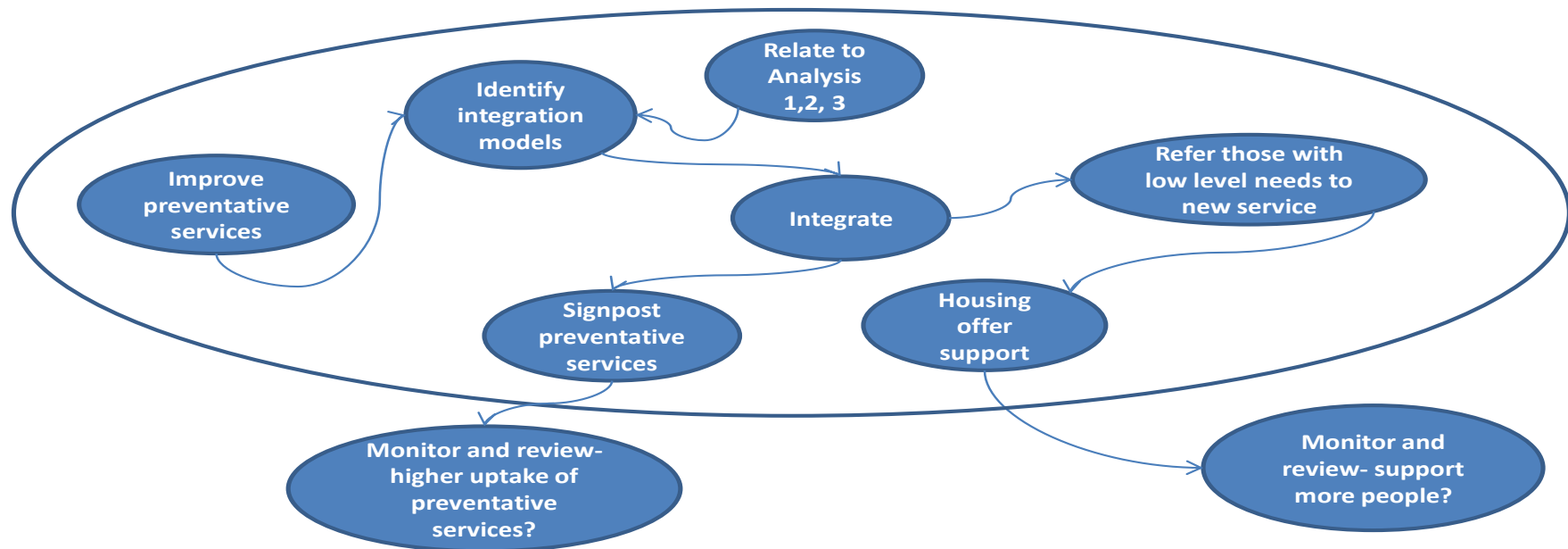
Figure 11: Purposeful Activity Model from Social Care's perspective

Reablement is a potential integrating function as it is provided in the home over a period of time, enabling relationships to be developed. The reablement team in Conwy is already multidisciplinary, comprising of employees from both Health and Social Services. Currently, it is a highly specialised, skilled team responsible for re-abling, or re-teaching, the client to do daily tasks on their own following deterioration in health or recovery. This service lasts for a six week period so it is short term intervention. This team could be given responsibility to inform the client of other services available to them in the local area, and liaise with Housing and support following the period of reablement. It has been suggested that closer working between housing providers and reablement could improve the impact of reablement, by using 'light touch' support to continue the work of the reablement team following the short-term intervention (Wood and Salter, 2012). However, on closer inspection, reablement was a newly evolving service in Conwy and was not yet a functioning service in all areas of the county. This meant that it was not possible to get access to shape the service, due to the strict implementation guidelines that had already been established in the pilot phase. Although reablement was not deemed to be a viable integrating function in Conwy, it should not be disregarded in counties with a well established reablement team, who are looking to develop the service further.

The Social Services representative highlighted that changes to the support service would help them to fill the gap left by cuts to Social Services funding. The representatives from the RSLs felt that the support role was at risk due to reductions in funding, so were keen to add value to the service. Therefore, the group decided that support, provided by wardens, was the most appropriate integrating function. The root definition for this system is to integrate Housing into the whole system of care, using support, in order to improve access to the system, and communication within it, for older people. The CATWOE and purposeful activity model is included in Figure 12 (page 127).

Root Definition for Steering Group

Integrate Housing into the whole system of care, using support, in order to improve access to the system, and communication within it, for older people.

CATWOE

C – clients
A – steering group
T – housing not integrated with whole system -> housing integrated
W- integration is necessary in order to improve access to the whole system of care and communication within it
O – health, social care and housing
E- changes to SP funding mean support must be needs-based

Purposeful Activity Model
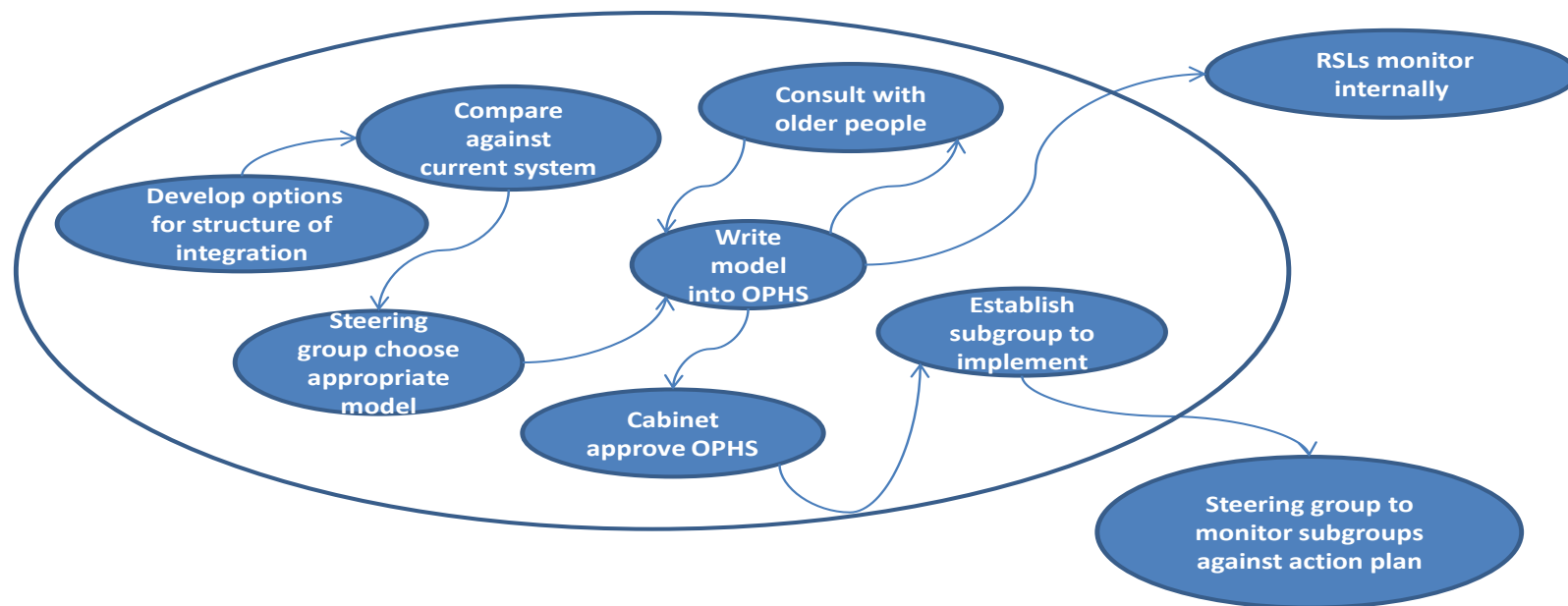
Figure 12: Purposeful Activity Model from Steering Group's perspective

The 'Finding Out' section of this SSM study highlighted that one of the main issues with the whole system of care was its complexity, resulting in difficulties accessing the system, especially when a person is in crisis. The Steering Group's discussion about potential integrating functions emphasised that access into the whole system of care is a significant issue that the integrating function should aim to address. There are multiple points of entry into the whole system of care for older people. When comparing this concept to the real world, it is clear that this is causing problems for Health, with current media attention on unacceptable Accident and Emergency (A&E) waiting times, caused by an increase in admissions (BBC News, 2015; NHS Wales Informatics Services, 2015). This increase in admissions can be partially attributed to the fact that the care system is fragmented and confusing, leading to people making the wrong decisions such as going to A&E for minor issues. A benefit of using support, as an integrating function for housing, is that support workers could help control entry into the whole system of care by providing advice and guidance to clients, helping them to make the right decisions.

The issue then arose of who should own the support function if these extra pressures were to be placed on support workers. Currently, support is owned by the RSL's, all of whom operate slightly differently in terms of their services. For support to bring housing into the whole system of care, closer ties with Health and Social Services are essential, in order to ensure that the wardens have access to the information they require to effectively signpost other services within the whole system of care.

5.3.3 Action to Improve

The researcher developed two conceptual solutions for using support to integrate Housing into the whole system of care for older people on a macro level, by examining different structures for the support service in terms of who would own it. The CATWOE table (Table 4, page 121) and the purposeful activity models (Figures 10, 11 and 12 on pages 124, 125 and 127) were all considered when developing these options. The analysis in this section, in terms of the positives and negatives for each solution, draws from the

application of operations management theory to this case study. Topics drawn on include strategic operations management, economies of scale, lean thinking and standardisation. Organisational structure affects the ability of the organisation to organise its resources and meet market requirements (Slack and Lewis, 2002:324). The market requirements for a support service that integrates Housing, Health and Social Care, as identified by the SSM study, are:

i. the service should be equitable; available to all, regardless of tenure;

ii. support workers should be trained to inform the clients of other services that are available to them, and help them navigate the complex Health and Social Care system;

iii. support should be provided consistently to enable relationships to be developed between support worker and client.

The organisations' resources are dependent on the model chosen. The models are represented using simple Venn diagrams, and compared to the market requirements in order to aid the discussion. The models were discussed during Steering Group meetings to identify the advantages and disadvantages of each, with a view that the most appropriate model would be chosen to be implemented as part of the OPHS. The discussion of the first two models led to the development of a third model, which was also presented to the group for discussion.

The priorities for the new integrated system were identified from the SSM. The interview with CCBC's Supporting People officer highlighted that the Welsh Government were changing the funding guidelines, so that funding for support would be provided on a needs basis, instead of the then current, tenure basis. This marks a significant change for sheltered housing, as people living in this type of housing will no longer be eligible for support due to their tenure, i.e. by default due to their choice of housing. Instead, need for support is demonstrated using standard assessments.

The new system, which will integrate Housing through support, therefore needs to be able to support older people living in other types of housing. This was one of the benefits of using support to integrate Housing into the whole system of care, as support is changing anyway due to the changes in funding, so the RSL's were keen to develop the scope of their services to ensure that support is still cost effective. The early consultation with older people identified that many who owned their homes were dissatisfied with the fact that support is not currently available to people living in their own homes, feeling that this was inequitable.

This part of the consultation also emphasised the importance of relationships to older people, with many stating that they were dissatisfied with the relatively high number of different carers that visited them as it meant that they could not develop relationships with these carers. Without consistent individuals providing care, it becomes increasingly complex to provide a consistent level of care to an individual, as information between carers may not be accurate. Having too many carers is a common complaint reported to the Local Government Ombudsman, along with carers being late or not turning up when scheduled and carers having a poor attitude (Local Government Ombudsman, 2014). For those who were in receipt of support, the fact that it was provided by a single individual was overwhelmingly positive to them. These findings were examined further in the later consultation, detailed in Chapter 7.

Option One- Develop the support service

This option (Figure 13, page 132) involves taking the service that is currently offered to tenants in sheltered housing and developing it to integrate Housing with Health and Social Services. The RSL's would maintain ownership of the service. This would involve:

i. Developing a database of support services available across the organisations operating in the whole system, which the wardens would be able to use to signpost clients, thus integrating with Health, Social Care and other services.

ii. Offering a needs-based, inclusive service regardless of tenure, including to people living in their own homes. This change is essential due to the changes in the Supporting People funding guidelines. The SSM research highlighted that some people are offered sheltered housing because of their age, regardless of the fact that they don't need support. Therefore, when support becomes needs-based, wardens are unlikely to be fully utilised as many people living in their assigned sheltered housing scheme will not meet the criteria that outlines 'need'. When interviewed about their support service (for Chapter 6), Wrexham Council reported that moving to a fully needs-based service released 25% of their wardens' capacity. During the interviews with older people, support was overwhelmingly viewed as a valued service. The RSLs felt it was necessary to look elsewhere, to see if the wardens can offer support to people living in other schemes or in their own homes, in order to achieve economies of scale, i.e. reducing unit costs by spreading "fixed costs over a larger volume output" (Slack and Lewis, 2002:128). This would ensure that support remains a cost effective service.

iii. Standardising warden services across RSL's so that wardens could support people living in another RSL's property. Not all sheltered housing schemes have wardens, as the law requires that sheltered housing has an alarm system for the tenant, but not necessarily a warden. However, some schemes that do not have a warden may still have tenants who require support. Pinning all of the sheltered housing schemes in Conwy on a map, colour coded by RSL, showed that schemes were fairly clustered, with at least one warden operating in each cluster of schemes. The map in Figure 14 (page 132) demonstrates this, focusing on the more popular coastal areas of Conwy (for link to full map, see OPHS Technical Annex). If the warden service was standardised, then a warden working for Cartrefi Conwy could support someone living in a Clwyd Alyn scheme, for example, i.e. collaborative provision of support through shared wardens.
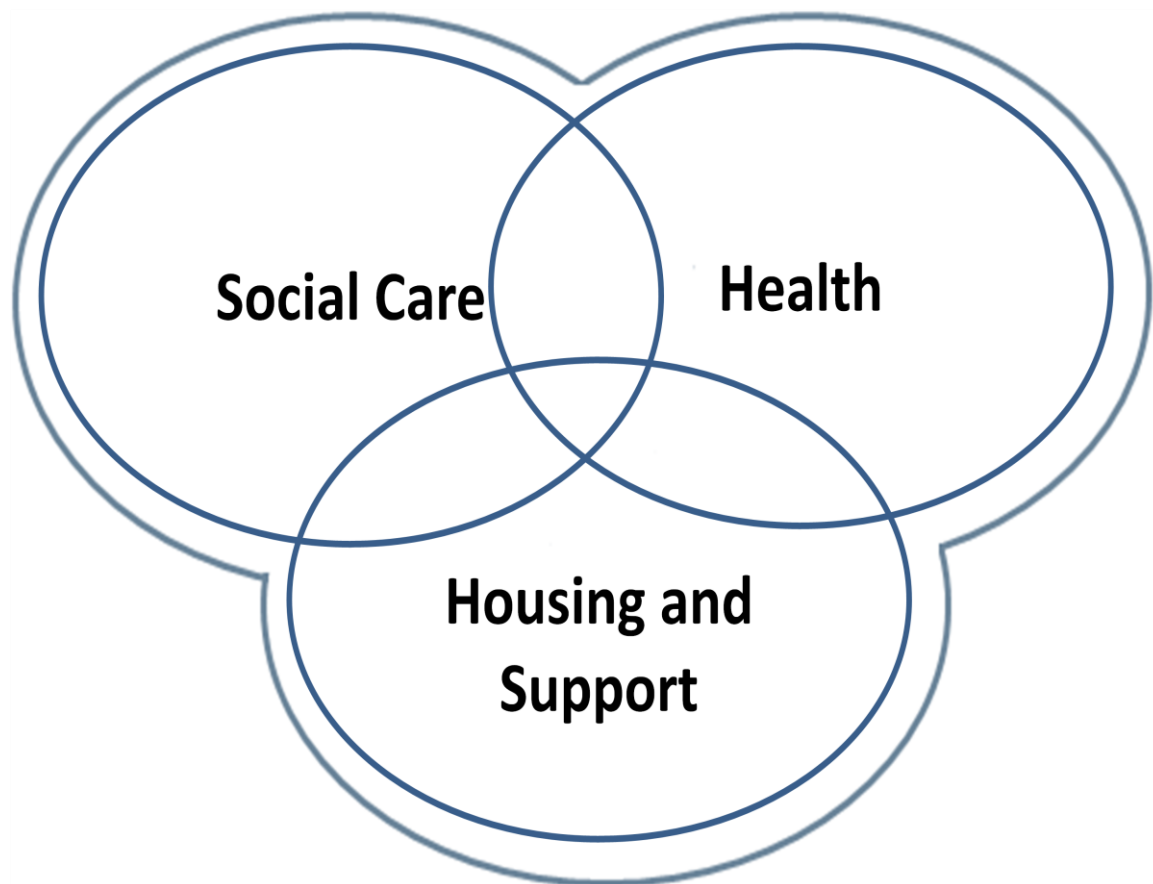
Figure 13: Venn diagram for Option One
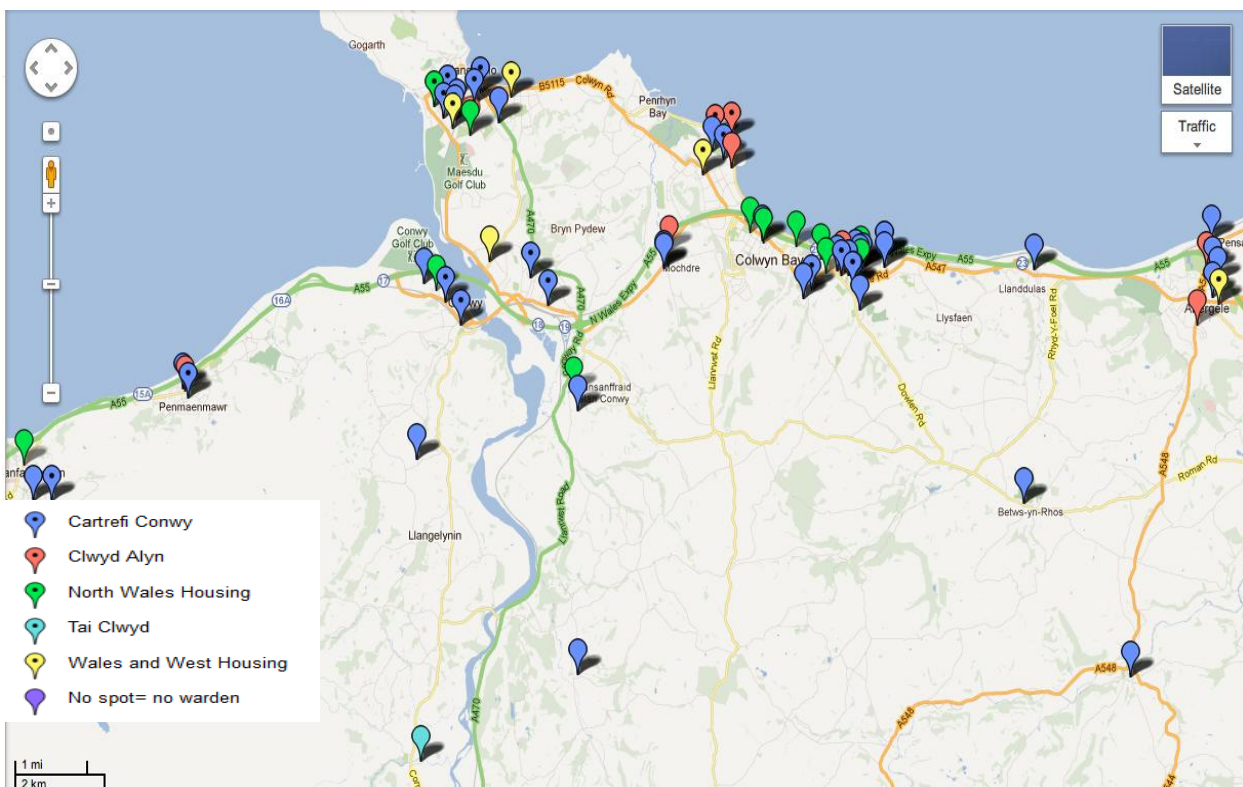
Figure 14: Map of sheltered housing schemes in Conwy

The advantages of this option, as discussed by the Steering Group are that it:

i.   Builds on the current warden service with very little restructuring which minimises the disruption to tenants.

ii. Keeps the operating costs relatively consistent when compared to the other two options.

iii. Promotes a shift in thinking from the isolated sheltered housing scheme, to the wider community. This has two benefits:

   a. It makes the system fairer by enabling people living in their own homes to receive support. If the client is not in receipt of housing benefit then they would have to pay for this service, but if they are then it would be covered by Supporting People funding.

   b. It could promote the sheltered housing schemes as community hubs. If the warden is supporting an individual living in their own home, then the development of this relationship could encourage the older person to visit the sheltered housing's community room and develop friendships with tenants. Loneliness can have a serious detrimental effect on older people, impacting on both their physical and mental health and ultimately resulting in an increased use of Health and Social Care services (Campaign to End Loneliness, 2014). Therefore, developing a support service that also helps reduce loneliness and isolation of those living in their own homes, improves the value of the service to Health and Social Services.

The disadvantages of this option are:

i.   Without more considerable change, there is very little drive to integrate with Health and Social Services. This option is an example of an incremental change, meaning it is "intended to do more of the same but better" (Kindler, 1979). Nadler and Tushman (1989) developed a typology of different changes based on the scope (incremental or strategic) and the positioning of the change in terms of key external events (anticipatory or reactive). Mapped onto this framework, this type of change is defined as an adaptation, as it is incremental and reactive;

necessary due to the external condition of the changes to Supporting People funding. Adaptations are relatively low intensity changes (Nadler and Tushman, 1989). There is relatively little evidence on how the implementation of change can be effectively achieved in the public sector, when compared to the private sector (Fernandez and Pitts, 2007; van der Voet, 2013; Van de Ven and Sun, 2011). However, there is consensus that effectiveness is dependent on the support of employees (van der Voet, 2013; Herold et al, 2007). By developing these options through the SSM study, the employees involved in implementing the change were also involved in the development of it, so they are invested in the chosen option. However, for each of the individuals involved, the implementation of this change is only a small part of their job role. There is a risk that, without substantial change, the momentum created by the project will be lost. The small changes being made would have to be carefully monitored to ensure that the goals of the integration are being achieved. For example, older people are attending more health awareness sessions and those living in their own home are beginning to access support services. "As a problem solver, a change agent attempts to intervene in and control a change initiative by diagnosing and correcting difficulties that prevent the change process from unfolding as the change agent thinks it should" (Van de Ven and Sun, 2011:58). The change agent, in this case the researcher, would need to carefully monitor progress to ensure that the implementation of the change is going to plan.

ii.   There is the potential issue that wardens would be biased, or viewed as biased, towards their own tenants in terms of time spent on support, so this would need to be carefully monitored, which implies a cost.

iii. Support is not the wardens' only responsibility, so this needs to be taken into account in developing the service to support the wider community. The majority of wardens also have responsibility for contacting building maintenance with any issues on their scheme, whilst some take a more managerial role on the whole. For example, the wardens at Wales & West Housing are involved in marketing their schemes and developing relationships with people on the waiting lists,

so that they can allocate properties appropriately. The responsibilities of the wardens differ between RSL's providing a barrier to standardisation.

This option was considered the least disruptive as it only involves minor changes to the current system of support provision. Arguably, this lack of change may not be the best way to integrate Housing with Health and Social Services, as without change, there is very little drive, so the other two options were discussed in order to provide further analysis.

Option Two- Separate support and Housing

This option (Figure 15, page 136) involves decoupling the support function from Housing to enable closer links with Health and Social Care, by providing a jointly funded support service instead. This would mean that Health, Social Care and Housing jointly own the support service. This would involve:

i.   Reassessing how support is funded by identifying Health and Social Care funding streams that could potentially be used for the development of a support service.

ii.   Developing a new support service that is a separate entity, responsible for providing support to people regardless of the type of housing they are living in. This support service would operate on a locality basis in order to minimise wasted travel time and integrate with communities. Clients would be able to buy support, or cover the cost through Supporting People funding if they were in receipt of housing benefit. Social Services could recommend the support service to people who fell below the eligibility criteria for care, which would help prevent deterioration. Support workers would be able to signpost clients to alternative services offered by Health as a preventative measure.

iii.   Redefining the sheltered housing product as it would no longer inherently include a warden. Decisions would need to be made about who would take on the other responsibilities that wardens have, such as triggering building maintenance and facilitating community events. Some existing sheltered housing schemes do not have a warden

service, just an alarm system, so there are existing schemes to model this on. People living on these schemes tend to trigger building maintenance themselves, the difference being that they have never had anyone else to do it; and thus show a higher level of independence.
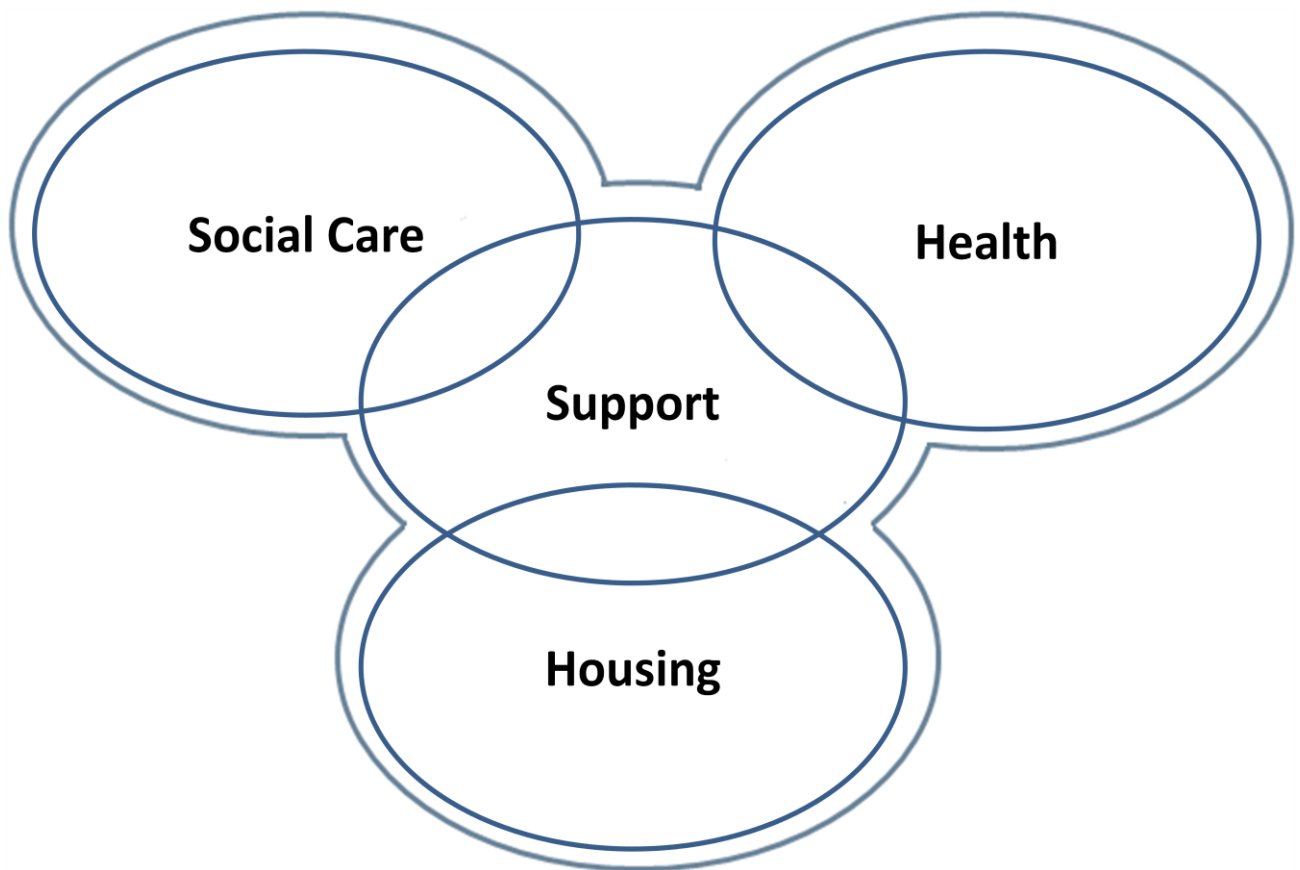
Figure 15: Venn diagram for Option Two

The Steering Group discussed this model and identified the following advantages:

i.   The high level of change would make it easier to create a new partnership model, as the OPHS would be driving this change and choosing this option would demonstrate the backing of all of the organisations involved in the Steering Group. Strategic-reactive changes, such as this one, are defined as 're-creation' in the aforementioned typology of changes based on scope, and are high intensity changes (Nadler and Tushman, 1989). This is an example of

structural integration, where organisations merge their services (Ham and Curry, 2011), whereas the other two options are examples of virtual integration. A commitment from all parties to this substantial, organisational change would demonstrate a commitment to implementing Housing into the whole system of care in Conwy.

ii. This option would be needs-based and inclusive as it would be available to everyone regardless of tenure.

iii. This radical solution would provide the opportunity for a complete overhaul of the way that support is provided. Chapter 7 provides more detail on what older people want from a support service, and this could be built into the new service much more effectively than by providing minor alterations to the current warden services. For example, jobs for support workers could be advertised as shift roles, so that the service could provide an out of hours rapid response team, which is something that the older people interviewed would value. However, the Steering Group highlighted that whilst the RSL's could in theory develop this service, the cost savings would be accumulated by Health and not them, as it would reduce ambulance callouts, so without funding from Health, it is not cost effective. A jointly funded support service would negate this issue.

iv. By separating the service from the housing providers, the wardens are less likely to be viewed as biased towards their own tenants. The joint service could hire employees with a strong local knowledge, who could recommend other services in their area.

The high level of change is also the main disadvantage to this option, as implementing this change is relatively complex:

i. Removing support from the control of the RSLs would require consultations with tenants, and changes to their tenancy agreements, which currently include support provided by the RSL. Therefore, there would need to be a high level of change for current sheltered housing tenants, which may not be met with enthusiasm.

ii. A new management structure for the new entity would need to be created, with funding from Health, Social Care and Housing.

iii. The high level of operational change would make this option expensive to implement, as it requires the hiring and training of new staff and the sourcing of office space. As a concept, it has unpredictable operating costs because it is so different to the current way of providing support.

Ultimately, this option was deemed too radical as it would require changes to government funding which the Steering Group had no control over. However, it was still discussed as some of the advantages to this option are desirable and the discussion opened up the conversation which ultimately led to the development of Option Three.

Option Three- Create separate support entity managed by an RSL

This involves creating a separate support entity which is still managed by Housing (Figure 16, page 139). It is a combination of Options One and Two as it separates support and Housing but having the new support entity managed by Housing. This model was developed following the Steering Group's analysis of the first two options. It would involve:

i. Standardising support across all RSL's, so that all support could be provided more efficiently by the new entity. In operations management, standardisation is a technique for improving design (Hill and Hill, 2011). It is synonymous with improved efficiency as, by standardising a process, waste can be easily identified and reduced; this is one of the cornerstones of lean thinking, which is a key tenet of operations management. When procedures are standardised, information can be easily disseminated (Meijboom et al, 2011). This would be beneficial, as a clear procedure for sharing information between wardens and other services in the whole system of care is currently non-existent, as identified by this research. From lean thinking, we understand that when something is standardised, it is easier to monitor and control its quality as parameters are clearly defined. By standardising the service,

it would be possible to ensure that the quality of support people are receiving does not vary based on their provider.

ii.   Choosing which RSL would manage the support provider for Conwy and moving current support staff over to the new support provider.

iii. Funding the service through Supporting People and the RSL's, but trying to attract funding from Health and Social Services by offering support that could potentially lighten their workload. This would involve demonstrating where support saves money elsewhere, by offering targeted prevention. Further funding could be used to develop the service further to bridge gaps in current services, for example, an out of hours rapid response team. This structure would simplify support into one service and thus make attracting funding easier.

iv.   Advertising support on a needs-basis, with the option to pay for the service if the client does not fit the assessment criteria but wishes to receive support anyway, or if the client is not eligible for Supporting People funding. This would help the new entity to achieve economies of scale for support by maximising the utilisation of each warden, as well as expand the provision of support across communities, instead of just offering it to those in sheltered housing.
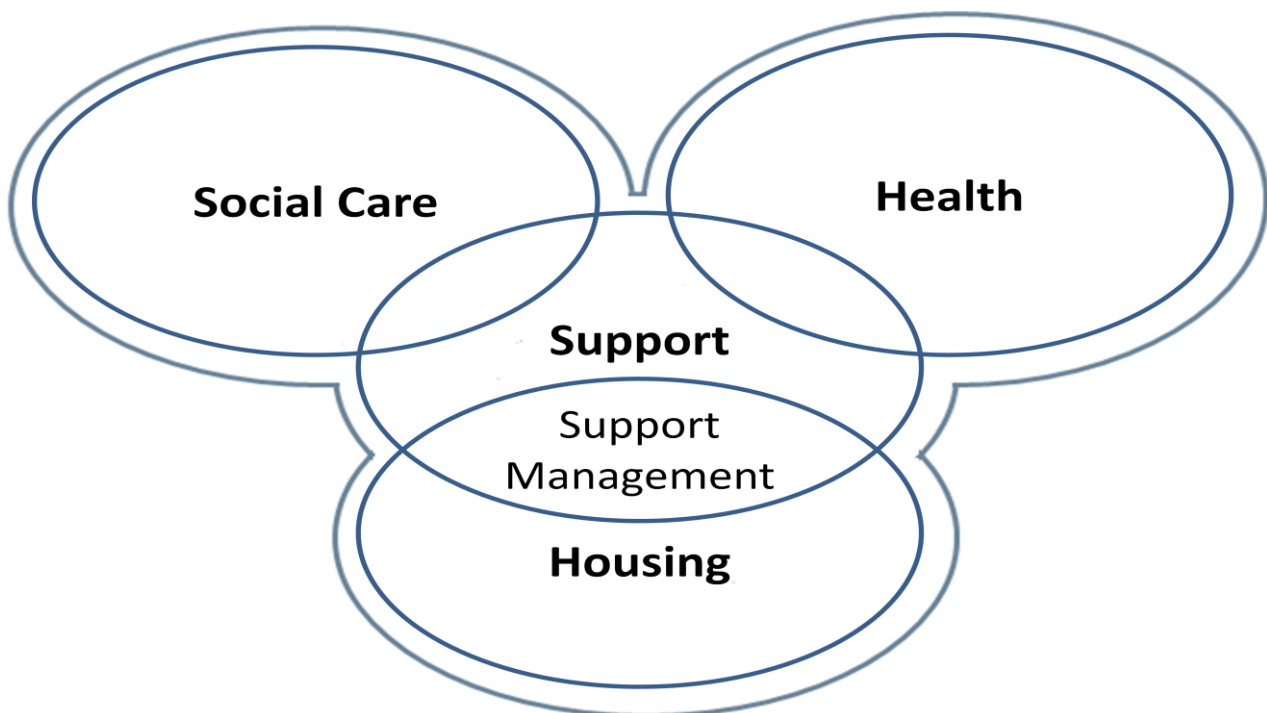
Figure 16: Venn diagram for Option Three

The Steering Group discussed this option and identified the following advantages:

i. The operating costs would be fairly predictable as support would still be managed by the chosen RSL.

ii. By choosing an RSL to manage the service, the group would ensure that the service would still be eligible for Supporting People funding. However, by combining all support into one service, Health and Social Services would be able to invest in its development. Currently, there are a lot of small, support services offered by each RSL, which is a barrier to investment; consolidation would reduce this complexity.

iii. It utilises the current management structures, making the best use of current staff. RSL's are experts at managing support services efficiently and effectively; it is an existing core skill. Separating the support and housing entities completely would mean losing these expertise.

iv. The new support service would be locality focused and inclusive, offering support to the wider community as well as to people living in sheltered housing.

The disadvantages are:

i. Most RSL's operate in numerous counties, so having another RSL providing the support in their schemes would not benefit them, as they would still need to offer support elsewhere. The reduction in their number of wardens may limit their ability to achieve economies of scale in terms of training and administration of the support team. So whilst this would be a good option for the county of Conwy, it may not be a good option from a business perspective for larger RSLs, who commonly operate in multiple counties.

ii. Legal complexities involved in creating a new entity and changing the service provider in current tenants' contracts would be costly.

iii. If wardens were no longer linked to particular sheltered housing schemes, someone else would need to take responsibility for triggering building maintenance, community development, etc.

iv.   There is also a barrier to this option from a funding perspective, as Supporting People funding goes straight to the RSL providing support, depending on the number of tenants in receipt of support. However, a couple of the RSL's had made the strategic decision to subsidise the cost of support through other means, so that they were not too dependent on Supporting People funding in light of the cuts.

5.3.4 Final Decision

Option Three seemed to address some of the key issues faced by Options One and Two, so it was considered to be the best option in theory, towards the integration of Housing into the whole system of care. However, the Steering Group felt that from a practical perspective, moving support to a separate entity would not be feasible in Conwy. This is despite the fact that this option was developed to address the Steering Group's concerns with Options One and Two. The main problem with this option is that four of the five RSL's (all but Cartrefi Conwy) operate across multiple counties and have standard systems in place for support provision. For example, Wales and West Housing has one hundred and twenty schemes for older people across Wales and the West of England, and only six of these are in Conwy, so only 5% of their volume of housing for older people is in this county (Wales and West Housing, 2012). Therefore, a change to their warden system in Conwy was not something that would fit with their support policy; this change would make Wales and West Housing's support service fragmented. This is a common problem in achieving integrated care, as identified by Leutz' "Law 3: Your integration is my fragmentation" (Leutz, 1999). The representatives from these four RSL's felt that they would not have the power to instigate this high level of change within their organisations. To operate differently in Conwy compared to other counties would not be cost effective and this option would only be worthwhile with the commitment of all RSL's to integrate their support services into a single entity. This made this option impractical with regards to implementation.

The Steering Group discussed the three options in detail and finally decided to move forward with Option One as this seemed the most feasible option to

implement. Option Two was ruled out early in the discussion as the group deemed it to be too radical, especially after concerns were raised that perhaps Health were not fully committed to the project. Some members of the Steering Group felt that Option Three would be worth pursuing, arguing that without substantial change to the way support is provided, Housing would remain on the perimeter of the whole system of care. However, others felt that the costs would outweigh the benefits, and were wary of losing control over their own support service. The SSM activity is not about reaching a consensus among the group, it is about finding an accommodation which usually requires compromise (Checkland and Poulter, 2006:55). Details of how the chosen option was implemented are included in Chapter 8.

5.4 Summary

This chapter focused on Research Objective 1: *Explore the current model of Health, Social Care and Housing in Conwy using soft system methodology (SSM) in order to identify potential integrating functions.* SSM provided a structured model of enquiry and the researcher found that extra care housing and residential homes are integrated with the whole system of care in Conwy, whereas sheltered housing and non-specialist housing are not, so the latter is where the research needs to focus. Developing a rich picture of the problematic situation helped to identify three potential integrating functions from existing services that visit older people in their homes: carers, support workers and reablement teams.

This SSM study concluded that support was the most feasible integrating function in Conwy, having ruled out reablement and carers. The benefits of using support are are:

i.   Support providers already have relationships with tenants in sheltered housing, so the change necessary to integrate Housing into the wider system of care is less substantial by using this existing service;

ii. The support role is at risk due to changes to Supporting People funding, making it essential to demonstrate the value of this service;

iii.   The changes to Supporting People funding mean that support now needs to be provided on a needs-basis and thus should be offered to people living in non-specialist housing anyway. By capitalising on a change that is happening already due to a change in policy, the RSL's in Conwy can shift this external influence from a threat to an opportunity.

SSM was effective at helping the Steering Group to develop an understanding of the whole system of care in Conwy, how the entities interlink and potential ways in which Housing could be integrated. Conducting the research in this way enabled the members of the Steering Group to sympathise with the pressures on other organisations within the system, thus breaking down barriers between them. Gaining the wealth of knowledge provided by bringing these people together was essential in conducting this research as, with a system as complex as this one, building a rich picture would not be possible without the experts who are able to describe how their own entity contributes and their perspective of the system.

This chapter then focused on Research Objective 2 which was to *develop conceptual models for integrating Housing into the whole system of care using support.* Three options were detailed and the Steering Group chose to implement Option One, which would involve standardising current warden services across RSL's, and offering support on a tenure neutral basis, meaning that anyone can receive support regardless of the type of housing they live in. A subgroup was established to implement the action plan for this in Conwy which was part of the OPHS.   More information about this is included in Chapter 8.

The next step in this thesis is to investigate changes to warden services in more detail in order to establish which operating structure is most appropriate on a micro level. A survey of warden structures in Wales was carried out in order to identify the strengths and weaknesses of the different models being adopted   and   to   conclude   how   Conwy   should   move   forward.

Chapter 6: Survey of other Local Authority Support Strategies in Wales

6.1 Introduction

This chapter addresses the case study objectives relating to hunting for, then analysing, best practice. Initially, the steering group wanted to look at other counties' Older Persons' Housing Strategies (OPHS) in order to compare content and build this into Conwy's strategy. However, it was found that no local authorities in Wales had a current OPHS under implementation. Although it was possible to use some of England's OPHS's for guidance, the group did not want this to be the focus of the survey, due to inherent differences in the ways in which England and Wales run their Health, Social Care and Housing departments. Therefore it was decided that it was still essential to look into best practice but the focus of the survey should change. Action research is commonly emergent, therefore a change in focus is not uncommon in action research. After much discussion, the Steering Group decided that investigating support and changes to warden services would be the most beneficial study for achieving the group's goal in providing a comprehensive OPHS. The justifications for this were as follows:

i.   The work prior to this had put an emphasis on support as a potential integrating function for Housing, Health and Social Care and highlighted that older people value their warden service;

ii. Changes to Supporting People funding meant that support was moving towards being funded on a needs basis instead of a tenure basis, meaning the service was in a transition phase dictated by policy;

iii. The transfer of housing stock by local authorities in order to raise capital to meet the Welsh Housing Quality Standards (WHQS) has also led to a transition phase, this time led by innovation, as these stock

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transfer organisations try to improve on the models they have inherited from the council;

iv.   The five Registered Social Landlords on the steering group ran their warden services differently and wanted more guidance on which way worked best;

v.   The literature indicated that the trend of moving towards floating support in England has not been well researched and may not be the best way to manage support services (King et al, 2009; Lawrence, 2008; Oldman, 2008).

Support therefore became the focus of Research Objective Three: *Explore and analyse existing support structures throughout Wales in order to identify the most effective and efficient way to structure the warden service*. This chapter analyses the current trends in support provision in Wales in order to identify issues and concerns associated with such a rapid change away from traditional support services. It provides some detail about the background of sheltered housing and support in the form of wardens. It then presents the research method for conducting the survey, the results and analysis.

6.2. Background

Sheltered housing was developed as an alternative to residential care (care homes) in the 1960's, following Townsend's 'The Last Refuge' (1964), which criticised the standards of residential homes in England. It became a popular choice for older people, as many people in existing residential (institutionalised) homes did not require the higher levels of care and support provided (Nocon and Pleace, 1999). Generally, tenants of sheltered housing were supported by a warden who lived on site so that they were always available in case of an emergency. The role of the warden was to provide support, advice and guidance (Milligan, 2009:96). However, this does not include care, such as personal or domestic care, but should instead complement and provide a bridge to care services. Housing related support usually involves checking in on a tenant, ensuring alarms work, signposting services, helping a tenant to claim benefits and encouraging community integration.

Other than the warden, benefits of living in sheltered housing include security, accessibility, social benefits and maintenance of the property and garden (Heywood et al, 2002:82). Some people have moved into sheltered housing as they were on the waiting list for social housing and, due to their age, this was what was offered to them. Therefore, it may not be the type of housing that attracted them, but other factors such as location, availability and cost.

The National Health Service and Community Care Act (1990) introduced new community care arrangements. The key principle was that no one should have to move house in order to receive care and support. The emphasis on keeping people in their own homes wherever possible brought the function of sheltered housing into question post-1990. Community Care arrangements often mean that older people with care needs are able to live in their own homes, whilst others who may be healthier live in sheltered housing. People wishing to avoid residential homes, as their health deteriorates, no longer have to move into sheltered housing to get the help they need, they can be cared for in their own homes, i.e. enabled to achieve the maximum possible independence (Drake and Davies, 2007).

Despite the push towards helping people maintain independence in their own homes, sheltered housing is still a popular option for older people, with 7% of Britain's older population choosing it (Essential Role of Sheltered Housing, 2010; English Housing Survey, 2011). However, "the new and emerging models of housing with care have received quite a lot of policy and research attention, as well as significant levels of funding, but 'traditional' sheltered housing has received far less attention" (Croucher, 2008). Traditional sheltered housing is therefore the focus of this work, in order to bridge this gap. Sheltered housing providers view it as an option where people can maintain their independence, with support if they require it. Whilst care can be provided in any type of housing, support can be difficult to access by a person living in their own home, whereas in sheltered housing, wardens provide it by default.

6.2.1 Funding

Traditionally, housing related support, provided by a warden in sheltered housing, was funded by a local authority's Housing Revenue Account, which was pooled from the rents of people living in council housing in the county. Therefore, anyone who lived in a council property was contributing to the cost of support, regardless of whether they received support or not. When the British Government introduced 'Supporting People' funding in 2003, there was a debate over whether the support provided by a warden in sheltered housing should be included (Wilson, 2012). There was concern that by separating funding for housing and support services, sheltered housing would become fragmented and confusing for older residents. Fears were justified and in trying to prove that their support service offers good value for money, many housing associations and local authorities have looked at restructuring. This is leading to a reduction in the use of traditional residential 24/7 wardens and a growth in non-residential 9-to-5 cover (a phrase commonly used to describe the conventional working day of 9am to 5pm) and floating support services (Wilson, 2012).

Previously, support was tenure-based so the Supporting People Programme paid the service charge of any sheltered housing tenant who was in receipt of housing benefit (from the state) and this went towards paying for the warden. However, following the Supporting People Review in April 2014, funding should now be dependent upon an assessment of individual needs, i.e. needs-based. Registered social landlords (RSLs) in Wales have been given two years to restructure their services to meet these changes. Many sheltered housing providers are assessing the demand for their warden service in the local community, so that their wardens will still be fully utilised and financed. In England, a common trend has been towards moving the wardens out of their schemes and having a mobile, floating support team instead (King et al, 2009).

6.2.2 Changes to warden services

Many tenants of sheltered housing who moved in prior to these changes chose this type of accommodation because they wanted the low level of

support that wardens provide (King et al, 2009). Having a residential warden makes people feel safer, as they think the warden would reach them faster than emergency services. Nocon and Pleace (1999) conducted a satisfaction survey of tenants living in sheltered housing and found that 54% of those who had 24 hour cover from an onsite warden and who received regular checks were wholly positive about the service, with a further 17% who were mostly positive. For those who did not receive these benefits, 62% made solely negative comments. In 2009, a High Court judge stopped Barnet Council scrapping residential wardens, as the provision of the warden was part of elderly residents' tenancy agreements (Booth, 2009). However, other local authorities, such as Derby, have gone through this process without protest from tenants, successfully removing residential wardens and replacing them with offsite support. It is estimated that 25% of sheltered housing schemes no longer have a warden (Age UK, 2014a).

The move away from residential wardens is partly driven by the European Working Time Directive, which makes it illegal for staff to work throughout the day and then still be on call at night throughout the week (European Parliament, 2003). In 2003, residential wardens in Harrow won their case against the council due to the high number of hours they were on call on top of their normal working hours. The council had to pay out a significant amount in compensation, and other local authorities began taking notice of the hours their wardens were on call (Lawrence, 2008).

Changing the warden service often means changing what attracted tenants to sheltered housing in the first place which raises legal and ethical issues. Therefore, local authorities and housing associations need to be very careful before removing residential wardens. They should ensure that they consult with current tenants to help them to understand why it is necessary and how they will be supported in the future (King et al, 2009). Many associations have chosen not to replace residential wardens once they leave/retire, making the change more comfortable for tenants, who naturally tend to become attached to their warden.

6.3 Research Method

Research Objective Three was conducted using telephone interviews during July-September 2011. One of the main benefits of telephone interviews is that they provide wider geographical access (Mann and Stewart, 2000). Co-ordinating visits for face-to-face interviews in every county in Wales would have been extremely difficult, especially during the summer months when people commonly take holidays. There was also limited funds available for travel, so telephone interviews were deemed the most appropriate method. Face-to-face interviews are widely considered to be a better method for interviewing, as they enable the researcher to also note body language and other social cues (Opdenakker, 2006). However, they were not possible in this instance due to cost and time limitations.

Participants were sent an email detailing the project and asking them to participate in a thirty minute telephone interview at a time that suited them. This ensured that the participants were expecting the call, and had set aside time for the interview so they did not feel rushed. Detailed notes were taken during the interviews, and written up shortly after whilst the interview was fresh in the researcher's mind. The majority of questions were open-ended, to enable the participant to provide rich, detailed information. Questions covered numerous aspects of the content for the OPHS, including care, rapid response and housing options available for older people. However, emphasis was placed on the support questions to ensure that participant responses were comprehensive. A full list of the questions asked during the telephone interviews is included in the Appendix.

The initial sample was each Welsh county's Older Persons Officer. An email was sent to each local authority's Older Persons Officer in Wales, requesting their participation in a thirty minute telephone interview. However, recommendations were made during the initial interviews for gathering further information and many of the people who were initially contacted forwarded the email to a colleague, so snowball sampling took place. During the interviews, participants were asked about the structure of their older persons support service and the responsibilities of the warden. Following the first two

interviews, it was found that housing officers were able to give a much clearer picture of the support strategies in place, so a housing officer from each local authority was contacted via email to arrange an interview. Local authorities that had undergone stock transfer often provided a contact for the individual currently running the warden service, so they were also interviewed wherever possible. Therefore, the summaries for each local authority were built from interviews with numerous individuals.

Fifteen of the twenty-two local authorities in Wales responded and were interviewed, giving a response rate of 68%. However, as many were suggesting moving towards a fully mobile service, but none had yet fully established this service with a charging structure, Derby in England was interviewed as its service fits these criteria. Westminster in England was also interviewed as the National Consortium for Housing and Support (a charity called 'Essential Role of Sheltered Housing or EROSH) highlight Westminster Council as providing a best practice model for community activities that integrate with Health and Social Services (Parry, 2008). These are examples of purposive sampling.

The findings on the case study of Conwy from the last chapter were also used to provide context to the responses. This highlighted the complex nature of support provision in sheltered housing, with a discourse between what tenants want from support and the concerns faced by providers. SWOT analysis was used in analysing the onsite 9-to-5 and offsite warden options being introduced to replace residential 24/7 wardens.

6.4 Results

The purpose of this part of the research was to explore and analyse existing support structures throughout Wales in order to identify the most effective and efficient way to structure the warden service. Therefore, a summary of the approaches used to provide support in each local authority interviewed is given below. These summaries are written based on the questions about support asked to each interviewee, which were, "*What is the structure of your warden service? What type of things do the wardens do? Are they funded by*

Supporting People?". Whilst the interviews covered other elements that were to be included in Conwy's OPHS (see Appendix), this was the most pertinent question for meeting this research objective. However, the notes from the whole interview were examined to ensure that everything pertaining to the theme of support was included in the summaries. For example, when asked about popular community activities, the majority of participants talked about the role of the support provided in facilitating or organising community activities. Whether or not the local authority had been through stock transfer has also been included in this summary in order to provide context.

Caerphilly

At the time of the interview, Caerphilly was waiting on the results of a stock transfer vote, so had decided not to replace wardens as they left (Caerphilly have since voted against transfer). Therefore, each warden was covering two to three schemes (depending on scheme size) on a floating support basis. This is proving to be successful and it was hoped that they would be able to develop the service further to support owner-occupiers in the community. Support plans were the priority, so wardens have minimal involvement in community development.

Cardiff

Housing stock kept in-house and on target to meet WHQS. Traditional, 9-5 wardens develop and follow support plans and are responsible for organising community activities. Council hoping to update service to have six floating support officers across the nine schemes. The new role would require the support officers to ensure that other services come into the community to support residents and a higher wage will reflect this extra work. A previous pilot into providing floating support was not managed well and left tenants disgruntled, so Cardiff had to look for another method to change the service.

Carmarthenshire

Retained housing stock and on track to meet WHQS by the end of 2012. Hire scheme managers who are responsible for managing the building

maintenance and providing support for the tenants living in their scheme. Developing the community should be a separate role as it requires different skills, so this is covered by the Community Planning Department. Currently piloting a scheme where its wardens provide support for non-residents. Tenants can opt out of support service and wardens use the free time to visit people in the community, in partnership with the Red Cross, who provide Community Workers to meet fluctuating demand. Pilot deemed a success so currently looking into commissioning Community Workers to roll out scheme.

Ceredigion

Transferred stock to Tai Ceredigion (RSL) in 2009, including sheltered housing and 9-5 wardens. Wardens responsible for support plans and community development. Lack of housing for older people in this county resulting in people choosing to move into sheltered housing in order to downsize. Therefore, the level of support required by tenants is often low, leaving the wardens more time to focus on community development. Housing associations have been praised for ability to win grants to financially support this. Currently, there is an emphasis on engaging with the local community due to a lottery bid.

Conwy

Transferred housing stock to Cartrefi Conwy (RSL) in 2008. Approximately one-third of stock is sheltered housing. Traditional wardens on most schemes are responsible for support plans and helping to organise community activities for tenants and the wider community. Currently working to develop a more integrated approach to providing support across all RSLs operating in the area. Wardens would be based at a scheme but would operate over an area, also visiting other RSLs tenants and owner occupiers when they require support.

Denbighshire

Retained housing stock and are on target to meet WHQS by the end of 2012. Currently phasing out residential wardens gradually (reduced from 23 to 4)

and are moving towards a more traditional, 9-5 warden structure. However, many schemes are rural, so either assign wardens one large scheme to work on 9-5, or a patch of small schemes to cover on a floating basis. For those wardens that are assigned to one scheme, they have a responsibility for organising community activities within that scheme.

Gwynedd

Transferred housing stock to Cartrefi Cymunedol Gwynedd (RSL) in 2010. At the time of the interview, had residential wardens at most sheltered housing schemes, however this was being reassessed and those who retire were not being replaced. Working hours are set on the basis of the warden spending forty minutes a week with each tenant. However, tenants can opt out if they wish, giving the wardens time to arrange community activities. This is part of their job role and many wardens often end up doing this in their own time. Some wardens also work part-time for Social Services, providing care to tenants. This works well as tenants only have to see one individual, although there are challenges in meeting the needs of both roles.

Isle of Anglesey

Retained housing stock and have 9-5 wardens but looking to develop a mobile support service. The remodelling is intended to make better use of existing capacity. Wardens are responsible for organising community activities and encourage tenants to invite people from outside the scheme to their events. This part of the job will potentially be covered by a Community Development Officer once the wardens become mobile. This officer would need to have a strong knowledge of the local community.

Merthyr Tydfil

Transferred housing stock in 2009 to Merthyr Valley Homes (RSL). Have some full time residential wardens and some part time wardens, responsible for housing management and housing related support. Also signpost tenants to Social Services if they develop care needs, and take a facilitating role in

community activities. Tenant participation officers help to develop tenant groups, so wardens are not too heavily involved in this side of things.

Newport

Transferred housing stock to Newport City Homes (RSL) in 2009. Have scheme managers at sheltered housing schemes, who take on a managerial role as well as the regular warden responsibilities. They facilitate the development of tenant committees, so that tenants can develop their own communities. In September 2011, Newport City Homes were consulting with tenants over changes to the services provided by the scheme manager. They found that tenants were happy for the role to evolve but often wished to keep their current warden. Newport set up an annual warden conference to give the scheme managers the opportunity to share best practice. This has resulted in the RSLs operating in the area slowly adapting their job descriptions, providing a much more standard service across the county.

Pembrokeshire

Retained housing stock although their business plan is under annual review to ensure they meet WHQS. Have 9-5 wardens at sheltered housing schemes, who provide support based on the needs of each tenant. Wardens do not currently get involved in developing community activities. However, there is a push towards this and one scheme is currently piloting a project. Also trying to develop a scheme to help people who are under occupying to move into sheltered housing and the wardens will be a key component of this new scheme.

Swansea

Retained stock and thus manage it in-house. Schemes generally have residential wardens. However, smaller schemes are covered by a mobile warden team. Wardens provide support and are responsible for facilitating the development of community activities. Some RSLs in the area are developing much more mobile teams and whilst Swansea are not driving this change,

they are in support of it due to the Supporting People Review. It is a matter of time before they begin to reconfigure their own support services.

Torfaen

Transferred housing stock in 2008 to Bron Afon (RSL). In 2010, Bron Afon decided to remove the wardens from its schemes to a central hub. These sheltered housing officers still provide support, but they now cover an area as part of a team, instead of being assigned a single scheme. They support people both in sheltered housing and the community, who are referred to them by the local authority based on need. Some of the sheltered housing officers are specialists in certain areas and the senior support officers take this into account when assigning visits. The service is funded by Supporting People and subsidised by the housing association and therefore is free to clients. In order to continue the development of community activities within schemes following the removal of wardens, two Volunteer Co-ordinators have been appointed to help implement a befriending scheme. They too float between schemes.

Vale of Glamorgan

Voted against stock transfer shortly before the interview took place. Therefore trying to make changes quite quickly in order to find other ways to meet the WHQS. Changes are being made to the warden service, which will now be provided only for people over 60. Support will be provided to the tenants that need it in the morning then to the surrounding community in the afternoon, making the scheme the hub in a hub and spoke model. One warden's role will change and they will become a Community Organiser, with the other wardens covering their scheme. This means that the regular wardens will no longer be responsible for community development, as this dedicated member of staff will take this role.

Wrexham

Voted against stock transfer. Some wardens are residential wardens and others provide floating support. Wardens conduct needs based assessments

to establish the levels of support required for each tenant, instead of providing support on a tenure basis. Doing this released about 25% of the wardens' capacity, enabling them to support to the wider community. This provides a natural change into a more flexible service, so as not to upset tenants. Those receiving support in the wider community must first sign up for a basic Telecare package, to ensure they can access support in an emergency. Tenants generally take responsibility for arranging community activities, and it is the warden's responsibility to ensure tenants engage with the wider community.

Derby

Derby Homes is an Arms Length Management Organisation that manages Derby's housing. It cut down its wardens from fifty to twenty over two years and halved the support budget by providing a floating support service instead of residential wardens. Derby Homes consulted with tenants before making the change gradually and received little opposition. The level of support provided can be stepped up or down depending on the clients' needs and the cost is standard regardless of how much support they receive. This cost is covered by Supporting People for those who do not have the means to pay. For those who do not require visits, a community alarm can be fitted in their home. For an extra 50p a week, this can be connected to the rapid response service which operates 24/7.

Westminster

Created an Arms Length Management Organisation in 2002 called City West Homes. This organisation manages all of the council's housing stock. Residential wardens in all sheltered housing schemes. Wardens provide support and trigger building maintenance. Over the years, wardens have developed a strong relationship with Social Services and their local PCT in order to provide community activities that benefit tenants and the local community. Daycare services run activities such as Tai Chi, falls clinic and flexicise classes in return for the use of the community room. People from Health come in to run activities and use the events as an opportunity to collect

data about tenant's health (eg overweight, breathing issues etc). Westminster trains its scheme managers to apply for lottery bids so that more activities can be run. Currently in Westminster, no individual pays for the warden service, the costs are covered by the Housing Revenue Account.

6.5 Analysis

The results show that local authorities and RSLs use various support strategies. The choice is dependent on numerous factors discussed in this analysis, along with the strengths and weaknesses of each. Although they may be named differently in each county, three common structures have been identified based on key elements of the warden's job.

i) *Residential wardens* live on site and are only responsible for their own scheme.

ii) *9-to-5 wardens* are based onsite but work weekdays only and have an element of community development as part of their job role. They may also be referred to as scheme managers and some counties have added some managerial duties to this role.

iii) *Floating support/mobile teams* are based offsite, so they can cover a number of different schemes, supporting tenants on a needs basis.

The following taxonomy of support services (Table 5, page 160) summarises the results. It shows that all of the local authorities have moved, or are in the process of moving, away from residential wardens to 9-to-5 onsite wardens or floating, offsite wardens. Some are using floating wardens to cover sites with no warden whilst they develop their new support policy, whilst others are simply replacing any residential warden that leaves with a 9-to-5 warden.

Residential wardens cannot work during the day and be on call at night due to the EU working time directive. If wardens do not offer 24/7 cover then the provision of accommodation is no longer a cost effective option. Furthermore, it has become increasingly difficult to find people who want residential employment (Wilson, 2012); perhaps this is something from a bygone age. The Cartrefi Conwy case study and other anecdotal evidence revealed this to

be a real issue. By advertising for 9-to-5 wardens Cartrefi Conwy has been able to attract candidates that treat the role as a professional job that offers them both empowerment and career progression. Whereas the traditional, residential warden was viewed as more of a 'good neighbour' role (Heywood et al, 2002). The type of person hired as a warden is important, as tenants are essentially locked into this relationship, so their warden greatly impacts their experience of sheltered housing. As the requirements of the warden function grow including provision of higher levels of support and a wider site management role, the professionalisation of the role is most important.

Eighty-two percent of the counties interviewed were either currently reviewing, or had recently reviewed the support that they offer tenants in sheltered housing. This further supports the Steering Groups decision to explore this area in more detail. Very little guidance on the relative merits of the different warden service structures can be found. This research bridges this gap.

The taxonomy in Table 5 (page 160) shows that the current trend is to move to 9-to-5 onsite or floating offsite wardens. A more detailed analysis of these structures of provision is therefore conducted below to understand them better. The discussion is based around a SWOT analysis and the points raised from this, summarised in Tables 6 and 7 (pages 162 and 164) for onsite and offsite support respectively. The SWOT analyses are used to illustrate how to seek the best from these models of support provision, whilst mitigating their weaknesses and defending against their threats. The strengths and weaknesses have been grouped into themes in order to highlight the fundamental differences between onsite and offsite support. These are then mapped against standard operations performance objectives.

Performance objectives are "the dimensions of an operation's performance, with which it will attempt to satisfy market requirements" (Slack and Lewis, 2002:41). This research has identified numerous models for further developing the support system in sheltered housing, with the analysis focusing on the two most feasible models (now that schemes are moving away from residential wardens). The SWOT analyses for both onsite and offsite support highlight the strengths and weaknesses with each system, but

the researcher wanted to further categorise these from an operations management perspective, in order to establish the ability of each model of support provision to meet the needs of the people who require support. The fundamental strategic performance objectives that are closely related to customer satisfaction requirements are speed, dependability, flexibility, quality, and cost and these apply to all organisations (Batista, 2012; Slack et al., 2011). Therefore, each support model was mapped onto these widely accepted strategic operations performance objectives, in order to consider these models from a variety of angles, instead of just focusing on cost.

Table 5: Taxonomy of Support Services

County	Stock Transfer			Reassessing Support Structure			Warden Service — Onsite		Offsite	Developing Community			
	Yes	No	Voted Against	Yes	No	Recently Completed	Residential	9-to-5 Warden	Floating	Wardens Organise	Wardens Facilitate	Community Organiser	Other
Ceredigion	X				X			X		X			
Conwy	X			X				X		X			
Gwynedd	X			X			X	X		X			
Merthyr Tydfil	X					X	X	X			X		X
Newport	X			X				X			X		
Torfaen	X					X			X				X
Cardiff		X		X				X		X			
Carmarthenshire		X		X				X				X	
Denbighshire		X		X			X	X	X	X			
Derby		X				X			X			X	
Isle of Anglesey		X		X				X		X			
Pembrokeshire		X		X				X					X
Swansea		X			X		X		X		X		
Westminster		X			X		X		X	X			
Caerphilly			X	X						X	X		
Vale of Glamorgan			X	X				X	X			X	
Wrexham			X	X			X	X			X		

6.5.1 Onsite Support

Onsite wardens tend to work approximately 9-to-5 on a particular scheme, providing support to tenants, based on biannual support plans, encouraging the growth of their scheme's community and helping to integrate new tenants. Individual dwellings on sheltered housing schemes are fitted with community alarms, so tenants simply pull the cord or press the button on their pendant to summon the warden. If they do this out of hours, the call goes through to a call centre that assesses the severity of the issue and either calls a relative of the tenant, a rapid response team or an ambulance. Telecare can be fitted to a property if a tenant has a specific need and sensors trigger a response, for example, if a tenant falls.

The role of the warden has shifted from "good neighbour" to one that "emphasises enabling and coordinating" (Heywood et al, 2002). For example, Communities and Local Government (2008) state that those moving into sheltered housing should expect, "facilitated access to care services", and "a facilitated social and recreational activity programme" and the role of a facilitator is to enable and coordinate. As discussed, the 9-to-5 warden is viewed as a more professional role, so these wardens are more able to deliver this than residential wardens, who the tenants still tend to view as a 'good neighbour'.

Table 6: SWOT analysis of Onsite Support

Strengths	Weaknesses
1. Dedicated 1.1 Consistent point of contact for tenant 1.2 Trust developed with tenants and their families 3. Trigger building maintenance **2. Signposting** 2.1. Monitor tenants health and signpost services 2.2. Empowers and encourages supportive warden **3. Community** 3.1 Strong knowledge of community 3.2 Integration of new tenants	**1. Cost** 1.1 Not charged based on needs 1.2 Difficult to monitor productivity **2. Inflexible** 2.1 No out of hours provision on-site 2.2 Locked-in relationship even if it is poor 2.3 Personality dependent 2.4 Covering sick leave/holidays
Opportunities	Threats
1. Support wider community by allowing people to opt in/out 2. Integrate community with Social Services 3. Keep tenants generally informed 4. Information Technology 5. Telecare 6. Those receiving housing benefit get the service paid for by Supporting People 7. Provide direct payment advice/support 8. Flexible working hours	1. Tenants health deteriorates to the point where sheltered housing is no longer appropriate 2. Supporting People funding at risk 3. Risk of isolating market by making everyone pay for service as those without support needs may be put off 4. Lone workers 5. Paperwork

6.5.2 Offsite Support

With offsite support there is no immediate or overriding link to sheltered housing schemes, meaning it is accessible to the wider community. Those in need of support can access the floating support team, regardless of the type of accommodation they live in. Thus the service supports Community Care and the more recent Personalisation Agenda which promotes both access and client control over services (HM Government, 2007). This service model is also more flexible and can be used to develop an out of hours rapid response team. Flexibility in the service also makes it easier for the provider to schedule training to upskill their staff.

Offsite support officers can be highly utilised reducing unit costs and enabling more support to be provided per pound spent. Due to the team focusing wholly on support, numerous schemes can be covered by one member of the team, reducing the total number of staff required. Technology such as tablets can be used to update support plans with clients, so each member of the team has up to date information. This structure is also more capable of supporting people outside of sheltered housing, and providing rapid response outside of regular working hours, due to its flexibility. The higher levels of utilisation afforded by offsite support can free up capacity to provide rapid response to alarm calls via the call centre, not only for sheltered housing tenants but also people in the wider community. It is common to have floating support officers with no fixed schedule to respond to emergencies and cover for those who are on leave. When visiting a client, the support officer can provide the same level of support and are able to signpost other services.

Table 7: SWOT analysis of Offsite Support

Strengths	Weaknesses
1. Cost 1.1 Needs-based charging 1.2 Wardens fully utilised so lower unit cost **2. Flexibility** 2.1 Include wider community in scope 2.2 Can be used to respond to emergencies 2.3 Easier to arrange cover and provide training 2.4 Varied, attractive job **3. Technology** 3.1 Reassurance from community alarms 3.2 Side effect of getting more community alarms into more homes	**1. Reduced consistency** 1.1 Tenants feel less secure 1.2 Deterioration of health may be missed due to different workers 1.3 Difficult to build relationships 1.4. More complex communication channels **2. Community Deterioration** 2.1. No community development 2.2. No one to trigger building maintenance 2.3 Integration of new tenants **3. Hidden Costs** 3.1 Complex scheduling 3.2 Travel costs
Opportunities	**Threats**
1. Supported by policy (SP Review) 2. Offer rapid response for out of hours emergencies 3. Information Technology 4. Telecare 5. Those receiving housing benefit get the cost of the service covered by SP 6. Develop voluntary groups to support community 7. Flexible working hours	1. Tenants health deteriorates to the point where sheltered housing is no longer appropriate 2. Supporting People (SP) funding at risk 3. Lose tenants to schemes with onsite wardens 4. Community deteriorates 5. Deterioration of buildings 6. Paperwork 7. Lone workers

6.5.3 Comparing Models against Performance Objectives

In operations, there are five commonly accepted strategic performance objectives: quality, speed, dependability, flexibility and cost (Slack and Lewis, 2011:47). "Strategic operations performance objectives are essentially related to satisfying customer requirements" (Batista, 2012:127). Mapping these established performance objectives against the two support service structures provides a theoretical anchor for the analysis, encouraging the consideration of the services operational abilities to meet market requirements, from all angles.

Quality

Measuring the quality of support is complex, as good quality support is dependent on what it is the client needs. Slack and Lewis (2011:48) advocate considering the hard and soft dimensions of the service specification and its ability to conform to that specification. Hard dimensions consider more objective elements that are easy to measure, such as the amount of time spent with each client. However, soft dimensions are arguably more important here, as there is little point in a warden who spends a decent amount of time with each client but does not help them in any way. By their very nature, soft dimensions of quality are difficult to measure. Subjective judgement results in an inability to place a value on the quality of the relationships between the client and worker and this is an issue that is also experienced in social care (Malley and Fernandez, 2010). However, soft dimensions cannot be disregarded as the Personalisation Agenda has placed an emphasis on a more client-centred approach, so meeting the needs of the client is now at the heart of the whole system of care.

Due to the fact that they are onsite daily, onsite wardens develop a strong knowledge of their community and their tenants, which enables them to notice any changes to a tenant's health and signpost the appropriate local services to deal with that change, thus offering a better quality service from the soft dimension. There is an opportunity to take this further by providing wardens with details of local services and encouraging them to refer tenants for direct payments if they are unhappy with the care they are receiving. There is an opportunity to improve the signposting of other services provided by wardens in sheltered housing, and to develop this as a

key feature of support. It is in a sheltered housing provider's interests to provide information about preventative services, because if a tenant's health and ability to live independently deteriorate too much, then they will have to move out of sheltered housing and into housing with care, such as extra care housing or a residential home.

Services involving signposting rely heavily on the concept of coproduction with clients. Coproduction has been defined as "the mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals, or 'regular producers' while 'citizen production' is based on voluntary efforts by individuals and groups to enhance the quality and/or quantity of the service" (Parks et al, 1981:1002). Whilst it is the signposter's job to refer the client to appropriate services, it is the client's job to follow up on referrals and generally exploit the opportunities. Onsite wardens are perfectly placed for coproduction, as they see tenants regularly and are therefore better able to follow up on any advice given, thus increasing the chances of citizen production and offering a more complete, better quality service.

Offsite support means tighter schedules and a rotation of wardens, so there is less opportunity to build relationships casually with clients. Consequently, the client may feel less comfortable sharing important personal information, such as if they are struggling with bills and need financial advice. The complex nature of scheduling for this type of service means that a tenant may be visited by numerous support officers, so deterioration in their health may not be noticed as quickly; human disasters in social care due to fragmented supply networks are well documented (see Ham et al, 2012). Complex scheduling is necessary to ensure that expensive travel costs and wasted time are kept to a minimum. However, it gives tenants less control over the times they are visited. Clients may be left unsure of whom to contact to change a visit time or to ask questions. This therefore goes against the Personalisation Agenda's emphasis on client's choice and involvement.

Offsite support therefore does not perform as well against the soft dimensions of quality as onsite support. It is a more transaction-based relationship between the customer and service provider, which limits relationship development and

coproduction. However, for the hard dimensions of quality, tighter scheduling increases the number of clients that can be visited in a day, leading to a more efficient service. The major benefit of offsite support is that the service can cover a wide area, visiting tenants of sheltered housing on a needs basis only, so it fits with the government's new Supporting People policy, (i.e. needs-based funding) and thus meets the specification of the service as established by the Welsh Government. It is argued that technological advancements mitigate the need for high level, residential support, as tenants of sheltered housing can feel safe and secure in the knowledge that they have an emergency alarm fitted. On top of this, Social Services can assess the tenants to see if they would benefit from Telecare products to reduce their vulnerability.

Flexibility

Flexibility represents the ability to fulfil existing customer requirements in different ways (range) as well as being able to change (adapt) the operations to fulfil new requirements (Batista, 2012). Onsite wardens also have a responsibility to their scheme, they trigger building maintenance when necessary and encourage the growth of the community, demonstrating range. Offsite support teams do not have these duties as part of their role and therefore the reduction in the cost of support provision will lead to costs elsewhere, as these functions will need to be performed by someone else. The taxonomy shows that the move away from residential wardens is leading to the introduction of another person to act as the community organiser. Another option is to see it as an opportunity to empower tenants to run their own scheme by reporting problems with the building and volunteering to set up community activities. This could reduce the attractiveness of sheltered housing; as such coproduction might not appeal to everyone in later life. Thinking more innovatively and positively, it might provide the basis for a social enterprise to engage some older people as well as other people in the community.

However, an offsite support team is a more flexible service in terms of adaptability, as the team is not tied to a particular scheme, area or type of housing. This enables offsite support services to support a wider target market and offer out of hours rapid response. "The move towards reducing onsite wardens needs to be set against the

positive developments in the role of mobile wardens in rural areas, able to develop a role in delivering services to people who want this kind of service in whatever tenure they happen to live in" (Bevan et al, 2006:18). A floating support service improves choice for people living in their own homes, but worsens choice for those living in sheltered housing.

Speed

In this system, speed is important in terms of the amount of time it takes for a warden to get to a tenant in an emergency. As the warden is based on site from 9 to 5, this system meets this performance objective, but only during these hours. Outside of these hours, there is no cover on the scheme, so the call would be passed through to a relative or the emergency services.

With offsite support, there is increased flexibility in the development of the service and therefore, more scope to develop an out of hours rapid-response service. With a team of people to call in an emergency instead of just one, this service is better able to respond, regardless of the time of day.

Dependability

Dependability is the "ability to deliver products and services in accordance to the promises made to customers" (Barnes, 2008:24). Onsite support is a more traditional model than offsite support, and it meets the criteria of what is promised to tenants when they move in to sheltered housing. However, support is not a one-off purchase and the link between support and sheltered housing is over fifty years old. Developments in technology have meant that all sheltered housing schemes are now fitted with an alarm for emergencies, and if this provides an appropriate level of support during the night, then it should also be appropriate during the day. Perhaps it is time that this service is brought up to date with modern day society, with a focus on efficiency and equality.

It is important that a change in the structure of a support service is handled appropriately as it is a most sensitive issue; consultation with tenants is key (King et al, 2009). The issue is sensitive as it involves changing the nature of sheltered housing as an option for older people, guaranteed onsite support may be the reason

that tenants chose to move in. In a study on supporting older people in rural communities, "on-site wardens with a generic support role were seen by some respondents as a pull factor, making sheltered accommodation an attractive option for them" (Bevan et al, 2006:17).

With regards to the ongoing services, onsite wardens are dependable in the sense that they are consistently around from 9-5, Monday to Friday. For an offsite service to be effective, effort must be made to ensure that clients can be given a workable time slot for their support. This type of scheduling is complex because the amount of support a client will need when the warden arrives my vary; the demand is unpredictable. Travel costs need to be kept to a minimum for this service to operate efficiently.

Cost

The main threat to the onsite model is reduced state funding. Wardens providing onsite support develop support plans with their tenants to ensure that they all receive the level of support that they require. However, all tenants pay the same for this service, regardless of the level of support they receive. Supporting People guidelines are changing, so support will have to be provided on a needs basis, instead of a tenure basis (Welsh Government, 2013a). Not everyone living in sheltered housing will need support under the new definitions, despite the fact that they may want it. This will reduce the number of people in sheltered housing that can access the support service, so onsite wardens will become underutilised and uneconomical. One solution, as discussed already, is to use offsite wardens so that capacity is spread across sites ensuring much higher levels of utilisation and therefore lower costs per client.

"Budget and other pressures have increasingly led local authorities to re-tender support contracts... many replacing them with peripatetic, shared or 'floating' support services" (Pannell and Blood, 2012:17). The reason that offsite support costs less is that it is more efficient, with wardens focusing solely on support provision and only visiting clients with an assessed need for support. Onsite wardens are commonly not fully utilised as the number of people requiring support in their schemes is not high enough, whereas offsite wardens cover multiple schemes. When Derby moved to

offsite support provision, they were able to cut their warden team from fifty to twenty, resulting in a significantly lower cost service. It is estimated that around 25% of sheltered housing schemes no longer have an onsite warden, following significant cuts in Supporting People funding; pushing local authorities to reassess their services (Age UK, 2014a). Those in favour of offsite wardens would argue that if this alarm service is appropriate for managing scheme support during the night, it is also appropriate during the day, so the cost of a onsite warden does not represent best value. However, this view does not account for the additional costs elsewhere that are caused by the loss of onsite wardens, for example, the cost of someone else checking the building, the cost of community development officers etc.

6.6 Discussion

Taking all of these elements into consideration offsite support offers an efficient, cost-effective and equitable alternative to onsite support. Changing the structure of support provision is disruptive for tenants. However, ensuring that they are part of this decision, by consulting with them, helps to ease this process and local authorities across England, such as Derby, are using this support structure to good effect. However, the value in onsite support is gained from the dedicated individual, enabling the development of a relationship. This trust between client and warden can offer a huge potential for integrating Housing into the whole system of care using support, as signposting other services is a key feature of this integration. However, the value in this is notoriously difficult to measure.

Another problem is that removing wardens from sheltered housing sites altogether could lead us to question the purpose of the sheltered housing product altogether; it is part of the 'sheltering'. Support is an attractive, defining feature of sheltered housing and it is currently difficult to access elsewhere. Onsite support in the form of a warden working 9-to-5, based at a scheme should not be so easily disregarded, as the trust-based relationship between the warden and tenants can be of high value.

An innovative solution, advocated here, is for the capacity freed up by some tenants not needing the warden to be used to support people in the wider community, at a cost to the individual needing the service. The case study and other secondary sources highlight that those who live in their own homes find it very difficult to access

the type of support that a warden offers tenants in sheltered housing, and therefore there is a need for this type of service. This would be a hub and spoke model (Figure 17), with the sheltered housing scheme acting as the hub or base for the warden, so that tenants still benefit from the relationship with their own onsite warden, unlike those with offsite support, which employs several wardens to visit them to allow for efficient scheduling and utilisation of wardens. This hub and spoke model would also address a potential inequality. As more people are being encouraged to remain independent in their own homes, they do not have access to warden-type support services like sheltered housing tenants do. Surely this is inequitable?
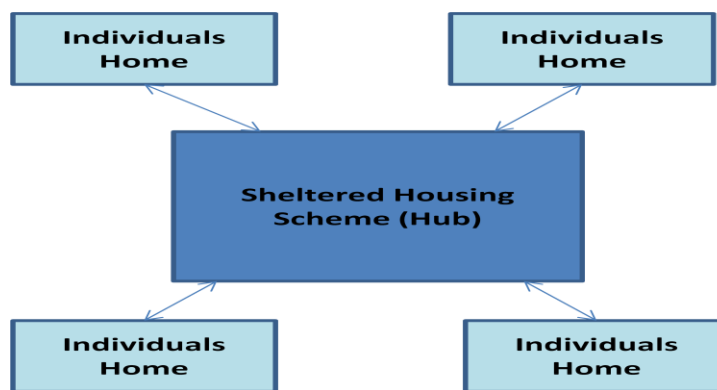
Figure 17: Hub and Spoke model of support

Older people are not a homogenous group and should not be treated as such. The case study in Conwy highlighted that, due to local trends and the layout of sheltered housing schemes, some schemes house very elderly people, some house relatively 'young old', and others house a mix of the two. Therefore, the decision about support provision in any given scheme should be dependent on the tenants in that scheme and the level of support they require. The location of the scheme should also be looked at as floating support may not be appropriate for a rural scheme that is a long distance from the floating support team's base location. One should assess the number of older people living in their own homes locally who wish to access support, to see if a hub and spoke model would be feasible and appropriate. It is essential that a flexible approach to changing services is taken in order to keep tenants happy and to save money further down the line, as there will not be a one size fits all model.

There is no longer a viable case for providing residential wardens in sheltered housing, due to:

i.   working-time laws;

ii. difficulties hiring for this role, especially with the professionalisation of wardens;

iii. the introduction of needs-based funding resulting in only some tenants paying towards the warden;

iv. the need to provide support to people now remaining in their own homes.

This leaves support providers with a choice between 9 to 5 onsite support or offsite support. The suitability of offsite support is dependent on the value placed on the signposting role of the warden. Onsite wardens are undoubtedly better placed to build relationships with tenants and are therefore in a better position to encourage them to take up other services. Tenants trust their wardens and are generally happy to share information with them (Parry, 2008). The current system of care and support services is fragmented and confusing, so signposting should be capitalised on as a core warden service. If the whole system of care is going to be successful, then organisations within the system need to share information and data with one another (Oldham, 2014). Achieving this requires improvements in communication between Health Services, Social Care, Housing and Voluntary Services, so that up to date information about the services available locally to older people can be accessed easily by the warden. Lessons can be learnt from extra care housing and the model it uses to integrate with Health and Social Services. Without explicit recognition of the importance of this area of warden support, the case for onsite warden provision is becoming weaker.

Another issue with the current system is the lack of support available to people who are striving to live independently in their own homes. Therefore, it is concluded that a hub and spoke model of support provision should be considered, with the sheltered housing scheme acting as a hub, as this model mitigates the issues of choosing to provide support either onsite of offsite. Stricter definitions of what constitutes a 'need'

for support will undoubtedly lead to a reduction in the number of people receiving support in sheltered housing, as demonstrated by the Wrexham case. With the spare capacity this creates, the warden should be able to support people in the surrounding community, whilst still developing those essential relationships with people living in their scheme. Maintaining the onsite association will save expenditure on additional people such as community development officers. This model is also supported by the charity Essential Role of Sheltered Housing (ERoSH) (Parry, 2008).

Whilst offsite support is a viable option, people do not want to see numerous different people when receiving support as this would make relationship building difficult and the wardens would not develop a detailed picture and understanding of their individual clients. The study in the previous chapter highlighted that older people do not like the fact that they are visited by numerous carers, so providing support in this way would show a blatant disregard for the clients' requests. A lack of relationship would also make signposting of support and care services difficult. A balance needs to be achieved between limiting the number of wardens an individual sees and providing the service in an efficient, affordable manner. However, even if this were mitigated, removing the onsite warden from sheltered housing schemes would mean taking away one of their most attractive and defining features. Would it simply become downsizing housing with physical features to support older people?

6.7 Summary

This chapter brings to light some of the current issues facing support provision in Wales and the rest of the UK. The fact that support is in a transition period makes it an attractive integrating function for Housing, Health and Social Care as it is already necessary for housing associations to invest time and money into restructuring warden services. The support service could potentially bring housing into this system by signposting tenants to services provided by Health and Social Services, if they were provided with the right information.

This chapter highlights that onsite support becomes essential if the local authority places an emphasis on the signposting role of the warden. Therefore, the Steering Group of the action research project decided to move towards a hub and spoke

model of support provision, with the wardens providing support on a needs basis on their own scheme, and then going out into the community with time freed up by tenants not in need of support. This will include supporting both owner occupiers and tenants from other housing associations, resulting in a much smoother system of support for older people living in the county. It was also written into the OPHS that Conwy Council, the third sector and the local health service would provide a database of services available to older people in the area. This will ensure that the wardens have access to the information that they need to signpost older people to appropriate Health, Social Care and Voluntary Services. Prior to this, support services provided by these organisations were often not getting the uptake that they required to renew their funding, resulting in a high turnover. On the other hand, older people were stating that they did not have access to support services as they had no way of finding out what was available to them in their locality. It is hoped that the warden service can fill this gap by signposting these services.

Chapter 7: Consultation with Key Stakeholders

7.1 Introduction

This chapter focuses on Research Objective 4: *Consult with older people to validate the proposed solutions and ensure they meet the needs of the target market*. This serves to triangulate the findings of the previous research objectives, an approach which is commonly used in action research to ensure rigour (Eden and Huxham, 2002). In terms of the case study, the purpose of the consultation exercise is to use focus groups to answer the question: 'Does Conwy's Older Persons Housing Strategy (OPHS) identify and address the concerns of older people living in the county?' The term 'older people', as defined by the strategy, includes anyone over the age of 55.

"It cannot be presumed that because a partnership is operating effectively that the resulting services are what users want and expect" (Dickenson, 2006:376). It is therefore a requirement of Conwy County Borough Council (CCBC), as with all local authorities, that any strategy developed is put through a consultation process to ensure that the document meets the needs of the people it is being targeted at. CCBC therefore provide guidelines for how to conduct an appropriate consultation. In terms of the thesis, the main focus is on support, which is only one section of the OPHS. It is important to identify how older people view the support services offered by wardens, to ensure that the developments suggested in Chapters 5 and 6 will not have a negative impact on the service users. However, feedback from the other three strategic objectives in the strategy (quality housing options, assistive technology and adaptations and information and advice) were also relevant, as all of the strategic objectives interlink. For example, one of the developments of the support service will be a database designed to enable wardens to signpost Health and Social Services, which improves their ability to provide information and advice.

Focusing the analysis purely on the responses to the questions about support would limit the findings.

A focus group was also conducted with the wardens themselves, in order to get an appreciation for the pressures involved in providing support to older people. As they are the people doing the job, they are best placed to identify whether the changes are achievable. The wardens were interviewed as part of the soft systems methodology (SSM) but this was on an informal basis, so the researcher wanted to strengthen their voice using formal focus groups. Wardens from each RSL were invited to participate in the focus group to ensure that the differences between the warden structures across RSL's were considered and addressed. Finally, the findings of the focus groups were presented to CCBC's Scrutiny Committee and passed by Cabinet. Details of this process are also included in this chapter.

7.2 Background

As this project was conducted using focus groups, the literature was examined to identify the strengths and weaknesses of using this method. A focus group can be defined as a "carefully planned series of discussions to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (Krueger and Casey, 2009). However, others argue that they are "in-depth group interviews, employing relatively homogenous groups to provide information around topics defined by the researcher" (Hughes and DuMont, 1993). Elements of each of these definitions fit with this research. However, the first seems more appropriate on the whole. In terms of the second definition, whilst the focus groups conducted here were not with homogenous groups (the only thing participants had in common was their age), the focus groups could be considered as in-depth interviews, as the participants felt comfortable and familiar with the topic matter and therefore offered detailed responses to the questions.

Focus groups were chosen as, during focus groups, when "responding to each other, participants reveal more of their own frame of reference on the subject of study" (Finch and Lewis, 2003). People's experiences of housing and support tend to vary greatly between individuals, so discussion is useful to encourage participants to justify their views. For example, someone in receipt of support might complain about

the reduction in residential warden services, as they have been used to having onsite support 24/7, whereas someone who is unable to gain access to support is more likely to be satisfied with the new, more efficient service, opening up a debate. Focus groups are a recognised method for public consultation and community involvement that reaches different social groups effectively, without the high cost and time associated with doing individual interviews (Morgan, 1997).

Discussion within the focus group minimises the influence of the researcher on responses (Finch and Lewis, 2003). This is important in qualitative research, as the subjectivity of the researcher has an impact on their research. Looking at the research from a more objective perspective improves the trustworthiness of the data (Lincoln and Guba, 1985). Subjectivity in focus groups can be minimised by member checking, and by not controlling the direction of the discussion too tightly. Member checking involves the facilitator summarising the information provided by participants and then questioning them on it to determine accuracy (Harper and Cole, 2012). There is no evidence to suggest that the researcher has more of an impact on results in focus groups than they do in interviews or observations (Morgan, 1997).

The focus group facilitator could either be a strength or a weakness to this research method depending on their skills and the group's attitude towards them. It is imperative that the facilitator shows respect towards the participants and appears interested in what they have to say (Krueger and Casey, 2009). Their personality, friendliness and appropriateness will all be important to ensure the smooth facilitation of the group. Franz (2011) wrote a paper on unfocus in focus groups, which concluded that allowing some unfocus can enhance understanding of the topic. This is particularly relevant for this project, where the researcher is trying to identify any gaps in the strategy, thus making it important to see where the group discussion leads. However, the facilitator needs to be able to control the impact unfocus has on the group's process, which requires skill and practice (Franz, 2011). To prepare for this, the researcher drew on their experience of leading multiple Steering Group's, sought advice from the Partnership Co-ordination Manager at CCBC who had been involved in a wealth of consultation exercises and read numerous texts on moderating focus groups, including Krueger and Casey (2009) and Barbour (2007).

Madriz (2000) identifies that focus groups put participants in an empowering environment, due to the self-validation and discovery of common ground. This suggests that people enjoy participating in focus groups, which is a major strength of this research method. Feeling involved and shaping policy can provide participants with a sense of self-worth. Focus groups also give the opportunity to raise issues and concerns about a topic that participants may not know where to raise elsewhere.

7.3 Conducting Focus Groups with Older People

Language when talking to older people is important, as generally, they place a lot of value in politeness, such as not using their first name unless they have told you to do so (Dignity in Care, 2008). It is important to be respectful and the moderator should ensure that they are not being patronising as older people are just people who are older and, whether they are experiencing deterioration in their cognitive abilities or not, they matter just as much as anyone else and should be treated as such (Help the Aged, 2007). People often make the mistake of referring to older people as 'the elderly', which sets them apart from the rest of the population based on their age, despite the fact that this group could include at least two generations (Wenger, 2003). The term 'older people' was used throughout this research to avoid offending participants. This enabled each individual to privately decide whether they include themselves in that group or not.

Older people are statistically more likely to suffer from disabilities, so the rooms in which focus groups are conducted need to be carefully considered to ensure good access and comfortable seating. Having a non-threatening environment is important as it enables us to gather people's opinions in a natural setting, making them feel more comfortable (Green, 2005). Using somewhere visited regularly by the older people who are participating in the study can have benefits, as they will be familiar with the surroundings and will not have to make any unusual travel arrangements (Barrett & Kirk, 2000). If they visit regularly then this implies that there is good access for those suffering from disabilities, both in terms of getting to, and into, the building. This is supported by Help the Aged in their guidelines for consulting and engaging with older people, where they suggest seeking advice from older

participants about appropriate venues, and also times, for consultations (Help the Aged, 2007).

Older people are also more likely to have sight or hearing impediments, be slower processing information and can become fatigued quickly (Barrett & Kirk, 2000). Careful moderation is required in focus groups with older people, to ensure the discussion is not inhibited by these common issues (Koopman-Boyden and Richardson, 2012). For example, the moderator needs to speak clearly, and ensure that the questions are short and easy to understand. However, with careful moderation, significant useful information can be obtained through focus groups with older people, and many participants find the process empowering (Stewart, 2003).

7.4 Initial Questions

The OPHS identified four key strategic outcomes. These were around the areas of quality housing options, support services, assistive technology and adaptations, and information and advice. To ensure that none of these were overlooked, one question was developed about each of these outcomes. The participants were also asked about what type of housing they currently lived in, as this helps to provide a context to their responses, whilst offering a simple question to start off the discussion.

Questions included:

1. What type of housing do you currently live in?

2. Why did you choose your current home?

3. In your opinion, what would a good support service offer clients?

4. If you have ever had any assistive technology or adaptations fitted to your home, what did you like/dislike about the service?

5. Where would you go for information and advice about:

    a. Housing for older people?
    b. Support?
    c. Assistive technology and adaptations?
6. What is the best way to inform you about housing/support etc?

Prompts were given about types of housing and the differences between care and support were pointed out. The participant's responses were recorded and issues raised were compared to the draft strategy to see if anything was missing or at odds with responses. Any differences were discussed in the Steering Group, who ultimately had the power to decide what should be added to the document and what should not.

7.5 Participants

Focus groups were carried out with older people living in Conwy, with the researcher acting as facilitator. The aim of a focus group is to "bring forth different viewpoints on an issue" (Kvale, 2007). They rely on interaction between the group in order to provide insight into a topic area (Morgan, 1997). It is therefore an appropriate method for identifying whether the OPHS identifies and addresses the concerns of older people, as the needs of older people are diverse. Further to this, CCBC advised that it had previously experienced extremely low response rates to surveys. Interviews were not appropriate due to time constraints as it is essential that the views of numerous people are considered, due to the heterogeneity of this group, and the numerous different types of housing that these people could be living in.

Each of the RSL's who offer housing for older people in Conwy were offered the opportunity to have focus groups run for their tenants, to ensure that the OPHS met their tenants' needs. Clwyd Alyn, Wales & West Housing and North Wales Housing each had one focus group run and Cartrefi Conwy had three, as they have a much higher quantity of housing for older people. Cartrefi Conwy also wrote to tenants living in their general needs properties to invite them to their local focus group, to ensure that the consultation exercise was not only conducted with people living in sheltered housing. People who had recently used Care and Repair to have adaptations fitted on their homes were also written to and invited to focus groups.

Existing groups were also utilised, namely the Age Concern Forums that take place in each locality in Conwy (five in total). These take place in various locations including extra care housing, sheltered housing and local community centres and they are attended by a good mix of people living in numerous types of housing. The forum co-ordinator was approached and, after consulting with each group, invited the

researcher along as the groups were keen to share their views on this subject. This is an example of using a 'natural group' and has the advantage that people already know, and feel comfortable with, one another (Green, 2005). The regular locations for the groups were used, so that people felt at ease and the groups were accessible for anyone with a disability. Focus groups were also advertised at the launch of the OPHS consultation, to enable volunteers to sign up.

Traditionally, the ideal size of a focus group within market research is ten to twelve people (Krueger and Casey, 2000:73). However, in reality, the number of participants was not easy to control, as people were able to choose to attend at any time, and attendance at Age Concern Forums is unpredictable. In reality, the focus groups with older people varied in size from four to twelve, with an average of eight participants. Smaller groups tend to lead to a more in-depth insight into people's experiences (Krueger and Casey, 2000:74), whereas larger groups give the opportunity to obtain more people's insight into the topic. Therefore, there are benefits to both smaller and larger groups which were realised during the course of this consultation exercise.

7.6 Ethical Considerations

There are a number of ethical implications for this project, some of which are exacerbated by the fact that this consultation was both for the local authority and for this thesis. As a University of Liverpool student, the researcher had to follow certain ethical guidelines, some of which the local authority felt were a step too far. For example, whilst they too were keen to behave ethically, they were concerned that obtaining written consent from participants would over formalise the process and make participants nervous. The researcher had to balance university requirements with the advice from CCBC, keeping the process of obtaining written consent light and explaining why it was necessary.

Underlying the application for ethical approval for this project is the fact that the local authority would need to conduct the consultation either way, so this process is just to determine the researcher could be involved and utilise the data. Indeed, it would be unethical of the council to take this strategy forward without consulting with older people as the document is targeted at them. Following the consultation, a

Consultation Report was written and made available for all to read. The report follows CCBC's 'we asked, you said, we did' structure, so that participants can see the impact of their involvement (available on CCBC's website).

Older people are technically classed as vulnerable adults because, as we age, there is an increased likelihood of us becoming unwell, frail, confused, unable to stand up for ourselves or unable to keep track of our affairs (NHS, 2013). However, active life well into retirement age has become the norm, with fewer older people conforming to our image of 'elderly people' (Wenger, 2003). As a result of this, many older people do not consider themselves to be old. However, rules are there to protect the people that are vulnerable, so the researcher obtained a CRB check and did not conduct any of the focus groups alone. The researcher also completed an application form for blanket ethical approval for all of the related work, involving care of older people, being undertaken by the research group she was in. This went through expedited review as older people are considered vulnerable, and was approved in June 2012.

Smithson (2008) highlights two main ethical considerations when conducting focus groups. Firstly, people may not feel comfortable sharing their concerns with the group and the researcher cannot guarantee that other participants will respond to participants appropriately. If people in the group feel uncomfortable sharing their views, then they are more likely to conform to other members of the group. The second is that you cannot guarantee that participants will keep the information shared anonymous. These are disadvantages of conducting focus groups, especially when looking into personal or sensitive areas.

To combat the ethical concerns highlighted by Smithson (2008), the questions were carefully worded to enable older people to offer as much or as little information as they felt comfortable with. If the researcher had asked participants about their experiences of support or specialised housing, then they may have felt that this was too personal to share in a group setting. However, by asking what they would want from a service, participants have the opportunity to disclose their personal experiences only if they want to. Information leaflets about the services that were likely to be discussed were made available at each focus group, as suggested by Barbour (2007:96) in her guidelines for debriefing participants to enable them to

access services discussed where appropriate. The telephone number for the Customer Care Team, who signpost these services, was also handed out to participants in case anyone required any further information or advice.

Research has shown that people commonly move into specialised housing due to deterioration in health (Croucher, 2008). Therefore, some older people may find discussion into these areas upsetting. The facilitator was careful not to delve further into any area that provided discomfort to anyone involved and encouraged the group to move on where necessary. It was made clear to participants that they were free to leave at any point during the focus group sessions; both in the introduction and in the participant information sheet. Participants were asked to be respectful of one another's views and to respect each other's confidences, as recommended by Smithson (2008).

This consultation exercise was limited to the type of people who attend focus group sessions. It is not feasible to guarantee that people living with dementia or in care homes can give informed consent, so it has not been possible to consult with these people as part of this project. The consultation exercise does not access the opinions of people currently living in social isolation, despite this being one of the problems that the OPHS is trying to tackle. This is a limit to this research, imposed by the ethical approval guidelines provided. Whilst there have been projects that have obtained ethical approval to work with people living in social isolation, or in residential homes (see Burns et al, 2014; Killett et al, 2013), this was not the main focus of this research, and therefore obtaining the ethical approval necessary to gain access to these people was not deemed to be an effective use of time. Hughes and DuMont's (1993) definition of a focus group session as a group in-depth interview suggests that focus groups can be considered as an extension of an interview, which suggests that the results from interviewing people living in social isolation in their homes, would be compatible with the focus group results. However, it is possible that showing a high level of interest in someone in this situation and then leaving them alone again could cause psychological harm (Wenger, 2003), so ethical approval for this part of the study was not granted.

7.7 Procedure

Eleven focus groups took place across Conwy in October/November 2012, five at Age Concern forums and six organised by the RSL's. A total of ninety-two older people took part in the focus groups, with an average of eight participants at each group. The type of housing that participants live in has an impact on their experiences around the topics under discussion, so they were asked about their housing at the start of each focus group. 60% lived in sheltered housing, 37% lived in non-specialist housing (owner-occupied, general needs or private rented) and 3% lived in extra care. This is not representative of the population of the UK, where it is estimated that only 7% of people live in specialist housing (Pannell and Kenway, 2012). However, one of the objectives of the focus groups was to gauge service users' opinions about support, but support is not currently accessible to people living in non-specialist housing. Therefore, sheltered housing tenants were targeted for this consultation exercise. One of the suggestions made in Chapter 6 was to offer support for people living in their own homes at a small charge, so people living in non-specialist housing were also targeted, but to a lesser extent.

On arrival, the facilitator thanked everyone for coming, introduced herself and the research and gave the participants the opportunity to read the briefing document and sign a consent form, as per the ethical guidelines set out by the University of Liverpool. Participants were then encouraged to introduce themselves and tell everyone about their home before the questions around the strategic outcomes began. Focus groups varied in length from 26-90 minutes. The researcher decided to allow the focus groups to progress naturally, instead of imposing a time limit, to ensure that the participants were not rushed in their responses and provided as much detail as they wished to. All focus groups were recorded, with permission from participants, so that the researcher could transcribe them before conducting the analysis. By recording the focus groups, the researcher was able to observe the group, noting any non-verbal cues, such as nodding in agreement.

7.8 Analysis

The analysis is split by stakeholder group, beginning with older people, then wardens and finally CCBC's Scrutiny Committee and Cabinet. Quotes included in the analysis section were quotes that were met with agreement from the group, either verbally or non-verbally, signifying that these were the views of multiple participants.

7.8.1 Older People

Krueger and Casey (2000:129) state that focus groups should be analysed from the beginning of the first group. To this end, the researcher made brief notes of potential themes/labels after each focus group. "As the researcher comes across an idea or phenomenon, a label is attached. When the idea or phenomenon reappears, the label is once again attached" (Krueger, 1998:10). The researcher then listened to the recordings, transcribed them and then read each transcript, all the while looking for themes in the data. The researcher went through several iterations of generating themes, reviewing the transcripts and coding them by theme, in order to establish a coding frame for this analysis. Transcripts were colour-coded by theme, as suggested by Barbour (2007: 117), to ensure that all discussion was encapsulated under one, or numerous, themes. Ten themes emerged, which were discussed in at least 8 of the 11 groups (72%). Six sub-themes were also identified, all of which were discussed in at least three groups, where they became a strong discussion point. The themes, sub-themes and number of focus groups where they were discussed are summarised in Table 8 (page 186). Once the transcripts had been colour-coded by theme, the text on each theme from each focus group was consolidated into a document. The document on each theme was then examined to identify similarities and differences across the focus groups. These are summarised by theme below with anonymised quotes where appropriate. The sub-themes are discussed under the theme to which they most pertain to, with details of how many of the groups they were included in.

Table 8: Table of Focus Group Themes and Subthemes

Theme	Number of focus groups discussed (Total 11)	Sub-themes and number of focus groups discussed
1. Reasons for moving	11	11. Family peace of mind (5) 12. Central Heating (6) 13. Problems moving into specialist housing (3)
2. Finding out about specialist housing	8	
3. Extra Care	9	14. Cost of extra care (6)
4. Warden/Scheme Manager support	11	15. Chemist runs for prescriptions (3)
5. Accessing services	11	
6. Community	9	
7. Information, advice and signposting	10	16. ICT (4)
8. Assistive technology	9	
9. Adaptations	11	
10. Handyman and gardening services	8	

Conwy's OPHS had a vision to "promote independence and wellbeing through a range of good quality, affordable and appropriate housing options for older people" and "create a partnership model of support provision to enable older people to live comfortably in the housing of their choice" (CCBC, 2012)

In order to achieve this vision, the draft OPHS included four strategic outcomes:

1. **Quality Housing Options:** Older People have a range of quality housing options available to them in Conwy, enabling them to live independently in safe, secure and warm housing.

2. **Restructure Support Service:** Older People in Conwy have access to support regardless of the type of accommodation they live in.

3. **Assistive Technology and Adaptations:** Older People in Conwy can access services that provide assistive technology and adaptations, enabling them to live independently.

4. **Information and Advice:** People in Conwy know how to access information and advice about older people's housing and support (CCBC, 2012).

Each of these strategic outcomes has actions assigned, with measurable performance indicators (See Appendix). The following analysis of the focus groups also includes information about the actions that the focus group conversation pertained to. A table of the changes made to the draft OPHS as a result of the consultation is included in Chapter 8.

Theme 1: Reasons for moving

The reasons for moving into specialist housing/downsizing were predominantly related to accessibility following a health issue or a disability which is in support of the findings in Chapter 5. For some, coping with maintenance and repairs on their old home and garden had become too much. Five focus groups discussed family in terms of their reasons for moving, with four participants stating that living in specialist housing gave their family peace of mind, which was met with general agreement, and two people had opted to move closer to their family. Central heating was discussed at six of the focus groups, usually as a positive aspect of specialist housing, but a couple of people did complain that their scheme was too warm and that they had no control over the temperature (issue isolated to one scheme).

After accessibility, the second most common reason was that specialist housing was appealing, although the reasons for this were varied. Many participants talked proudly about the location, scenery and their flats. Whilst for others it was the warden/scheme manager that was the attractive feature of specialist housing, as the support provided made them feel safe, secure and part of a community. This supported the Steering Group's decision to keep wardens based on schemes, instead of using offsite support.

Another sub-theme to this topic of conversation, discussed at three of the groups, was the problems involved in moving from one's own home, into specialist housing.

Participants were confused about whether home owners were able to move in without first selling their house, as the majority of sheltered housing is social housing, designated for those with low incomes. Accessibility issues that commonly trigger the move mean that people often move in crisis; they cannot wait for their house to sell. Clearer guidelines on what an older person in this situation should do are required.

Theme 2: Finding out about specialist housing

This theme naturally split the focus groups as some participants were living in specialist housing and thus had already found out about it, whereas others were not. Table 9 summarises the participants responses.

Interestingly, there is no correlation between how the participants thought that they should be informed about sheltered housing, and how they themselves found out about it. Integrating Housing with Social Services and Health implies that these services would have better information about the housing options available for older people, enabling GP's and Social Services to pass this information on to patients as these were the most popular options with participants.

Table 9: Participants responses regarding finding out about specialist housing

How I found out about specialist housing...	How I would like to find out about specialist housing...
- Word of mouth - Occupational Therapist - Magazine - Visiting friends in specialist housing - Joining community groups - Placed here due to age- unaware it was sheltered - Practice nurse - Lived nearby - Family researched it - Age Concern forums	- Doctors - Social Services - Ask current Housing Association if we need to move - Informed of new builds by the media - Manager of the scheme you are interested in - Estate agents - Age Concern Advocacy

The draft OPHS included an action to widely circulate information about the housing options available for older people. Open days at existing schemes were considered

essential as part of this, with better information sharing between RSL's and the local authority. This was because leaflets are already available and placed at GP surgeries, hospitals and community centres, but the information still isn't reaching everyone so alternative methods need to be explored. The local authority also committed to developing a specific section for older people on their housing options website. Although not all older people use the internet, some mentioned that their families helped them research specialist housing, so this could be a useful tool.

Theme 3: Extra care housing

Those living in extra care housing were positive about their choice, and reported that they felt comfortable using the staff as a first point of contact for any issue they were experiencing. However, the majority of participants did not live in extra care and they thought that there was a lack of information about what this type of housing is, what it offers, whether the flats are available to buy or rent and whether the buildings are accessible as community hubs or not. Again, this supports the identification in the draft OPHS that information is not viewed as being readily accessible. Whilst participants reported being pleased that the range of housing options available to them was increasing, they clearly wanted more information about newer options such as extra care housing. The issue of cost was brought up in six of the nine groups who mentioned extra care, with participants overwhelmingly viewing extra care as an expensive option, with one stating *"I think the extra bit is the extra cost!"* Clearly, this housing option is not currently viewed as an option that is accessible to everyone due to the high cost.

Whilst some participants described the extra care buildings as *"beautiful",* others disputed the design on account of the buildings not being very accessible. A few people knew someone living in extra care but found it very difficult to access the building to visit their friends, who had to buzz them in using intercoms from within their flat. One participant reported seeing friends and relatives walk away, having not been granted access to the scheme, and was concerned that tenants would become lonely if extra care was not made more accessible to visitors. The two housing providers currently offering extra care housing in Conwy (North Wales Housing and Clwyd Alyn) both stated that they viewed these schemes as community hubs, hoping

that locals would come in to use the restaurants and other services on offer. The focus groups highlighted that people living local to these schemes are not currently aware that they are able to do this. Well publicised open days at these schemes are clearly required in order to establish them as accessible community hubs.

Theme 4: Warden/Scheme Manager support

Ten out of the eleven focus groups were predominantly positive about the support provided by wardens, with comments such as *"If you need any advice about anything she is there", "If we want something we have it don't we? We are lucky"* and *"The warden makes the place".* Groups reported using their wardens as the first point of contact for any issue, demonstrating the effectiveness of the wardens' signposting role. *"She gives very good advice",* was a common statement when describing wardens*.*

Overall, there was acceptance in the reduced warden roles from residential to 9-5 as the RSL's had consulted with tenants when making this change, so they understood why it was necessary. A few tenants felt that they were not at the stage in life where they needed support, but felt reassured by the fact that their warden would be there to provide it in the future, as they already knew them. This demonstrates the importance of building up a relationship and trust with support providers. Criticisms about warden services seemed to be based on personality clashes and not the service as a whole, especially at the one focus group which was predominantly negative about warden support. There was also an issue with collecting prescriptions in one of the more rural areas, as this is not a service offered locally, but is no longer part of the warden role which was creating an issue for the older people living in this area. This was a sub-theme as it was discussed at 3 focus groups. However, all of these groups were either in, or referring to, a specific rural area. This highlights the importance of accessible local amenities when building specialist housing for older people.

For those who did not live in sheltered housing, there was a lack of understanding about what support was, with many feeling that receiving support equates to a reduced level of independence. Following an explanation about housing-related support, many stated that they would like more information about the service, and

that they would consider paying for it if it became available to them. Some people demonstrated a high level of dissatisfaction about the services available to people living in their own homes, with one lady saying, *"I always feel if you live in your own home and you don't claim benefits then you have no entitlement to anything, you know, you get on in life and you are left to cope yourself. And surely this is wrong because if your health fails, I mean you can control your finances, but you can't control your health".* Services are available to owner occupiers but, currently, there is no one to signpost these to them, which is a gap that the support service could fill if it were offered outside of sheltered housing. One of the actions of the OPHS was to develop support services so that they are available to people outside of sheltered housing, using a hub and spoke model.

Theme 5: Accessing services

Accessing services came across as a real issue for the older people involved in the focus groups. Participants highlighted that they do not know what is available, what to ask for or who to ask. Once they do identify who to ask, the battle is not over, with one participant stating, *"I was thinking that outside of this environment [sheltered housing], which is to be admired, whilst all these services are available through Social Services, I find that if a person is not more persuasive or more energetic in trying to get help they tend to get left behind".* Other groups used words such as *"assertive"* and gave examples of how they had to be insistent and pushy in order to access services.

Generally, the feedback on services designed to help people stay in their own home, such as reablement, occupational therapy, etc, was very good, once these services had been accessed. The comment, *"I think that once you actually do get hold of the services they do tend to be very good. It is knowing where to go and how to access the service that is the problem",* was met with firm agreement from the rest of the group. So it was not the services themselves, but accessing these services, that was identified as a problem for people in non-specialist housing. They felt that they should be better informed about what is available, but that the onus was actually on them to find out about services and they did not know how. When suggested by the

facilitator, a database of services that could be made available to them in printed form, was met with positivity as they would then be aware of what is out there.

For those living in sheltered housing or extra care, they were happy to ask their warden/scheme manager about where to go if they needed to access another service. The feedback from doing this was positive, demonstrating that support already plays a key role in integrating services through signposting, but currently only on a tenure dependent basis. One of the actions in the OPHS is to develop warden services to offer support to people outside of sheltered housing, using a hub and spoke model with the scheme acting as the hub. To further capitalise on the support service, there is an action to upskill the wardens by offering training in order to develop their knowledge about other services that are available in the whole system of care. Finally, there was also an action to explore the possibility of a support service that links Housing with Health and Social Care, which ensured the Steering Group's commitment to the development of options covered in Chapter 5.

Theme 6: Community

A sense of community was inherent with the tenants of sheltered housing and extra care, when discussing the type of housing that they live in. One tenant stated, "*There is the warden who keeps everybody under control, but we have good neighbours and there is a nice community feeling that when you are walking in and out of the building you see people: how are you fine? Have you heard about this and that? And it is vibrant in that respect".* Many talked about feeling reassured by the community that these types of housing offer. For people who discussed fundraising activities and trips, they usually also mentioned the wardens' role in facilitating these. For those living in their own home, the opportunity to visit the community centres at sheltered housing sites improved their knowledge of this housing option.

In order to further develop the community in sheltered housing, the pilot of a Swedish programme called 'Passion for Life' was written into the OPHS. Passion for Life is a six-week programme of weekly activities, designed to empower older people. The weekly sessions also provide a platform to provide information to attendees about some of the services that are available to them. Each week has a theme, such as safety in the home, movement, networking, etc. Attendees are encouraged to think

about the small changes that they could make to their lives around each of these themes, implement these changes and then feedback at the next meeting. Cartrefi Conwy have since piloted the scheme and found it to be an extremely popular and effective way to disseminate information whilst simultaneously developing the community.

It is important to note that the people who attend focus groups are likely to have a skewed view of the community as, by coming out to the focus group, they imply that they are active within their community. Help the Aged warn against only consulting with the "usual suspects" for this very reason, however, the ethical guidelines for this research prevented the researcher from accessing people living in social isolation, who, by definition, are unlikely to attend focus groups. This is something that the participants are aware of; numerous people stated that it is usually the same people at community events.

Theme 7: Information, advice and signposting

In the majority of focus groups, it was clear from the conversation that there was some confusion amongst the participants about who provides what service. The system is confusing and, for those who are not yet service users, there is little motivation to put in the effort required to understand it. Those who lived in specialist housing highlighted that they were comfortable asking their warden/scheme manager for information about services that they might need to access, stating that the warden would be their first point of contact. They felt strongly that Health and Social Services should work more closely with their wardens, so that they could pass the information on to tenants.

For those who live in non-specialist housing and do not have a warden, there is no obvious first point of contact if they are experiencing a problem. The places they would go for information varied widely, including: doctors, Age Concern, landlords, newsletters, local paper, family, tenancy handbook and CCBC customer care service. The problem with this is that none of these outlets have all the information that they need; the system is far too complex. One participant demonstrated their frustration with this by stating, *"with the council, would it be possible for them to perhaps have one person with responsibility towards older people who could actually*

coordinate the services. So we would know that I have just got one person that I need to contact". The development of support into a tenure neutral service where wardens are better informed about signposting would bridge this gap.

The sub-theme 'ICT' came under discussion in four of the focus groups when talking about finding information about the services and housing options available to them. Whilst a couple of participants were keen to learn more about finding information on the internet, the majority were not interested in doing this. Some felt resentment towards the government for pushing them towards having to use the internet, as at the time of the focus groups, the government had just announced that applications for Universal Credit could only be made online. Whilst the internet is a useful tool for finding information, we should not assume that all older people want to use it but just lack the knowledge to.

Information and advice is the title of one of the strategic outcomes of the OPHS. It is arguably the most important strategic outcome, as if older people do not know about the housing, support and other services that are available to them, then they will not be able to take advantage of these services. As this strategic outcome was intrinsically important within the other three strategic outcomes, it became a focus of each of the three subgroups. Having a separate subgroup for information and advice would have led to overlap between the subgroups, as each area of service needs to focus on getting information out to people. Ideas regarding information and advice were shared during Steering Group meetings to ensure that this remained a central topic of the OPHS.

Theme 8: Assistive technology

The discussion on assistive technology was limited to the alarm systems built into specialist housing and linked to a call centre. This was the only assistive technology that any of the participants had, or were aware of. A few participants demonstrated a reluctance to find out about other forms of assistive technology available to them, stating, *"We don't do technology"* and, *"They are things of the future!".* Some people living in their own home had also had an alarm system fitted by Social Services. Users felt reassured by the system, and reported that the call centre never took long to answer in an emergency. One participant said, *"They respond straight away, it*

makes you feel secure". However, many reported not wearing their pendants (which enable the wearer to trigger their alarm in case of a fall) as they made them feel old. Those who were more comfortable with technology reported carrying around a mobile phone in case of emergency, instead of using their pendent. Whilst this is a valid choice, it negates the purpose of the alarm system, as the older person would contact their relative or the emergency services themselves on their mobile phone, bypassing the call centre.

The main criticism about assistive technology was the inappropriate placement of the system, usually in older schemes. Some also reported being disappointed if their warden did not follow up on an out-of-hours call the following day. Finally, there was a reluctance to press the button to call the call centre in order to report non-emergencies, such as going away on holiday, despite this being recommended policy. Participants clearly felt that the pull cords should only be used in an emergency, but were unsure of who to call for system maintenance or to inform the call centre of changes in their circumstances.

Theme 9: Adaptations

Discussion around adaptations showed a clear divide between the organisation of services and the final product. Many participants had had their kitchens and bathrooms redone as part of the Welsh Housing Quality Standard (WHQS), which included guidelines for RSL's about the standards of kitchens and bathrooms in social housing. Participants reported being very happy with the quality of work that had been done. Participants were impressed with the occupational therapists, with one stating, "*I had an OT assessment and she actually came up with one or two things that I hadn't even thought about so I was very impressed with that".* They were also impressed with the builders, who they thought to be both polite and smart. It can therefore be concluded that participants experiences of services in terms of fitting adaptations were good.

One participant did complain about builders being messy whilst the work was carried out and not clearing up after themselves. However this was not the experience of other participants, who felt that builders had smartened up and become more respectful in recent years. An action was written in to the OPHS to ensure that

approved builders have 'Dignity and Respect' training. The majority of the RSL's reported only using builders who have had this training and equated the positive feedback to this training having raised the builders awareness of what is expected.

There were numerous complaints voiced about the amount of time between application, assessment and completion, with frustrating delays in the work seeming to be commonplace. *"I have been waiting a while"* was a fairly common statement when discussing adaptations. Quite a few participants had adaptations fitted because their kitchens and bathrooms were being redone anyway, so that their landlord could achieve WHQS, these participants were positive about their experiences and felt well looked after by their landlords. But for those that *needed* adaptations fitting and had applied for a DFG, many reported a long wait. They were happy with the work once it had been done, but the period between application and completion was frustrating and difficult.

Theme 10: Gardening and handyman services

The need for gardening and handyman services was one identified by a lot of participants, but was especially an issue for people living in their own homes. Although tenants of sheltered housing do not necessarily get these services included, the sense of community meant that they often felt comfortable asking a neighbour to do odd jobs that they were struggling with. The focus groups highlighted that it is the smaller, regular jobs that they would like to have help with, such as mowing the lawn or changing a light bulb. A lot of people living in their own homes reported relying on their family to do these jobs, which, for some, meant waiting quite a while.

There is an issue with trust if they were to hire someone for themselves, they would be worried about being ripped off. Therefore, an approved list of handymen and gardeners, similar to what Care and Repair offer for adaptations, was a proposed solution that went down well during focus groups, *"because then you would know who you are dealing with and you wouldn't have to worry"*. People reported being happy to pay a reasonable charge for these services, with one lady stating, *"Just because we are over 60, doesn't mean to say that we don't think that we should put something towards what we are having. Surely we don't think that everything should*

be free? You know and you value what you pay for". This suggests that if support was offered as a chargeable service, people would be willing to pay a reasonable price for it as it is a desirable service. A couple of people reported that they already pay privately for a gardener, having hired through recommendations from friends, and valuing the consistency of having the same person do their garden for years.

The draft OPHS included an action to explore potential ways of funding handyman and gardening services. Existing handyman services were identified, again suggesting that there is an issue with the information about services that are available, as opposed to services not existing. This action led to some innovative suggestions within the subgroup with regards to gardening, such as working with the local college. One RSL also began looking into the development of a social enterprise, offering the gardening work to their existing tenants.

7.8.2 Wardens

A focus group for the wardens in Conwy was also arranged, so that the researcher could gather the views of those who provide support to older people in Conwy. Nine wardens attended, including at least one from each RSL with specialist housing in Conwy. Cartrefi Conwy, who have the most wardens in Conwy (see Table 10, page 198), randomly selected only a few of their wardens to attend the focus group, in order to avoid overpowering the conversation. All of the wardens in the focus group were onsite wardens, with a couple of residential wardens as the RSL's had opted to move away from residential provision naturally by not replacing residential wardens when they retire. There are not currently any offsite wardens in Conwy. The topic areas remained the same, providing the themes of: quality housing, support, assistive technology and adaptations, and information and advice. However, the questions were phrased differently in order to reflect the different participant group. Another theme that emerged during the conversation was the changing demographics of tenants. The focus group lasted for 90 minutes, signifying that the wardens had a lot of information that they wanted to share.

Table 10: Number of wardens in Conwy (Autumn 2012)

RSL	Number of Wardens	Number Attending
Cartrefi Conwy	18	5
Clwyd Alyn	3	2
North Wales Housing	1	1
Wales and West Housing	4	1
Total	26	9

The question around what the wardens thought quality housing meant for older people quickly led to the discussion of support, the two topics were clearly interconnected in the minds of the participants. With regards to support, they saw consistency as a key aspect of providing good quality support, stating that, *"they [tenants] see you less as a warden and more of a friend, someone that is there for them".* A point that was highlighted in this conversation that had not been considered in the discussion of warden structures, was the importance of consistency to the wardens themselves, in terms of knowing what tenants need, and what they do not need. They talked in depth about the importance of being flexible and responsive to the individual needs of their tenants. They also discussed the differences in their job roles when getting to know a new tenant, compared to supporting established tenants. With a new tenant, they felt that they needed to establish barriers to ensure that they are encouraging them to maintain their independence, whereas long-term tenants have a better understanding of the limitations of support. Would an offsite support service be able to provide a consistent level of support to a tenant, regardless of support worker, or would the service get stuck in the 'new tenant' phase due to a lack of relationship building? For new tenants, *"there is an element as well that ask us to do things which are more care side of things than support side of things as well, and it's sometimes hard to make them realise we are there as a supporting role and not a home carer".* This demonstrates that new tenants are easily confused about the difference between care and support, again highlighting the complexity of the whole system of care.

The onsite, 9-5 warden role was too inflexible for the wardens, who reported frequently working after 5pm as, *"there is always something as you are walking out the door".* This was especially an issue for residential wardens as they lived on their scheme. One RSL had started using flexi-time, which was met with approval. They highlighted that there is more to the role than providing support, with some wardens covering multiple schemes, handing the scheme over to the call centre whilst they were not onsite, whilst others spent time in their office doing paperwork. However, they felt that it was important to tenants that they were never far away during working hours, stating, *"they can always call me on the mobile if they need me"* and *"I'm available if needed wherever I am".* One warden told their tenants where they would be on a regular basis, in order to provide structure, whilst others just came when called. The ever-increasing amount of paperwork was a sore topic that the wardens felt took them away from providing the support which is core to their role. One warden stated, *"you aren't as visible",* implying that patrolling the scheme makes the tenants feel secure and paperwork detracts from the wardens ability to do this.

When asked about the type of support being asked for, "repairs" was the most common response. This highlights the importance of the warden in triggering building maintenance. Interestingly, it also emphasises current coproduction between wardens and their tenants, as many wardens would ask their tenants to call the repair through to the landlord, if they thought they were capable as this maintains independence, and then follow up on it later. This is an example of the coproduction model being suggested for signposting, already working in practice, with one warden stating, *"I find the residents appreciate that [the follow up] as well, they think it is a better link with the association because you are more on top of things. And they are really sort of appreciative of that, it leads to better relationships".* However, for adaptations, the wardens all reported helping their tenants start the application process, acting as an advocate for them throughout the process. The implication was that this process is long and complex, and the tenants feel reassured by having the warden to support them through it. This is similar to the suggestions made about the wardens role in signposting direct payments, again a complex process.

In terms of the changing demographics in schemes, many of the wardens reported that they struggled to integrate tenants into the community when the age of tenants

varies from 55 to over 100. Younger tenants have a tendency to maintain their own social life and may not have a need for support, or a desire to integrate into the 'older' community. In terms of the governments initiative to maintain independence, this is positive. However, it alters the role of the warden as not all tenants require support, meaning that the wardens are no longer fully utilised. A hub and spoke model, as suggested in Chapter 6, could improve the utilisation of the wardens, by filling their spare time with support visits to people living in the wider community. As long as they were never too far from their scheme, this would be no different to the experiences that the wardens described when managing two schemes or completing their office work. Many of the wardens provided examples of their schemes integrating with the wider community and this approach was met with positivity when suggested. However, one warden reported that their tenants did not like outside groups using their community facilities, which was a barrier to integration in this particular scheme.

The warden focus group session provided the basis for a bi-monthly warden forum, with wardens from each RSL attending. This was because the wardens enjoyed the opportunity to find out about the differences in their job roles across RSL's and learn from one another. One participant commented, *"We should all be working the same because we are all governed by the same people",* which was met with agreement from the group, demonstrating the wardens' approval of a more standardised support service across Conwy. They also took the opportunity to share ideas on attracting funding and collaborating across schemes on trips for tenants. Providing training for all of the wardens, regardless of their employer, is a step towards standardising support services in Conwy, an objective which has been identified as necessary for integrating Housing into the whole system of care in Chapter 5.

The suggestion around using warden forums as an opportunity to provide training on topics such as direct payments, assistive technology and adaptations was met with enthusiasm. The wardens highlighted that they receive a lot of complaints about the multiple carers that visit their tenants regularly, and felt that direct payments could provide a solution to this if they were given the relevant information to pass on to their tenants. It is hoped that in the future, the wardens will suggest their own topics for training at the warden forum.

7.8.3 Scrutiny Committee and Cabinet

CCBC's Scrutiny Committee approved the initial draft of the OPHS to go through consultation on 31st May 2012. At this point, it was made available on CCBC's website for the public to read. In total, six additions were made to the draft OPHS (detailed in Chapter 8) following the consultation and the post-consultation draft was presented to the Scrutiny Committee on 3rd January 2013, where it was approved for Cabinet following discussion about some of the key outcomes, which were received favourably. One issue that had been raised in two of the focus groups, but that was considered outside the scope of this research was the reduction in transport provision for hospital appointments. The Scrutiny Committee agreed that this was not within the remit of this strategy and passed the information on to the relevant department. The OPHS was approved by Cabinet on 8th January 2013. One cabinet member raised a concern that the researcher had not consulted with enough older people living in their own homes during the final consultation phase. Evidence that we had invited people living in their own homes to the focus groups was provided. Due to the fact that consultation with key stakeholders had been ongoing throughout the whole strategy development process, the document was approved with no alterations.

7.9 Summary

This chapter summarises the focus groups completed as part of the consultation exercise for Conwy's OPHS. Of the ten themes that emerged from the focus groups with older people, support was mentioned in seven:

- Theme 1: Support was seen as an attractive feature of specialist housing
- Theme 2: Some participants would like to find out about specialist housing by asking the warden based on the scheme they are considering
- Theme 3: Residents of extra care housing use the staff based onsite as their first point of contact for all issues
- Theme 4: Participants were predominantly positive about their support service, however, there is a lack of understanding about what support is outside of the sheltered housing environment
- Theme 5: Tenants of specialist housing use their warden as their first point of

contact when trying to access services

- Theme 6: Tenants mention their wardens in terms of facilitating community activities
- Theme 7: Tenants of specialist housing use their warden as their first point of contact when seeking information or advice

This highlights the value in using all of the data gathered from the focus groups and not just the data pertaining to the support question. Although the participants did not mention support in Theme 9, the warden focus group emphasised that the wardens have a key role in helping tenants to access adaptations. Support is inherent in the majority of the themes developed from discussions around the four strategic objectives of the OPHS, signifying that this is a valuable service to those who are currently in receipt of it. Clearer information about what support is and how to access it needs to be provided to people living in their own homes, as they currently perceive the support in sheltered housing as resulting in a loss of independence, which is the opposite of what support providers are trying to achieve.

In terms of support service development, participants demonstrated that they value the opportunity to develop a relationship with their warden. This is an opportunity that they do not get with their care providers, which they view as a problem with this service. The focus groups were split between those who lived in specialist housing and thus received support and those who did not. With regards to the themes about obtaining information and advice and accessing services, those with access to a warden can, and do, use them as their first point of contact. Those who cannot access support do not have a guide to help them navigate the complicated whole system of care, which is clearly a frustrating concern for them. Once services are accessed, the feedback was that they are very good. However, finding out about the services available and how to access them was a real problem. The warden could provide the same signposting services that they are providing so effectively to their own tenants, to ease this burden on people living in their own homes.

The warden focus group highlighted that some of the suggestions for developments to the support service, such as signposting and coproduction, are already working effectively in practice but are limited to housing services. However, they do not

currently have access to the information required to signpost tenants to Health and Social Services. This emphasises the importance of the relationship, as the warden is aware of what their tenants are able to do themselves, and what they need doing for them. The wardens use their experience to identify whether the service they are suggesting to the tenant is a simple process which they can signpost them to (such as repairs), or a complex process for which they will need to advocate for their tenant (such as adaptations or direct payments). This demonstrates that the wardens already have, and are utilising, the skills necessary to integrate Housing into the whole system of care through signposting other services. They simply require more standardised information about the services that Health and Social Care offer, so that they can signpost them.

One limitation of this chapter is that the researcher was unable to consult with people living in social isolation, due to the ethical constraints imposed on the study. As previously mentioned, developing solutions to integrate care needs to be done on a local basis, due the differences between local authorities. Therefore, it is important to speak to older people living in isolation in Conwy, instead of drawing on secondary sources of research conducted elsewhere, as problems faced may be specific to the whole system of care in Conwy. Receiving support could potentially aid these people to integrate into the wider community and access services. It should be noted that consultation with experts took place throughout the entire project, through the Steering Group presentations and feedback, and that some of the people sitting on the Steering Group were advocating for people living in social isolation. But as the strategy was aimed at older people, it is essential that their views are considered and not talking to people living in social isolation leaves a gap in this work. However, it was not the main focus of the research, and service developments resulting from this work will still be accessible to these people, if they can be reached. In a systematic review of which "included studies evaluating interventions aiming to alleviate social isolation or loneliness, only 12 out of 32 (38%) studies explicitly targeted people in this situation" (Dickens et al, 2011). This is despite the fact that these people were the focus of each study in the review, highlighting the difficulties involved in accessing the views of people living in social isolation.

The warden forum is a positive outcome of this research. The wardens now have forums quarterly, using them as an opportunity to visit one another's schemes. They have received training on assistive technology, direct payments, tenant empowerment programmes and fire safety, to name but a few. Some wardens have used the opportunity to develop social programmes where they provide transport between two schemes and run social events, which is proving to be popular with tenants and helps to liven up the community.

The consultation chapter supports the suggestion in Chapter 6 for the hub and spoke model of onsite support provision, by highlighting the value that both older people and wardens place on relationship development. It provides evidence that the wardens are already using this relationship with tenants to signpost services and to help them access the whole system of care. Providing the wardens with better, more up-to-date information about services on offer would enable them to do this more effectively.

Chapter 8: Reflections on Research and Conclusions

8.1 Introduction

This chapter reflects on the approach taken to work in partnership in order to integrate Housing into the whole system of care in Conwy. Action research lends itself to reflection as it is a form of enquiry that stimulates change and usually has an impact on both the researcher and the co-researchers (Wisker, 2001). It has been identified in the literature that there are no clear methods for developing a project aimed at achieving virtual integration across the whole system of care (Warmington et al, 2004). The importance of a shared vision or purpose is identified as a key feature of successful partnerships (Glasby and Littlechild, 2004:7; Grieg and Poxton, 2001; Banks, 2004). However, there is little information about the methods that are effective in establishing a shared vision between individuals with the power to act as change agents in their organisations. More work needs to be done in order to exploit the potentially powerful benefits of achieving integrated care, "which demands a greater understanding of the relationships between structures, partnership working, services and results" (Kodner, 2006:389). Forms of partnerships for integrated care include pooled budgets, joint commissioning and integrated services (Freeman and Peck, 2006). However, although the forms of partnership working are well described in the literature, there is less understanding about the requirements necessary for implementing partnerships to achieve integrated care in practice (Clarke and Glendinning, 2002; Freeman and Peck, 2006).

The implementation of the chosen option for integrating Housing into the whole system of care using support is described, along with some of the issues faced. This chapter then reflects on each method adopted as part of the wider action research project, drawing out the value obtained from the soft systems methodology (SSM), the survey and the focus groups with older people.

8.2 Reflections on Research Approach

8.2.1 Implementation of Proposed Changes

After the Steering Group chose Option One as part of the SSM, an action plan to 'Restructure Support Services' was written into the Older Persons' Housing Strategy (see Appendix). This action plan breaks up the primary tasks involved in the transformation from sheltered and non-specialist housing not being part of the whole system of care for older people, to them being integrated into the system. One of the main disadvantages of Option One was that it is a low intensity change, and therefore the implementation of the OPHS may not be a strong enough catalyst to integrate these types of Housing into the whole system of care. In order to combat this, the action plan was written taking a results-based approach to accountability, ensuring that measurable outcomes were assigned to each task (see Appendix). Results-based accountability is a disciplined way of embedding measurable outcomes into the planning and delivery of projects, to ensure that performance can be measured (Friedman, 2005). CCBC ensures that all of their strategies are developed using results-based accountability, so that it can demonstrate the impact of each document. Consequently, each action in the OPHS has performance indicators assigned to monitor progress. The researcher then, as the change agent, monitored these indicators as suggested by Van de Ven and Sun (2011), reporting progress back to the Steering Group bi-annually.

Based on the evidence provided by the analysis of the survey, the Steering Group opted to adopt a hub and spoke method of support provision. The RSLs involved have tentatively started offering their warden services to people living outside of schemes, with Cartrefi Conwy reporting that they are so far supporting twenty-four extra people using a new 'menu of support services' that is dependent on need. This addresses the issue with equality in terms of access to support; support is no longer just for people living in sheltered housing. Alongside this, the RSLs have started to work together to see if any of their schemes can offer their warden out to other local schemes. For example, a Cartrefi Conwy warden might offer support to someone living in a Clwyd Alyn property, if there is no Clwyd Alyn warden operating locally. So that the wardens feel more comfortable working together in this way, a bi-monthly Warden Forum has been established so that they could meet regularly and discuss

issues, a suggestion that proved popular with wardens during their focus group. Since establishing the Warden Forum, four wardens have run trips to other schemes for their tenants, giving them the opportunity to socialise with new people and visit new places. This is intended to help break down the barriers between different RSL's schemes and gradually standardise the warden services across Conwy. The Conwy Warden Forum also provides a platform to offer training to wardens, regardless of who they work for. To date, they have been provided training on direct payments, Telecare, an empowerment programme for older people called 'Passion for Life' and how to signpost the free services available to tenants through the Red Cross.

The other main implication of using support to help integrate Housing with Health and Social Services in Conwy has been to upskill the wardens to improve their ability to signpost other services. It is not possible for the wardens to be able to know about all of the services that are on offer, the whole system of care is too complex for that. However, the mechanisms are now in place for the wardens to access specific information when the tenants require it. Social Services obtained a grant from the EU as part of a larger project. A small percentage of this grant was assigned to the employment of a dedicated member of staff whose role was to develop a database of support, care and health services available throughout Conwy, whether provided by Health, Social Services, Housing or the third sector. The wardens have been given access to this database so that tenants with issues can be signposted to an appropriate service. The wardens in Conwy have already begun using mobile tablets in order to complete support plans, and these can also be used to access the support database. This established infrastructure is important because, "Information sharing must be considered in the context of an organisation's work processes" (Hägglund et al, 2009).

A support subgroup was established in order to implement the action plan, feeding back their progress to the Steering Group. This was the most problematic of the three subgroups established to implement the OPHS, as big decisions need to be made. It took around twelve months to put a team together that had, not only the time to commit, but also the power to implement the changes necessary within their own organisations. There was also an issue with deciding who should Chair the subgroup; the RSL's have the power over changes to the provision of support within

their own organisations, but there was the issue of which RSL should lead on this. Eventually, Cartrefi Conwy took the lead as they have significantly more wardens than the other RSLs, so the changes they make have the biggest impact on the system as a whole. Consequently, the initial progress of this subgroup was slow so the actions were still being implemented when the researcher left at the end of the three year project.

8.2.2 Effectiveness of SSM

It would be rational to assume that it is the final, implementation stage of SSM where the results are produced. However, the whole process requires communication between members of the Steering Group combined with group learning to achieve positive results, which is something that was also found by Sanchez and Mejia (2012) in their application of SSM within a school setting. The emphasis that SSM places on understanding the various group member's perspectives on the system has been essential to the success of this partnership approach. It has enabled the Steering Group to establish a shared vision, as well as group values and principles that are sympathetic to each group member's perspectives. A recent study into what factors make integrated care partnerships successful found that, "being explicit and voicing the interests of the partners, was one of the preconditions related to the success of a partnership" (Valentijn et al, 2015:11). The SSM study required the Steering Group to voice their worldviews, explicitly stating their interests, thus improving the success of this partnership.

This research has aimed to integrate Housing into the whole system of care for older people, and having the key stakeholders involved in an SSM study to learn about the system, and discuss how it could be achieved, has been, arguably, as valuable as the implementation of the resulting action plan. "When SSM thinking informs an inquiring process, the whole methodology becomes a tool for intentional learning and purposeful change" (Marijamdotter & Bergvall-Kareborn, 2006:83). During SSM discussions, the group learnt invaluable information about the other organisations in the system and the difficulties that they face. They had the opportunity to discuss ways in which their organisations could collaborate to improve the system as a whole. SSM can also be used to help structure thinking about the research problem, to gain a better understanding before other methods are adopted (Sankaran et al,

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2009). In this project, the process of conducting SSM itself, as opposed to the results from it, has been one of the key benefits of this methodology.

To provide an example of improved understanding, the managers from the RSLs developed an appreciation about the budget constraints experienced by Social Services that had led to a reduction in control over care providers. This was resulting in the RSLs' tenants complaining to them about their care, as it can be confusing for the tenants to know who is providing each service. Whilst this is not something that the RSLs can deal with directly, it does demonstrate the importance placed on developing relationships, which can be addressed in the development of the support service. Instead of just passing the complaint onto Social Services, the RSL managers were able to recognise that with current funding cuts, the social care system was struggling and discussion began on how they could help, for example, by signposting people who are not eligible to care from Social Services (following the changes to their assessment criteria) to other services.

Although it is inadvisable to generalise from a single SSM study (Checkland and Haynes, 1994), there are still some key points that can be taken from this research. The options developed during the SSM may provide a starting point for other counties to work from, if they have chosen to use support as the integrating function for Housing, Health and Social Services. But more importantly, conducting the study using SSM provided added value that the researcher had not originally predicted, by building relationships between key stakeholders. "It is not only new practical knowledge about the problem situation that can be gained, but also new practical knowledge *about how to work together*, either generally or specifically towards its improvement [resulting in a] positive impact on organisational learning" (Sanchez and Mejia, 2012:122).

One criticism of SSM is that it has no mechanisms to seriously challenge the status quo and stimulate radical change (Mingers and Taylor, 1992). This is because, although it provides structure to qualitative inquiry, it is still a soft methodology and therefore does not produce a singular strong solution that can be supported by evidence. Options Two and Three were both more radical solutions for integrating Housing into the whole system of care for older people. However, the group felt that

they did not have the evidence base to justify pursuing either of these solutions. Whilst SSM gave the group an appreciation of the situation from various worldviews, it did not provide the group with a cost-benefit analysis for the proposed solutions and, consequently, the least radical option was chosen.

The purposeful activity models were not as useful to this project as the findings from the first stage of SSM (Finding Out). This is not uncommon in SSM. One study of SSM users found that many did not utilise the modelling and comparison stages (Ledington and Donaldson, 1997). A recent study supports this, reporting that during the SSM workshop, participants "did not appear to directly engage the CATWOEs and conceptual models", but still found the workshop informative (Gerwel and Bodhanya, 2014:1131). More value is commonly placed on the philosophy of multiple perspectives and the practice of expressing the situation when SSM is put into practice (Ledington and Ledington, 1999). The researcher was wary of being too abstract in the Steering Group meetings, thus developed the conceptual models outside of the group setting. The purposeful activity models and CATWOEs were instead used to aid the researcher's thinking; as 'sense-making tools' which is a term used by Checkland and Poulter (2006) to describe this approach. The Venn diagrams (Figures 13, 15 and 16 on pages 132, 136 and 139) were used instead to structure the discussion around the proposed options in this case. This was because the Steering Group members were busy professionals and time constraints meant that developing and examining conceptual models was not viable. The purposeful activity models instead aided the researchers thinking about the most appropriate solution and the development of the Venn diagrams, which were then used to structure the discussion about actions to improve.

In terms of this work, the majority of the discussion was around how to achieve the transformation rather than the transformation itself. Policy had already dictated that the transformation of housing being integrated into the whole system of care for older people was necessary (Department of Health, 2014; Rochira, 2013; Communities and Local Government, 2008). The methods for developing these discussions were still of great use to this work, in particular the CATWOE, which the researcher used as a tool to help structure questions in the first stage of the SSM, and capture the overall perspectives of each organisation. As mentioned, the discussions on the

actions to improve focused on the Venn diagrams instead of the purposeful activity models, as the participants were comfortable conceptualising the options in this way. As a methodology, SSM is "a set of ongoing principles which can be adapted for use in a way which suits the specific nature of each situation in which it is being used" (Checkland and Poulter, 2006:6). Therefore, SSM is a flexible process; it has to be, in order to deal with different complex, real-life situations. The value of the SSM stage of this action research project was in the underlying principles of SSM, as opposed to the process.

The emphasis SSM places on understanding worldviews makes it a useful methodology when embarking on a partnership to achieve integrated care, as it provides a mechanism for the members of the group to articulate their perspectives, ensuring that group values and principles reconcile these varying perspectives. A shared vision and group principles are identified as essential for achieving successful partnerships towards integrated care (Valentijn, 2015; Banks, 2004; Grieg and Poxton, 2001). "When employees from different departments or organisations are united in one team, their decisions will be less focused on the short-term benefit for their own department or organisation, and more focused on the consequences of each decision for each department or organisation" (Meijboom et al, 2011:171). SSM provides the basis to ensure that the vision is agreed by all group members, creating an appreciation for the impact of decisions across other organisations, and enabling the group to unite over a shared goal.

In order to ensure that the SSM is effective to achieve integrated care, it is necessary to ensure that the group comprises of the right people. This study took an iterative approach to Steering Group participation, with the group collectively deciding when there would be value in inviting someone new, based on a perceived gap in the group's knowledge. One of Leutz' (1999) laws of integration is that, "The one who integrates calls the tune". However, in this study, all stakeholders involved in the care or housing of older people in Conwy were represented on the Steering Group and thus 'doing the integrating'. As the SSM helped us establish the individual's and organisational worldviews, this approach starts to address this issue in achieving integrated care.

8.2.3 Effectiveness of Survey

SSM provided the researcher with an in-depth view of the as-is situation in Conwy. However, it was identified in the early stages of the research that it would be necessary to look wider than Conwy, in order to draw on the experience of other local authorities. Whilst each local authority is different in terms of their population, work processes and political agenda, it is still possible for them to learn from one another as some issues are common to all local authorities, such as, the ageing population, changes to Supporting People funding, the development of extra care housing, etc.

It was decided in the early stages of the project that a survey of other local authorities would be required. However, the topic of the survey was emergent as the work developed, based on the identification of support as an appropriate integrating function. The information about how other local authorities and RSLs are structuring their warden services has been consolidated into a taxonomy and used as the basis to conduct a SWOT analysis of onsite and offsite support. The researcher found that a hub and spoke model of support provision mitigated some of the weaknesses of each model and the Steering Group opted for this approach. Therefore, wardens are still linked to sheltered housing schemes and onsite the majority of the time, but can support people living in the local community with the time freed up by only supporting tenants who have an identified need. This is in line with changes to Supporting People funding, but it enables the relationship between tenant and warden to develop as, unlike with the offsite model, the tenant only receives support from one, consistent person. It is this relationship between tenant and warden that is a key feature for integrating Housing into the whole system of care for older people.

The results of the survey have been positively received by the Steering Group, as they provided an evidence base for changes to be made. Two of the RSLs asked the researcher to present the findings to their Board of Directors, in order to disseminate the work and ensure that these organisations were on board with the changes being made to their support services.

8.2.4 Effectiveness of Focus Groups with Older People

The focus groups with older people serve to demonstrate the effectiveness of the rest of the action research project. Basing the strategy development on the SSM has enabled the researcher to develop a strategy with objectives that meet the needs of older people, as demonstrated by the consultation. This is because the main stakeholders have been involved throughout the process and effort has been made to understand the current situation compared to future requirements. Examination of the pre-consultation draft compared to the final Older Peoples Housing Strategy has revealed the following written changes in Table 11 (page 214). The majority of the changes detailed in Table 11 support or prioritise actions that had been identified already from the SSM, suggesting that the draft document meets the needs of the older people targeted. This demonstrates the effectiveness of this approach.

The focus group with wardens in Conwy identified that wardens already demonstrate the skills required to signpost services and coproduce with tenants. They already utilise these skills with regards to tenant's housing-related issues such as repairs or adaptations. The wardens make judgements on how much help they should provide the tenant, based on their perceptions of the tenants capabilities and the complexity of accessing the required service. This suggests that the foundations are already in place to expand the signposting role of the warden, in order to integrate Housing into the whole system of care. Tenants of sheltered housing who have a warden already unequivocally highlighted that they felt comfortable using their warden as a first point of contact for any issues they are experiencing. Those without access to a warden are frustrated that they do not know who to ask for help when problems arose.

Table 11: Changes to the OPHS as a Result of Consultation

Theme	Changes written in to strategy	Type of Change	Resulting Action
1	Sheltered housing offers the benefit of family reassurance	**Supports** keeping wardens onsite	Identify ways to keep onsite wardens viable, such as supporting people outside of sheltered housing
3	Extra care housing is not a viable option for everyone due to high cost and limited units	**New** addition	Focus on other housing options in terms of integration
4	People are pleased that there are more housing options available in Conwy	**Supports** development of housing options	Cartrefi Conwy used as evidence to work with council to develop new sheltered housing scheme
4	People liked the idea of the wardens having access to a database of support service	**Supports** existing action	Assign part of EU grant, obtained by CCBC's Older Peoples officer, to the development of database
5	Accessing information and advice about services is a serious issue across all services	**Prioritise** the dissemination of information **Supports** wardens offering support outside of sheltered housing	Made this strategic objective a priority in all action plans
10	Access to handyman and gardening services are important and should be prioritised	**Prioritise** existing action	Subgroup to identify what is already available and find innovative methods to develop additional services e.g. working with local colleges

8.2.5 Effectiveness of Overall Action Research Project

The use of different methods is common in action research as they enable the researcher "to triangulate the findings by helping to confirm/disconfirm the findings"

(Sankaran et al, 2009:182). As previously discussed, the focus groups helped confirm the findings of the SSM, whilst simultaneously meeting the local authority's duty to consult with older people on the development of the OPHS. The survey provided an evidence base for the RSLs to decide the best way to structure the warden service, in terms of onsite or offsite support.

In her framework for integrated care (detailed in Chapter 2), Banks (2004) identified that for a partnership towards integrated care to be effective, all partners must have a shared vision. The SSM has been effective at creating a shared vision for the Steering Group, that considers the worldviews and perceptions of all group members. In line with the framework, the approach has also supported shared learning and ensured coherence with other policies, because key stakeholders have been involved throughout the project and empowered to state if anything contradicted. Whilst this is a policy framework, it still provides valuable guidelines for the successful development of partnership working to achieve integrated care on a local level. Overall, the project fits well within the guidelines of this framework. Measures are in place for evaluation and monitoring, although the project has not got that far yet as actions are currently being implemented.

The overall project can be deemed as a success because:

i.   stakeholder involvement throughout ensured that the OPHS was acceptable to all partners;

ii.   the consultation confirmed that the draft OPHS met the needs of older people living in Conwy, with the consultation serving to strengthen the convictions of some of the strategic objectives, rather than alter them;

iii. the Steering Group funded the project on an annual basis, highlighting members satisfaction with the progression of this partnership model.

The action research project was an effective method for partnership working (in terms of the Steering Group) leading to virtual integration in the form of agreed changes to support, written into the OPHS. The project utilised SSM for the macro

level and then explored other methods to develop solutions on an organisational level.

The Council has been essential for making this partnership happen; it acts as the power broker in this network and thus needs to provide strategic direction. The important coordinating and encouraging role of the Council illustrates the role of the state when services are outsourced (Drake and Davies, 2007), as housing has been in Conwy. The strategy provides the RSLs with strategic direction, but by developing it in partnership; the group also developed a solution to integrate Housing into the whole system of care. The key elements to the success of this partnership have been:

i.   having a clear outcome from the outset (the approved OPHS), this is supported by the CARMEN framework for achieving integrated care (Banks, 2004);

ii.   using SSM as it provided a systematic approach to establish the as-is and gave all partners an appreciation for the various worldviews of the system (demonstrated in Chapter 5);

iii.   using an external researcher to conduct the work.

Whilst the first two points have been explained in this chapter, the final one requires further examination. Firstly, the external researcher has been able to work on the project full-time, which is not something that the other partners would have been able to commit to, due to their full-time roles. Stoeker (1999) identifies different roles which researchers commonly assume when conducting action research. During this project, the action researcher adopted the role of 'the consultant'. In this role "the community commissions the research, and the academic carries it out while being held accountable to the community" (Stoecker, 1999:844). This role was adopted because, whilst researchers are able to commit their work time in a participatory action research project, co-researchers still have to meet the demands of their regular workload (Maguire, 1987). However, 'the community', i.e. the Steering Group, also acted as participants during the SSM stage of this project, so there are also similarities with the researcher taking the role of 'the collaborator' in this research

project, due to the high level of involvement of the community in this stage of the project. Following this stage, the researcher returned to the role of consultant, feeding back to the Steering Group to ensure that the research met its needs and expectations.

Secondly, funding an external researcher to develop the OPHS meant that the project had a clear end date; deadlines were absolute. This put pressure on outcomes right from the early stages of the research. It also meant that the Steering Group had a common purpose from the outset, to support the researcher to develop an OPHS that meets the needs of the group, and of older people. The buy-in to the project from the multiple organisations involved in the Steering Group undoubtedly improved the researcher's access, in terms of data collection. This was because these organisations wanted to demonstrate value for money in terms of this project, so were cooperative and engaged throughout the project. Improved access is a recognised benefit of an action research approach, "for academic researchers, action research can increase access to important research sites that otherwise would remain off-limits, while simultaneously increasing the relevance and scope of the research issues addressed" (Zhang et al, 2015:153).

Finally, the researcher is from an external organisation which limits preconceptions about the organisations involved in the early stages. Partners felt able to talk candidly to the researcher about their organisations' involvement in the whole system of care, and their frustrations with the system. Whilst using an external researcher with a Health or Social Care background may have helped the research get started quicker, having to go 'back to basics' when explaining the interactions between services in this system helped the Steering Group members to articulate their worldviews and perceptions of the system. A researcher with experience in these areas is likely to have preconceptions about the system that could subconsciously alter the way in which they question participants. As action research is grounded in the participatory worldview, it is accepted that research is subjective and the researcher will have an impact on the process (Reason and Bradbury, 2004).

8.2.6 Limitations of the Project and Future Research

The downside of using an external researcher to develop a project for partnership working is what happens after they leave. As the researcher had taken the approach of being 'the consultant' on this project during the first two years, the Steering Group became used to having a dedicated member who would go away and do the work suggested following a meeting. However, as the OPHS is a five year strategy (2012-2017), the researcher will not be available to implement all of the actions and measure outcomes. It was deemed essential that the researcher withdrew during the implementation stage in year three, to ensure that the implementation of the strategy continued at the end of the three year PhD. Whilst the researcher still attended the meetings of the three subgroups, she had to encourage other group members to take work away and explore setting the actions into motion.

Another limitation with this work was the limited involvement from Health during the early stages. Members of the Steering Group identified that this was a problem across numerous projects in Conwy working towards integrated care. The integration of the Health Service in North Wales had led to a period of turmoil, which resulted in difficulties about knowing who to contact and invite onto the Steering Group. This problem was only resolved once CCBC's Councillor for Health got involved, utilising his high level contacts in order to ensure that someone from Health attended meetings.

The final limitation with this project is that the researcher did not consult with older people living in social isolation. These people could potentially benefit from accessing the support service, as regular contact through support would limit their isolation. Wardens could act as a point of contact and introduce clients to other tenants and social activities if they so wish. However, as this was not the main focus of the research, the researcher was unable to obtain ethical approval to visit people who are socially isolated in their homes. Other avenues for accessing the views of people living in social isolation need to be explored.

It has not yet been possible to measure outcomes in terms of the OPHS's impact on older people, as actions are currently being implemented. The literature suggests that not measuring the outcomes in terms of the target population is a common

problem with partnership working to achieve integrated care (Cameron, 2014). However, it should be addressed and a follow up study identifying the effects of the changes on the older population in Conwy should be conducted in the future. Performance indicators that can be used to help measure outcomes are already written into the action plans. However, it has not been possible to measure the impact of the OPHS on older people within the timescale of this PhD project.

8.3 Conclusions

This thesis has used soft systems analysis to identify the problematic situation in Conwy, and to develop a range of appropriate solutions to the practical question of how to integrate Housing into the whole system of care for older people. Support has been identified and explored as an appropriate integrating function, as support is provided in the home. The wardens delivering support could provide a link into the whole system of care through the better provision of information, supporting tenants to navigate this complex system. This is a form of virtual integration "in which providers work together through networks and alliances" (Ham and Curry, 2011). The structure of the support service has been considered in-depth, using a survey of current practice to take the solution further, identifying potential owners and service structures for the proposed solution. Finally, the appropriateness of this solution has been tested by conducting focus groups with the target audience. This section breaks down the conclusions to clearly establish the findings from the case study, broken down by research objective, and the contributions to both theory and practice.

8.3.1 Conclusions from Literature Review

It has been seen that 'whole system of care' and 'integrated care' are both ill-defined terms in the literature. Despite this, a growing enthusiasm for integrated care has been identified in government policy, as it is now recognised that the problems dealt with by public services cannot be solved by one agency acting in isolation; they are too complex (Hudson, 2006). This is because, as our population is ageing, people increasingly have complex care needs due to multiple illnesses. The pressure put on public services by our ageing population is further exacerbated by pressures to cut costs of existing services, due to austerity measures implemented by government. It

has been argued that a whole systems approach to care is needed to enable more efficient and effective care provision with reduced overlapping of services, better information sharing between services and a more person-centred approach to care. It has been identified from the literature that a whole system of care is difficult to achieve because:

i.   Health and Social Services have fundamentally different cultures, work practices, access criteria, funding streams and administration, which makes it difficult to integrate these services (Leutz, 2005). There is no 'one size fits all' solution to integrated care;

ii.   differences exist between local authority systems of care, depending on the county's population, political agenda and commissioning practices;

iii.   efforts to integrate need to be localised but there are also legal, administrative and bureaucratic barriers to working in partnership towards integrated care, requiring more action at central government level (Glasby et al, 2011);

iv.   there is a lack of understanding in the research literature about the aims and objectives of integration (Cameron et al, 2014);

v.   integration takes time and efforts to explore the development of integrated practices put pressure on Health and Social Care staff (Glendinning and Lloyd, 1997), at a time when staff are already stretched due to funding cuts;

vi.   there is no evidence about the cost savings of integration (Leutz, 1999; Cameron et al, 2014), but there is a cost involved in developing solutions to provide integrated care.

Therefore, any piece of research into the development of integrated care must be local, realistic in terms of scope, supported by funding and clear in its objectives, as the action research project detailed in this thesis has been.

The literature has been examined to identify why housing should be integrated into the whole system of care for older people. This identified that the majority of literature about the whole system of care/integrated care is focused on the

integration of Health and Social Services (McCormack et al, 2008; Reed et al, 2005). Whilst housing is often referred to as an important element of the system, it is not a main focus of this body of literature. However, despite this gap, numerous government policies and studies identify that without Housing, the integration of Health and Social Services will not be a success (Department of Health, 2014; Rochira, 2013; Communities and Local Government, 2008). This is because:

i. a person's living environment has an impact on their health (Davidson et al, 2011; Roys et al, 2011);

ii. due to community care arrangements and the emphasis placed on 'ageing in place', care happens in the home;

iii. as people age, they spend relatively more time in their homes, so the home environment is intrinsically linked to wellbeing (Fange and Ivanoff, 2009);

iv. better links between Health and Housing would reduce bed blocking caused by people who are waiting for adaptations to their home before they can be discharged from hospital;

v. it is in the housing provider's interest to prevent the deterioration of each tenant's health, to avoid them deteriorating past the point where their home becomes unmanageable and they have to move out.

Although Housing is identified as important for the above reasons, it has been found that there is a gap in both literature and practice around how to integrate Housing with the whole system of care for older people. Housing policies such as 'Lifetime Homes, Lifetime Neighbourhoods' (CLG, 2008), place the onus on Housing to integrate into the whole system of care. However, Housing does not have the power in the supply network for care, as care is not necessarily intrinsic in what housing providers offer, whereas it is intrinsic for Health and Social Services. The integration of Housing into the system will not be successful unless Health and Social Services enable this partnership. This thesis addresses the gap in the literature about how to integrate Housing into the whole system of care for older people, using support.

8.3.2 Empirical Evidence from Case Study

Four research objectives were derived from the review of the literature on the whole system of care, and from the case objectives identified for the development of

Conwy's Older Persons Housing Strategy (OPHS). The conclusions from each of these will be discussed in this section:

1. Explore the current model of Health, Social Care and Housing in Conwy using soft system methodology (SSM) in order to identify potential integrating functions.

This research objective was addressed in Chapter 5. Based on the review of the literature and the 'Finding Out' section of the SSM study, it has been established that extra care housing and residential care homes are already integrated into the whole system of care for older people. Care is included in these housing options as part of the housing package, therefore housing and care providers work together closely to deliver services to tenants. However, it has been seen that sheltered housing and non-specialist housing do not include care and are not linked into the system, despite the fact that many older people living in these types of housing receive care; their care is provided completely separately from any housing related services. Therefore, the focus of the research shifted to considering how to integrate sheltered housing and non-specialist housing into the system, as 93% of older people live in non-specialist housing.

Three potential integrating functions have been identified, by looking into services that already visit the client in their home. There is no budget allocated to the development an entirely new service in Conwy, therefore existing services were examined. The three potential options were reablement, support and care. Support has been identified as the most appropriate integrating function because;

  i.   care is only provided to people assessed as having a substantial or critical need for it, so using carers would exclude people with low-moderate needs from accessing the service;

  ii. Conwy was in the early stages of implementing a pilot for reablement, with guidelines for the pilot already approved by its Cabinet. Therefore, there wasn't the scope to build this opportunity into the pilot. Reablement could potentially still offer an appropriate integrating function in other counties where it is a more established service;

  iii. support providers already have relationships with tenants in sheltered housing, so the change necessary to integrate Housing into the wider system of care is less substantial by using this existing service;

iv. housing-related support, as a service, is at risk due to changes to Supporting People funding, making it essential to demonstrate, and improve, its value;

v. the changes to Supporting People funding mean that support now needs to be provided on a needs-basis and thus should be offered to people living in non-specialist housing anyway, so using support to integrate Housing into the whole system of care for older people capitalises on this necessary change.

2. Develop conceptual models for integrating Housing into the whole system of care using support.

Three options for integrating Housing into the whole system of care using support were developed for this objective in Chapter 5, and have been explored by the Steering Group:

Option One: Develop the existing support service.

Option Two: Separate support and Housing.

Option Three: Create a separate support entity managed by an RSL.

The Steering Group discussed the advantages and disadvantages of each option at length. Option One has been chosen by the Steering Group as the most appropriate choice in the case of Conwy. This option is deemed the most feasible because Health has not been as engaged with the project as the Steering Group would have liked and Option Two required a significant commitment from Health in terms of funding and development. As well as this, four of the five RSLs with housing for older people operate in numerous other counties. To radically change their support provision in Conwy would fragment their provision of support which rules out Option Three. "Your integration is my fragmentation" is one of Leutz' laws of integration (1999), highlighting that this is a common problem in the field of integrated care.

The main disadvantage of Option One is that it is a low intensity change and thus could potentially lack drive. Outcomes have been written into Conwy's OPHS to maintain the drive for restructuring the support service, and the researcher has been responsible for ensuring progress throughout the duration of the project.

3. Explore and analyse existing support structures throughout Wales in order to identify the most effective and efficient way to structure the support service provided by wardens.

From the survey of RSL's and local authorities in fifteen counties in Wales and two in England (detailed in Chapter 6), it has been concluded that support is currently in a transition phase, with 82% of the counties interviewed currently or recently reviewing the support that they offer tenants in sheltered housing. This is due to changes to Supporting People funding meaning that support should now be provided on a needs-basis. Support (in this form) is not currently available to people living in their own homes in Conwy, which is inequitable. A taxonomy of support structures has been developed and this highlights that some local authorities in Wales are starting to examine the potential for offsite support.

It has been argued that there is no longer a viable case for providing residential wardens in sheltered housing, due to:

i.   EU working-time laws which mean that wardens can no longer support people out of working hours, negating the necessity for them to live onsite;

ii. difficulties hiring for this role, especially with the professionalisation of wardens;

iii. the introduction of needs-based funding resulting in fewer tenants paying towards the warden;

iv. the need to provide support to people now remaining in their own homes.

This leaves support providers with a choice between regular, 9-5 onsite support or offsite support. A SWOT analysis has been conducted on onsite and offsite support structures, in order to provide an evidence base for RSLs who are considering restructuring their service provision. Strategic performance objectives, commonly used in operations management, have been used to provide a framework to ensure that the analysis of support structures considers other important variables, instead of just focusing on cost.

It has been seen that many local authorities in England are now using offsite support, as it is perceived as a lower cost model and improvements in technology

mean that tenants can be supported from afar. However, the implications of this are not well researched (King et al, 2009). Offsite support involves complex scheduling in order to make the service cost-effective. An implication of this is that it reduces the consistency of the service for the tenant/client, as they can be visited by numerous different wardens, limiting the opportunities for a relationship to develop. It has been established that older people in Conwy are dissatisfied with the high number of carers that visit them, so keeping the number of support workers to a minimum is a more desirable option.

It has been argued that onsite wardens are well-placed to signpost services, due to the consistency of their presence, which enables them to follow up with tenants, resulting in coproduction. The value of having an onsite service is dependent on the value that is placed on integrating Housing into the whole system of care. The relationship between warden and tenant is a key element of the effectiveness of support as an integrating function; they can act as a guide into the system. The focus groups have revealed that tenants feel comfortable asking their wardens to signpost other services, using them as their first point of contact. Evidence of coproduction can be seen between wardens and tenants in terms of accessing adaptations and repairs, suggesting that the relationship is well established, ready for the warden to take this signposting role further. For this to happen, the wardens need to be provided with clear information about services offered by Health and Social Services throughout the county. However, for support to remain based onsite implies that it would not be made available to people living in their own homes, which is not in line with the changes to Supporting People funding.

This research has advocated the use of a hub and spoke model of support provision; a compromise between onsite and offsite support that mitigates some of the weaknesses of each. A hub and spoke model enables the warden to still be linked to a scheme, and thus maintain their relationship with tenants, whilst also supporting older people living in their own homes; meeting the changes to the funding guidelines. For example, the warden could visit tenants of the scheme on a needs-basis in the morning, and then support local people outside of the scheme in the afternoon. The consultation revealed that older people living in their own homes felt that it is unfair that they do not have access to the kind of support that wardens give

to people living in sheltered housing. It has been argued that the hub and spoke model of support provision would address this inequality. The focus groups revealed that support is valued by tenants, with the majority of respondents who currently have a warden stating that they would use them as their first point of contact for any issues they were experiencing. The relationship between wardens and tenants is essential for coproduction and the hub and spoke model of support provision would allow for this to be developed and maintained more effectively than when wardens only provide offsite support, due to the complex scheduling that this involves.

4. Consult with older people to validate the proposed solutions and ensure they meet the needs of the target market.

Based on the consultation process (Chapter 7), Conwy's Older Persons' Housing Strategy (OPHS) meets the needs of older people living in Conwy. Following the consultation period, very few changes needed to be made to the strategy which is a reflection of the success of the initial SSM work in establishing the needs of stakeholders. Of the six changes that were made, only one was an entirely new addition, the rest were in support of existing actions, or served to prioritise existing actions. Evidence from the focus groups is also used to support many of the other conclusions to this work.

8.3.3 Contribution to Theory

Operations Management

This thesis has demonstrated that operations management theory can provide useful insights into whole systems working, building on the knowledge developed in the manufacturing and service sectors. Operations and supply chain management are commonly being applied to healthcare as a way to reduce costs and improve quality (Dobrzykowski et al, 2014; de Vries, 2011; McCormack et al, 2008). Integrated care implicitly requires the integration of operations, at structural, organisational and individual levels. Structural integration is assumed to be the most superior form of integration but this is not the case when considering Health and Social Services, as centralising power and administration for such large, complex organisations does not necessarily ensure network efficiency, especially when accounting for the level of local variation of services (Goodwin et al, 2004). Therefore, virtual integration has

been brought to the forefront in terms of a feasible, appropriate solution to reducing the overlap between Health and Social Care and encouraging joint working. Virtual integration refers to when organisations work together through networks and joint projects.

The whole system of care is a complex network, characterised by multiple suppliers of care with unclear communication channels, leading to customers (patients) feeling confused about who is able to meet their needs. The complexity of this network has led to numerous issues such as an increase in patients incorrectly accessing A&E services and bed blocking in hospitals. Solutions to help patients navigate this complex system are becoming increasingly essential, due to austerity and the pressure on the system of care caused by our ageing population. Many companies also have complex supply chains, but use technology and clear communication channels to collaborate and work closely with their suppliers to help overcome this complexity, resulting in an efficient and effective supply chain. For example, supermarkets stock thousands of fresh products daily to sell to customers. Their supply networks are extremely complex due to the perishable nature of some products, the range of different products they sell, and the resulting number of suppliers they work with. But supermarkets use technology to communicate with their suppliers in real-time, and consequently they are able to coordinate this complex network effectively, with IGD reporting the on shelf availability of supermarket products at 97.3% (IGD, 2015). Many of the solutions used by supermarkets and other companies are based on supply chain management theory, which is now also being applied to the public sector to improve the efficiency and effectiveness of public sector services. However, one significant difference is that supermarkets are clearly the powerful player in the supply network, enabling them to dictate terms of contracts to some extent. In the supply network for care, the SSM study revealed that both Health and the local authority are powerful, but neither has power over the other which is an interesting dynamic. This thesis has found that examining the issues in the supply network for care from a supply chain perspective has provided insight and has been an effective method for developing and exploring solutions.

Although not enough research has yet been conducted to propose a supply chain management based framework specifically for integrated care, the rhetoric between the two topics is strong. "Combining a supply chain perspective with cross-functional and cross-organisational teams, continuous integration practices, lead time control, and appropriate information technology is promising at least conceptually" (Meijboom et al, 2011:171). By considering the barriers to integrated care from an operations management perspective, it is possible to begin to develop solutions to begin to overcome these barriers. This is demonstrated by the effectiveness of the proposed solution at integrating Housing into the whole system of care for older people. Support providers are well placed to help people navigate the complex system of care, and are already demonstrating skills at signposting and coproduction. Providing them with the right information so they can help the people they support to navigate the system is a low cost solution that could have a significant impact on patients. However, it is not possible to simply retrofit operations management theory onto Health and Social Care, due to the unpredictability of illness and patient behaviour.

This thesis has drawn on operations management theory to add depth to some of the suggestions made. For example, the supply chain principle of hub and spoke design is well established, it is used regularly for warehousing and distribution centres. But applying this well established principle to support in order to improve warden services is an innovative solution; these principles are not well utilised in the public sector. The application of common operations management performance objectives to the structure of support services also ensured that a range of issues were discussed, instead of merely focusing on cost, which appears to be the main driving force behind offsite support.

Integrated Care

Integrated care requires organisations within the whole system of care to work in partnership, in order to co-ordinate services to reduce fragmentation and overlap. However, it has been found that there is little information available about the methods that are effective in establishing a partnership approach. Action research is a recognised approach towards integrated care, which "can result in the initiation of change at the level of both individual professional practice and organisational

structures and practices" (Hart and Bond, 1995:4). However, action research is typically a combination of methods, designed to make sense of a situation and support change, so there is still no clear guidelines on which specific methods are effective.

This thesis has found that the specific combination of methods utilised during this action research project, can be effective at developing a solution for integrated care, focusing on a specific area (Housing). By using SSM, the stakeholders who are involved in implementing the solutions were involved in their development, and thus bought in to the implementation of the proposed solutions. The survey then provided the Steering Group with details of how other local authorities across Wales are evolving their support services. This provided an evidence base for onsite support versus offsite support. Whilst it is too early to assess the outcomes of the proposed solutions, they were developed with the 'experts', meaning that the technical and practical implications of implementing this solution have been considered. The SSM ensured that the proposed solution has been built to take into account the worldviews of these stakeholders. The OPHS includes expected, measurable outcomes that can be used once the solution has been fully implemented. Finally, the focus groups have served to demonstrate rigour in the approach, by ensuring that the proposed solutions, derived from the SSM and the survey, meet the needs of their target market.

The value in soft systems methodology (SSM) during this study has been in its underlying principles which encouraged shared learning in the Steering Group. The approach encouraged the partner organisations on the Steering Group to consider one another's worldviews with regards to the whole system of care. Clearly stating and understanding the underlying views and principles of each group member in terms of this problematic situation enabled the group to establish a shared vision for what the OPHS should offer. A shared vision is a prerequisite for a successful partnership approach to achieving integrated care, across complex organisational boundaries (Glasby and Littlechild, 2004:7; Grieg and Poxton, 2001; Banks, 2004). The whole system of care is a complex network, characterised by different funding streams, fragmented services and unclear communication channels. The SSM provided a rigorous approach to develop a picture of the as-is system in Conwy, and

then laid the foundations for the development of solutions to integrate one, relatively minor element of this system (Housing). The complexity and scale of the whole system of care makes it a daunting research topic, but the SSM helped to identify the boundaries for the focus of this research. For example, the researcher chose not to delve into the throughput of the Health subsystem, instead focusing attention on the inputs and outputs of Health, i.e. how this subsystem interacts with the other subsystems. This was logical as Housing and Health only interact when Housing causes a barrier to the discharge of patients. SSM procedures have been useful as 'sense-making tools' for the researcher, using CATWOE to ensure that the different elements of each root definition are considered. This thesis argues that SSM provides a range of principles and tools that fit well with the development of an integrated care service.

8.3.4 Contribution to Practice

This thesis has contributed to practice by identifying a solution to the question of how to integrate housing into the whole system of care for older people. The integration of housing into the whole system is identified as essential for the system to be effective in the literature, but there is no clarity on how this is to be achieved. For housing that does not have associated care services, warden support offers an appropriate integrating function as wardens can help tenants to navigate the whole system of care through signposting, feeding back the tenants requirements to the housing provider.

The focus groups identified that wardens already signpost tenants to the services they are aware of, however, this was limited to services provided by their housing association or that they know of personally. This is because a comprehensive database of support services offered locally by any organisation did not exist. A clear procedure for the sharing of information between wardens and other services in the whole system of care did not exist before this research. This research has instigated the development of a comprehensive database of support services, to be made accessible to wardens across all RSLs. The development of this database has enabled the wardens to increase the number of services they signpost to. If services have a greater uptake, they will attract funding, thus lowering the turnover of support services provided by Health, Social Services and the third sector.

This thesis also provides an evidence base for local authorities and housing providers to use when restructuring their warden services and trying to decide between onsite and offsite support. The SWOT analysis was conducted based on the survey of support services across Wales and provides useful insight to those trying to make this decision. A third alternative has been suggested, using a hub and spoke model of support provision, which mitigates some of the weaknesses of both onsite and offsite support. These findings were disseminated to the RSLs involved in the project, some of whom have already began developing hub and spoke warden services. The survey identified that support is currently in a transition phase, due to the changes to Supporting People funding, so this research is timely.

A warden forum has been instigated through this research. This now provides an effective platform to break down the boundaries of providing support between the various RSL's. The forum offers a platform to share ideas and concerns, whilst gradually resulting in a more standardised support service across Conwy, by ensuring that the wardens all receive the same external training and information, regardless of their employer. It has proved popular with wardens who enjoy the opportunity to share ideas. The Steering Group for this project ensured that this research had a high impact, with suggestions being discussed and piloted during the course of the action research.

Using a single case study for this action research project has been appropriate as the elements that make up the whole system of care vary greatly between local authorities in terms of funding, political agenda, facilities, commissioning practices, population needs, work processes etc. Leutz (2005), added a sixth law to his "Five Laws of Integration" which stated that, "all integration is local", for this very reason. Conducting in-depth action research in one county has enabled the research to have high impact, with the OPHS being implemented in Conwy (see Appendix). To date, there are twenty-four older people, who would not previously been eligible for the support service, receiving support from wardens. The wardens in Conwy are now better equipped to provide clients with guidance into the whole system of care and signpost other services, due to the development of a database of support services and training which has improved their knowledge of the system.

References

Age UK (2011). *Making it work for us: A residents' inquiry into sheltered and retirement housing.* London: Age UK

Age UK (2013). *Care Homes: Finding the Right Care Home.* London: Age UK

Age UK (2014). *A lack of suitable housing costing the NHS millions every year*. Available at: http://www.ageuk.org.uk/latest-press/archive/lack-of-suitable-housing-costing-the-nhs-millions-every-year/ [Accessed 15/02/2015]

Age UK (2014a). *Housing in Later Life*. London: Age UK

Age UK (2014b). *Later Life in the United Kingdom: October 2014. Factsheet.* Available at: http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true [Accessed 23/10/2014]

Age UK, (2013a). *Improving Later Life, Understanding the Oldest Old.* London: Age UK

Anderson, W., (2004). Specialist support teams: influencing the nursing care of older people, *Nursing Older People*, **16**(1), pp. 18–20.

Armitage G. E., Suter, N. Oelke and C. Adair, (2009). Health systems integration: state of the evidence, *International Journal of Integrated Care,* **9**(17), pp.1–11.

Arnesson, K. and Albinsson, G. (2014). Interaction patterns in a Steering Group: Power and action outcome, *Economic and Industrial Democracy*, **35**(2), pp. 325–340.

Atwal, A. and Caldwell, K. (2002). Do multidisciplinary integrated care pathways improve interprofessional collaboration? *Scandinavian Journal of Caring Sciences*, **16**(4), pp. 360–367.

Audit Commission (1998). *A Fruitful Partnership: Effective Partnership Working.* London: Audit Commission.

Ball, R., Forbes, T., Parris, M., and Forsyth, L. (2010). The evaluation of partnership working in the delivery of health and social care. *Public Policy and Administration*, **25**(4), pp. 387-407.

Baltes, M.M., Maas, I., Wilms, H.U., Borchelt, M., Little, T.D., (1999). Everyday competence in old and very old age: Theoretical considerations and empirical findings. In: Baltes, P.B., Mayer, K.U. (Eds.), *The Berlin Aging Study*. Cambridge: Cambridge University Press

Banks, P. (2004). *Policy Framework for Integrated Care for Older People*. London: King's Fund

Barbour, R. (2007). *Doing Focus Groups.* London: Sage Publications

Barnes, D. (2008). *Operations Strategy: An International Perspective*. London: Cengage Learning

Barrett, J. and Kirk, S. (2000). Running focus groups with elderly and disabled elderly participants, *Fundamental Reviews in Applied Ergonomics*, **31**(6), pp. 621–629.

Batista, L. (2012). Translating trade and transport facilitation into strategic operations performance objectives, *Supply Chain Management*, **17**(2), pp. 124–137.

Bäumker, T., Netten, A. and Darton, R. (2010). Costs and Outcomes of an Extra Care Housing Scheme in England, *Journal of Housing For the Elderly*, **24**(2), pp. 151–170.

Baxter, J., (2008). *Welsh Housing Quality Standard.* Members Research Service: Topic Briefing. Available from http://www.assemblywales.org/tb-08-021.pdf [Accessed 27/03/2013]

BBC News (2012). *Disabled facilities grants delays criticised by the commissioner.* Available at http://www.bbc.co.uk/news/uk-wales-19721267 [Accessed 13/03/2015]

BBC News (2013). *Why old age need not be a burden.* Available from http://www.bbc.co.uk/news/health-21757212 [Accessed 15/03/2013]

BBC News, (2015). *Wales and Northern Ireland A&E waits 'worsen'.* Available at: http://www.bbc.co.uk/news/health-30847730 [Accessed 03/03/2015]

Belvedere, V. (2014). Defining the scope of service operations management: an investigation on the factors that affect the span of responsibility of the operations department in service companies. *Production Planning and Control,***25** (6), pp. 447-461.

Bergvall-Kåreborn, B. (2002). Enriching the model-building phase of soft systems methodology, *Systems Research and Behavioral Science*, **19**(1), pp. 27–48.

Bevan, M., Croucher, K., Rhodes, D.. Riseborough, M. and Fletcher, P. (2006) *The Housing and Support Needs of Older People in Rural Areas*, London: The Countryside Agency.

Bhatia, N. and Drew, J., (2007). Applying lean production to the public sector. *Mckinsey Quarterly*, **3**, pp. 97–98.

Bicheno, J., (2012). *The Service Systems Toolbox: Integrating Lean Thinking, Systems Thinking and Design Thinking.* Buckingham: PICSIE Books

Booth, R. (2009). *The Guardian: Barnet council's 'no-frills' approach to housing blocked by injunction.* Available from http://www.theguardian.com/society/2009/sep/16/barnet-council-no-frills-injunction [Accessed 19/07/2013]

Boumans, N. P., Berkhout, A. J., Vijgen, S. M., Nijhuis, F. J., and Vasse, R. M. (2008). The effects of integrated care on quality of work in nursing homes: A quasi-experiment. *International Journal of Nursing Studies*, **45**(8), pp. 1122-1136.

Bradshaw, S. A., Playford, E. D. and Riazi, A. (2012) Living well in care homes: a systematic review of qualitative studies, *Age and Ageing*, **41**(4), pp. 429–440.

Brydon-Miller, M., Greenwood, D., and Maguire, P. (2003). Why action research? *Action research*, **1**(1), pp. 9-28.

Bryman, A. (2006). Paradigm peace and the implications for quality'. *International Journal of Social Research Methodology*. **9**, Pp. 111-126.

Burholt, V., Windle., G. (2006). *The material resources and wellbeing of older people.* York: Joseph Rowntree Foundation

Burlumi, S. and Tuck, J. (2008). Working with planners to maximise choice for older people, *Housing, Care and Support*, **11**(1), pp. 26–31.

Burns, D. (2007). *Systematic Action Research: A strategy for whole system change.* Bristol: The Policy Press

Burns, D., Hyde, P., Killett, A., Poland, F. and Gray, R. (2014). Participatory Organizational Research: Examining Voice in the Co-production of Knowledge, *British Journal of Management*, **25**(1), pp. 133–144.

Burton, J. (2010) "Call it personalisation if you like": the realities and dilemmas of organising care in a small rural community, *Journal of Social Work Practice*, **24**(3), pp. 301–313.

Butler, T. and Jeffrey, A. (2004). In Glasby J. and Peck E. (2004). *Care Trust Partnership Working in Action.* Oxon: Radcliffe Medical Press Ltd

Callender, G. (2011). Alignment of inter-agency supply chains to enhance public sector performance management, *International Journal of Productivity and Performance Management*, **60**(1), pp. 9–23.

Cameron, A., Macdonald, G., Turner, W. and Lloyd, L. (2007). The challenges of joint working: lessons from the Supporting People Health Pilot evaluation, *International Journal of Integrated Care*, **7**, pp. 1–10.

Campaign to End Loneliness (2014). *The Cost of Loneliness*. Available at http://www.campaigntoendloneliness.org/wp-content/uploads/downloads/2014/01/Campaign-to-End-Loneliness-Costs-of-Loneliness-scoping-report-January-2014.pdf [Accessed 05/01/2015]

Carey, J. W. (1993). Linking qualitative and quantitative methods: Integrating cultural factors into public health. *Qualitative Health Research*. **3**, Pp. 298–318

Chapman, J. (2004). *Systems Failure: Why Governments Must Learn to Think Differently,* 2nd ed. London: Demos.

Chartered Institute of Housing (2013) *Delivering housing, health and care outcomes*. Available from:
http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/Delivering%20housing,%20health%20and%20care%20outcomes.pdf [Accessed 15/08/2013]

Chartered Institute of Housing (2013). *Supporting People in Wales*. Available at http://www.cih.org/resources/PDF/Wales%20general/CIH%20Supporting%20People%20English.pdf [Accessed 13/01/2015]

Checkland and Poulter, (2006). *Learning for Action: A Short Definitive Account of Soft System Methodology, and its use for Practitioners, Teachers and Students*. West Sussex: John Wiley and Sons Ltd

Checkland and Scholes, (1990). *Soft Systems Methodology in Action.* West Sussex: John Wiley and Sons Ltd

Checkland, P. (2000). Soft systems methodology: a thirty year retrospective. *Systems Research and Behavioural Science*, **17**(1), pp. 11-58

Checkland, P. B. and Haynes, M. G. (1994). Varieties of systems thinking: the case of soft systems methodology, *System Dynamics Review (Wiley)*, **10**(2/3), pp. 189–197.

Chevalier, J. M., and Buckles, D. J. (2013). *Participatory action research: theory and methods for engaged inquiry.* UK: Routledge

Christiansen, C., Baum, C. (Eds.), (1997). *Occupational therapy. Enabling function and well-being (2nd ed.).* New Jersey: Slack

Christopher, M., (1992). *Logistics and Supply Chain Management.* London: Financial Times

Clapham, D. (1997). Problems and Potentials of Sheltered Housing, *Ageing and Society*, **17**(02), pp. 209–214.

Clark, H., Dyer, S., Horwood, J., (1998). *That bit of help.* Bristol: Policy Press

Clarke J. and Glendinning C. (2002). Partnership and the remaking of welfare governance. In: C. Glendinning, M. Powell and K. Rummery (Eds) *Partnerships, New Labour and the Governance of Welfare*. Bristol: The Policy Press

Cohen, C. S., Mulroy, E., Tull, T., Bloom, C. C. and Karnas, F. (2007). Integrating Services for Older Adults in Housing Settings, *Journal of Gerontological Social Work*, **49**(1-2), pp. 145–164.

Commission on the Future of Health and Care in England (2014). *A new settlement for health and social care: interim report.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/new-settlement-health-and-social-care [accessed 21/05/2014]

Communities and Local Government (CLG) (2008) *Lifetime Homes, Lifetime Neighbourhoods. A National Strategy for Housing in an Ageing Society.* London: Department for Communities and Local Government

Communities and Local Government, (2006). *A Decent Home: Definition an guidance for implementation June 2006 update.* London: Department for Communities and Local Government

Communities and Local Government, (2008a). *More Choice, Greater Voice: a toolkit for producing a strategy for accommodation with care for older people*. London: Housing Learning and Improvement Network

Communities and Local Government, (2009). *Delivering Lifetime Homes, Lifetime Neighbourhoods, A national strategy for Housing in an Ageing Society*. London: Department for Communities and Local Government

Communities and Local Government, (2011). *Definition of General Housing Terms*. Available at: http://www.communities.gov.uk/housing/housingresearch/housingstatistics/definitiongeneral/ [accessed 31/10/2011]

Conwy County Borough Council, (2012). *2011 Census Bulletin: key population characteristics. Corporate Research and Information Unit*. Available at: http://www.conwy.gov.uk/upload/public/attachments/558/2011_Census_key_pop_characteristics__bulletin_201212.pdf [Accessed 26/08/14]

Conwy Local Health Board (2008). *Conwy Health, Social Care and Well-being Strategy: 2008-2011*. Available at: http://www.conwy.gov.uk/upload/public/attachments/310/Healthy_Conwy_Strategy_200811_draft.pdf [Accessed 20/08/2014]

Cooper, L. (2005). A vision for sheltered housing, *Working with Older People: Community Care Policy and Practice*, **9**(1), pp. 37–40.

Cronkright, I. (2007). It is possible to age gracefully at home, *Fairfield County Business Journal*, **46**(47), p. 16.

Croucher, K., (2008). Karen Croucher: developing a housing strategy for our ageing population. *Policy and Politics,* **36** (4), pp. 613-614

Croucher, K., Hicks, L. and Jackson, K. (2006). *Housing with Care for Later Life: A Literature Review,* York: Joseph Rowntree Foundation.

CSED, (2000). *Homecare Reablement Discussion Document Volume 2: Case Studies – Leicestershire: External Evaluation of the Home Care Reablement Pilot Project*, De Montfort University

Darton, R., Bäumker, T., Callaghan, L., Holder, J., Netten, A. and Towers, A.M. (2012). The characteristics of residents in extra care housing and care homes in England, *Health and Social Care in the Community*, **20**(1), pp. 87–96.

Davidson, M. Nicol, S., Roys, M., and Beaumont, A. (2011). *The real cost of poor housing in Wales*. Watford: BRE Press

Davies, S. L., Goodman, C., Bunn, F., Victor, C., Dickinson, A., Iliffe, S., Gage, H., Martin, W., and Froggatt, K. (2011). A Systematic Review of Integrated Working between Care Homes and Health Care Services. *BMC Health Services Research* **11**, (1), pp. 320-241.

Davies, B. M., Drake P. R., (2007). Strategies for Achieving Best Value in Commissioned Home Care. *International Journal of Public Sector Management*. **20**(6), pp. 206-225.

Davis, H. and Martin, S., (2002). Evaluating the best value pilot programme: measuring 'success' and 'improvement'. *Local Government Studies,* **28**(2), 55–68.

Dawson, L., Williams, J. and Netten, A. (2006) Extra care housing: is it really an option for older people?, *Housing, Care and Support*, **9**(2), pp. 23–29.

De Vries, J. and Huijsman, R. (2011) Supply chain management in health services: an overview, *Supply Chain Management: An International Journal.* **16**(3), pp. 159–165.

Department of Health (2003) *Government announces funding for extra care housing*, Press Release 20/03/0248. London: Department of Health.

Department of Health (2003). *Fair Access to Care Criteria: Guidance on Eligibility Criteria for Adult Social Care.* London: Department of Health

Department of Health (2004*) Housing for Older People: An Introduction for Commissioners*, London: Department of Health.

Department of Health (2005) *Independence, well being and choice: Our vision for the future of social care for adults in England.* London: Department of Health.

Department of Health (2009). *CSSR Scheme Directory Update March 2009.* London: Department of Health

Department of Health (2009). *Developing a whole system approach.* Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandst atistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4923908 [accessed 24/02/2015]

Department of Health (2010) A Vision for Adult Social Care: Capable Communities and Active Citizens. Department of Health, London.

Department of Health (2014). *Guidance: Care Act Fact Sheets.* Available at: https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets--2 [Accessed 09/03/2015]

Department of Health (2001). *National service framework for older people.* London: Department of Health.

Dickens, A. P., Richards, S. H., Greaves, C. J., and Campbell, J. L. (2011). Interventions targeting social isolation in older people: a systematic review. *BMC Public Health*, **11**(1), 647.

Dickinson, H. (2006) 'The Evaluation of Health and Social Care Partnerships: An Analysis of Approaches and Synthesis for the Future'. *Health and Social Care in the Community.* **14**, pp. 375–383.

Dignity in Care, (2008). *Nursing and Midwifery Council New Guidelines on the care of Older People*. Social Care Institute for Excellence. Available at: http://www.dignityincare.org.uk/News/newsItem/?cid=4852 [accessed: 09/04/2012]

Dignity in Care, (2008). *Nursing and Midwifery Council New Guidelines on the care of Older People*. Social Care Institute for Excellence. Available at: http://www.dignityincare.org.uk/News/newsItem/?cid=4852 [accessed 09/04/2012]

Dobrzykowski, D., Deilami, V. S., Hong, P., and Kim, S. C. (2014). A structured analysis of operations and supply chain management research in healthcare (1982–2011). *International Journal of Production Economics*, *147*, pp. 514-530.

Donovan, T. (2013). Personalisation, outsourcing and less residential care- how adult social care is being cut. Available at: http://www.communitycare.co.uk/2013/03/12/personalisation-outsourcing-and-less-residential-care-how-adult-care-is-being-cut/ [accessed 28/02/2015]

Doyle, L., Brady, A. M., Bryne, G., (2009). An overview of mixed methods research. *Journal of Research in Nursing.* **14** Pp. 175-185

Drake, P. R., and Davies, B. M. (2007). Approaches to commissioning home care from the independent sector. *International Journal of Public Sector Management.* **20** (6), pp. 497-518.

English Housing Survey, (2009-10). *Household Report 2009-10.* Communities and Local Government. Available: http://www.communities.gov.uk/documents/statistics/pdf/1937206.pdf [accessed 12/12/2013]

ESRC (2011). *Economic and Social Research Council: 'What is Social Science?'.* Available at http://www.esrc.ac.uk/about-esrc/what-is-social-science/ [accessed 24/10/2012]

Essential Role of Sheltered Housing (ERoSH),(2010). *Position statement on resident wardens and their alternatives*. Available at: http://www.shelteredhousing.org/library/news/1255690303document_2_eroshpsr esidentwardens.pdf [accessed 01/01/11]

European Parliament (2003). *Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time.* Available at http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32003L0088:EN:N OT [accessed 20/06/2012]

Evandrou, M., Falkingham, J., (2007). Demographic Change, Health and Health Risk Behaviour across Cohorts in Britain: Implications for Policy Modelling. In Gupta, A., and Harding, A., (eds) 2007. *Populating our future: Population Aging, Health and Aged Care. International Symposia in Economic Theory and Econometrics*. Oxford: Elsevier

Fänge, A. and Ivanoff, S.D. (2009). The home is the hub of health in very old age: Findings from the ENABLE-AGE Project. *Archives of Gerontology and Geriatrics*, **48**(3), pp.340–345.

Fernandez, S., and Pitts, D. W. (2007). Under what conditions do public managers favor and pursue organizational change? *The American Review of Public Administration*, **37**(3), 324–341.

Field, E. M., Walker, M. H. and Orrell, M. W. (2002) Social networks and health of older people living in sheltered housing, *Aging and Mental Health*, **6**(4), pp. 372–386.

Field, E., Walker, M., Hancock, G. and Orrell, M. (2005) The Needs of Older People in Sheltered Housing, *Journal of Housing For the Elderly*, **19**(2), pp. 107–117

Finch, H., Lewis, J., 2003. Focus Groups. In Richie, J., Lewis, J. 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage Publications

Flood R. L. (2010). The Relationship of 'Systems Thinking' to Action Research. *Systemic Practice and Action Research*. **23**, pp. 269-284.

Flood, R. L., (2001). The Relationship of "Systems Thinking" to Action Research in Reason, P. and Bradbury, H. (eds) (2001). *Handbook of action research: Participatory inquiry and practice.* London: Sage Publications

Flood, R., and Jackson, M. (1991). Cre*ative Problem Solving: Total Systems Intervention*. Chichester: Wiley

Flyvbjerg, B. (2001) *Making Social Science Matter: Why Social Inquiry Fails and How it Can Succeed Again*, Cambridge: Cambridge University Press.

Fonad, E., Wahlin, T.-B. R., Heikkila, K. and Emami, A. (2006) Moving to and Living in a Retirement Home, *Journal of Housing For the Elderly*, **20**(3), pp. 45–60.

Franz, N. K., 2011. The Unfocused Focus Group: Benefit or Bane. *The Qualitative Report.* Volume 16, Number 5, Pp. 1380-1388

Freeman, T. and Peck, E. (2006) Evaluating partnerships: a case study of integrated specialist mental health services, *Health and Social Care in the Community*, **14**(5), pp. 408–417.

Friedman, J. (2005). *Trying hard is not good enough: How to produce measurable improvements for Customers and Communities*. Charleston: Booksurge Publishing

Frontier Economics (2012). *Enablers and Barriers to Integrated Care*. London: Monitor.

Furlong, P. and Marsh, D., (2002). A skin not a sweater: Ontology and Epistemology in Political Science. In Marsh, D., Stoker, G., 2002. *Theory and Methods in Political Science*. New York: Palgrave Macmillon

Gerwel, C. N. P. and Bodhanya, S. (2014). Managing Learning and Change: Factors Influencing the Effectiveness of Soft Systems Methodology, *Mediterranean Journal of Social Sciences*, **5**(9) pp. 1125-1135.

Gibb, C. E., Morrow, M., Clarke, C. L., Cook, G., Gertig, P., and Ramprogus, V. (2002). Transdisciplinary working: evaluating the development of health and social care provision in mental health. *Journal of mental health*, **11**(3), pp. 339-350.

Glasby, J. (2004) cited in Leutz, W. (2005). Reflections on integrating medical and social care: five laws revisited. *Journal of Integrated Care*, **13**(5), pp. 3-12.

Glasby, J. (2003). *Hospital discharge: Integrating health and social care.* Oxon: Radcliffe Medical Press

Glasby, J., and Littlechild, R. (2004). *The Health and Social Care Divide: The experiences of older people*. Bristol: The Policy Press

Glasby, J., Dickinson, H. and Miller, R. (2011) Partnership working in England—where we are now and where we've come from, *International Journal of Integrated Care*, **11** (Special 10th Anniversary Edition)

Glasby, J., Dickinson, H. and Miller, R. (2011) Partnership working in England—where we are now and where we've come from, *International Journal of Integrated Care*, **11** (Special 10th Anniversary Edition) pp. 1-8.

Glendinning, C. (2008) Increasing Choice and Control for Older and Disabled People: A Critical Review of New Developments in England, *Social Policy and Administration*, **42**(5), pp. 451–469.

Glendinning, C. and Llyod, B. (1997). *Developing Local "Continuing Care" Policies and Guidelines: The Implications for Primary and Community Health Services.* Manchester: National Primary Care Research and Development Centre

Glendinning, C., Newbronner, E., (2008). The Effectiveness of Homecare Reablement – Developing the Evidence Base. *Journal of Integrated Care.* **16** (4), pp. 33-40

Goodman, C. and Woolley, R. J. (2004). Older people in care homes and the primary care nursing contribution: a review of relevant research, *Primary Health Care Research and Development.* **5**(3), pp. 211–218.

Goodman, C., Woolley, R. and Knight, D. (2003). District nurses' experiences of providing care in residential care home settings, *Journal of Clinical Nursing,* **12**(1), pp. 67–76.

Goodwin, N., Peck, E., Freeman, T. and Posaner, R. (2004). Managing Across Diverse Networks of Care: Lessons from other sectors. Report to the National Co-ordinating Centre of NHS Service Delivery and Organisation R&D. Available at: www.sdo.nihr.ac.uk/files/adhoc/39-policy-report. pdf [accessed 04/08/2015]

Goodwin, N., Perry, C., Dixon, A., Ham, C., Smith, J., Davies, A., Rosen, R., Dixon, J. (2012). *Integrated Care for Patients and Populations: Improving outcomes by working together. A report to the Department of Health and the NHS Future Forum.* London: The King's Fund.

Green, J., (2005). Focus Groups. In Green, J., Browne, J. (2005). *Principles of Social Research.* Berkshire, England: McGraw-Hill Education

Greenwood, D. and Levin, M. (2007). *Introduction to Action Research: Social Research for Social Change,* 2nd ed. Thousand Oaks: Sage

Greig, R., and Poxton, R. (2001). From joint commissioning to partnership working- will the new policy framework make a difference? *Managing Community Care.* **9**(4), pp. 32-38.

Guba, E. G., Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research.* **2**, Pp. 163-194.

Hägglund, M., Scandurra, I., and Koch, S. (2009). Studying Intersection Points– An Analysis of Information Needs for Shared Homecare of Elderly Patients. *Journal on Information Technology in Healthcare*, **7**(1), pp. 1-20.

Hale, B., Barrett, P., Gauld, R., (2010). *The Age of Supported Independence: Voices of In-home Care.* London: Springer

Ham, C., Curry, N. (2011). *Integrated Care Summary: What is it? Does it work? What does it mean for the NHS?* London: The King's Fund.

Ham, C., Imison, C., Goodwin, N., Dixon, A., South, P. (2011). *Where Next for the NHS reforms? The case for integrated care.* London: The King's Fund.

Ham, C. (2014). *The Kings Fund: Removing the barriers to Integrated Care.* Available at: http://www.kingsfund.org.uk/blog/2014/01/removing-barriers-integrated-care [Accessed 26/02/2015]

Ham, C., Curry, N. (2011). *Integrated Care: What is it? Does it work? What does it mean for the NHS?* London: The Kings Fund

Ham, C., Dixon, A. and Brooke, B. (2012) *Transforming the delivery of health and social care.* London: The Kings Fund

Harper, M., and Cole, P. (2012). Member checking: Can benefits be gained similar to group therapy? *Qualitative Report*, **17**, Pp. 510-517

Hart, E., Bond, M., (1995). *Action Research for Health and Social Care: a guide to practice.* Buckingham: Open University Press

Hayes, J. (2007). *The Theory and Practice of Change Management.* Second ed. Hampshire: Palgrave

Hazlett, S. A., McAdam, R. and Walker, T. (2013) The role of operations management in public sector policy and practice alignment: a local government analysis, *Production Planning and Control*, **24**(10-11), pp. 988–1001.

Head, J. (2009) Personalisation within a housing context, *Working With Older People*, **13**(2), pp. 25–27.

Help the Aged (2007). *Consulting and Engaging with Older People.* Available at http://www.ageuk.org.uk/documents/en-gb/for-professionals/participation-and-involvement/id6980_consulting_and_engaging_with_older_people_dos_and_don%E2%80%99ts_2007_pro.pdf?dtrk=true [accessed 12/01/2015]

Herold, D. M., Fedor, D. B., and Caldwell, S. (2007). Beyond change management: A multilevel investigation of contextual and personal influences on employees' commitment to change. *Journal of Applied Psychology*, **92**(4), 942–951.

Herr, K., and Anderson G. L., (2005) *The Action Research Dissertation: A guide for Students and Faculty*. London, UK Sage Publications Ltd

Heywood, F. (2001). *Money well spent: The effectiveness and value of housing adaptations.* York: Joseph Rowntree Foundation. Available at http://www.jrf.org.uk/system/files/jr100-effectiveness-housing-adaptations.pdf [accessed 25/06/2014]

Heywood, F., Oldham, C., Means, R., (2002). *Housing and Home in Later Life.* Buckingham: Open University Press

Hill, A. and Hill, T. (2011). *Essential Operations Management.* Hampshire: Palgrave Macmillan

Hillcoat-Nalletamby, S., Ogg, J., Renaut, S. and Bonvalet, C., (2010). Ageing Populations and Housing Needs: Comparing Strategic Policy Discourses in France and England. *Social Policy and Administration.* **44** (7), pp. 808-826.

HM Government (1998) *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards.* London: HM Stationery Office

HM Government (2009) *Shaping the Future of Care Together.* Norwich: HM Stationery Office

HM Government (2010). *The Coalition: Our Programme for Government.* London: HM Stationary Office

HM Government (2007). *Putting People First: A shared vision and commitment to the transformation of Adult Social Care.* London: HM Stationary Office

Hockley, J., Dewar, B. and Watson, J. (2005). Promoting end-of-life care in nursing homes using an 'integrated care pathway for the last days of life'. *Journal of Research in Nursing*, **10**(2), pp. 135–152.

Hodge, G. and Coghill, K. (2007), "Accountability and the privatized state", Governance. *An International Journal of Policy, Administration, and Institutions.* **20** (4),pp. 675-702.

Hollander, M., and Prince, M. (2008). "Organizing healthcare delivery systems." *Healthcare Quarterly* **11**(1) pp. 44-54.

Hollywood, M. (2006). 2020: moving forward to a new vision for housing and care. *Working With Older People*, **10**(1), pp. 37–40.

Homes and Communities Agency (2009). *Housing our Ageing Population: Panel for Innovation Report.* London: Homes and Communities Agency.

Hood, C., (1991). A public management for all seasons? Public Administration, **69**, pp. 3–19.

House of Lords (2013). *Select Committee on Public Services and Democratic Change: Ready for Ageing?* London: The Stationary Office Ltd

Housing Act (1980). *Chapter 51*. London: HM Stationary Office

Howe, K. R. (1988). Against the quantitative-qualitative incompatibility thesis or dogmas die hard. *Educational Researcher.* **17**, Pp. 10–16.

Hübner, U. and Elmhorst, M. A., (2008) *eBusiness in Healthcare: From eProcurement to Supply Chain Management.* London: Springer

Hudson B., Hardy B., Glendinning C. and Young R. (2002) *National Evaluation of the Use of Section 31 Partnership Flexibilities of the Health Care Act of 1999.* Leeds: Nuffield Institute for Health

Hudson R, Hardy B (2002) 'What is a Successful Partnership and How Can It Be Measured?'. in Glendinning C, Powell M, and Rumney K (eds*) Partnership, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Hudson, B. (2006). *Whole Systems Working: A Guide and Discussion Paper.* London: Care Services Improvement Partnership

Hughes*,* D., Dumont, K., (1993)*.* Using focus groups to facilitate culturally-anchored research. *American Journal of Community Psychology.* **21**(4), Pp. 775-806.

IGD, (2015). *Measuring Availability: The ECR UK availability survey.* Available at: http://www.igd.com/Research/Supply-chain/In-store/2654/Promotional-On-Shelf-Availability-Insight-and-Best-Practice/Measuring-Availability/Promotional-On-Shelf-AvailabilitybrMeasuring-Availability/ [accessed 12/08/2015]

Ipsos MORI (2012). *Public perceptions of the NHS and social care: an ongoing tracking study conducted for the Department of Health, December 2011. London: Department of Health.* Available at: www.dh.gov.uk/health/files/2012/06/Public-Perceptions-of-the-NHS-Tracking-Survey-December-2011-Report-v1-FINAL-080612-PUBLIC.pdf [accessed 02/042014]

Jackson M.C. (1991) *Systems methodology for the management sciences.* New York: Plenum

Jackson, M. C. (2000) *Systems Approaches to Management.* New York: Klewer

Jackson, M. C. (2003). *System Thinking: Creative Holism for Managers.* Chichester: Wiley

Johnson, G. M. (2008). Firm systems thinking: unifying educational problem solving. *Systems Research and Behavioral Science*, **6**, pp. 797-805.

Johnston, R., (2005). Service operations management: from roots up. *International Journal of Operations and Production Management*, **25** (12), pp. 1298–1308.

Jones, C. (2005) *Welsh Assembly Government: Review of Housing Adaptations Including Disabled Facilities Grants- Wales.* Available at: http://www.whnb.org.uk/uploads/media/reviewe_1_.pdf [accessed 25/06/2014]

Ketchen, D. J., and Hult, G. T. M., (2007). Bridging organization theory and supply chain management: The case of best value supply chains. *Journal of Operations Management.* **25** (2), pp. 573-580.

Killett, A., Hyde, P., Burns, D., Gray, R. and Poland, F. (2013). How organizational factors interact to influence the quality of care of older people in the care home sector, *Journal of Health Services Research and Policy*, **18**(1), pp. 14–22.

King, N., Pannell J., and Copeman, I., (2009). *Nobody's Listening*. London: Help the Aged

King, P. (2006). *Choice and the End of Social Housing.* London: Institute of Economic Affairs

Kingston P, Bernard M, Biggs S, Nettleton H (2001). Assessing the health impact of age-specific housing**.** *Health Social Care Community*; **9** pp. 228–34.

Kodner, D., Sherlock, M., and Shankman, J. (2001). Bringing managed health care home: a new service strategy for people with chronic illnesses and disabilities. In: Heumann, L., McCall, M., Boldy, D., editors (2001). *Empowering frail elderly people: opportunities and impediments to housing, health and supportive services delivery.* Connecticut: Praeger

Kodner, D. (2006). Whole-system approaches to health and social care partnerships for the frail elderly: an exploration of North American models and lessons, *Health and Social Care in the Community*, **14**(5), pp. 384–390.

Kodner, D. and Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications – a discussion paper. *International Journal of Integrated Care*, **2**, pp. 1-6.

Koopman-Boyden, P. and Richardson, M. (2013). An evaluation of mixed methods (diaries and focus groups) when working with older people, *International Journal of Social Research Methodology*, **16**(5), pp. 389–401.

Krueger, R. (1998) *Analyzing and Reporting Focus Group Results.* London: Sage Publications

Krueger, R., and Casey, M., (2000). *Focus groups: A practical guide for applied research.* Thousand Oaks, CA: Sage Publications.

Krueger, R., and Casey, M., (2009). *Focus groups: A practical guide for applied research.* Fourth Edition. Thousand Oaks, CA: Sage Publications.

Kvale, S., (2007). *Doing Interviews.* London: Sage Publications.

Laing and Buisson. (2009). *Extra-care housing UK market report 2009* (9th ed.). London: Laing and Buisson.

Lane, D. C., and Oliva, R. (1994). *The Greater Whole: Towards a Synthesis of the System Dynamics and Soft System Methodology*, Working Papers Series, London: City University Business School

Law, J. (2004). *After Method: Mess In Social Science Research.* Oxon: Taylor and Francis.

Lawrence, N. (2008). Sheltered Housing Wardens. *You and Yours*. BBC Radio 4. 10.03.08. Radio

Ledington, P. W. J. and Ledington, J. (1999) The problem of comparison in soft systems methodology, *Systems Research and Behavioral Science*, **16**(4), pp. 329–339.

Ledington, P. W. J., Donaldson, J. (1997). Soft OR and management practice: a study of the adoption and use of soft systems methodology. Journal of the Operational Research Society **48**(3), pp. 229-240.

Leece, D. and Leece, J. (2006). Direct Payment: Creating a Two-Tiered System in Social Care?*' British Journal of Social Work*, **36**. pp. 1379-1393

Lega, F., Marsilio, M. and Villa, S. (2013). An evaluation framework for measuring supply chain performance in the public healthcare sector: evidence from the Italian NHS, *Production Planning and Control*, **24** (10-11), pp. 931–947.

Leutz, W. (1999). "Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom." *The Milbank Quarterly*. **77**(1) pp. 77-110.

Leutz, W. (2005). Reflections on integrating medical and social care: five laws revisited. *Journal of Integrated Care*, **13**(5), pp. 3-12.

Lincoln, Y., Guba, E. G., (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage

Local Government Improvement and Development Group, (2009). *Registered Social Landlord (RSL)*. Available at: http://www.idea.gov.uk/idk/core/page.do?pageId=7175736 [accessed 31/10/11]

Local Government Ombudsman (2014). *Focus Report: learning the lessons from complaints about adult social care providers registered with the Care Quality Commission.* Available at: http://www.lgo.org.uk/publications/advice-and-guidance#focus [accessed 20/02/2015]

MacAdam, M. (2008). *Frameworks of integrated care for the elderly: a systematic review.* Canadian Policy Research Networks: Réseaux canadiens de recherche en politiques publiques.

Madriz, E., (2000). Focus groups in feminist research. In Denzin, N., and Lincoln, Y., (2000). *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications.

Maguire, P. (1987) *Doing participatory research: A feminist approach.* Amherst: Centre for International Education.

Mann, C. and Stewart, F. (2000). *Internet communication and qualitative research.* London: Sage

Manthorpe, J. and Moriarty, J. (2011). Housing or care workers? Who is supporting older people with high support needs?, *Journal of Integrated Care*, **19**(1), pp. 16–25.

Matthews, B. and Ross, L., (2010). *Research Methods: A practical guide for Social Sciences.* Essex: Pearson Education Ltd

Marijamdotter, A. and Bergvall-Kareborn, B. (2006). An Appreciative Critique and Refinement of Checkland's Soft Systems Methodology. In Strijbos, S. and Basden, A. (2006). *In Search of an Integrative Vision for Technology Interdisciplinary Studies in Information Systems.* New York: Springer

McCormack, B., Mitchell, E., Cook, G., Reed, J., and Childs, S. (2008) Older persons' experiences of whole systems: The impact of health and social care organizational structures, *Journal of Nursing Management*, **16**(2), pp. 105–114.

McCormick, J., McDowell, E., Harris, A. (2009). *Policies for Peace of Mind? Devolution and older age in the UK*. London: Institute for Public Policy Research.

McNair, S., (2007). *Demography and adult learning a discussion paper for the NIACE Commission of Inquiry*. London: NIACE

Meehan, L., Meyer, J. and Winter, J. (2002). Partnership with care homes: A new approach to collaborative working, *Nursing Times Research*, **7**(5), pp. 348–359.

Meijboom, B., Schmidt- Bakx, S. and Westert, G. (2011) Supply chain management practices for improving patient- oriented care, *Supply Chain Management: An International Journal*, **16**(3), pp. 166–175.

Menezes F. F., Bordignon F. C. and Pinheiro M. D. (2002). The systemic approach of SSM: The case of a Brazilian company, *Systemic Practice and Action Research*, **15**(1), pp. 51–66.

Milbourne, P. (2012). Growing old in rural places, *Journal of Rural Studies*, **28**(4), pp. 315–317.

Miles, M., and Huberman, A., (1984). Drawing valid meaning from qualitative data: Toward a shared craft. *Educational Researcher.* **13** Pp. 20–30

Milligan, C., (2009). *There's no place like Home: Place and Care in an Ageing Society.* Surrey: Ashgate Publishing Ltd

Milne, A. (1999). *Later Lifestyles: A Survey by Help the Aged*. London: Help the Aged.

Mingers J., (2000). Variety is the spice of life: combining soft and hard OR/MS methods. *International Transactions in Operations Research*, **7**, pp. 673–691

Mingers, J. (1984). Subjectivism and soft systems methodology—A critique*. Journal of Applied Systems Analy*sis, **11**, pp. 85-104.

Mingers, J. (2011). Soft OR comes of age-but not everywhere!, *Omega-International Journal of Management Science*, **39**(6), pp. 729–741.

Mingers, J. and Taylor, S. (1992). The Use of Soft Systems Methodology in Practice, *The Journal of the Operational Research Society*, pp. 321-332.

Molineux, J., and Haslett, T. (2007). The use of Soft Systems Methodology to enhance group creativity. *Systemic Practice and Action Research*, **20**, 477-496.

Moore, D. C. and Hanratty, B. (2013). Out of sight, out of mind? A review of data available on the health of care home residents in longitudinal and nationally representative cross-sectional studies in the UK and Ireland, *Age and Ageing*, **42**(6), pp. 798–803.

Morgan, D. L., (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research* **8**. pp. 362–376

Morgan, D. L., (1997). *Focus Groups as Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Nadeem, B. (2007). *Inside Housing: Stock Transfer only option in Wales*. Available at: http://www.insidehousing.co.uk/ihstory.aspx?storycode=144912 [accessed 04/12/2012]

Naraen, S., cited in Mulley, G., Bowman, C. Boyd, M., and Stowe, S. (2015). *The Care Home Handbook.* West Sussex: John Wiley and Sons

National Assembly for Wales (2001). *Better Homes for People in Wales: A National Housing Strategy for Wales.* Cardiff: National Assembly for Wales

National Collaboration of Integrated Care and Support (2013). *Integrated Care and Support: Our Shared Commitment.* London: Department of Health

National Statistics (2007). *Community Care Statistics Referrals, Assessments and Packages of Care for Adults, England (2005–06)*, London: Information Centre, National Statistics

National Statistics (2013). *Community Care Statistics: Social Services Activity, England (2012-2013)*, London: Information Centre, National Statistics

Naughton ,J. (1984). *Soft Systems Analysis: An Introductory Guide.* Milton Keynes: The Open University Press

Neven, L. (2014). By any means? Questioning the link between gerontechnological innovation and older people's wish to live at home. In Press, *Technological Forecasting and Social Change*, [online] Available at: http://www.sciencedirect.com/science/article/pii/S0040162514001371 [accessed 25/06/2014].

Newbronner, L., Baxter, M., Chamberlain, R., Maddison, J., Arksey, H. and Glendinning, C. (2007). *Research into the Longer Term Effects/Impacts of Reablement Services.* London: Homecare Reablement Workstream, Care Services Efficiency Delivery Programme

NHS (2013). *NHS Choices: Vulnerable adults.* Available at: http://www.nhs.uk/CarersDirect/guide/vulnerable-people/Pages/vulnerable-adults.aspx [accessed 11/01/2015]

NHS and Community Care Act (1990). London: HMSO, 1990

NHS England (2014); *"Delayed Transfers of Care Data 2013/14"*. Available at http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2013-14/ [Accessed 15/02/2015]

NHS Information Centre, (2013). *Personal Social Services: Expenditure and Unit Costs. England 2011-12.* Retrieved 25/04/2013 from https://catalogue.ic.nhs.uk/publications/social-care/expenditure/pss-exp-eng-11-12-fin/pss-exp-eng-11-12-fin-rpt.pdf

NHS Wales (2014) *Betsi Cadwaladr University Health Board: About us*. Available at: http://www.wales.nhs.uk/sitesplus/861/page/40836 [Accessed 20/08/2014]

NHS Wales Informatics Services (2015) *Performance against 4 hour waiting times target, all emergency care facilities by local health board*. Available at: https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/PerformanceAgainst4HourTargetAllEmergencyCareFacilities-by-LocalHealthBoard [Accessed -3/03/2015]

NHS, (2014). *Vulnerable Adults.* Available at: http://www.nhs.uk/CarersDirect/guide/vulnerable-people/Pages/vulnerable-adults.aspx [accessed 07/03/2014]

Nocon, A., Pleace, N., (1999). Sheltered Housing and Community Care. *Social Housing Policy and Administration,* **33** (2), pp. 164-180

Office for National Statistics, (2014). *Changes in the older resident care home population between 2001 and 2011*. Available at: http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/changes-in-the-older-resident-care-home-population-between-2001-and-2011/rpt---changes-in-the-older-resident-care-home.html [accessed 26/03/2015]

Office of National Statistics, (2013). *What does the 2011 census tell us about older people?* Available at: http://www.ons.gov.uk/ons/dcp171776_325486.pdf [accessed 25/06/2014]

Office of the Deputy Prime Minister (2006). *A Sure Start to Later Life: Ending Inequalities for Older People. A Social Exclusion Unit Final Report.* London: Office of the Deputy Prime Minister

Oldham, J. (2014). *One person, one team, one system. Report of the Independent Commission on whole person care.* Available at http://www.yourbritain.org.uk/agenda-2015/policy-review/whole-person-care [accessed 08/11/2014]

Oldman, J. (2008). Winners and Losers: Sheltered Housing and Floating Support. *Housing, Care and Support*, **11** (4), pp. 6–9.

Opdenakker, R. (2006) Advantages and Disadvantages of Four Interview Techniques in Qualitative Research, *Forum: Qualitative Social Research*, **7**(4), p. 1.

Pannell, J., Aldridge H., and Kenway, P. (2012). *Older Peoples Housing: Choice, Quality of Life and Under-Occupation.* Joseph Rowntree Foundation. London: New Policy Institute

Parks, R., Baker, P. et al. (1981). Consumers as Co-producers of Public Services: Some Economic and Institutional Considerations, *Policy Studies Journal*, **9** (Summer): 1001–1011

Parry, I. (2008). Sheltered Housing: Building Bridges between Nurses and Housing Staff. *British Journal of Community Nursing*, **13**(6), pp. 278–279.

Eden, C. and Huxham, C. (2002) Action Research cited in Partington, D. (Ed.). (2002). *Essential skills for management research.* London: SAGE Publications Ltd.

Pawson, H., Davidson, E., Morgan, J., Smith, R., Edwards, R., (2009). *The impacts of Housing Stock Transfers in Urban Britain.* Joseph Rowntree Foundation. London: New Policy Institute

Propper, C. and Wilson, D., (2003). *The use and usefulness of performance measures in the public sector.* Oxford Review of Economic Policy, 19 (2), 250–267.

Pynoos, J.,and Regnier, V. (1991). Improving residential environments for frail elderly: Bridging the gap between theory and application. In J. Birren, J. Lubben, J. Rowe, and D. Deutchman (Eds.). *The Concept and Measurement of Quality of Life in the Frail Elderly* (pp. 91-119). New York: Academic Press

Radnor, Z. J., Noke, H. (2013). Conceptualising and contextualising public sector operations management. *Production Planning and Control*. **24** (10-11), pp. 867-876

Reason, P. (1998). A Participatory World. *Resurgence*, **168**, pp. 42-44

Reason, P. and Bradbury, H. (eds) (2001). *Handbook of action research: Participatory inquiry and practice.* London: Sage Publications

Redding, D. (2013). The narrative for person-centred coordinated care, *Journal of Integrated Care*, **21**(6), pp. 315–325.

Reed, J., Cook, G., Childs, S. and McCormack, B. (2005). A literature review to explore integrated care for older people, *International Journal of Integrated Care (IJIC)*, **5**, pp. 1–10.

Reeves, P., (2005). *An Introduction to Social Housing.* Oxford: Elsevier Butterworth-Heinemann

Rich, N. and Piercy, N. (2013). Losing patients: a systems view on healthcare improvement, *Production Planning and Control*, **24**(10-11), pp. 962–975.

Richie, J. and Lewis, J. (2003). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage Publications

Rioux, L. (2005). The well-being of aging people living in their own homes, *Journal of Environmental Psychology*, **25**(2), pp. 231–243.

Rodriguez-Ulloa, R. and Paucar-Caceres, A. (2005). Soft System Dynamics Methodology (SSDM): Combining Soft Systems Methodology (SSM) and System Dynamics (SD), *Systemic Practice and Action Research*, **18**(3), pp. 303–334.

Rogers, P., cited in Mulley, G., Bowman, C. Boyd, M., and Stowe, S. (2015). *The Care Home Handbook*. West Sussex: John Wiley and Sons

Royal Voluntary Service (RVS) (2012). *Loneliness amongst older people and the impact of family connections*. London: RVS.

Roys, M. Davidson, M., Nicol, S., Ormandy, D., and Ambrose, P. (2011). *The real cost of poor housing*. Watford: BRE Press

Sale, J. E. M., Lohfeld, L. H., Brazil, K. (2002). Revisiting the Quantitative-Qualitative Debate: Implications for Mixed-Methods Research. *Quality and Quantity.* **36**, Pp. 43–53

Sánchez, A. and Mejía, A. (2008). Learning to support learning together: an experience with the soft systems methodology. *Educational Action Research*, **16**(1), pp. 109–124.

Sankaran, S., Hou Tay, B., and Orr, M. (2009). Managing organizational change by using soft systems thinking in action research projects. *International Journal of Managing Projects in Business*, **2**(2), pp.179-197.

SCIE, (2013). *What is personalisation and where did it come from? Timeline.* Available at:
http://www.scie.org.uk/assets/elearning/personalisation/module1/deploy/html/object/object1_2.htm#slide2h [accessed 02/04/2013]

Silverman, D., (2006). *Doing Qualitative Research: A practical handbook*. London: Sage Publications

Slack, N. and Lewis, M., (2002). *Operations Strategy*. Essex: Pearson Education Ltd

Slack, N. and Lewis, M., (2011). *Operations Strategy: Third Edition*. Essex: Pearson Education Ltd

Small, A. and Wainwright, D. (2014) SSM and technology management: Developing multimethodology through practice, *European Journal of Operational Research*, **233**(3), pp. 660–673.

Smithson, J., (2008). Focus Groups with Older People. In Alasuutari, P., Bickman, L., Brannen, J., 2008. *The SAGE Handbook of Social Research Methods*. Thousand Oaks, CA: Sage Publications

Social Services Improvement Agency (2011). *Better Support at a Lower Cost: Improving Efficiency and Effectiveness in Services for Older People in Wales.* Available at: www.ssiacymru.org.uk/olderpeople [accessed 15/10/2012]

Staadt, J. (2012). Redesigning a project-oriented organization in a complex system: A soft systems methodology approach, *International Journal of Managing Projects in Business*, **5**(1), pp. 51–66.

Statistical Focus Wales, (2008). *A Statistical Focus on Older People in Wales*. Welsh Assembly Government, 2008 Edition

Stewart, S. (2003). A tapestry of voices: Using elder focus groups to guide applied research practice. *Journal of Applied Gerontological Social Work,* **42**(1), pp.77-88

Stoecker, R. (1999). Are Academics Irrelevant? Roles for Scholars in Participatory Research, *American Behavioral Scientist*, **42**(5), pp. 840–854.

Strandberg-Larsen, M., and Krasnik, A. (2009). Measurement of integrated healthcare delivery: a systematic review of methods and future research directions. *International Journal of Integrated Care*, **9** (1)

Stringer, E. T., (2007). *Action Research. 3rd edition*. Thousand Oaks: Sage Publications

Szczepura, A., Clay, D., Hyde, J., Nelson, S. and Wild, D. (2008). *Models for providing improved care in residential care homes: a thematic literature review*. York: Joseph Rowntree Foundation

Tan, K.C., Lyman, S.B. and Wisner, J.D. (2002). Supply chain management: a strategic perspective. *International Journal of Operations and Production Management*, **22**(5/6), pp. 614-31.

The Kings Fund (2014). *The Kings Fund: About us.* Available at: http://www.kingsfund.org.uk/about-us [accessed 23/10/2014]

Tian, Y., Thompson, J., Buck, D., Sonola, L. (2013). *Exploring the system-wide costs of falls in older people in Torbay.* London: The King's Fund. Available at: http://www.kingsfund.org.uk/publications/exploring-system-wide-costs-falls-older-people-torbay [accessed 09/05/2014]

Tinker, A. (2004). Future role of housing, *Working with Older People: Community Care Policy and Practice*, **8**(4), p. 15-17.

Tinker, A., (1997). Chapter 2. Housing and Household Movement in Later Life. *Journal of Housing for the Elderly*, **12** (1-2), pp. 9-17

Todd, C. and Skelton D. (2004). *What are the Main Risk Factors for Falls among Older People and What are the Most Effective Interventions to Prevent these Falls? Health Evidence network report.* Copenhagen: WHO Regional Office for Europe. Available at: www.euro.who.int/document/E82552.pdf (accessed 09/05/2014]

Todd, Z., Nerlich, B., McKeown, S. (2004). *Mixing Methods in Psychology.* Hove and New York: Taylor and Francis Group

Tomassini, C., Kalogirou, S., Grundy, E., Fokkema, T., Martikainen, P., Van Groenou, M. B., and Karisto, A. (2004). Contacts between elderly parents and their children in four European countries: current patterns and future prospects. *European Journal of Ageing*, **1**(1), pp. 54-63.

Towill, D. R. (2006) Viewing Kaiser Permanente via the logistician lens, *International Journal of Health Care Quality Assurance*, **19**(4), pp. 296–315.

Townsend, P. (1964). *The Last Refuge: A survey of Residential Homes and Institutions for the Aged in England and Wales*. London: Routledge and Kegan Paul

Turrell, A. (2001). Nursing homes: a suitable alternative to hospital care for older people in the UK? *Age and Ageing*, **30**(3), pp. 24–32.

Twinch, E. (2011). *Inside Housing: Failing the Standard*. Available at: http://www.insidehousing.co.uk/failing-the-standard/6513920.article [accessed 29/10/14]

Valentijn, P. P., Vrijhoef, H. J. M., Ruwaard, D., de Bont, A., Arends, R. Y. and Bruijnzeels, M. A. (2015) Exploring the success of an integrated primary care partnership: a longitudinal study of collaboration processes, *BMC Health Services Research*, **15**(1), pp. 1–18.

Value Adding, (2010). *Partners in Transformation: Transforming reablement*. Available at: http://www.valueadding.com/socialcare/reablement.htm [accessed 16/08/2010]

Van Bilsen, P. M. A., Hamers, J. P. H., Groot, W. and Spreeuwenberg, C. (2008). Sheltered housing compared to independent housing in the community, *Scandinavian Journal Of Caring Sciences*, **22**(2), pp. 265–274.

Van de Ven, A. H. and Sun, K. (2011). Breakdowns in Implementing Models of Organization Change, *Academy of Management Perspectives*, **25**(3), pp. 58–74.

Van der Voet, J. (2014). The effectiveness and specificity of change management in a public organization: Transformational leadership and a bureaucratic organizational structure. *European Management Journal*, **32**(3), pp. 373–382.

Wales and West Housing (2012). *Introducing concept 50+ our housing for older people*. Available at: http://www.wwha.co.uk/About-Us/Our%20Services%20for%20Older%20People/Pages/default.aspx [accessed 15/10/2014]

Wanless, (2006). *Securing Good care for Older People: Taking a long term view*. London: The Kings Fund

Warmington, P., Daniels, H., Edwards, A., Brown, S., Leadbetter, J., Martin, D., and Middleton, D. (2004). *Interagency Collaboration: a review of the literature.* Bath: Teaching and Learning Research Council

Watson, J., Hockley, J., and Dewar, B. (2006). Barriers to implementing an integrated care pathway for the last days of life in nursing homes. *International Journal of Palliative Nursing*, *12*(5), pp.234-241.

Welsh Assembly Government (2003). *Strategy for Older People in Wales*. Cardiff: Welsh Assembly Government

Welsh Assembly Government (2006). *National Service Framework for Older People in Wales.* Cardiff: Welsh Assembly Government

Welsh Assembly Government (2007). *A Strategy for Social Services in Wales over the next decade: Fulfilled lives, supportive communities.* Cardiff: Welsh Assembly Government

Welsh Assembly Government (2008). *Welsh Housing Quality Standard: Revised Guidance for Social Landlords on Interpretation and Achievement.* Cardiff: Welsh Assembly Government

Welsh Assembly Government (2010). *Improving Lives and Communities: Homes in Wales*. Cardiff: Welsh Assembly Government

Welsh Assembly Government (2010a). *The Supporting People Programme in Wales: Final report on a Review commissioned by Jocelyn Davies AM, Deputy Minister for Housing and Regeneration.* Cardiff: Welsh Assembly Government

Welsh Government (2013). *Strategy for Older People in Wales: Living Longer, Ageing Well*. Cardiff: Welsh Government

Welsh Government, (2013a). *The Supporting People Programme in Wales-Factsheet.* Cardiff: Welsh Government

Welsh Government (2014). *The Social Services and Wellbeing Act Wales 2014.* Cardiff: Welsh Government

Wenger, G. C., (2003). Interviewing Older People. In Holstein, J., Gubrium, J., 2002. *Handbook of Interview Research.* Thousand Oaks, CA: Sage Publications

Westerman, M. A. (2006). Quantitative research as an interpretive enterprise: The mostly unacknowledged role of interpretation in research efforts and suggestions for explicitly interpretive quantitative investigations. *New Ideas in Psychology*, **24**, Pp. 189–211

WLGA (2012). Local Authority Position on Stock Transfer. Available at; http://www.wlga.gov.uk/local-authority-position-on-stock-transfer [accessed 03/12/2012]

Whyte, W. F. (ed.) (1991). *Participatory Action Research*, Thousand Oaks, CA: SAGE Publications

Wilcock, A. A. (1998). *An occupational perspective on health.* New Jersey: Slack

Wilson, W. (2012). *Warden support in sheltered housing.* London: House of Commons

Wisker, G. (2001). *The Postgraduate Research Handbook.* Hampshire: Palgrave

Woodward, K. (2003). *Social Sciences: the big issues.* London: Routledge

Wright, F., Tinker, A., Hanson, J., Wojgani, H. and Mayagoitia, R. (2009). Some social consequences of remodelling English sheltered housing and care homes to 'extra care', *Ageing and Society*, **29**(1), pp. 135–153.

Wright, F., Tinker, A., Mayagoitia, R., Hanson, J., Wojgani, H. and Holmans, A. (2010) What Is the 'Extra' in Extra Care Housing? *British Journal of Social Work*, **40**(7), pp. 2239–2254.

Yan. Z., and Yan, X. (2010). A revolution in the field of systems thinking—A review of Checkland's system thinking. *Systems Research and Behavioural Science.* **27**: 140–155.

Yeates, M. (1979). The need for environmental perspectives on issues facing older people.In S. Golant (Ed.). *Location and Environment of Elderly Population* (pp. 71-80). Washington, DC: V.H. Winston and Sons.

Yin, R. K. (2009) *Case Study Research: Design and Methods.* Fourth Edition. London: Sage Ltd

Zhang, H. (2010). Soft systems methodology and 'soft' philosophy of science, *Systems Research and Behavioral Science*, **27**(2), pp. 156–170.

Zhang, W., Levenson, A. and Crossley, C. (2015). Move Your Research From The Ivy Tower To The Board Room: A Primer On Action Research For Academics, Consultants, And Business Executives, *Human Resource Management*, **54**(1), pp. 151–174.

Appendix

Appendix 1: Conwy's Older Persons' Housing Strategy 2012-2017.

Note: A Technical Annex was also written by the researcher to support the strategy and add detail. This can be found at: http://www.conwy.gov.uk/doc.asp?cat=10553&doc=32735 along with the Consultation Report. The final strategy, included in this Appendix, is the summary document, designed to be a brief and accessible.

Appendix 2: List of Steering Group Members

Appendix 3: Survey Questions

Appendix 1: Older Persons' Housing Strategy

Older Persons' Housing Strategy

Conwy County Borough Council

2012-2017
Final Strategy

Vision:

- *Promote independence and wellbeing through a range of good quality, affordable and appropriate housing options for older people*
- *Create a partnership model of support provision to enable older people to live comfortably in the housing of their choice*

Partners for Strategy Development

Foreword

We recognise that Conwy as a county has the highest percentage of older people in Wales, making it essential that we ensure this important group of people's housing needs are looked at carefully and addressed specifically. This is the strategy that sets out clearly how we aim to deliver these identified housing needs and support requirements for our older generation in Conwy over the next five years and beyond.

As Conwy's population ages, the Local Authority faces new challenges to meet the needs and aspirations of an ever more diverse and increasingly owner-occupying older population with rising expectations.

We have spoken with a number of older people in preparing this strategy and many have told us that their preference is to stay in their own homes. We will support this choice by helping them retain their independence at home wherever possible, through the use of support services, assistive technology and property adaptations.

We also aim to improve access to information and advice regarding housing options and support in order to allow people to make informed choices.

Quality, manageable housing options in Conwy include smaller properties, sheltered housing, extra care housing or residential homes for those residents who decide that moving is best for them. We aim to ensure that information about each of these options is widely available.

Whatever the circumstances and choices of individual older residents, we believe that all should be able to live in safe, secure and warm homes, adapted as necessary and supported where appropriate, with services which meet individual needs at a time when they are needed.

We are indebted to all residents and partners who have, together, contributed and helped to draw up this strategy and we look forward to working with them as we now work together to put our words, hopes and aspirations into positive action.

Councillor Phil Edwards

Cabinet Member for Communities

Conwy County Borough Council

Introduction

Conwy County Borough council is committed to ensuring that older people have the housing and support available to enable them to live as independently as possible. For the purpose of this strategy, older people are defined as being people over the age of 55. It is acknowledged that the majority of people aged 55 do not require specialist housing or housing related support; however, it is important that we do not exclude those who do. The research supporting the strategy found that it is usually people over the age of 75 who have a greater need for housing related support.

Following the stock transfer to Cartrefi Conwy in 2008, the role of the local authority has changed with regards to Housing. Conwy County Borough council is now the 'strategic enabler' and has a responsibility to direct Cartrefi Conwy and other Registered Social Landlords operating in the county. Through partnership working and the standardisation of support services across Registered Social Landlords, we envisage a smoother system of support and care for our county.

The development of an Older Persons Housing Strategy was a recommendation in **Conwy's Local Housing Strategy 2008-2012**. This strategy is designed to support the aims of the Local Housing Strategy, whilst focusing on the diverse needs of older people. It also links in to One Conwy and the corporate plan.

This strategy was developed through a research project with the University of Liverpool, funded by Cartrefi Conwy, Clwyd Alyn Housing Association, North Wales Housing, Wales and West Housing Association and Conwy County Borough council . All Registered Social Landlords operating in the area sat on the Steering Group, which also had representatives from Social Services, provider services, health and voluntary services. The involvement of these partners from the start of the project will help the development of joint working across the strategic outcomes identified. This fits with the priorities set by the Welsh Governments **'Making the Connection Agenda 2006'**.

In addition to this, the researcher also consulted with older people throughout the development of this strategy. By attending Age Concern meetings in each of the six localities in Conwy, we ensured that views were collected from across the county. We also spoke to tenants of sheltered housing and extra care housing, as well as some of the Wardens, who have a strong knowledge of tenant's requirements.

Issues and Trends

- The population of older people is growing rapidly
- Government emphasis on older people maintaining their independence
- Housing for older people is changing as a reflection of this, with an increase in extra care housing and a reduction in residential homes

- The proportion of older people in Conwy is the highest in Wales, with many people choosing to move here once they have retired

- The majority of older people want to stay in their own homes or, failing that, their own neighbourhood

- The number of people who have specialist needs due to dementia is rising

- The expectations and aspirations of older people are raising

- Many older people feel that moving out of their own home would lead to them becoming less independent

Vision

The vision of Conwy's Older Persons Housing Strategy is to:

- *Promote independence and wellbeing through a range of good quality, affordable and appropriate housing options for older people*

- *Create a partnership model of support provision to enable older people to live comfortably in the housing of their choice*

Strategic Outcomes

In order to meet the vision for this strategy, four areas were identified as important strategic outcomes. A number of actions for each strategic outcome were developed, based on the concerns of the older people we consulted with and the opinions of the professionals interviewed throughout the course of this project.

1. Quality Housing Options

Older People have a range of quality housing options available to them in Conwy, enabling them to live independently in safe, secure and warm housing.

Key actions for this outcome:

1. Welsh Housing Quality Standards met by all social housing by 2012
2. Widely circulate information on housing options for older people so it is readily available
3. Evaluate the demand for specialist housing for older people in Conwy
4. Help older people to afford to keep their homes warm by informing them about schemes available to them
5. Link with Local Housing Strategy to engage with private sector to improve quality of housing for older people

6. Develop older people's section for Conwy County Borough Council's 'housing options' website

2. Restructure Support Service

Older People in Conwy have access to support regardless of the type of accommodation they live in.

Key actions for this outcome:

1. Explore the possibility of a joint support service linking Health, Social Care and Housing
2. Review the structure of support provision within all local sheltered housing in line with the Supporting People Review
3. Explore the potential for offering warden support to local residents, allowing sheltered housing to act as the hub for support
4. Upskill support officers by offering training at forums to improve their ability to signpost services for older people and raise awareness of direct payments
5. Develop a joint rapid response team which is available 24/7 for older people
6. Passion for Life piloted in sheltered housing in order to keep older people informed and improve communities
7. Evaluate the need for specialist dementia care housing

3. Assistive Technology and Adaptations

Older People in Conwy can access services that provide assistive technology and adaptations, enabling them to live independently.

Key actions for this outcome:

1. Ensure older people know who to contact if they have a problem and require an assessment for assistive technology or an adaptation
2. Promote Telecare development amongst staff so that they can pass on the knowledge to clients
3. Explore potential funding methods for a handyman and gardening service
4. Help older people to free up homes that have become impractical for them to live in by providing support and guidance
5. Develop Adapted Matching Property register that spans across all Registered Social Landlords, matching tenants to appropriately adapted

properties

6. Develop training programme around Dignity and Respect for people going into tenants homes to fit assistive technology or adaptations

4. Information and Advice

People in Conwy know how to access information and advice about older people's housing and support.

This strategic outcome is covered by the actions designed to meet the previous three. It is possibly the most important as if people do not know about the housing options, support or adaptations services available to them then they will not be able to take advantage of them. Therefore, a key aspect in each of the three action plans is to improve the quality and accessibility of the information and advice available.

The focus groups conducted with over 100 people during the consultation period reiterated the importance of this strategic objective. It was commonly indicated that participants want signposting and advocacy services to help them with accessing services. The Steering Group concluded that these services do exist in Conwy but people clearly are unaware of them. Therefore Information and Advice will now be the focus of future Steering Group meetings, to enable the subgroups to feedback on their progress, update one another and ensure that information provided is consistent across the groups.

How we are going to deliver this Strategy- Action Plan

The strategy sets out an action plan for meeting each of these outcomes. Subgroups comprising of experts in each of the three areas have been established to further develop the actions and assign resources. The Steering Group will continue to meet every 6 months to monitor the implementation of the strategy. Leaders of each subgroup will be required to feedback on progress at these meetings. Each action has measures of performance linked to it so that we know the impact of the strategy. To ensure that we know we have made a difference, a number of population indicators have been set and will be monitored.

The population indicators for this strategy include:

- A reduction in the number of older people falling in their homes
- An increase in the number of people being supported to live in their own home
- An increase in the number of under occupied homes being brought back onto market

1. QUALITY HOUSING OPTIONS: Older People have a range of good quality housing options available to them in Conwy, enabling them to live independently in safe, secure and warm housing					
Action	Sub-Actions	Performance Indicators	Partners	Responsible Officers	Target Date
1. Welsh Housing Quality Standard is met by all social housing by 2012	1.1 Review of the work that has been done so far to meet this target 1.2 Report of how much work is left to do from each RSL	% of total designated older people properties that meet the standard	RSLs Housing Department	**LM and RM-** Compile Report RSLs- send info about work being done above and beyond standards	Complete
2. Information about housing options for older people is readily available	2.1 Open days at sheltered housing sites and Extra Care 2.2 Sheltered housing with community centres to open up to the surrounding community	Number of open days/community activities held in schemes Attendance at events	RSLs Housing	**RM & LM** to arrange event and link in the OPHS launch.	1st May
3. Evaluate the demand for specialist housing for older people in Conwy	3.1 Analysis on the number of older people living in Conwy 3.2 Analysis of waiting lists for sheltered housing and extra care housing	Action completed	Housing Private landlords RSLs	RM- link in with Local Housing Market Assessment LM and RM- develop Excel spreadsheet to collect appropriate information from RSLs	1st May
4. Enable older people to afford to keep their homes warm throughout winter	4.1 WHQS ensures that tenants of social housing have home insulation 4.2 Inform people about Warm Home discount scheme 4.3 Inform people about NEST scheme 4.4 Provide information about schemes to organisations who are in contact with older people, eg. Age Concern, doctors surgeries etc	% of homes for older people meeting WQHS % increase in benefit uptake Number of people accessing NEST and Warm Home discount scheme in Conwy	Conwy Council RSLs Energy companies Warm Front	**IWJ** – to report back on ARBED funding.	1st May
5. Link with LHS to engage with private sector to improve quality of housing for older people	5.1 Annual forum to inform landlords of what is required to ensure their properties are up to standard	Landlords improved awareness of quality after meeting (baseline and follow up questionnaires)	Housing	Action RM and Julie Jones- Attend next Landlords forum meeting to provide information on Adapted Property Matching Service	1st May
6. Development of housing options website dedicated older people page	6.1 Addition of housing options for older people section on website 6.2 Link this section to EAC for information on specific properties in the area 6.3 Ask tenants of various schemes to do a short film of their experiences of sheltered housing	Number of hits to housing options website older persons page	Housing	**Action RM**- find out who is developing the website and if they can develop this page **Action RSLs**- identify and facilitate groups wishing to produce a short film of experience	1st May

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2. RESTRUCTURE SUPPORT SERVICES: Older people in Conwy have access to support regardless of the type of accommodation they live in					
Action	Sub-Action	Performance Indicators	Partners	Responsible Officers	Target Date
1. Explore the possibility of a joint support service linking Health, Social Care and Housing	1.1 Engage with missing members on the Steering Group for this project 1.2 Stock profile to identify supply of sheltered housing in Conwy and accompanying facilities 1.3 Identify the need for a support service and the different types of help people ask for 1.4 Identify potential hubs for services based on the previous tasks 1.4 Draw up a partnership model for developing the service following the chosen model (option 1 or 3)	Number of wardens in Conwy	RSLs Housing Social Services Health	**1.1 LM-** summary of work and benefits to health **SL-** invite Abbe Harvey and Keith Owen (Head GP) **RL-** invite Wyn Thomas **1.2 RSLs-** Complete stock profile- feedback **LM-** Add community centres on SH map **1.3 AC-** feedback results of survey conducted where tenants requests were recorded **LM-** contact Careline to do a demand analysis based on call received over the last 12 months **MH-** Summary of services used in sheltered housing, including people whose needs were too low to be met by Social Services	May 12 Sept 12 Sept 12
2. Review support within sheltered housing to comply with new Supporting People guidelines	2.1 Undertake consultation with tenants 2.2 Assessment of which tenants need support in sheltered housing 2.3 Interview the wardens to identify frequently requested services that aren't currently in place		RSLs Wardens Supporting People	Completed- information held by CCBC Supporting People team	Done
3. Working together so that older people know how to access support services in areas surrounding sheltered housing	3.1 Advertise support service to community 3.2 Encourage those living in their own homes to have community alarms fitted once they have applied for support 3.3 Social Services recommend support service for those with low level needs	Number of people enquiring about service Percentage increase of community alarms fitted in homes Measure requests to access before and after	RSLs Social Services Wardens	3.1 Awaiting completion of Action 1 3.2 MH ask social workers to start noting where people who don't meet UA criteria are signposted to LM to collect and analyse data from Social Services about those who do not meet substantial or critical needs criteria. Also look at those who do meet criteria but do not have complex care needs 3.4 Explore signposting opportunities of raising awareness of older peoples support services	Mar 13

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2. RESTRUCTURE SUPPORT SERVICES: Older people in Conwy have access to support regardless of the type of accommodation they live in					
Action	Sub-Action	Performance Indicators	Partners	Responsible Officers	Target Date
4. Support officers are able to signpost other services for older people and raise awareness of direct payments	4.1 Develop a comprehensive list of support services available for older people 4.2 Run ongoing training for support officers so they are familiar with key services. Wardens forums would provide a strong platform for this. 4.3 Train support officers about the benefits of direct payments 4.4 Ask them to signpost to Rowan	Number of older people accessing each support service % change in number of services Number of over 55's receiving direct payments % decrease in care complaints	Voluntary services Wardens RSLs	**SL**- feedback on bid for voluntary sector to provide low level social care and support database Identify a method of collecting data to measure performance indicators CS- development of Wardens Forum. Training to be delivered as part of this	Sept 12 Mar 13
5. Develop a 24/7 rapid response team	5.1 Engage with other agencies over the development of a rapid response team 5.2 Identify possible options for funding and operating this team	Action complete	Health Social Care Housing Support services	Awaiting completion of Action 1 **LM**- Speak to Wrexham about their savings to health work with regards to rapid response	Ongoing
6. Pilot Passion for Life Scheme	6.1 Run the six session pilot in sheltered housing scheme 6.2 Conduct evaluation	Number of people who state they learnt from sessions Number of people who live in their own homes who attend	Cartrefi Conwy University of Liverpool Denbighshire CBC	**Cartrefi Conwy**- Run pilot from Jan- March **LM**- Compile evaluation report	Mar 13
7. Evaluate the need for specialist dementia care housing in Conwy	7.1 Analysis on the number of people suffering with dementia in Conwy 7.2 Research into options for dementia care housing in the area 7.3 Evaluation of other options, such as using Telecare to help dementia sufferers stay in their own home	Action Completed	Housing RSLs Health Social Services	**7.1** • **Action RSLs** – to request data on number of people with dementia in each sheltered scheme (rough indicator only). • **Steering Group** Discuss definition of " Dementia" • **Steering Group** - need to consider who could lead on a study to identify need for specialist dementia care housing	

3. ASSISTIVE TECHNOLOGY AND ADAPTATIONS: Older People in Conwy can easily access services that provide assistive technology and adaptations, enabling them to live independently					
Action	Sub-Action	Performance Indicators	Partners	Responsible Officers	Target Date
1. Older people know who to contact if they have a problem and require an assessment for assistive technology or an adaptation	1.1 Registered Social Landlords inform tenants about adaptations services 1.2 Care and Repair access home owners through the health service and referrals 1.3 Community Care Officers refer people to housing renewals 1.4 Support service signpost appropriate adaptations service	Increase in referrals	Registered Social Landlords Housing Renewals Care and Repair Support Services Customer Care	**RM**- Contact Kate to link in with Customer Care Officers	Next meeting
2. More people use Telecare products	2.1 Annual training for support staff on the development of Telecare products and how they can help	% of older clients using Telecare product % of support staff completing training	Social Services Telecare Officer Call Centre Customer Care	**RM**- Contact Abby Harvey	Next meeting
3. Options appraisal for the development of handyman service for owner occupiers	3.1 Consider the demand for handyman service 3.2 Identify potential funding opportunities for developing this service- matched funding?	Number of older people trying to access service Number of people receiving the service	Housing Renewals Care and Repair	**IWJ**- provide information on handyman bid	Next meeting
4. Options appraisal for the development of gardening service for owner occupiers	3.1 Consider the demand for gardening services 3.2 Identify potential funding opportunities for developing this service	Number of older people trying to access the service Number of people receiving the service	Registered Social Landlords Supporting People	**LM**- discuss with Cartrefi Conwy whether their gardening service will be available for these clients	Next meeting
5. Help for older people to move out of large properties that have become impractical	5.1 Identify a lead who can support people when leaving their family homes 5.2 Inform older people about the different housing options available	Number of people supported by Conwy County Borough Council during move Feedback from service	Registered Social Landlords Support Services	**NE**- provide information about Hospital to Home pack **LM**- feedback to RSLs benefits of added support for people moving house	Next meeting
6. Identify existing assistive technology and adaptations in properties to match applicants to suitably adapted housing	6.1 Develop database of adapted housing for Cartrefi Conwy 6.2 Develop database of adapted housing for other Registered Social Landlords 6.3 Support the private sector in fitting adaptations by enabling landlords to go on the Adapted Property Register 6.4 Use information to match people to appropriate properties	Reduction in cost of adapting a property to suit a new tenants needs	Registered Social Landlords Adapted Property Register Team Contractors Housing Renewals	**RMathews**- Contact Julie Jones to inform her that the adaptations database is included in this strategy	Next meeting

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3. ASSISTIVE TECHNOLOGY AND ADAPTATIONS: Older People in Conwy can easily access services that provide assistive technology and adaptations, enabling them to live independently					
Action	Sub-Action	Performance Indicators	Partners	Responsible Officers	Target Date
7. Develop training programmes around Dignity and Respect for people going into clients homes	7.1 Assessment of current training for building staff etc 7.2 Identification of any gaps in training or people who should be trained based on report	% of complaints about workers Quality of work done Number of people completing training	Older Persons Strategy Officer Registered Social Landlords Care and Repair	**IWJ & NE**- provide information on satisfaction reports then liaise to develop training day	Next meeting

Glossary

Term	Definition
Action Plan	Sets out what is going to be done, who is going to do it and when it is going to be done by.
Adaptations	Changes made to a property to help someone who is disabled or frail. Common adaptations include grab rails, ramps, walk-in showers.
Adapted Matching Property Register	Details the adaptations that a house has had so that people can be offered houses that meet their current needs.
Assistive Technology	Technological equipment that helps to keep people safe in their own homes. Examples include fall detectors, gas detectors and systems to monitor a person's health.
Community Alarms	Provide users with 24hr contact should there be a problem. Contact can then arrange for the appropriate response to the problem.
Consultation	Asking target group about their thoughts and opinions on a topic.
Direct payments	Cash payments from the local authority to people assessed as needing care, so they can pay for someone to provide care/support
Extra care housing (ECH)	A specific model of sheltered housing that provides twenty-four hour, flexible, on-site care to meet tenants changing needs and which is commonly used by local authorities to replace older models of residential care provision.
Housing-related support	Support services which are provided to any person for the purpose of developing that person's capacity to live independently, based on their needs. Support differs from care and does not include personal care tasks, such as washing and dressing.
Older person	Someone over the age of 55.
Owner-occupier	Someone who owns the home they live in.
Passion for Life	Empowerment framework for older people, enabling them to make small changes to move them from where they are now to where they would like to be in their lives
Registered Social Landlord (RSL)	RSLs are not-for-profit organisations that provide affordable housing in partnership with the local authority. This may include specialist housing for older people.
Residential Care	A residential setting where older people live, usually in single bedrooms, and have access to 24hr, on-site care to help with daily tasks such as washing, dressing and taking medication.
Sheltered Housing	Housing which consists of grouped, self contained accommodation which is fitted with an alarm system for emergencies and is specifically developed to enable older people to reside there safely with estate management designed to encourage independence.
Signposting	Pointing a client in the direction of services that may be of use to them.
Stock transfer	Council signing the ownership of their housing stock over to another organisation, in this case Cartrefi Conwy which was created for this.
Supporting People	Supporting People funding was introduced in 2003 to fund housing-related support for vulnerable people.
Under occupation	Living in a house that is too big ie. has more bedrooms than your family need.
Wardens	Provide support for people living in sheltered housing and manage the building, arrange activities etc. Also called Scheme Managers.
Welsh Housing Quality Standards	Standards set to improve the physical standard and condition of housing in Wales, to encourage Housing Associations to improve and maintain their stock. To be met by 2012.

Appendix 2: List of Steering Group Members

Sam Parry (Chair)	Conwy County Borough Council: Housing Strategy
Gwynne Jones	Cartrefi Conwy: RSL
Kevin Hughes	Pennaf Housing Group: RSL
Noella Jones	Cymdeithas Tai Clwyd: RSL
Ann Caloe	Wales and West Housing: RSL
Eirlys Parry	North Wales Housing: RSL
Ian Travette	Abbeyfield Society: Charity with Housing for older people
David Scott	Conwy Voluntary Services Council
Sian Lewis	Conwy County Borough Council: Older People
Marian Hankin	Conwy County Borough Council: Social Services
Rona Mitchell	Conwy County Borough Council: Social Services/OT
Gareth Griffiths	Conwy County Borough Council: Housing Renewals
Angela Smith	Conwy County Borough Council: Provider Services
Cllr. Phil Edwards	Conwy County Borough Council: Housing
Cllr. Andrew Hinchcliffe	Conwy County Borough Council: Older Peoples Champion
Cllr. Liz Roberts	Conwy County Borough Council: Social Care and Health
Nicola Eccles	Conwy Care and Repair: Co-ordinate housing adaptations
Laura Menzies	University of Liverpool: Researcher
Paul Drake	University of Liverpool: PhD Supervisor
Marie Waugh	NHS Wales (2nd year onwards)

Appendix 3: Survey Questions

Questions asked to those sampled for the survey in Chapter 6.

1. What is the structure of your housing eg in-house, outsourced to a charity, outsourced to a housing association?

2. What sort of housing for the elderly do you offer eg ECH, SH and how many units do you have?

3. What is the structure of your warden service? What type of things do the wardens do? Are they funded by supporting people?

4. What sort of community activities prove to be popular with the elderly tenants?

5. Are there any intergenerational schemes?

6. Is there a rapid response team in the area? How are they structured? Funded?

7. How do you keep people in their own homes informed about their future options?

8. Are you doing anything that you would consider different when housing older people?

Care

1. What support, if any, is in place to encourage older people to take up direct payments?

2. How is the re-ablement service structured in your local authority?