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# **Limes Livingstone Integrated Care Project**

## **Report of findings from research for the PROCARE study**

### Acknowledgement

The Procure research team are very grateful for the support that managers, staff and service users have shown towards this project. We would particularly like to thank Christine Ballard and Chris Belton for their help in setting up the 'Procure' research, and for allowing us access to the Limes Livingstone project.

**Kirstie Coxon and Jenny Billings**

**September 2004**

**Centre for Health Services Studies, University of Kent**



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## **1. Introduction**

The 'Procare' project is a European study, funded by the European Commission's fifth framework programme. A major challenge facing all European countries is population ageing, and the rising costs of long-term health and social care. This has been the subject of the 'Procare' study into issues, problems and solutions of providing integrated health and social care for older people.

### **Integrated care**

In the UK, the problems of 'joint working' between health and social care have been documented since the 1940s, and evidence of fragmented working is widely recognised across the public sector. The demographic challenges of funding care and managing NHS and social services resources for an ageing population has led governments here and across Europe to focus upon integrated care for older people.

The intentions of integration are twofold – firstly, it is expected to improve quality of care and enhance the older person's experience of care, and secondly, there is an expectation that integrated working will be more streamlined, and therefore a more efficient use of resources. In terms of outcomes, there is a belief that integrated working will mean that older people get the support they need, and will then be able to remain independent for longer, with fewer admissions to acute hospital beds or residential care units. To date, this is a common sense assumption rather than being supported by empirical evidence, and the difficulties of conducting large scale, quantitative research amongst a section of the population for whom research access opportunities are limited mean that this may remain the case for some time.

### **How LLICP became involved in the 'Procare' project.**

In the first phase of the 'Procare' project, each country compiled a national report of current integration policy and practice, and identified innovative models of integrated working. The UK models included the LLICP (Limes Livingstone Integrated Care Project), which is a partnership between a community hospital and a social services recuperative care centre, both of which provide short term rehabilitation to older people to help them return to independent living after a period of illness or hospitalisation. This model was chosen because it brings together a number of integration initiatives, including the 'Intermediate Care' service framework, a working 'partnership' between health and social services and the planned development of pooled budgets and single management, using section 31 financial flexibilities (Health Act 1999).

According to the Audit Commission<sup>1</sup>, a 'partnership' may be defined as a type of joint working where otherwise independent organisations co-operate to achieve a common goal. This describes the LLICP well, as the Livingstone Hospital is part of the DGSPCT (Dartford, Gravesham and Swanley Primary Care Trust) and the Limes Recuperative Care Centre is part of Kent Social Services. These two organisations both offer intermediate care to older people with the goal of discharge home to independent living. They are housed in separate buildings on the same site, and a fence with a locked gate divides the grounds between them, both literally and metaphorically.

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<sup>1</sup> Audit Commission (1998) 'A Fruitful Partnership: Effective Partnership Working' Audit Commission, London

## **Designing the ‘Procare’ research**

After the ‘Procare’ national reports had been written, the next phase of the research was to design a study approach that would identify issues, barriers and solutions within current models of innovative health and social care integration. There was a lot of interest in studying outcomes for clients, and for services in terms of costs, but the project resources did not permit a large, quantitative trial or a prospective, follow up design. Instead, a qualitative design was adopted, to examine integrated working at some depth from the perspective of managers and commissioners, staff and service users. This design was employed to generate in-depth data, and then compare common themes across different groups within the service.

### **1.1 Methodology**

The full methodology paper is available at <http://www.euro.centre.org/>. Briefly, the research was developed using a ‘case study’ design. This approach was considered appropriate because it brings together different forms of data, and permits the study of both the objective characteristics of systems and subjective experiences of staff and users within the system<sup>2</sup>. Case study design also incorporates the use of exploratory methods that are sensitive and able to reveal and explain complexities within this area of health and social care<sup>3</sup>. In the ‘Procare’ research, semi-structured interviews and focus groups were the chosen methods for data gathering, and these provided a rich source of data about staff and user experience of LLICP. (See Table 1, p.5 for a breakdown of interviews and focus groups held at the site).

### **Aims and Objectives of Procare Research**

The following points summarize the aims and objectives of this research project:

- To describe how services work to provide integrated health and social care,
- To explore the experiences of integrated care from the user and carer perspective,
- To identify the impediments to effective working and how to overcome them
- To assess the extent to which these services are ‘person-centred’
- To provide recommendations regarding the development of joint working to other similar ventures

### **Criteria for selecting sites for ‘Procare’ research:**

- The organisation is established and has been providing service for six months or more
- There is a key organisational goal of providing integrated health and social care for older people
- There is existing evidence of integrated/collaborative working between health and social care professionals
- There are existing systems within the organisation to gather information about client group and service uptake
- Organisations of any size can be selected, but there should be sufficient numbers of staff and clients to provide 5-10 interviews from each group.

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<sup>2</sup> Yin R (1994) *Case Study Research: Design and Methods*. Second edition. Newbury Park CA; Sage Publications.

<sup>3</sup> Pope C & Mays N (2000) Qualitative methods in health research. In Pope C & Mays N (eds) *Qualitative Research in Health Care* London: BMJ Books Chapter 1 pp.

### Types of information gathered by the research

The case study design was organised loosely into ‘structure’, ‘process’ and ‘outcome’ components, in keeping with Donabedian’s (1980<sup>4</sup>) framework for quality analysis, which underpins the conceptual approach of the ‘Procare’ methodology.

Organisational information about the ‘structure’ of LLICP was gathered during interviews with key senior personnel. The ‘process’ of care provision was explored in staff focus groups, and one to one interviews with staff and service users. Within this project, ‘outcomes’ are related to staff or service user *experience* of integrated care. For example, staff perceptions of job security and a rewarding role are positive outcomes, as are a client’s perception that they have received good care during their stay, and that they have individually benefited from the service they received.

**Table 1 - Summary of Interviews/Focus groups:**

|  | <b>Managers (interviews)</b> | <b>Staff focus groups</b>         | <b>Key worker Interviews</b> | <b>Service user interviews</b> |
|--|------------------------------|-----------------------------------|------------------------------|--------------------------------|
| <b>Limes Centre</b>                                  | 1                            | 1 (8 staff)                       | 3                            | 8                              |
| <b>Livingstone Hospital</b>                          | 3                            | 1 (6 staff)                       | 1                            | 2                              |
| <b>TOTAL</b>   | 4                            | 2                                 | 4                            | 10                             |
| <b>Total number planned for LLICP model overall:</b> | (1-2)                        | At least 1 with 6-10 participants | 6-10                         | 10-15                          |

### 1.2 Comment on data collection and analysis

The research team were able to gain access to the LLICP and complete the required number of focus groups and interviews for the ‘Procare’ study between September and December 2003. However, data collection was slightly unbalanced across the two sites (see Table 1 above). When the project was started, it was anticipated that the LLICP would operate as a single unit, and therefore the data collection was planned across both sites. However, it became clear quite quickly that this was not the case. For example, staff requested that focus groups were held separately at the Limes centre and the Livingstone hospital, although the initial intention was to have one or more combined focus groups. It was also the intention of the researchers to concentrate on clients who had stayed at both the Livingstone hospital and the Limes centre, because it seemed likely that these individuals would have a good insight into the way the two units provided integrated working and liaised with each other. It became apparent though that few clients stayed in both centres, and that in fact the Livingstone Hospital and Limes centre operated independently of each other most of the time.

Most of the ‘service user’ interviews (n=10) took place at the Limes centre (n=6), and this included just one client who had been moved from the Livingstone hospital to the

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<sup>4</sup> Donabedian, A. (1980) *The Definition of Quality and Approaches to its Assessment* Health Administration Press, Ann Arbor, Michigan

Limes. Two clients were interviewed at the Livingstone hospital, and 2 Limes centre clients were interviewed at home after their discharge.

The majority of client data therefore came from the Limes centre, and this may be relevant to how service user feedback is interpreted. The reasons for the greater recruitment at the Limes centre were mostly pragmatic. There was room at the Limes centre for researchers to interview clients in privacy, the predictable routine at the Limes made it possible to plan interviews without interfering with the clients' rehabilitation programmes, and the stability of the staff (especially in the office) made it feasible to plan visits and take referrals of clients who agreed to take part. Similarly, of the four rehabilitation assistant interviews, 3 took place at the Limes, because it was possible for staff to be made available, and there was room to conduct interviews in privacy. Attempts were made to do further interviews with rehabilitation assistants and professional staff at the Livingstone hospital, but this was unsuccessful due mainly to the intense pressure under which individual staff were working. However, a good amount of data was gathered through the hospital focus groups and interviews, and the overall contribution of each unit's staff to the project was sufficient to meet the aims of the study.

All of the interviews and focus groups were taped, and the resulting data was organised into themes, using an approach similar to 'content analysis'. Quotes and observations from each interview and focus group were entered onto a sheet that had headings for all of the main areas of enquiry, for example 'perceptions of joint working' or 'person-centred care'. The strength of this approach was that the interview schedules for all groups covered the same basic questions, so that data relating to the same issue could be compared and differences between the different groups of respondents became apparent. This provides an opportunity to enhance the rigour of the research by using 'data triangulation' or 'cross checking' the data within the study. A key weakness of the data analysis was that the subject areas for analysis were pre-determined and driven by the questionnaires rather than by the responses, which would be more usual in exploratory research. This was in effect a pragmatic step to keep the data quantity manageable and to ensure that all European partners would be able to compare main areas of discussion arising from the 'Procare' research.

### **1.3 Ethical Issues**

The study was granted ethical approval by the East Kent Local Research Ethics Committee (LREC). The research team also gained approval of the Dartford, Gravesham and Swanley Primary Care Trust research and development steering group. Both researchers were granted honorary contracts with the PCT to facilitate access to the LLICP.

When the project was presented to the LREC, the main areas for consideration were protection of respondent confidentiality and ensuring that staff and service user engagement in the study was voluntary.

Information sheets and consent forms were designed so that staff respondents could make a decision whether or not to take part and then send their details if they were willing to attend focus group or interviews.

Service users were approached by members of staff who were familiar with the aims of the project and with the criteria for inclusion. This 'third party' approach was used to prevent service users feeling pressure to take part and their details were only passed

on to the research team once clients had agreed to being approached by researchers. The researchers also discussed participation with every respondent, and made clear that they did not have to take part if they did not want to. Each respondent was reassured that his or her confidentiality would be protected. In this report, staff respondents are not individually identified, and the job or role of respondents is indicated only if this is clearly relevant to the findings. Usually, quotes are attributed to either 'Livingstone staff' or 'Limes staff'. Where data from service users has been used, identifying details have been altered to protect the identity of participants.



## **2. Findings from the ‘Procare’ research at the Limes Livingstone Integrated Care Project**

This report presents the main findings of the ‘Procare’ research into issues, problems and solutions of integrated care at the LLICP. The findings reported here are mainly derived from staff and service user responses, as these seem most relevant to local (UK) policy and practice. Structural and strategic data will be analysed separately as part of the European comparison, and will be published following the final ‘Procare’ conference in Venice<sup>5</sup>.

The findings are presented in separate sections:

- 2.1 Staff and service user definitions of joint working (pp8-17)
- 2.2 Staff experience of joint working at LLICP (pp18-31)
- 2.3 Service user experience of LLICP (pp32-44)

### **2.1. Staff and Service User Definitions of Joint Working.**

The term ‘integrated care’ is used within the ‘Procare’ study to describe organisations that aim to meet both health and social care needs of their clients. One of the clearest issues to emerge from the ‘Procare’ national reports was the diverse terminology used in individual countries to describe this, and the exercise of describing and defining ‘integrated care’ is continuing within the ‘Procare’ study generally. In the UK, terms such as ‘joint working’, ‘partnership working’, and ‘collaborative working’ are all used to describe integrated care. Within this report, the term ‘joint working’ is used as an umbrella for all these descriptions, because this was the expression most readily understood and used by staff.

#### **2.1.1 Staff definitions of joint working**

LLICP staff were asked to describe what ‘joint working’ means to them in focus groups and also in individual interviews. The following account summarizes the major themes to emerge from this, and highlights some differences between various groups of staff.

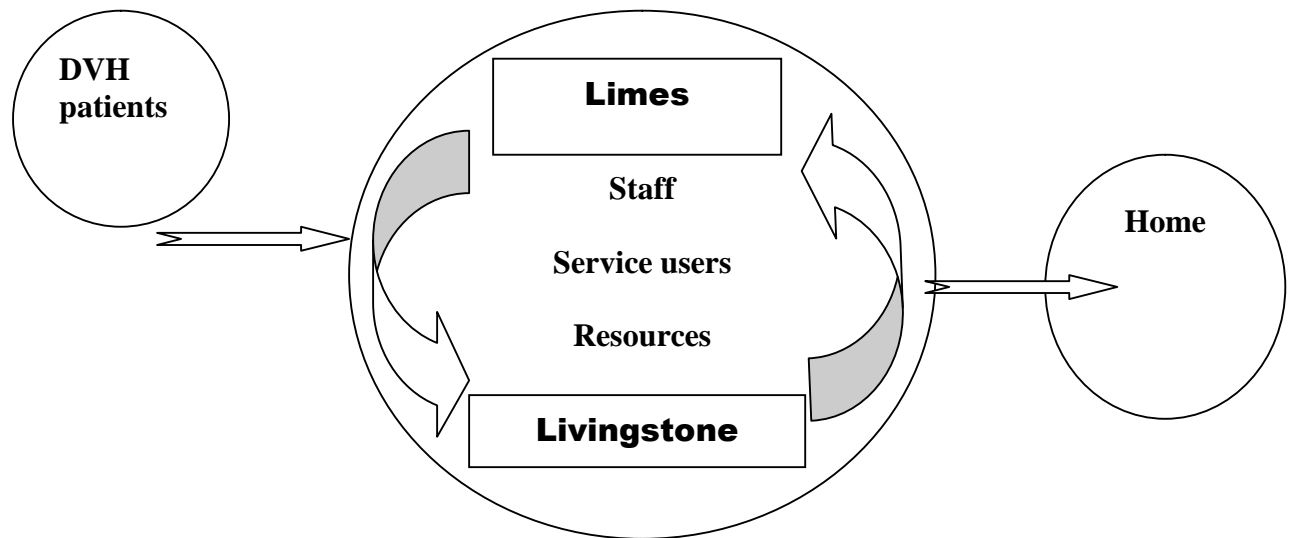
##### **How staff conceptualise ‘joint working’ at LLICP**

During interviews with staff at the LLICP site, it became clear that there were different visions of ‘joint working’ in operation, and that these different views all existed and operated side by side. For example, the model of LLICP amongst senior managers was that the LLICP was a partnership, and that the two separate units could work together to reduce ‘delayed discharge’ from hospital (see Figure 1, page 8).

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<sup>5</sup> October 21-24 2004, International Procare conference for presentation and dissemination of findings, Venice.

Figure 1 'Integration' model of Limes Livingstone Integrated Care Project



According to this view, clients and staff can move fluidly between the Livingstone hospital and the Limes centre, professionals working between the two units can manage rehabilitation care together, and the clients' progress can be jointly managed from admission to discharge:

*'The care pathway isn't fixed, it's flexible....there can be different care pathways...some will go from the Livingstone into the Limes, some will go to the Limes and maybe get worse and need to go to the Livingstone, others won't even see Livingstone and will just go home. So there are various care pathways.'*

This model of joint working was not however evident amongst the staff groups, and none of the staff referred to the LLICP in these terms. Rather, the staff talked of joint working within their units, that is, in the Limes centre or in the Livingstone hospital.

### 2.1.2 Limes Staff: Perceptions of Joint working

Limes staff described a complex model of joint working, which is described here as a 'wheel and spoke' model (see Figure 2 below). The 'wheel' consists of the strong multi-professional team at the Limes centre (care management, team leaders, occupational therapists) working together in an inter-disciplinary manner ('intra-agency' joint working). The Limes core team then works jointly with an array of other groups ('inter-agency' joint working).

Figure 2. 'Wheel and spoke' model of joint working at Limes recuperative care centre

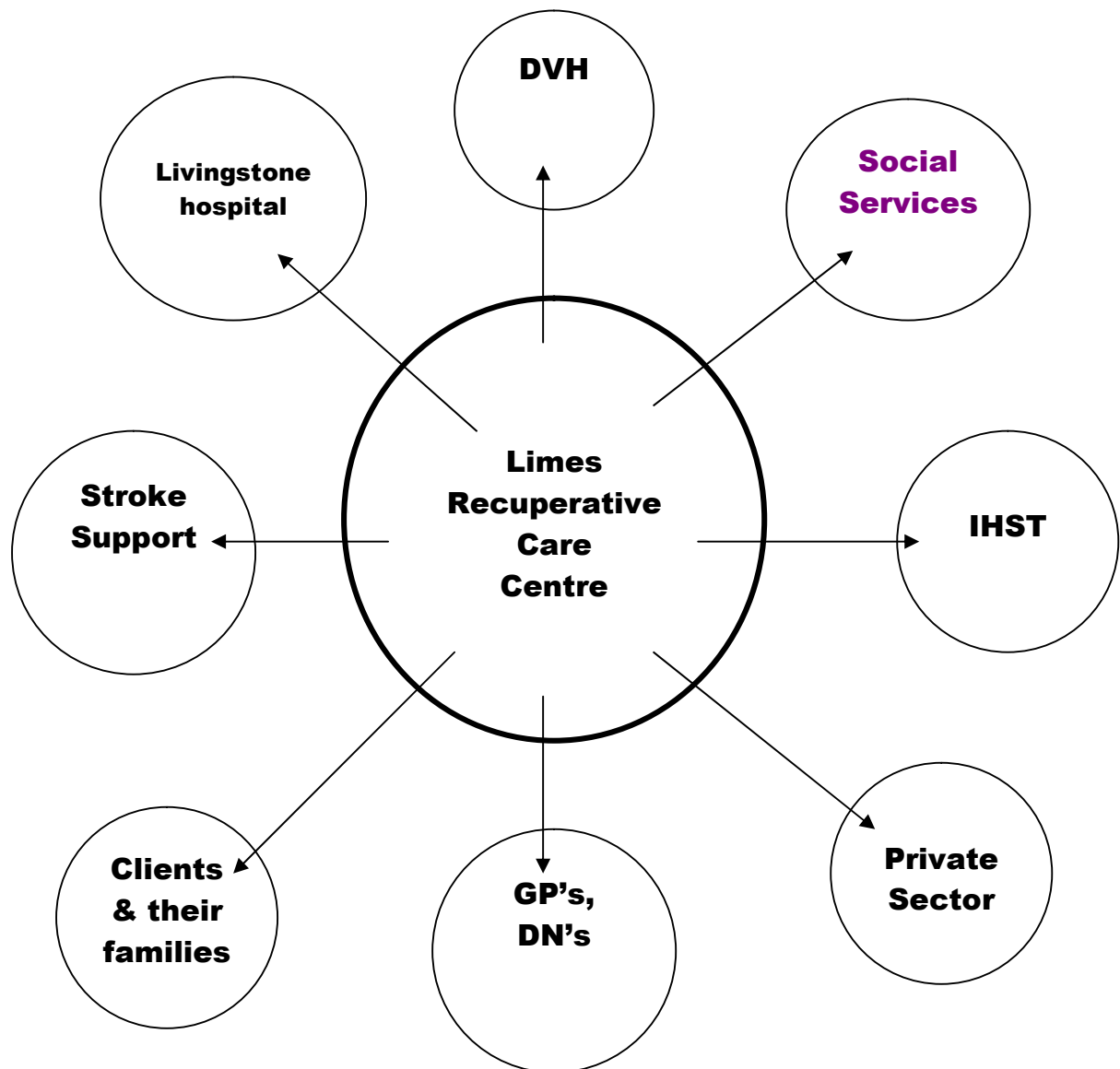




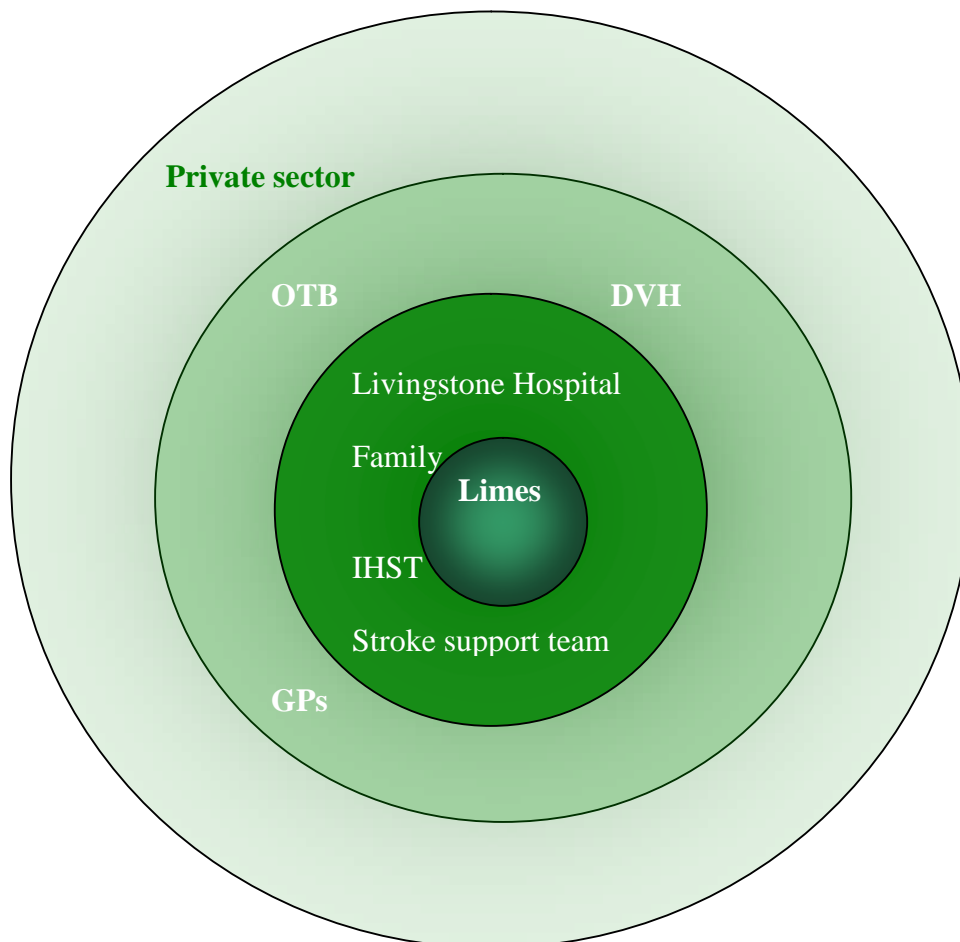


Figure 2 (p10) demonstrates the view held by Limes staff, which was that ‘joint working’ occurred within their organisation, and that working with external agencies occurs in a more distanced and dilute form, which staff referred to as ‘liaison’. However, the ‘wheel and spoke’ model is in itself an over-simplification of the liaison process. In fact, Limes staff were able to identify degrees of separation between themselves and other providers, and this is illustrated below in figure 3.

Figure 3 – Degrees of inter- and intra-agency working at the Limes centre

**Key:**

-  ***Intra-agency joint working***
-  ***Close (informal) inter-agency joint working***
-  ***Formal inter-agency joint working***
-  ***Remote inter-agency joint working (occurs via third party)***



## Degrees of 'joint working' identified within the Limes model:

### 1. 'Intra-agency' joint working

The features of 'intra-agency' joint working included having a shared work-base and client group, regular formal and informal meetings or discussions, knowing each other of 'first name' terms and a sense of common purpose. The Limes organisation is part of Kent Social Services, and a care manager worked within the Limes, arranging admissions and discharges, attending daily handovers and working directly with clients and their families. The innermost circle in Figure 3 represents this type of joint working, and this type of integration appeared to be cohesive and effective at LLICP.

### 2. Close 'inter-agency' joint working

The second circle represents close (or 'informal') inter-agency joint working. This occurred when different groups (such as Livingstone nurses or the Stroke Support Team) had physical access to the Limes centre and could interact on a face-to-face basis. The relationship was therefore relatively close and there was opportunity for getting to know people and exchanging information, but was also formalised because staff (or families of service users) were invited into the Limes centre as guests. Intermittent contact and changes of staff could limit the effectiveness of the joint working relationship, and this may help explain why the visiting groups are perceived to be external (to the Limes organisation):

*'Sometimes the physios that come from that side we don't actually know – you get to recognise them, but we don't actually know them. We sort of work in parallel'*

### 3. Formal inter-agency joint working

In the third circle are groups including DVH, GPs and OTB, which do not have regular, personal contact with the Limes centre. To combat this, formal strategies for inter-organisational communication have been developed (for example, referral letters or discharge summaries). The lack of personal relationships means that the Limes must communicate with these organisations through key individuals (such as the care manager), or by contacting other professionals who may or may not be known to them personally. Crucially, decisions are made and pressure brought to bear by people that are unknown to the Limes, and who may not have a good understanding of the Limes recuperative care programme. This could potentially lead to the sense of service fragmentation, as the following comment conveys:

*'...joint working generally involves 2 agencies liasing but working very much to their own specific standards ...it's not necessarily something that is seamless or client-centred - you can still have people falling through the net'*

Key issues that exist in the grey area between these organisations included the appropriate use of each other's services, accountability for patients as they move through the system and disagreements about who should fund aids and adaptations and care for individual clients.

### 4. Remote inter-agency joint working

The outer circle contains agencies such as private sector care agencies (or residential homes). The relationship with these providers is described as 'remote' because there is no natural interaction of personnel between LLICP and these agencies, although

both often care for the same clients. Communication between these organisations occurs through a chain or individuals. For example, the Limes staff may ask care management to arrange a care package for a client's discharge. The care manager then contacts the agencies and negotiates the 'care package'. The agency delegates the delivery of care to its administrators, who organise the carers' visits – but Limes staff will not be able to pick up a phone and discuss the needs of an individual client with their prospective carers, because the number of links in the communication chain inhibits personal communications.

The relationship between Limes and private sector providers was problematic for a number of reasons. The business culture of this sector is efficiency-led, and Limes staff felt that the onus of private carers was to complete calls as quickly as possible and 'do for' the client, rather than enabling a client to remain independent. Private carers were therefore perceived to 'undo' the rehabilitation work of the Limes, partly because of the time pressures on carers, and also because carers may lack the skills and training to maintain a client's rehabilitation. The organisational cultures of Limes and private agencies were perceived as incompatible, and there was no opportunity for the Limes staff to follow through their programmes of care after clients are discharged from their centre.

### **Cohesive joint working at LLICP**

The discussion above refers mainly to the liaison between Limes staff and external agencies, because this group described the graduation of relationships between themselves and other organisations. However a similar model was observed at the Livingstone hospital, and it seemed likely that the Livingstone staff had a similar experience although they did not describe joint working in quite the same way.

The overriding impression from Limes staff was that the most cohesive form of joint working occurred amongst staff at the Limes, which is described here as 'intra-agency' joint working. Joint working with external groups is then liaison between a range of services, with varying degrees of proximity and contact. For Limes staff, the Livingstone hospital is perceived as being an external organisation, as are the IHST<sup>6</sup> and the stroke support team. However, the relationship with Livingstone is closer than that with local GPs or with the DVH. The most distant partners are the private care agencies that provide community care to clients after they have been discharged home.

The implication of identifying 'degrees of joint working' within this model was that as interpersonal relationships become increasingly formal and distant, the practice of joint working becomes correspondingly fragmented. The importance of co-location to effective joint working has been identified in a number of studies, and this is thought to be due to improved communication and information sharing<sup>7</sup>.

### **2.1.3 Livingstone staff: Perceptions of joint working**

The staff at Livingstone gave a quite different account of joint working. Their model was expressed as the idea of a 'correct pathway' through the service. This started in the acute sector, and following discharge from hospital, a patient *should* come to the Livingstone for their 'medical' rehabilitation, and after this they *should* go to the Limes for their 'social' rehabilitation:

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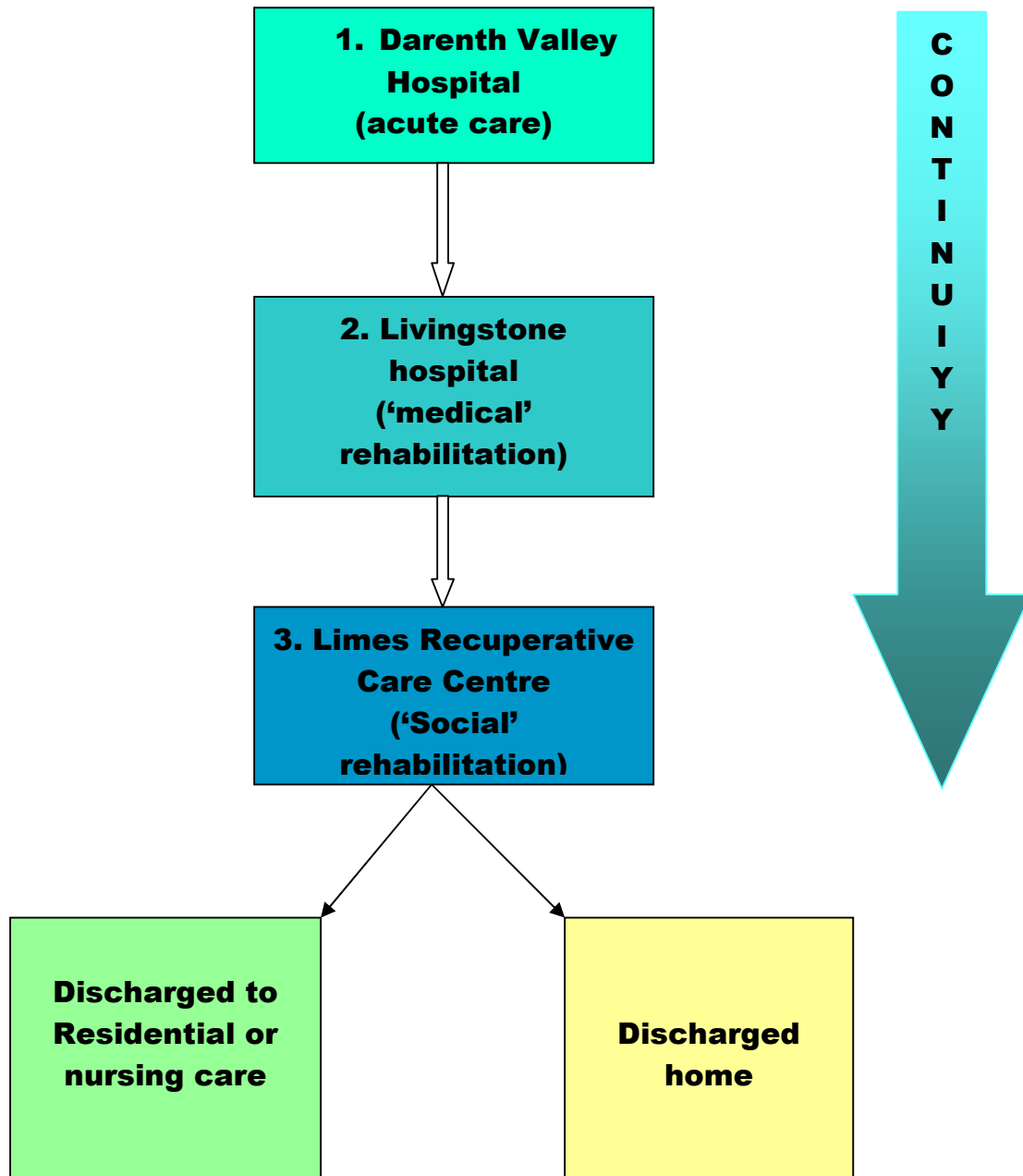
<sup>6</sup> IHST – Intensive Home Support Team

<sup>7</sup> Cameron, A and Lart, R (2003) 'Factors promoting and obstacles hindering joint working: A systematic review of the research evidence' *Journal of Integrated Care* vol 11 no 2 pp9-17

*'The idea was that if people were coming from out of the acute hospital to us, they don't need to take up an acute bed...We rehab them as far as possible to get their maximum potential rehab and then they go over to the Limes for social rehab and get them back into the routine of going home and caring for themselves'*

This model is illustrated in Figure 4 below.

**Figure 4 – Linear (or 'biomedical') model of joint working at Livingstone Hospital, with conceptual theme ('continuity of care').**



In this model, the concept of ‘joint working’ is very much rooted in the practicalities of patient flow through the LLICP, and this reflects the experience of staff at the time, which was coloured by a perceived high level of ‘inappropriate admission’ to both units. The problems surrounding appropriate use of the LLICP were mentioned in all staff focus groups and interviews, and this issue is examined again later in this report (see section 2.2.7, page 25).

A second theme emerged from the Livingstone hospital staff’s views of joint working, and this was related to the concepts of continuity of care, and ‘sharing of goals’ by staff and service users. The following quotes provide some examples:

*‘It’s a nice follow through because I mean it’s continual care isn’t it? It’s a nice follow through all the way through for that client which is good for them.’*

*‘...when it’s working well they know they’re going there and the focus is to go home and that’s what everybody, with them, is working towards..’*

Despite the different visions they held, staff at both units were generally very positive about the idea of joint working, and could see benefits for clients. For hospital staff however, this optimism was tempered by frustration about the slow progress of the project, and continued separation of the two agencies involved. The following quote illustrates how the fence separating the Limes and Livingstone sites had become a metaphor for the barriers between the two units:

*‘In fact if you had a really wonderful picture in your head about this service you’d knock down that fence, it would be one complex... and it would all be attached and it would be under one umbrella’*

For Livingstone staff then, the concepts of ‘continuity of care’ and ‘sharing goals’ were important, and fitted into a framework of a ‘correct care pathway’ of admission from DVH to Livingstone hospital for ‘medical rehabilitation’ and then transfer to the Limes recuperative care centre for ‘social rehabilitation’ (Figure 4). Livingstone staff felt frustrated that the ‘care pathway’ was not being followed, and that clients with high levels of nursing dependency were being admitted to both Limes and Livingstone without their involvement.

#### **2.1.4 Service user perceptions of ‘joint working’**

When the interview questionnaires were designed, it was generally felt that it would be difficult to ask older people directly about ‘joint working’ as the term might not mean much to them. Instead, we asked questions such as:

Q. ‘Do you find that the staff looking after you know what is happening to you?’

Q. ‘Are staff able to communicate with each other about your care or your progress?’

#### **Family members and joint working**

An initial finding was that service users tended to think of their families first when we asked about co-ordination and communication. With hindsight, this should not have been surprising, but what came across from the perspective of users was that close



family members (for those clients who have them) have a bridging role between older people and the services that they use.

For example, one respondent commented that all the carers at Limes were very good, and she knew that they communicated with each other by writing in her 'care pathway'. When she was asked whom she would talk to if she had any questions about her care, she replied, '*my daughter*'. When pressed and asked if there was anyone in the centre she would ask, for example, about her discharge, she said, '*My daughter, she arranges everything, she organises everything*'.

Whilst many clients felt buoyed up by the support and involvement of their family, there were also examples where the client felt powerless when the family was making decisions for them:

Interviewer: 'So it's quite difficult to remember how you came to be here?'

Respondent: '*Really and truly it was done by my wife and daughter*'

Interviewer: 'Did you feel that you made a choice?'

Respondent: '*I didn't have any choice, no... (crying)...but I did realise...the decision was as difficult for them as it was for me...*'

These quotes demonstrate considerable differences between the policy of client autonomy and choice found within the NSF framework<sup>8</sup> and the experience of these respondents, which was that their families played a powerful role in negotiating admission to LLICP on their behalf, with or without their agreement. This suggests that supporting client autonomy is complex when service users are reluctant to distinguish between what they want, and what their families want for them, or to express choices that are at odds with those of family and professional carers.

### **2.1.5 Summary of staff and service user definitions of 'joint working'**

Focus groups and interviews with staff at LLICP suggested that a number of conceptual models of joint working co-exist at this centre. These were described here as the 'integrated model', the 'wheel and spoke model' of graduated intra- and inter-agency working and the 'linear' or 'biomedical model', which incorporated continuity of care and goal sharing.

The differences between these models introduced some questions about how each unit saw their role within the wider service provision, and whether there is overlap between the services, or whether the units complement each other in terms of care provision. Service managers were the only group to articulate clear goals of care for LLICP, and these were:

- Reducing delayed discharge at DVH, together with
- Helping older people to return home to independent living where possible.

Limes staff had a clear idea of their rehabilitation role, and felt their strength lay in supporting recuperative care clients through to independent living. They were less clear about their role with 'step down' clients. These clients are admitted to

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<sup>8</sup> Department of Health (2001) 'National Service Framework for Older People' London, Department of Health

the Limes for short-term care, but not recuperative<sup>9</sup> care – they might be awaiting alterations to their homes, or residential care placement. However, they often had rehabilitation needs as well, but these were not considered a primary reason for admission. Instead, they seemed to occupy a ‘grey area’ where their residential needs were met, and their rehabilitation needs might be addressed if sufficient resources were available.

Livingstone staff demonstrated the most uncertainty about the aims of their service –mainly because they felt their beds were used for a different group of patients to those requiring rehabilitation:

*‘It would help if we had the right patients to start with instead of a mish mash of patients that are all different types, that aren’t rehabable’*

The existence of several models of joint working at LLICP reflects the practical reality, which is that the Limes and Livingstone worked separately from each other most of the time, and this limited the potential for joint working between the two units. However, there were also a number of creative strategies in place which enhanced joint working at LLICP. These included the nursing care of Limes clients by Livingstone nurses, and the creation of the ‘generic rehabilitation worker’ role at the Limes. These innovations are discussed more fully in section 2.2.

Discussions with service users identified that, amongst our respondents, there was a quite distinct perception of ‘joint working’. These service users described ‘joint working’ as the interactions between their families and professional service providers, whether these are hospital, social services or intermediate care staff. Some service users delegated decision-making to their family members, and felt that the involvement of their family was very important to their recovery. Most of the respondents to this study had family members involved in their care, which limits this finding to this particular group. How a more socially isolated client would view ‘joint working’ is unclear, and why there were no clients without family support interviewed for the study is unknown. This may simply be a result of the limited sample, or it may be that strong family interest and involvement may be one factor that helps people be selected for admission (to the Limes unit particularly).

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<sup>9</sup> ‘Recuperative care’ is the term used to describe a residential placement of up to 6 weeks, in a social services run centre which has OT staff dedicated to providing short-term, intensive therapy to individuals for whom discharge home is a preferred and realistic goal.

## **2.2 Staff Experience of Joint Working at LLICP**

In order to explore *how* the different services work together, researchers explored the process of joint working from the perspectives of both staff and service users. The question schedules followed a chronological pattern, from ‘initial contact and admission’, through ‘assessment’ and ‘care planning’ to ‘discharge home’. The questions that generated many of the resulting themes were those relating to admission of clients to LLICP and discharge home, and these points of service provision have a correspondingly high profile within the results. Admission and discharge issues particularly highlight what occurs at the ‘interface’ between LLICP and other health and social care agencies. This is likely to be very relevant data, because service interfaces are widely regarded as barriers to joint working, and exploring what happens at these junctures may illuminate problems that are present along with any solutions that the LLICP has developed.

This chapter discusses joint working at LLICP in some detail. The perceptions of Livingstone hospital staff are presented first, along with the innovative role of Livingstone nurses at the Limes centre. The experience of Limes staff is considered next, and the findings from interviews with generic rehabilitation assistants are presented. The following section looks at the issue of ‘inappropriate admission’. This is considered separately because it was important to all the staff who took part. Finally, we present some observations about how LLICP staff view each other. The academic literature on ‘joint working’ consistently maintains that inter-professional problems present a barrier to care integration, and consequently the research team felt it was important to identify any examples of this found at LLICP.

### **2.2.1 Livingstone hospital staff: Perceptions of joint working**

One of the key differences to emerge from the data on staff perceptions of joint working at LLICP was that Livingstone and Limes staff each had very different views on this issue. During focus groups and interviews, Livingstone hospital staff expressed uncertainty and frustration about the ‘joint working process’.

*‘Even if somewhere there is a folder somewhere (which contains a co-ordinated policy) it feels as though it’s a separate service that hasn’t been integrated’.*

*‘It’s disjointed, yes. It’s not joined up at all at the moment’.*

The experience of the Livingstone staff was that admissions occurred without their involvement, often of clients who were not ‘appropriate’ for rehabilitation. This included patients who are too dependent on care to benefit from rehabilitation, ‘respite care’ patients admitted under a pretext of needing rehabilitation and patients requiring ‘end of life’ care.

Staff also commented that measures devised to ensure safe care of patients in both Limes and Livingstone were not adhered to, so that highly dependent clients might end up at the Limes centre and then demand a lot of the Livingstone nurses’ time, or require transfer to the Livingstone hospital:

*‘...the referral forms are not being filled in correctly....there are a series of tick boxes where you have to tick their medical needs.....and their nursing requirements. If there’s more than one tick whoever refers the*

*patient should inform us and we say whether we feel it's appropriate for that patient to go there (I.e. to Limes) and that's not happening. The people who are taking referrals don't understand the medical and nursing needs of these people. It's social services who haven't got a nursing background always so don't understand the implications of the nursing input'.*

A related problem was that clients were admitted to the Limes with limited medical records, so that the Livingstone doctors and nurses then had to intervene with insufficient information. There were clear concerns about safe administration of medicines and transfer of data<sup>10</sup>:

*'Most of the time patients come from the acute hospital to the Limes without a proper referral letter....One of the problems is that proper communication is very important. And the problem is how we plan our time with the patient, and find out whether the patient is awaiting for special investigations....'*

The ethos of 'joint working' seemed to have become lost amongst the problems and challenges the staff were facing at the time. The staff also felt excluded from the management and planning of the project:

*'You're not allowed to go to any of the meetings for the planning'*

*'There's nobody to organise what is happening at the end of the day. Nobody has got any information or knows what to do'*

There was also a sense of frustration at the lack of rehabilitation resources available to the Livingstone hospital. This demonstrates the difference between the 'vision' of fluidity and transfer of staff, and the perceived reality where staff remain in their 'own' workplaces, unavailable to the other unit. There was also a feeling that the current arrangement was unfair, because Livingstone nurses visited the Limes daily to provide nursing care to their clients, but Limes occupational therapy was not available to the Livingstone:

*'We haven't got a full-time physio that we desperately need and we haven't even got a part-time OT. We're almost having to borrow a post from over there. And if you haven't got anyone based on the premises you don't use them'*

*'I'm not sure the OT comes. There is an assessment but I'm not sure...'*

*'These teams, whether they are a stroke team, whether they are an Intensive Home Support Team, they should be within this vicinity of this hospital. They weren't'*

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<sup>10</sup> A number of specific problems around medication were identified. For example:

1. Patients at the Livingstone hospital were encouraged (where possible) to self-administer their medicines. However, on transfer to the Limes the same clients would no longer be allowed to 'self medicate with supervision' and could consequently lose the skill and lose confidence.
2. The management of 'warfarin' regimes and INR tests/results was not optimal (recognition of this problem had led to increased, improved input from the nursing staff)
3. There was a perceived lack of knowledge about drugs amongst Limes staff and that this led to staff calling doctors frequently.

## **Rehabilitation at the Livingstone Hospital**

Livingstone staff gave the following description of the joint working process within their unit, relating to a patient's stay:

*'...they have a nursing assessment, rehab assessment, mobility assessment and then a social services assessment. All of those are within 24 hours of being here. And then their care plans are written out according to all these assessments. Then that's followed through throughout their time of being here and each time they're upgraded until they get to a stage where a nurse says right I think it's time for them to move on. And then they take it on from there'*

The role of the nurse is clearly central here, and the way that other multi-professional team members contribute is less clear. The following comment describes the kind of difficulty Livingstone staff experienced when working alongside other rehabilitation professionals:

Interviewer: 'It sound as though you almost have to pin (the physiotherapist) down a bit sometimes..'

Respondent: *'We do sometimes, and sometimes you miss her. We've now got a book though that we write in about patients...she only comes about 3 days a week anyway.'*

Respondents also reported fragmentation between the Livingstone and the stroke support team:

*'We haven't seen the stroke team for a while, but...we didn't always feel that they were working with us. They'd come in, they'd take a patient up to the gym, we'd be looking for that patient, and we'd say, well, where's the patient gone? And they wouldn't tell us...they wouldn't ask if was OK for the patient to go over with them, so there was a bit of...well, you know...– they'd forget that we haven't just got stroke patients, we've got others, and we used to have to say, well I'm sorry, but unless you put it in the diary that you want them up early, then you're going to have to wait your turn, because we've got other patients to do'*

Livingstone staff clearly felt that there were some barriers to joint working within their unit. The lack of resources was keenly felt, and this had implications for patient recovery and smooth progress towards independence. The process of discharge planning appeared to be very reliant on individual nurses as opposed to a structured multi-disciplinary team approach.

### **2.2.2 The role of Livingstone nurses at the LLICP**

One of the most established joint working arrangements at the LLICP was that the Livingstone nurses provided nursing care to Limes clients. This meant that the continuity of care was improved (especially if clients moved between the units) and also that the district nursing workload at the Limes was minimised. This innovative service marked a departure from the 'traditional' ward nursing role towards a role that incorporated both hospital and community nursing.

This arrangement had led to some problems, such as the lack of medical and nursing data held by the Limes centre about their clients, and a greater workload than was envisaged originally:

*'They had a lot of nursing needs over there. [Mmm] And we were taking 2-3 hours a day over there for their nursing needs.'*

There were also a number of solutions to problems of joint working that had been initiated by the nurses and the Limes staff. For example, generic rehabilitation assistants at Limes are able to assist the Livingstone nurses, and receive training in basic wound and pressure area care. This extended the knowledge base of Limes staff, which further enhanced the level of care that Limes clients receive. A problem of managing 'warfarin' prescriptions at the Limes centre was solved by the use of increased documentation and care planning by nurses and improved communication with Limes centre staff.

These examples of effective joint working and problem solving that are at risk of being overlooked within the wider picture of problematic inter-agency working at the Livingstone. In fact, the Livingstone staff had generated a model of identifying problems, addressing them with the involvement of cooperating unit managers and achieving a change through negotiation, and this may be regarded as an approach that other joint working organisations could adopt.

### **2.2.3. Comment on Livingstone Hospital staff perceptions of joint working**

The above findings summarize the main problems and challenges that Livingstone hospital staff encountered as a result of 'joint working' within the LLICP. The difficulties of inappropriate admission also clouded their experience of liaison with other agencies, including social services, local GP's and the DVH. Overall, the staff appeared to feel disempowered – they felt excluded from the assessment/admission process, unwelcome at management and planning meetings and genuinely did not feel that their concerns were being addressed.

At the time the data gathering took place there were already changes in motion to address some of these problems. These included the creation of a nurse consultant post, with the intention that the post-holder would become involved in admissions to the unit. This was viewed positively, and staff were hopeful that things would improve in the near future. The following quote is an example of how the (new) management team at Livingstone hospital was perceived:

*'Listening to them I think that they will value us, and they are very aware of how we work and how hard we work...if what they say is true, I think that they will be for us and help us.'*

### **2.2.4 Limes staff perceptions of joint working**

In contrast to the uncertainty expressed by staff at the Livingstone hospital, the staff at the Limes centre held a clearer view of the process of joint working. They identified that the care manager arranged admissions from the DVH, and once again, there was debate about 'appropriate' use of the service. If a client was admitted from their own home, a GP made the initial referral, following which the care manager and an occupational therapist visited the client to assess whether admission to the Limes was appropriate. The client's willingness to take part in the rehabilitation programme was seen as being an important factor in admission to the unit:

*'we need their participation, really strongly and this is something that is going to involve hard work really. It needs them onboard'*

After admission to the Limes unit, a range of staff complete assessments on clients. Care workers and generic rehabilitation assistants can all take biographical data and complete scores for 'risk' issues such as moving and handling, pressure area care and 'Barthel' scales (at the Livingstone hospital, nurses complete these assessments). They also instigate and update client care plans. Specialised assessments are made separately by Occupational Therapists, but all the client assessments are kept together in one folder in the office, and available to all staff.

Every afternoon, staff attend a daily handover session. This allows the multi-professional team to stay informed about individual clients, and also ensures that carers are aware of any improvements in progress, so that these are maintained. At these meetings, discharge arrangements for clients are planned from early in their stay. The occupational therapist will estimate the likely length of stay, and ask the care manager to become involved if a care package or home aids/adaptations may be required. Before discharge, each client goes on a home visit with the Occupational Therapist. During this visit, the OT can assess whether the client can manage at home as well as they do at the centre, and identify any needs for equipment in the home. Members of external groups such as the IHST and Stroke support team are invited to attend these meetings, so that an individual's care can be co-ordinated across these groups:

Interviewer: 'Can you tell me what 'joint working' means to you?

Respondent: '*Well, the truth is, it's about communication and working alongside each other, so that everybody knows what everyone else is doing*'

Limes staff also expressed confidence in their team and felt well supported by their managers:

*'I do think you are well supported here, compared to working as a community carer, because here you have other staff to hand, and team leaders to call on'*

These responses indicated that multi-professional joint working was standardised and structured at the Limes, with responsibility for various aspects of care clearly delegated to particular groups of staff. This in turn produced a sense of confidence amongst the staff that their rehabilitation service was both flexible and effective.

### **2.2.5 Generic rehabilitation assistants**

The creation of 'generic rehabilitation assistants' or 'generic workers' was one of the innovative strategies of the LLICP. This new role was that of an enhanced care worker, who received additional training in nursing, occupational therapy and physiotherapy skills. The generic carers also have an extended role of dispensing medication at the Limes centre, (which they only take on after receiving specialised training). The initial intention was that generic workers would be able to work in both Livingstone hospital and the Limes centre. However, this has not yet happened, mainly because it has proved impossible to generate a joint contract, and the 'generic' worker contracts are only held by social services staff. A subsequent problem was the need to use newly employed 'generic workers' to cover night duties at the Limes centre.

The 'generic worker' contract was attractive to social services carers, partly because they were better paid than they were in the 'basic carer' role, and also because they found the extra responsibility rewarding. However, it was unattractive to health care staff, because of differences in salary, terms and conditions between health and social care:

*'we were asked, but they wanted us to take a (social services) contract, which meant less money, and the same amount of money whenever you worked – nights, days, weekends, and I feel we're worth more than that...and that's why I wouldn't change my contract.'*

At the time that data collection took place, generic rehabilitation assistants worked at the Limes centre, whilst the Livingstone hospital employed 'rehabilitation assistants' in a role which builds on the traditional 'health care assistant' job description.

There was a perception within the LLICP that generic workers had become disillusioned with their role, and some of the workers who took part in interviews did feel that they were poorly paid for the level of responsibility they took on. Other issues mentioned by staff included:

- Being expected to do extra training (for example, NVQ's, administering medications) without being financially rewarded for completing these qualifications.
- Working at nights and weekends at 'flat' hourly rate.
- Feeling that their knowledge and experience was undervalued – there was a demarcation between 'professionally qualified' and 'non-professionally qualified' staff.
- Frustration at the low availability of training courses which delayed taking on a fuller role.
- Frustration at having to wait until the LLICP is 'up and running' as intended (when staff are able to work at both Livingstone Hospital and Limes)
- Anxiety about giving medications (fear of making errors).
- Over-reliance on agency staff

This last problem caused some resentment amongst Limes staff, as the following quote shows:

*'And of course the problem is that we will come in at weekends for the flat money and agency staff get a fantastic amount from their agency, or from us via their agency for weekends and night duties'*

It is interesting to note that the Limes generic carers did not express any resentment towards Livingstone hospital rehabilitation assistants, even though this group had better basic terms and conditions, but clearly felt that their unit's reliance on agency staff- and willingness to pay more to these staff - was unfair.

However, there was also a high level of job satisfaction amongst generic rehabilitation workers at the Limes centre. One important factor which was mentioned by all the generic workers was that they worked in an environment where service users actually get better and go home, and this was a positive and rewarding part of the job – especially for carers used to working in residential homes:

*'It's nice to be in a setting where you can see them progress, where you can see them getting on, and that they are actually going home'*



*'The best thing about working at the Limes is helping someone to get back home when they really want to'*

Other positive aspects included that the day-to-day variety of work means that the job is always interesting and that generic workers are paid at a slightly higher rate than they were in their 'traditional' carer role. Staff enjoyed the predictability of the duty rota, and the fact that managers would take their individual needs into account when writing the rota. Some carers mentioned that 'contact with clients' was the best thing about the job, and that everyone pulls their weight, and treats clients well:

*'I can't think of one member of staff that doesn't pull her weight or work well and has a nice attitude to the residents, which is very, very important'*

Generic workers identified the following differences between working in the integrated care setting, and previous jobs that did not focus on 'joint working':

- There was a more relaxed atmosphere at the Limes, and there is time to help people do things by themselves instead of doing things for them as quickly as possible.
- Clients are more positive (compared to residential home clients) because they are working towards independence and home discharge.
- Seeing clients motivate each other:

*'I think when you live alone in the community you lose touch with reality because you sit in your chair and everything is done for you and you don't know what's going on really. When they come in here at least they discuss life with people of their age bracket that perhaps have the same problems. And if they suddenly see that this lady that's also got an ulcerated leg is walking and not just stuck in a wheelchair forever and a day I think that encourages them because they do... you do get a competitive spirit to a degree'*

Overall, it appeared that generic rehabilitation workers felt a great deal of job satisfaction within their new role, and this was related to seeing clients get better and go home, and having a varied and interesting job. The downside was that they felt underpaid and, at times, poorly valued. The view of this staff group was that rehabilitation was beneficial to their clients in a way that went beyond physical improvement and encompassed social and psychological support from staff and fellow residents.

### **2.2.6 Comment on the process of joint working at Limes centre**

Staff at the Limes centre were generally very positive about the process of joint working, and felt confident in their own roles and abilities to meet the needs of their client group. The daily meeting was considered to be an opportunity for exchange of information, and this was seen as being key to effective joint working at the unit. Other strategies that facilitated joint working included supportive, flexible management and sharing the same workplace. The 'generic rehabilitation worker' role was well developed. There were few negative comments from staff, and where these occurred, they mainly related to lack of financial resources, 'inappropriate admissions', and some difficulties in the relationship with the health care sector.

### 2.2.7 'Inappropriate admission' and 'professional stereotyping'

The problem of 'inappropriate admissions' came up repeatedly during staff interviews and focus groups at Livingstone and Limes, and at all levels of the staff hierarchy. This theme therefore emerged very strongly from the data, and concern about admissions and about how the service was being used was a unifying factor across the two units. 'Professional stereotyping' is usually highlighted in the research and academic literature as a major barrier to integrated working, and so researchers noted any examples of this. In fact, there were relatively few instances of 'professional stereotyping' during the data gathering, and it appeared that the examples we found could be linked to the issue of appropriate service use, and so these two issues are discussed here together.

#### **Inappropriate admission.**

Comments relating to 'inappropriate admission' often referred to the DVH and mentioned that pressures on hospital beds led to pressure in turn upon LLICP to accept patients who were not suitable for rehabilitation:

*'...they (acute sector) need to empty their beds and so they're looking at it as a way of getting that person out of that bed'*

This implies that moving patients out of DVH is a prime reason for admission to LLICP. As the following quote shows, this may be more of a priority than deciding whether LLICP is the most appropriate place for a patient to go:

*'We have targets to meet for delayed discharge, and therefore it seems a crime if you have empty beds, and people ask questions...why aren't they filled?...and so our nurses are taking in the heaviest dependency patients that they really shouldn't be taking...but they need to fill their beds...'*

That pressure to fill beds in this way is seen as coming from 'on high':

*' the powers that be came along and said you've got beds over there, they're not filled, we have to fill them. So (beds at the Limes) then got filled with inappropriate patients, patients that we should have had over here...So that meant all their beds were filled, so our patients couldn't filter through and their patients were filtering back this way...'*

This issue aroused strong feelings in staff, and it was generally felt to be the main 'problem' affecting the LLICP. Although the DVH was usually cited as being responsible for 'inappropriate admission', the ramifications affected both the Limes and Livingstone units. Limes were expected to take clients who were not likely to respond to rehabilitation. Livingstone were then expected to accept these clients from Limes, as well as getting clients from DVH that were too dependent for their services.

It appeared that the problem of bed-blocking was being transferred from the acute hospital to the LLICP, and that this was considered efficient resource management in the sense that the LLICP is a cheaper alternative to the acute hospital. How an 'inappropriate admission' affected the outcomes of individual clients is uncertain, although staff certainly felt that this was a poor use of their service, and the long-term impact of this on the 'whole system' is of course unmeasured. The use of LLICP as a destination for clients who do not fit the admission criteria may prevent the admission of those who would benefit, and also limit the staff resource available to offer

rehabilitation care to those clients who need it. At the time that data gathering took place, there was dissonance between the management priority of effectively emptying beds in the acute sector and the staff priority of offering effective rehabilitation care, and this caused an overall perception that the goal of providing the LLICP service was unclear and open to misuse.

The effect of this upon joint working at LLICP was that both Limes and Livingstone units reported receiving transfers of 'inappropriate admissions' from each other, and this generated distrust between Limes, Livingstone and the DVH. The next quote demonstrates how the judgement of the professionals assessing clients is called into question when they appear too dependent for the LLICP service:

*'We've had patients who've not been assessed properly, and we've looked and thought, 'she's either had an extension since she was assessed to come here, or this lady was like this when she was assessed', and there's no way – they couldn't even sit up..'*

Although the Livingstone staff appreciated that some clients would become unwell or more dependent after admission, there remained a lack of trust in professional judgement and bed management skills at the Limes:

*'On odd occasions, we've had to take patients back (from Limes) because they've needed hoisting, or they've suddenly become more poorly, **or they have been transferred there and (Limes staff) have been told (by acute hospital) 'they are walking well with a zimmer frame' and in actual fact they need an awful lot more help and more physio***

A further issue raised by Livingstone hospital staff was that an 'inappropriate' admission was very unfair on the client. A number of staff commented that rehabilitation and home discharge might be unrealistic goals for the clients, but that the clients' hopes would be raised by the admission, and by the attention from the multidisciplinary team. The following quote gives an impression of the emotional impact on service users, from the perspective of staff:

*'We had one lady, and for six weeks this lady thought she was going home, and we were saying amongst ourselves, 'there's no way - this lady can't even sit up' ...and when she was finally told that she wouldn't be able to go home, she just seemed to lose the will to live, and we felt it was very cruel to keep her going for that long.... we feel that within the first two weeks they should be assessed and they should be told 'yes we can rehabilitate you' or 'really, this is as far as you're going', and I feel, personally, that they give these people false hope....Sometimes they talk to you and say, 'I'm really trying' or 'I really want to go home' or 'if I work really hard', but you know, there's no way.'*

A related concept that was mentioned by staff was whether or not a client is 'rehabable' (having potential to improve with rehabilitation). This issue impinges upon the overall model of rehabilitation throughout the LLICP, and suggests that a further difference of opinion exists about the *purpose* of offering rehabilitation. One respondent provided an alternative to the consensus view (that clients should only be admitted if they will benefit from rehabilitation), arguing that rehabilitation may at times be the last opportunity for clients to return to independent living, and the LLICP can offer much more intensive rehabilitation than the acute hospital can. This

respondent proposed that all motivated clients should have the opportunity to undergo intensive rehabilitation, and that some degree of ‘failure’ must be an expectation of a system that does not make judgements about the potential of clients before every attempt has been made to assist them to reach maximum independence.

What these findings suggest is that the tension within LLICP regarding ‘inappropriate admissions’ stems from the presence of clients at either Limes or Livingstone with high levels of nursing dependency, or complex problems that reduce the potential success of the rehabilitation programme. Staff at the Livingstone feel frustrated that rehabilitation is not effective for some clients, and express concern that this could have negative consequences such as depression or loss of hope for others. An attendant issue is the lack of a unifying vision of rehabilitation across the LLICP, which limits cohesion between the Limes centre and the Livingstone hospital.

### **Professional stereotyping**

The existing literature suggests that a professional divide exists between health and social care staff due to what is variously termed ‘cultural intransigence’ or ‘mutual incomprehension’. There is however little detailed explanation of this phenomenon within policy papers, or, in fact, in contemporary research literature. The research team were therefore interested to note any comments that might indicate professional stereotyping, and to consider the extent to which this impeded joint working.

Of the comments that were made and recorded (some respondents requested that comments of this type were ‘off the record’ and in these cases, the comments were excluded from transcripts), there was a notable imbalance. Nearly every negative comment made involved health service staff being critical of ‘social services’. Such criticisms were normally abstract – that is, directed at the organisation generally, rather than specific people, as the following quotes demonstrate:

*‘Social services are being very obstinate at the moment. There’s no give and take over there.’*

*‘I do have difficulty with social services, and their policies and procedures, and everything is set in stone. I think with health, if there is a guideline or whatever that doesn’t fit, then we make one that does. But they’ve got some very archaic policies, and they are almost blocking us...’*

A further problem was ambivalence about supporting Limes care staff with nursing or medication issues:

*‘They (Limes staff) call you for simple things or things that they don’t know’*

The overall impression from Livingstone staff was that staff at the Limes were not able to respond creatively to problems, and instead became implacable and refused to budge their position. There was also concern that the Limes staff had insufficient knowledge to take on additional roles that traditionally fall within the nursing domain.

There were no negative comments about the health services in the data from Limes staff. This was surprising, because the majority of the data came from the Limes site. There was however a wry acceptance that social services were attracting criticism from their health care colleagues:

*'the health sector have a limited understanding of this unit's national regulating body (NCSA) and therefore views the unit management as obstructive at times – for example, the health sector wanted to admit clients with nursing dependency needs for a temporary period whilst building work was done to hospital. However, the NCSA would not allow the unit to accept patients of this dependency level, as it viewed the admission to a residential unit as unsafe for patients...'*

This gives rise to the possibility that the tendency to make negative comments is related more to the sense of frustration felt by Livingstone hospital staff about the 'inappropriate' use of their service, than to an actual health/social care divide at LLICP. This view is supported by the fact that the only profession which was singled out for criticism was in fact care management, and there was palpable resentment that this group had power to make admissions to the Limes and Livingstone units from DVH without necessarily having a nursing or medical background:

*'the people who are also taking referrals don't understand the medical needs of these people and nursing needs of these people. It's social services who haven't got a nursing background always so don't understand the implications of the nursing input'*

Professional stereotyping appeared to take place to a degree at LLICP, usually in the form of a belief that social services and their managers were unable to be flexible. There was also concern that the staff at Limes had taken on nursing tasks and responsibilities without holding formal nursing qualifications. However, the most consistently problematic issue was seen as being the role of care management in assessing clients for admission to the LLICP, and this was difficult to separate from the problem of 'inappropriate admission' that affected both Limes and Livingstone at the time of data gathering.

### **2.2.8 Strengths and weaknesses of joint working at LLICP**

All of the staff respondents were asked to comment on the strengths and weaknesses of joint working at LLICP during focus groups and individual interviews. The following section provides an overview of these responses, and an opportunity to compare the similarities and differences between the Limes and Livingstone staff perspectives.

#### **i. Strengths of Joint working at LLICP**

Livingstone staff identified the following strengths of joint working, and tended to focus on their role at Limes, their rehabilitation care and their hopes for a more integrated future at the LLICP:

- Livingstone hospital nurses visit the Limes centre, and are well informed about the medical and nursing care of Limes clients.
- Livingstone hospital staff felt confident that their assessment procedures were robust, and that they were able to accurately establish the needs of their patients.
- Livingstone hospital staff felt that they were willing to work jointly with the Limes unit, and felt generally positive about joint working

Limes staff also felt that the involvement of Livingstone nurses in their clients' care was a strength of the project. However, their view of successful joint working was focused on the processes that occurred within the Limes, in keeping with the 'wheel and spoke' model described earlier, and they identified the following factors as positive strengths of joint working at their unit:

- Joint working is normal practice at the Limes centre.
- Staff communicate every day in meetings and also informally.
- The daily handover meeting at the Limes centre, attended by the care manager and by staff from 'visiting teams' (IHST, stroke support), facilitates inter-disciplinary communication to support joint working.
- Care plans for Limes patients are written by Livingstone nurses, and left at the Limes centre.
- Weekly meetings of Limes and Livingstone unit managers provide a forum for co-ordination and problem management.
- Different professionals (at Limes) value each other's input into client care
- There are good relationships between all Limes staff – there is an 'open door' policy and equality between staff (*'not intimidated'*).
- A wide network of hospital, community, health and social sector services are incorporated into the Limes model.
- The 'can do' management approach means that the unit is open to change and refinement.
- Staff feel rewarded in their work and positive about their work environment.
- A 'client centred' philosophy operates at the Limes
- There is ongoing evaluation of unit by service users.

Perhaps the major difference between the two groups of staff was that the Livingstone staff found it more difficult to identify positive aspects of joint working. Although they felt confident in the patient care offered by their unit, they did not express the robust confidence in management that the Limes staff felt. Both units recognised the value of the Livingstone nurses working with Limes patients, but curiously, Limes staff did not identify the role of generic rehabilitation workers as a strength of their model.

The most striking similarity between the two staff groups was that both focused on the strengths of joint working within their own model, and only passing reference to joint working with other agencies was made.

## **ii. Weaknesses of joint working at LLICP**

Livingstone hospital staff identified a number of weaknesses in the joint working process at LLICP. Not surprisingly, 'inappropriate admissions' was central to the hospital staff perspective:

- Inappropriate admissions to the Limes have led to transfers of dependent patients from the Limes to Livingstone hospital.
- Medical problems are overlooked or poorly managed for Limes clients.
- There is poor understanding of LLICP by outside agencies such as the DVH, so that '*bed-blocking*' patients are admitted to Limes or Livingstone, when they have little '*rehab potential*'. This was seen as

*'compromising patient care'* as well as limiting the role of LLICP to a waiting area for those patients who require permanent residential care.

- Lack of sufficient support from PAM (professions allied to medicine) – not enough physiotherapy input, no occupational therapy input.
- Not enough planning – the need for nursing resources at the Limes was underestimated.

Similarly, 'inappropriate admission' was seen as a problem by Limes staff, although interestingly, the *exclusion* of dependent clients from recuperative care was also seen as an issue here, although this was not a consensus view. Other weaknesses were more local to the Limes unit itself:

- Problematic relationship with health sector – 'inappropriate admissions', pressure on beds
- Some client groups are excluded from admission (E.g. clients with mental health needs or high dependency upon care staff)
- Clients may refuse to take on the rehabilitation programme after admission
- There was a perceived overlap of some services (e.g. stroke service in addition to rehab)
- Funding issues – 'health' and 'social' needs divided
- Time limited intervention (6 weeks) – sometimes not long enough for clients with complex care needs
- Lack of objective, independent or long term evaluation

### **2.2.9 Summary – Staff Perceptions of joint working at LLICP**

What these responses show is that both staff groups felt most confident about the joint working strategies of their own units, and were much less aware of how patient care was organised in each other's units. The impact of 'inappropriate admission' was keenly felt at each centre, and both groups identified resource issues that impacted upon their potential to provide a seamless, client-centred service.

Based upon the perceptions of the LLICP staff, it appears that the project has made the following achievements:

- **Staff at the Limes centre worked together in a cohesive manner, and liaised effectively with visiting teams to achieve integrated rehabilitation care for their clients. They felt confident in their managers and found their work satisfying and rewarding.**
- **Livingstone hospital staff worked together well within a medical rehabilitation model. They have established relationships with other visiting professionals, but did not yet feel fully engaged in a multi-disciplinary approach. They felt confident that they could provide effective rehabilitation care, and valued 'continuity of care' and sharing goals with patients.**
- **Limes and Livingstone staff felt that the nursing input at Limes enhanced the care of these clients.**

Whilst the key ongoing challenges that face the project are:

- **To address the issue of ‘inappropriate admission’, so that staff feel able to work effectively.**
- **To develop further links with acute and primary care agencies, so that the service at LLICP is well understood,**
- **To identify resources so that sufficient professional expertise and rehabilitation support is available to both units within the project.**



## **2.3 Service User Experience of LLICP.**

One of the main aims of the 'Procare' research was to explore the experiences of service users at the LLICP, and to identify their experience of the care they received there. The above results have revealed staff perceptions of joint working, and this provides a context for discussing the users' comments. Very few individuals actually stay at both Livingstone and Limes, and because of this, the findings tend to reflect users' experience of one unit or the other, with the majority of the data coming from Limes service users.

Earlier in the report, we identified that clients thought of 'joint working' mainly in terms of how staff communicated with their families about their care. Here, the focus is on the clients' experience of the care process, including admission, assessment, care planning, rehabilitation and discharge. Ten service users took part in interviews, two of whom were from Livingstone hospital, and seven from the Limes. One further respondent had stayed at both centres. Two Limes 'step down' clients were included in the sample, and two interviews were conducted in service users homes after discharge from the Limes centre.

### **2.3.1 Initial contact and admission to LLICP**

Staff at the Limes described a clear process of assessment and admission to the Limes unit, and the care manager usually arranged admission for clients who were in the acute hospital (DVH). The admission process for Livingstone hospital was less clear. Several issues came up when admission and 'initial contact' were discussed with clients. Firstly, talking about admission and the events that had led to it was very emotional for respondents, and many cried during this part of the interview. Secondly, a number of respondents felt uncertain about *why* they had been admitted, sometimes volunteering that they were 'bed-blockers' and had to be moved out of hospital. Other themes included a fear that they were actually being placed in a residential home (especially amongst Limes clients), and the influential role of families in securing admission and persuading clients that this would benefit them.

#### **Uncertainty about reason for admission**

The following quotes are both from clients who were admitted to the Livingstone hospital from the DVH:

*'I was just told I was going over to the Livingstone, and they packed me up and sent me off'*

*'They said you're going to this hospital, and I said, what sort of hospital? They said, it's very nice. I said, oh well, I'll come'*

The small number of respondents involved means that this data can't be considered a true and representative account of admission to the Livingstone hospital. However, the uncertainty that these clients felt does indicate an apparent lack of client involvement in the discharge from DVH and admission to LLICP. To balance this, it is important to include the comment from another respondent, who had had elective surgery at DVH and knew before her admission to DVH that she would be transferred to LLICP:

*'What I understood I came for was to make room for operations up at the (acute hospital) and the second (reason) was that you would get rehabilitation treatment.'*

This client understood that she would receive rehabilitation care at Livingstone hospital. However, the first reason for admission she gave was to make room for other patients at DVH. This leads on to the issue of ‘bed-blocking’, which a number of respondents mentioned in their interviews.

### **‘Bed-blocking’ as a reason for admission to LLICP.**

Considering the pressure that staff described upon the unit to empty beds at the DVH, and media coverage of this problem, it was not surprising that service users were aware of the need to be transferred out of the acute hospital. Like the client quoted above, another service user saw this as the main reason for their admission to DVH:

*‘Well, they didn’t have any more room so I had to come over here. I had no idea what it was like’*

The following quote is from a Limes client:

Respondent: *‘I was taking up a bed, but I wasn’t a sick person ...I was there a fortnight, taking up a bed’*

Interviewer: *‘Were you given information about the Limes? Was it explained to you?’*

Respondent: *‘No. Actually, my son knew more. They said, Mum, if we can get you into the Limes, then you’ll be OK’*

These clients were clearly aware of the pressures on beds in acute hospitals, and this is certainly part of contemporary health care. What seems worrying is that they were uncertain of what the benefits of admission might be to them, and did not feel that they were involved in the decision about where they would go after leaving the DVH. Instead, a number of respondents felt that their families were involved in a decision-making capacity prior to their admission to LLICP, and this was the case whether they were admitted from DVH or from home.

### **The role of families in admissions to LLICP**

Discussions about ‘initial contact’ (with LLICP staff) and ‘admission’ to LLICP gave rise to a number of examples of how family members act as a conduit for information between clients and service providers, and these are illustrated in the following quotes:

*‘My daughter got in touch with the carer here, and she arranged for me to come here’*

The next quote came from another Limes client. This respondent was particularly insightful about her transfer from DVH to the Limes:

*‘My son talked me into going. He said ‘you won’t be able to manage on your own’. Well I realise now that I couldn’t have managed on my own at that particular time and I really loved it there.’*

Had she been left to make the decision herself, she would have refused to go to the Limes. This was mainly because she was unhappy at the DVH and just wanted to go home. However, her family persuaded her that a stay at the Limes would be beneficial, and after receiving a recuperative care program and then

being discharged home, she agreed in retrospect that this was the right decision. She continued by saying:

*'My son went and spoke to the doctors and said... because he was going back to Ireland, he couldn't stop any longer, and so he consented for me to go to the Limes'*

The role of this client's family was clearly central, and it is interesting that she believed her son was able to consent to her admission to Limes on her behalf. In English law, this is not the case, yet these comments show how difficult it can be to separate what the client wants from what the family wants. If, as in this example, a client decides that her family's choice was ultimately more beneficial to her than her own, then staff have an ethical dilemma on their hands – should they respect the choice of the client, even though this may have adverse consequences? Or should they follow the wishes of the family, if these are believed to be in the client's best clinical interests? Again, the law is clear that any adult must consent to treatment on his or her own behalf (unless they have mental incapacity, in which case staff should consult with families and identify the most beneficial treatment). However, as only one of the ten clients interviewed for this study identified that they (as opposed to their families or nursing/medical staff) had agreed to be admitted to undertake a rehabilitation programme, it appears likely that current practice falls short of engaging clients in the decision to admit them to LLICP.

### **Service users' fear of residential placement**

The respondents quoted above felt that their family members had an important role in negotiating their admission to LLICP. Another role that the families of clients had was passing information on to them, and allaying anxieties about the LLICP. One worry that a number of respondents from the Limes expressed was that they were being admitted to a residential home, even if they did not want this. This was understandable, because the Limes centre had been a residential home for a long time before it was re-opened as a recuperative care centre. The following quotes provide some examples of the roles of families in managing this anxiety:

*'When I was in hospital, they gave me a bit of paper to say I've got to go in a home' (respondent crying at this point)... 'I didn't have a clue what to expect. I was crying, and my family said, 'Mum, you're not going in an old people's home, you're going to get help. That took a lot off my mind'.*

*'I don't know how I came to be here to be quite honest... (to begin with) I thought, oh dear, a home? That's the first thing that goes through your mind...[but] after chats to my sister and my niece, I thought, oh no, this isn't going to be a home'*

Both of these respondents were very anxious when they learned they would be going to the Limes. Like the Livingstone clients mentioned earlier, they did not feel they had a choice or control over their destination. Both turned to their families for explanations and support, rather than to hospital or care management staff. It seems reasonable to suggest that this is because there is already a trusting and supportive relationship between clients and their families, although it would be naïve to assume that this is always the case, as the following extract illustrates:

*'How I come in here, I wouldn't know really, but...it was done between my wife and daughter... I thought they were trying to get rid of me, didn't I? (crying)'*

This service user felt that his family had admitted him to LLICP and that they would also be admitting him to residential care afterwards. Whether or not this is the case, what this client's situation illuminates is the emotional distress that can occur when older people feel powerless about what is happening to them.

### **Summary of service user perceptions of 'initial contact' and admission to LLICP**

In most of these cases, there was a good relationship between the client and their family, and the family was very much involved in the client's admission to the LLICP. But the message from respondents was that they were often unsure how they had come to be admitted to LLICP, or of the reasons for their admission. Where clients gave explanations about their admission, these were as often related to pressures on hospital beds rather than to the opportunity for rehabilitation care. In fact, only one client identified rehabilitation as a reason for admission to LLICP. Clients usually felt very anxious and upset when admission was discussed with them, sometimes because they remembered the illness events that led up to this, and also because of the fears that they were entering residential placement. Only one of the respondents felt involved in the decision to admit them to LLICP, most believing that family or hospital staff made this decision. These findings from clients provide quite a stark contrast to the staff view of admission process, and indicate that there is much potential to reduce anxiety and distress surrounding the admission process from the perspective of clients.

#### **2.3.2 Assessment and care planning**

During focus groups and interviews, staff explained that care plans (at the Limes) were written with clients, and that clients signed the care plan to show their agreement with it. When 'care plans' or 'care pathways' were discussed during interviews, there was a varied response. Some clients were fully aware of the care planning and documentation that took place, others less so. However, most of the clients felt that they had been given a good programme of rehabilitation, and that the carers were supportive, encouraging and made allowances for how they were feeling and how much energy they had. The emerging picture was one of effective, person-centred rehabilitation care.

All respondents were asked about how their care was planned during their stay, and the following quotes reveal that, although most clients knew that there was some kind of reporting system in place, the assessment, care planning and updating process was blurred from the clients' perspective. As the next quote shows, this may be partly due to anxiety during the time of transfer:

*'They did ask you a few questions...but I don't think I was with it really, I hadn't got over the shock (of admission) but they ask you some personal questions...and ask you what they'd like you to do'*

There was variation within the respondents, however. These clients remembered having the rehabilitation care explained at the beginning of their stay:

*'They gave you a paper about what they were going to do and what it was all about and everything'*

*'I know (the OT) was saying what we'd achieve while we were there...able to walk better for a start and do lots of things, you know'*

Another client seemed to feel quite distanced from the recuperative care plan, although he was undergoing a rehabilitation programme:

Interviewer: 'Did the staff do any assessments, or ask you any questions?'

Respondent: *'Well one or two of them did and one or two of them didn't. They write a report, it's over there'*

Interviewer: 'So, do you have a care plan, saying what you are going to do while you are in here?'

Respondent: *'er, no, I'm just here to recuperate'*

This Livingstone hospital client commented that assessments were made covertly:

Interviewer: 'When you got here, were you aware of any assessments being done, by the nurses or the physios?'

Respondent: *'No. But you see, what they do...when you are getting washed and dressed etc...they keep an eye on you. You're not aware of it at the time – they are crafty!'*

Whilst the processes of assessment and care planning were less than clear to some of the respondents, there was general agreement that care was documented and that staff communicated in the daily handover:

*'Staff know how I'm doing, it all goes down on my report three times a day'*

*'I think there must be something [written care plan] because they have what they call a changeover...[where] you are commented on by one set of carers [who] pass it on to another set of carers so they all know.....[what sort of things] are happening to you'*

The daily documentation of care and 'handover' were familiar to the respondents at the Limes. Assessment and care planning were less well recognised, even though staff felt that these processes were intended to engage clients in the rehabilitation programme. This finding relates mainly to Limes respondents, and could have been affected by the length of time between admission to Limes and interview for this study, and by the high levels of anxiety that may be present during transfer to Limes. There was less data from Livingstone clients, and one patient's view of a covert assessment process must be considered within this context.

### **2.3.3 Rehabilitation Programmes**

From the service provider perspective, the main reason for a stay at LLICP was rehabilitation and becoming more independent, with a view to being discharged home. Nevertheless, there was again some variation in clients' perceptions of the rehabilitation care they had received.

### **Positive experiences of rehabilitation care**

The following quote provides an example of effective joint working between the DVH, which established a programme of rehabilitation exercises for this patient, and the Livingstone hospital, which continued the same exercise regime:

*'...the physio gave me walking exercises, and I walked to and fro today and did the stairs. She gave me exercises to do, which I had been doing because they were in the book I had before the operation. They started that off at the Darent Valley'*

The patient's involvement in the plan of care before her elective surgery seems to be an important aspect of this smooth transition – her awareness of the exercises that would be needed prepared her both for the rehabilitation program, and for the likelihood of short term transfer to the LLICP. Similarly, another client commented that she felt the rehabilitation service at LLICP had met her needs. This client had stayed at Livingstone and Limes:

Interviewer: 'Do you think you got the care you needed here at the Limes?'

Respondent: *'Yes...I'm a lot better now than I was at the hospital. I'm more confident, and I can get about more now...I do feel better. I mean, it's a lot to come to terms with, having a stroke. I've had some time, and I'm physically better now.'*

In making this comment, this respondent referred to several elements of recovery from her stroke: her confidence had increased, she was able to use her affected limb more, she 'felt better', had time to come to terms with her stroke and had made a physical recovery. Similar factors were recently identified in a qualitative study of life after stroke, which found that having time to adapt to changes was important to stroke survivors<sup>11</sup>. The opportunity for an extended period of rehabilitation at the Livingstone and then the Limes appears to have been effective for this respondent, but the potential need for an extended rehabilitation period may not always be met at the Limes centre, which normally has a six-week limit to length of stay.

### **Physiotherapy resources**

When service users felt that their rehabilitation needs had not been fully met, they usually mentioned the lack of physiotherapy resource at Limes and Livingstone. For example, this Livingstone patient required rehabilitation after a hip replacement, and noted that staff shortages limited the amount of physiotherapy she received:

Interviewer: 'How often do you have physiotherapy?'

Respondent: *'No regular time – I mean, they're so busy, the physios – too many patients for so few physiotherapists – same with nurses – they are short of nurses, short of everything'*

Interviewer: 'When the physios are not around, do the nurses help you with your physiotherapy activities?'

Respondent: *'No, dear. No. The physios are there to show us how to walk and how to get upstairs.'*

Similarly, this 'recuperative care' client felt he had not had enough physiotherapy at the Limes, although this was his main rehabilitation need:

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<sup>11</sup> Alaszewski, H (2004) Life After Stroke – Reconstructing Everyday Life, CHSS, University of Kent (This paper is available as a pdf download from the CHSS website)

*'I never saw the physiotherapist very much...It wasn't the Limes physiotherapist, it was the health authority physiotherapist, but she was the only one available, I think'*

Another respondent made the following comment:

*'I don't know when they are going to make any assessments, you know...as far as I know, it is just between here and either the hospital or the physiotherapy department, I don't know, I haven't got a clue'*

In this case, the lack of resources had translated into uncertainty for the service user, who was not only unsure whether he would receive physiotherapy, but also unclear about who should arrange this and what was being done. This means that some service users experience effective joint working that meets their rehabilitation needs at LLICP, whilst others report a lack of physiotherapy input, which has a negative impact on their experience of rehabilitation. Whilst there is not sufficient data to draw any firm conclusions, the implication of these responses is that those entering the service via an elective route are engaged in their rehabilitation program before admission, and have a correspondingly realistic understanding of their needs and of the service being offered.

#### **2.3.4 Discharge planning and management**

Like admission, discharge from LLICP could be a time of anticipation and anxiety for clients. For some, the way home was clear and welcome, whilst others appeared unsure where they would be going next, or how they could cope after discharge. There were differences to the discharge process between Limes and Livingstone, and so the findings from each unit are discussed separately.

At the Limes, a client's stay is limited to six weeks. A stay of this period is fully funded on the client's behalf, but a longer stay could incur charges that the client may have to meet. Consequently, discharge planning was structured at the Limes, and began from about two weeks into each client's stay. It was not clear from the data whether the Livingstone works to the same timeframe, although staff gave the impression that the higher than intended dependency of their patients meant that short rehabilitation stays were not appropriate in many cases. For those patients who were likely to return home, named nurses initiated discharge planning at multi-disciplinary meetings when the patient appeared to be improving, and nearing the end of their rehabilitation programme.

All respondents were asked about their discharge from the service, and asked to comment on how this was being planned, or had been planned in the case of those who were already discharged.

#### **Livingstone clients**

The following comments are drawn from interviews with Livingstone hospital patients. Once again, it is important to recognise that the amount of data from the Livingstone hospital was limited – but the few respondents who did take part spoke as passive recipients of the discharge process. The definition of discharge given by the first respondent is particularly interesting in this respect:

*'Discharge is...whenever they say you're ready to go... (The physiotherapist) has sort of said, that it might be the weekend, but I*

*haven't said anything because I think it's also got to come from the sister...'*

This respondent felt that staff would decide when discharge was appropriate and inform her when they were ready. She was waiting for the ward sister to confirm what she had heard from the physiotherapist. In these examples though, being a recipient of care has not caused obvious anxiety. Instead, the service users felt they could trust staff to make appropriate arrangements for their return home:

*'When I go home, I shall hopefully have a carer to help me in the mornings...the hospital here have arranged that, it's what they call a 'care package'. They set it up for when you leave'.*

This small amount of data from Livingstone clients seemed quite revealing, and described a situation in keeping with the staff view, which was that nursing staff would initiate the discharge process when the client appeared to be approaching readiness. Service users did not feel involved, but did feel confident that staff would make arrangements for them. However, both of the respondents were due to return home after a straightforward rehabilitation period, so this is a limited insight from which the perspective of patients with more complex needs is absent.

### **Limes clients (Step-down)**

Earlier in this report (section 2.1.5), we identified that 'step down' clients occupied a grey area between residential and rehabilitation care, and that staff were uncertain about the goals of care for these clients. Not surprisingly, the service users we spoke to in 'step down' beds were also uncertain about their discharge from LLICP. They were different from the Livingstone patients in that they felt anxious about their discharges. For example, one client had talked to other residents about discharge, but not to staff. He said he had '*no idea*' what would happen when he is discharged. Another client felt similarly unsure, and this led to feelings of powerlessness and exclusion:

Respondent: *'I don't know...all I've heard is that they let you stop here for 6 weeks then they turf you out'.*

Interviewer: 'Has the care manager talked to you about going home?'

Respondent: *'No-one's spoken to me at all...it's obvious I want to go home, but I don't want to go home if I'm not ready, I want them to make sure that I'm ready to go....'*

For this client group, discharge was a worrying prospect and they felt excluded from discharge planning discussions, and also concerned that they might be sent home before they were ready.

### **Limes recuperative care clients**

These clients are usually admitted for a maximum of six weeks, and a return to independent living is the goal of recuperative care provision. As their discharges are planned from early in their stay, it was not surprising that most respondents seemed aware of what would happen, and when they would return home. However, despite this, there was variability within the responses from this group, and whilst some were confident that their discharge would be organised for them, a number expressed anxieties about their discharge.



### **Confidence about discharge**

One respondent said that his daughter would arrange his discharge when the time was right and did not express concern about this:

Interviewer: 'So, do you know when you are going to go home?'

Respondent: 'No, I don't. My daughter arranges everything'

Like those clients who felt their families arranged admission on their behalf, this respondent was confident that everything was safe in his daughter's hands, and that he need not get involved. Once again, the role of immediate family (rather than health or social care staff) is central to reducing anxiety for the client, and the position of clients without close family is likely to be more tenuous.

### **Paying for service after 6 week period**

One client was worried that she may have to pay for the service if they weren't ready for discharge when her six-week period was finished:

*'They take you on a home visit...I haven't had that yet...my six weeks is getting near now. But whether they will assess me and I can go home, I don't know. If they assess me and I need extra time, well that's when I'll have to start to pay.'*

Another client had a housing problem and was waiting for a flat. She worried that she would have to wait for a long time, and would then have to pay for staying at Limes. Staff at the Limes centre had discussed this with her and told her she would have to pay after 6 weeks. Her family had looked into this, and found out that the council would have to fund her stay, once again illustrating the important role of families in responding to client anxieties.

The problem of funding after six weeks can be described as an inequity within the system, as Livingstone hospital patients do not have to worry about paying for their care after six weeks has elapsed, but Limes clients can be charged if this happens. The time limit is an anomaly of intermediate care funding that only affects people in social services centres, and ways of managing this problem varies between recuperative care providers.

### **Anxieties about coping at home after discharge**

A number of the clients interviewed for this study were worried about whether or not they would cope at home, usually because they would be alone for the first time after sometimes very long periods in hospital and rehabilitation care. For example, this service user expressed some anxiety about returning home:

*'Well they said I was ready to go home then and I think they also want the beds quite desperately... I wouldn't have minded stopping a bit longer because when you come home and you've got to wait on yourself it's a bit hard'*

It is telling that others had decided that she was ready, rather than allowing her to decide for herself that the time had come to return home, although this is likely to be inevitable within a time-limited system.

Confidence about managing alone at home was another issue raised by clients. One client had been admitted to the Limes from her home, when her mobility

problems led to a number of falls. She received rehabilitation to help her regain her strength and stamina and mobilise safely. However, she had a continuing medical problem, which she did not feel had been addressed during her stay. The net affect was that she did not feel confident that she would cope when she went home:

*'It's difficult to say whether I feel confident about it or not...I think on the whole I'm very dubious about going home, but the knee position isn't as well as I thought it was going to be...and you can only get the answer about that from a doctor, or a surgeon'.*

Two clients were interviewed at home after discharge from the service. Both expressed that discharge was difficult to cope with, despite the discharge planning process and home visits. The following quote suggests that this was due to the difference between being in company and having 24-hour support and being at home, alone:

*'When I came back home, I thought I would be alright and I felt confident in myself. But as I was leaving there, it dawned on me that I would be on my own. It gradually dawned on me, and on the day they brought me back and left me here on my own, I just went to pieces....I just couldn't look after myself...it wasn't the physical side, but the isolation....'*

This client felt that discharge home was too abrupt, and suggested alternatives such as a staged discharge (returning home for a weekend then back to the Limes centre for a few days) or being able to attend Limes for one day a week, to maintain social support and also to continue rehabilitation exercises with staff supervision.

### **Comment on service user perceptions of discharge from LLICP**

The service user data seemed to reflect the different approaches to discharge in the Livingstone and Limes unit. Livingstone clients believed the hospital would sort out their discharge when they were ready to leave, and felt confident about the arrangements being made on their behalf. The Limes 'step down' clients were the most uncertain about their future. Limes recuperative care clients were aware of the 6-week limit to stays, and also knew to expect a home visit prior to discharge.

Discussing discharge caused anxieties to surface, and clients sometimes expressed uncertainty about whether they would cope at home. This was most in evidence where clients had spent a long time away from home (sometimes as long as nine months) or when medical problems remained after the rehabilitation programme was complete. Interviews with two clients after discharge from the Limes suggested that there was difficulty coping at home without the support and companionship they had enjoyed at the Limes.

### **2.3.5 Person-centred care at LLICP**

The previous section identified some findings from clients' experience of admission, assessment, rehabilitation and discharge, and this data was gathered to establish the clients' views of experiencing the 'joint working' process at LLICP. However, another purpose of the research was to consider what the 'outcomes' of integrated care are for clients, and whether or not the service can be considered 'person-centred'.

Measuring outcomes is fraught with difficulty from a research perspective, partly because of the high costs associated with long term follow up studies, and also

because it is so difficult to establish the effects of one service upon clients who have complex needs and widely different levels of support and resources. For these reasons, the 'outcomes' discussed here relate to client *experiences* of staying at the LLICP rather than long term changes that have occurred as a result of their rehabilitation period. Similarly, 'person-centredness' is a difficult concept to research directly, because this concept necessarily has subjective interpretation, and the question is more about whether the LLICP has been able to meet the individual needs of its clients than identifying a set of practices or rules that confirm the service to be 'person-centred' (or not).

The following comments have been included here because they capture the effect that LLICP had on some interview respondents, and these relate to quality of life issues, such as how it feels to be more independent, or to have an increased sense of dignity. It would be valid to argue that similar comments may arise from any service that encourages independence, and are not necessarily a direct result of 'joint working'. They are nevertheless included, because the message from clients was that LLICP staff were skilled in rehabilitation, and were able *to modify the levels of support they gave* according to the changing needs of individuals. This suggests that the LLICP approach leads to 'person-centred' care, and that this in turn creates a relationship based on trust, allowing the client to feel safe and regain confidence.

#### **'Modified care'**

One aspect of 'person-centred' care was the ability to adapt levels of support firstly to the client's ability, and secondly to allow for how the client is feeling day-to-day. Limes clients particularly felt confident that they were encouraged to do things independently, but could ask for support if they were tired or feeling 'low':

*'Sometimes I like to be taken into the dining room, then once I've had my meal, I say, can I walk back? And that's a long distance'.*

This flexibility seemed to enhance the trust between carers and clients, because clients felt able to stretch themselves and achieve new things, without fearing that they would get less support or help while they gradually increased their stamina.

#### **Encouragement**

Several service users gave quite emotional accounts of the help and encouragement they received:

*'When I first came here, they made me most welcome...they've been most helpful, they've encouraged me ...if I failed (to do something)...I was encouraged not to think I was a failure, because I hadn't walked for years, not properly'*

*'I can't find words to explain. It just seems out of this world that there's a place like this that exists to help me walk again'.*

Some clients related the achievements they made, and how this made them feel. In the following example, the client described a major improvement in her mobility:

*'The OT said, I'll take the wheelchair as far as the dining room door, then get out of the chair...and I got out the chair..and I walked! And that was the first time for years'.*

Whilst this client described how she felt when she was able to manage to get to the toilet by herself:

*'When I came over, I was a double-hander, but I surprised them all one night, I got myself back into bed! I managed to get up from the commode and get myself back into bed, and I cannot tell you the joy that that gave me.'*

These service users are clearly pleased with the progress they have made, and between the lines there is a feeling that they had almost given up hoping to achieve independence again. The next and final quote draws together the different aspects of care that one client found helpful in his recovery:

*'This is not a medical place, but they give you something more than the medical...well, you get all their love, and honestly, they look after you and the food is...well it's beyond belief really. I couldn't explain how lovely it is, or how surprising it is.'*

This client was describing an experience of holistic care, where medical, social and emotional needs are met, so that an environment that supports recovery and rehabilitation is achieved. These examples are encouraging, because they provide some feedback about a service that is designed to support rehabilitation and a return to independence directly from clients who have benefited from staying at LLICP.

### **2.3.6 Summary of service user's experience of care at LLICP**

This section has used data gathered from service users to explore their experience of the LLICP. A number of themes have emerged during the analysis of this data. Admission and discharge seem to be times when levels of anxiety are at their highest, and this clouds the client's experience of entering the service. Most of the respondents were unclear how or why they had come to be admitted to LLICP, and several remained anxious about their ability to cope at home after discharge. From the perspective of clients, admission and discharge are out of their hands.

The role of immediate family emerged as strong and influential. Clients felt their families were involved in negotiating their admission to LLICP, answering their concerns about the type of help they would receive, and liaising with staff about their discharge arrangements. Clients with no family support, or poor relationships with their family, could feel powerless and vulnerable.

Clients spoke warmly about their formal carers and said that they had benefited from the rehabilitation care they received. However, there was wide variability between respondents regarding how involved they felt in their assessments, care planning and discharge management. The most positive feedback described a service that provided high levels of care, individualised rehabilitation programmes and consistent emotional and social support. At the other end of the scale, some clients felt that they lacked appropriate therapy input (physiotherapy), that medical and medication issues were not always addressed (at the Limes) or that they were somehow excluded from the decision-making process. Speaking very broadly, the problems identified by clients matched the perceptions of staff, and can be summarised as admission/discharge issues and resource problems. A full range of comments from service users who took part in interviews is included in Appendix A, because these may be helpful to staff

and managers, and because service users wanted their participation in the study to help others who stay at LLICP in the future.

### **3. Conclusions and recommendations**

This report has brought together findings from research with staff and service users at LLICP. The aim of the research was to identify staff and service user perceptions of integrated health and social care (or ‘joint working’), and to explore the experience of either working within, or being cared for by, an organisation that promotes and facilitates joint working.

One of the first issues to emerge from the data analysis was that there are a number different ways in which staff at LLICP describe ‘joint working’. These were identified as:

- **An ‘integrated model’, based in a whole system approach, that allows free movement of staff, service users and resources within the LLICP. Managers and service commissioners used this model for strategic development of the Limes Livingstone Integrated Care Project.**
- **A ‘Wheel and Spoke’ model of joint working, described by Limes recuperative care centre staff. Within this model, fluid joint working had been established amongst the Limes staff, and this was described here as ‘intra-agency joint working’. Features of this model included regular formal and informal communication, and confidence that the Limes organisation was able to deliver effective rehabilitation, supported by a responsive management team.**
- **The core group of staff at Limes then liaised with outside groups. External liaison of this kind was termed ‘inter-agency’ joint working. It became clear that ‘inter-agency’ joint working was most effective when staff met face-to-face, and progressively less effective when dealing with people and organisations separated by geography, organisational culture, unfamiliar rules and procedures and data protection systems. This confirmed the view found within existing literature and similar research studies, which is that such factors present potential barriers to effective inter-agency joint working. The ‘Procure’ research findings suggest that these barriers have a cumulative effect, so that joint working becomes increasingly difficult as the number of organisational barriers between different agencies increases.**
- **A different model of care was identified at the Livingstone hospital. Livingstone hospital staff sought to distinguish between ‘medical’ and ‘social’ rehabilitation and valued medical care above social care interventions. Despite this, there was evidence of negotiated solutions to problems of inter-agency working with the Limes centre, and examples where service users had experienced seamless rehabilitation care when transferred from DVH to Livingstone hospital.**

Part of what these different models represent is that the divisions between Limes and Livingstone were more in evidence than the strategies of joint working that had been

adopted by the project. It was not possible to relate findings from the staff of LLICP as a whole, because the project was made up from two separate organisations with quite different views and cultures. The Limes recuperative care centre is a social services organisation, and applies this agency's rules, protocols and management approach to its everyday running. Livingstone hospital is very much a health service organisation and works with the priorities of medical and nursing care very much at the forefront. Both organisations worked separately, as might be expected. They were also housed in different buildings, and a locked fence divides the two, making informal visits between the two sites difficult.

This has a number of implications for joint working at LLICP. What this study identified is that *intra-agency* joint working is established to some extent at both Limes and Livingstone, but *inter-agency* joint working is subject to the usual barriers and restraints that exist between organisations. Table 2 below lists some differences between these two kinds of joint working.

**Table 2. Differences between 'intra-agency' and 'inter-agency' joint working.**

| <b>Intra-agency joint working</b>  | <b>Inter-agency joint working</b>   |
|--|---|
| 1. Staff share premises and work for the same clients  | 1. Staff have different premises, but the same clients or at least an overlap between their client groups   |
| 2. Staff recognise each other and are on first name terms.   | 2. Staff may not recognise each other, or know each other's names.  |
| 3. Staff are more likely to talk to each other face-to-face than to phone or email each other.   | 3. Staff may rely on phones and email. They may have to ask for each other by role if names are unknown, or leave messages with an intermediary. Staff may be expected to communicate formally through 'referral forms' or letters. |
| 4. Staff meet regularly, both formally and informally.   | 4. Staff have to arrange meetings, which may be delayed due to different work routines, or sick leave/annual leave.   |
| 5. Staff are familiar with the rules, procedures and routines of their workplace. They either have or develop a shared professional culture. | 5. Staff must learn the rules, procedures and routines of each other's workplaces. They learn about each other's professional cultures and may or may not accommodate any differences.  |
| 6. Inter-personal relationships either blur or reduce the impact of inter-professional demarcations  | 6. Relationships are demarcated by professional groupings and hierarchies.  |

### **Limes centre**

The Limes centre supported intra-agency joint working by holding daily handover meetings, and developing management techniques that encouraged problem solving and change. The care manager, occupational therapists, generic rehabilitation workers, team leaders, carers and managers therefore worked closely and effectively together, and this provides a positive model of joint working. However, the challenges to intra-agency joint working were somewhat limited in that all the staff were part of social services. Whilst Limes staff encouraged and facilitated good inter-agency working with the visiting specialist teams, and with the Livingstone nurses, these groups were treated with more formality, which marked them as *external* groups.

Joint working with the DVH and with local GP's was then more distanced, because the Limes centre is kept 'out of the loop' of medical information, being a social services organisation. The Limes centre held limited medical records for their patients, and had poor information transfer regarding their medical care from hospitals and GPs. This meant that visiting health professionals such as the Livingstone nurses, or doctors who gave medical cover, had to care for individuals with complex medical problems without up-to-date information. Because the problem of data transfer between health and social care agencies had not been addressed, health professionals blamed the Limes staff for their 'lack of knowledge', and reasoned that they did not have sufficient skills to care for their clients safely. This represented a barrier to joint working at the LLICP site.

### **Livingstone hospital**

The staff at Livingstone had developed a biomedical model of rehabilitation, and nurses and doctors worked together well. The physiotherapy support for the Livingstone team came from the community team, and both staff and patients reported a lack of physiotherapy input. There was no OT support at the Livingstone. When the LLICP was developed, it was envisaged that the Limes OT would visit the Livingstone, in a way similar to the Livingstone nurses' role at the Limes, but this had not happened. Staff at the Livingstone felt they were able to provide effective rehabilitation, but were frustrated partly by the lack of PAM input, and also by the relatively high dependency of their patient group. So, although there was some liaison with multi-disciplinary professionals, intra-agency joint working at the Livingstone involved nurses and doctors, with physiotherapists and specialist teams occupying the role of external visiting agencies. The care manager who worked for both Limes and Livingstone clients was also seen as an external visitor, probably because she was a social care professional. The role of care management in selecting clients for LLICP was a focus of resentment amongst Livingstone staff, and this represented a barrier to effective interagency working at LLICP.

Livingstone staff had nevertheless made some inroads into developing closer inter-agency working with the Limes centre. Livingstone nurses provided nursing care for Limes clients, thereby taking over a role that would usually be fulfilled by local district nurses. This had initially caused problems, mainly because of the amount of time that Livingstone nurses had to spend at Limes. However, a number of difficulties had been resolved effectively by liaison and negotiation. Nevertheless, the nursing role was limited to task-based care, and the nursing staff did not attend meetings or have any input into the ongoing care of Limes clients.

### **Joint working – barriers and solutions at LLICP**

Joint working at LLICP was therefore affected by a number of barriers. It appeared that the different organisational cultures of Limes and Livingstone were incorporated into their operating models, and this limited the natural convergence of staff and management at the project. The Limes model could be summarised as 'effective rehabilitation within a social care framework' and the Livingstone model as 'effective medical rehabilitation for those patients who are fit for this kind of care'. The integrated model that represented the LLICP strategy was absent from staff accounts of their working practice. Besides the organisational differences, there were continued difficulties of joint funding, shared management and disparities of contractual terms and conditions for staff at each unit that had yet to be resolved.

On the other hand, there was also evidence of solutions to inter-agency barriers within the LLICP. The role of nurses at the Limes mentioned above is one example. The development of a flexible and responsive management style at the Limes centre meant that visiting staff became part of the process of care provision at this centre. The 'generic worker' role was also well developed, and this has contributed to the development of in-house training across disciplines at LLICP. In many ways, LLICP can be considered a relatively young organisation, whose staff have a willingness to develop joint working together. We identified the following models of good practice from the research data:

- **The model of care for DVH elective surgery patients appeared to be effective. Respondents said that they were told before their surgical admissions what rehabilitation program they would require, and that admission to LLICP was likely following surgery. This had the effect of engaging them in their rehabilitation, and helping them to be realistic about their recovery. It would seem appropriate to offer the same support to other patients who might be transferred to LLICP, even if their admission is not elective.**
- **The provision of nursing services to Limes clients by Livingstone staff was an innovation that worked successfully within the project, despite initial problems. Staff and managers at LLICP had worked hard to overcome difficulties and achieve better patient care. The development of a nursing role that incorporated community nursing by ward nurses appeared effective and should be highlighted as a successful joint working innovation that could be further developed and adopted in other areas.**
- **Staff at the Limes unit had developed a structured model of joint working. The key features were daily handover meetings that were open to external visiting professionals, regular formal and informal contact between staff and a discharge planning strategy that identified plans for transfer to the community from about two weeks into the clients stay.**
- **Service users said that they felt safe and confident because staff offered personalised care that could be tailored to them as their needs changed, whether they were able to manage more independently or needed more help because they felt low. This flexibility was a key feature of successful rehabilitation at the Limes centre.**
- **Generic rehabilitation workers expressed high levels of job satisfaction, due to the variety within their role and the rewards of seeing clients get better and go home. This role represents a good model for interagency support working, although the differences in pay and conditions were a continued barrier to true integration of health and social care staff.**

There were a number of areas within the service strategy where staff expressed a desire for change, and it is likely that some of the difficulties within the unit will already have been addressed. The following recommendations are derived from the



analysis of data from both staff and service users, and these represent areas for future consideration:

- **Staff and managers at LLICP may need to consider together the goals of care at Limes and Livingstone, and express consensus about the priorities of care for each unit. It may be useful to consider re-engineering some aspects of the service to address the needs of more dependent clients from the acute sector.**
- **Limes centre should clarify the purpose of the step-down beds, and make transparent the availability of rehabilitation support for this group of clients. Any differences between the ‘recuperative care’ facility and ‘step-down’ beds should be clearly explained to clients who are considering admission to the unit.**
- **The process of admitting clients with ongoing medical or nursing needs to the Limes should be reviewed. Assessment by Livingstone nursing staff should ideally form part of the admission process.**

### **Client choice and rehabilitation at LLICP**

The research into service user perceptions of ‘joint working’ identified that clients place their families very firmly within the framework of care co-ordination and communication. For service users, family members are effectively key workers, negotiating and organising care on their behalf. The following observation and recommendation is based on the data from both staff service user respondents:

- **Service users told us that it is very difficult for them to differentiate between what they want, and what their families want for them. In many cases, they would prefer to be guided by their families. However, staff believed that ‘client choice’ and ‘motivation towards rehabilitation’ was an important aspect of successful rehabilitation and appropriate use of beds. Therefore, when transfer to LLICP is being suggested, the views of the older person should ideally be sought before this is discussed in a forum that includes their families. After a decision to go to Limes or Livingstone is made, staff at the hospital should re-iterate information about the type of care they will receive and the time-limited nature of their stay, to allay any anxieties that may occur regarding care home admission. (This is particularly relevant to Limes clients, due to the continuing perception that Limes is a residential home).**

### **Admission to LLICP**

There were parts of the ‘joint working’ process that emerged as being important for all groups. The clearest example of this was admission to LLICP. For staff at Limes and Livingstone, the issue of ‘inappropriate admission’ was a frustrating problem that had knock-on effects upon their service provision. In their view, individuals who would not benefit from rehabilitation were wrongly admitted to LLICP, usually from DVH.

It was clear from interviews with service users that some respondents felt that they were ‘bed-blockers’ and had taken up space unnecessarily at the DVH. This contributed to service users accepting that they were being transferred to LLICP without demur, even when they were very uncertain what the service might offer. The

clearest finding from service users was that most of the clients interviewed either did not know, or could not recall, how they had come to be at LLICP. None of the clients said that they had a choice about admission, and several remembered 'being told' they would be transferred to the LLICP. Clients were often anxious about the service, and they discussed their worries with their families rather than with staff. The implication of this finding is that pressure upon acute beds affects service users as well as staff. The need to move people out of acute beds creates a position where client choice is limited, so that admission to a unit such as LLICP is presented as a *fait accompli*, rather than as a positive step towards independence. When service users see themselves as onerous, they are inhibited from asking questions or weighing up choices. This affected how they perceived the rehabilitation programme, and whether or not they felt confident that they would be able to go home afterwards. The following recommendations are made on the basis of the findings from this research.

- **It would seem beneficial if DVH and LLICP staff could reconsider the admission process from client's perspective. Some suggestions include providing clients with written information that includes comments and case stories from people who have stayed at LLICP before. It is likely that staff already explain the rationale for admission to clients (at either unit), but it would be helpful to reiterate this information after a day or so, to allow for the difficulty service users have in retaining information when they are anxious or worried about 'the next stage'.**
- **Service users who have no immediate family (or for whom there is tension within the family) felt particularly vulnerable. It may be helpful to identify a named advocate for these clients (for example, through the hospital 'PALS' service, or an existing formal carer who is close to the client) to offer support to isolated clients, especially when transfer between services is being discussed.**

### **Rehabilitation resources at LLICP**

A second theme that united staff and service users was the availability of the right kind of rehabilitation support. Staff at Limes felt they were able to provide good rehabilitation, and overall, clients were very positive about the help, support and encouragement they received. The exceptions to this occurred where clients felt they had a physiotherapy need that had not been addressed fully, or a medical/medication issue. The view of service users was that health problems were not within the remit of the Limes staff, and whilst this may be true in terms of the nature of the service provided, there remained evidence of missed opportunities to address medical problems that were central to the client's view of their situation. Limes clients did report good nursing care, and this appeared to be a successful aspect of inter-agency working at the LLICP.

Livingstone hospital staff also felt they were able to provide effective rehabilitation care, although they believed their clients would benefit from OT input and increased availability of physiotherapy. There was also some concern that the mix of clients did not provide a good rehabilitation environment – specifically, they questioned whether rehabilitation clients could stay positive when other patients were receiving end of life care. Livingstone service users reported that the level of care they received was high, but commented on staff shortages and a lack of physiotherapy input. Both staff and service users at Livingstone also found the hospital facilities to be cramped. The

following recommendations arise from comments that clients and staff made about multi-disciplinary input at LLICP:

- **When clients are discharged from DVH to LLICP, it would be useful if their existing physiotherapy or OT care plans were documented and given to the LLICP. Expected outcomes should be indicated, and it would be helpful to clients and staff if the time frame for existing goals were made clear. This would allow rehabilitation programmes at LLICP to follow seamlessly for existing care, and help clients to have a realistic idea of what the outcomes of rehabilitation could be.**
- **To strengthen links between DVH and LLICP, any follow up appointments, or long-term follow up arrangements from the hospital should be passed on to service users and LLICP staff. A contact number/email address for the consultant, or hospital physiotherapy/OT should be available to rehabilitation staff at LLICP so that any problems can be addressed and resolved quickly. Information of this kind should follow the patient during their stay at the LLICP.**
- **Similarly, medical patients should have improved discharge documentation that includes current medical and nursing regimes, particularly if they are going to the Limes centre.**
- **To facilitate smooth transition of patient care at LLICP, the project could adopt single sets of notes/assessments/care plans for clients and shared protocols of updating so that notes follow clients. Ideally, consent from the clients should be sought so that this data accompanies clients on their discharge back to the primary care sector.**

### **Discharge from LLICP**

Although staff at LLICP were generally happy with their discharge processes, service users expressed some difficulties at the time of discharge. The following recommendations are derived from the comments of service users.

- **Service users at Limes told us that they found discharge home from 24 hour care too abrupt. Some clients would welcome the opportunity for a more staged approach – for example, going home for a weekend (or a night) and then returning to Limes for a few more days. Respondents also mentioned that the loss of social contact was difficult to cope with, and said that they would like to return to Limes on a regular basis (similar to a daycentre service) so that they could spend time with other people, and maintain their rehabilitation achievements.**
- **To engage service users more fully in discharge planning arrangements, it would be helpful if the Livingstone hospital adopted a structured approach (perhaps similar to the Limes model) for rehabilitation clients. Involvement of the multidisciplinary team in discharge planning could be formalised, and strategies for communication about discharge within the team developed. Patients**

**at the Livingstone could be much more involved about the discharge process and kept informed about this all through their stay.**

- **The current situation where Limes clients may have to pay for care after six weeks (whilst Livingstone patients do not) does not seem fair. LLICP may be able to develop clearer and more flexible guidelines within the intermediate care framework, so that all service users have the same rehabilitation opportunities. This is particularly relevant if a client is transferred to the Limes unit several weeks before they are able to undertake a rehabilitation programme.**

These conclusions and recommendations are made in response to the findings from the Procure research with staff and service users at LLICP. Most of the issues that confront the LLICP relate to barriers that are traditionally associated with inter-agency working, such as cultural or communication problems between organisations, and geographical separation, and these findings are reflected in the wider research literature. Although the LLICP has taken strides towards configuring a service that meets the health and social care needs of older people requiring rehabilitation, the boundaries between the main agencies involved remain. Despite this, there is also evidence of effective inter-agency working at the LLICP service and successful innovations in nurse-led care and the generic support worker role. There was little evidence of inter-professional conflict, except in relation to the admissions strategy of the LLICP service. This finding represents a deviation from the existing literature in this area, which suggests that problems between professions are a major barrier to collaboration in health and social care (E.g. Hudson 2002<sup>12</sup>). This may be because data about professional conflict is not easily volunteered, or because there are fewer opportunities for inter-professional working at LLICP than might be anticipated, due to the basic separation of the Livingstone hospital and Limes recuperative care centre.

The feedback from services users was largely positive, with many particularly pleased by their progress in rehabilitation. All service user respondents praised the standard of care from staff at LLICP. Some service user comments did not naturally 'fit' into this report, and these (both positive and critical) are included in Appendix A. The limitations of this report are related to the relatively small size of the study, the imbalance of the sample (with most service user data coming from Limes clients) and the fact that it remains very specific to the Limes Livingstone project. To balance this, similar research findings from other collaborative ventures have been highlighted. The challenge that remains for researchers and service providers is to evaluate the longer term effectiveness of sub-acute or intermediate rehabilitation services, and find ways of identifying changes in outcomes and quality of care that occur where these services are provided.

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<sup>12</sup> Hudson, B. (2002) Interprofessionality in Health and Social Care: The Achilles' Heel of Partnership? In *Journal of Interprofessional Care* Volume 16, no 1(pp8-17).

## Appendix A - Service user comments

### 1. Livingstone hospital

#### Positive comments

*'I tell everybody, if they want to get well after being ill, just ask to go to the Livingstone.'*

*'I've had all the good care that anybody could possibly give me..'*

#### Best thing about staying at the Livingstone:

*'Well, it takes you away from the atmosphere of a hospital...with all the medical, everything like that, and seeing people go away for their operations and coming back, ...I suppose you would say that ....it's a home from home.'*

*'I know I will be well treated here, the staff are all absolutely fantastic'*

*'Actually, this is a wonderful place, the Livingstone. It's a very, very good place, and I wouldn't want to go anywhere else after an operation'*

*'The best thing about Livingstone is the treatment you get. They don't treat you like children, they treat you like adults'*

#### Negative or critical comments

One respondent mentioned that she prefers not to sit in lounge because she finds it crowded with furniture and tables and is afraid of falling in there.

*'They're so busy, the physios – too many patients for so few physiotherapists – same with nurses – they are short of nurses, short of everything'*

*'It's no good me making complaints, because most of the complaints would be because of lack of staff...I can't do anything about it.'*

#### Comparing Livingstone and Limes

Interviewer: 'Can I ask you, as you are one of the few people who has stayed in both Limes and Livingstone, whether you have any comments about moving between these two places?'

Respondent: *'Livingstone's a hospital...do you know what I mean? And...they're a bit more strict....'*

Interviewer: 'Can you give me an example?'

Respondent: *'Well, in the morning, you all have to sit in their conservatory...and you have to go back to your bed, and go to sleep at certain times, whereas here, you don't.'*

## **2. Limes Recuperative Care Centre**

### **Positive comments**

#### **Limes step-down clients:**

*'They have looked after me, fed me, waited on me hand and foot'*

*'I can't find words to explain. It just seems out of this world that there's a place like this that exists to help me walk again.'*

*'They encourage me. I know they put it on a bit, but it gives me help to encourage me.'*

*'I couldn't fault this place at all, the staff, not with anything, the staff or being looked after by them'*

*'The staff are really lovely, you can't fault them. They used to help me with personal care, but now I can manage.'*

#### **Limes recuperative care clients**

##### **Comments referring to staying at the centre:**

*'I think the management here are very nice. They're not restrictive really, I can do what I want to do...if I want to watch telly, or go upstairs for a sleep'*

*'If I've asked for anything and they can possibly help me out, then they've done so, if they can't quite do it, well they've been open and said so'*

*'It's very sociable, they make it as pleasant as they can for you'*

*'I couldn't wish for a better service here...we get good food'*

*'Everybody's perfect here, the carers...it's a very nice place'*

*'Assistants were 'all over you'...very helpful... great patience.'*

*'It was bright and cheerful and the staff was really lovely and food was even better. Because I like cooking and I'm afraid in the (DVH) hospital it wasn't very good food'*

*'It was your own room and ..that was your own room the complete time you were there which was very nice. They were lovely rooms actually.'*

*'It's been nice being waited on (laughs)...the food is excellent and...everybody's as much help as they can be''*

*'Made me realise there are exercises I should be doing and haven't been doing'*

One client mentioned that she valued the 'comradeship' and had made a friend during her stay, but did not expect she would be able to continue this friendship after her discharge home.

## **Comments referring to how the rehabilitation program had made a difference to individual clients:**

One client felt that social support he received at the Limes was as important as the therapy/rehabilitation support: *'I think it was a confidence builder'*

*'I think the best bit was the feeling of being cared for – people cared about you'*

One respondent felt the exercises he had been doing were very helpful, especially the breathing exercises (relaxation), *'I feel very steady on my feet now'*

*'I felt all the time that I was being cared for and comforted, which I don't get here'*  
[at home]

*'It gave me confidence and made me a lot happier actually'*

## **Negative or critical comments:**

### **Medication issues**

*'The only fault I have got is that I always have to wait until late at night for my sleeping tablets... one night, they said they didn't have no sleeping tablets, so I lay awake all night. I told the woman next day, and she said I should have bleeped, but I don't know anything about that.....'* (Step-down client)

Another comment about medication, suggesting that there was little flexibility in providing pain relief when it was required:

*'They would give you loads and loads of pills which perhaps you didn't want. They would feed you paracetamol all the time (laughs). I've got two bottles of laxative upstairs, which I haven't even taken yet. When you go, they piled you up with bags of drugs'* (Limes client)

### **Rehabilitation**

One client observed that the physiotherapist he had been promised was not much in evidence – physiotherapy was his main rehab need, but instead the Limes OTs oversaw his physiotherapy.

### **Staff problems**

*'I think the staff were pretty harassed, overworked a bit...all of them, really'*

When asked if anything could be improved, one (step down) respondent commented:

*'Not really, but only one thing I have noticed – it's only a few, you can't put them all in the same pot – some of these women, they treat the old people shocking, talk to them like sergeant majors – oh, it does annoy me, poor old dears'*.

### **Staying at the Limes centre**

*'The worst bit was the contrast between feeling cared for in the centre and feeling that nobody cares for you when you are at home'*.

*'It was very hot there'*

*'They could have a bit more entertainments. They do come occasionally and do a bingo session, but I suppose that's not everyone's cup of tea'* (Limes client)

The only part of the stay one client was really unhappy about was the toilets – these were mixed (i.e. shared by men and women):

*'We could do with more toilets....Men never keep the toilet as clean as women, and there's nothing you can do about it, I think'*

### **Younger clients**

One client was younger than the majority of people staying at the Limes. He felt rather cut off from people of his own age:

*'I find that I feel a bit lonely. I go upstairs and watch my telly in the evening. I can't sit down and watch them all go to sleep all day, which they do. In fact, I got to the stage where I was going to sleep in the end'*

*'They made too much of a fuss about age concern, which is really not quite my cup of tea...'*

A second respondent felt unable to maintain contact with others she had met there, and expressed a sense of a gap between her and other clients because she was a fair bit younger and fitter than most:

*'I don't look like a very old person...a lot of them were quite infirm...You had to be very careful what you said....if you picked up their newspaper thinking they had read it, well they got very annoyed about that..this kind of thing...'*