DOES INTEGRATED GOVERNANCE LEAD TO INTEGRATED PATIENT CARE?

FINDINGS FROM THE INNOVATION FORUM

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ABSTRACT

Good integration of services that aim to reduce avoidable acute hospital bed use by older people requires frontline staff to be aware of service options and access them in a timely manner. In three localities where closer inter-organisational integration was taking place, this research sought patients' perceptions of the care received across and within organisational boundaries.

Between February and July 2008, qualitative methods were used to map the care journeys of 18 patients (six from each site). Patient interviews (46) covered care received before, at the time of and following a health crisis. Additional interviews (66) were undertaken with carers and frontline staff.

Grounded theory-based approaches showed examples of well-integrated care against a background of under-use of services for preventing health crises and a reliance on 'traditional' referral patterns and services at the time of a health crisis. There was scope to raise both practitioner and patient awareness of alternative care options and to expand the availability and visibility of care "closer to home" services such as rapid response teams. Concerns voiced by patients centred on the adequacy of arrangements for organising on-going care, while family members reported being excluded from discussions about care arrangements and the roles they were expected to play. The co-ordination of care was also affected by communication difficulties between practitioners (particularly across organisational boundaries) and a lack of compatible technologies to facilitate information

sharing. Finally, closer organisational integration seemed to have limited impact on care at the patient/ practitioner interface.

To improve care experienced by patients, organisational integration needs to be coupled with vertical integration within organisations to ensure that strategic goals influence the actions of frontline staff. As they experience the complete care journey, feedback from patients can play an important role in the service redesign agenda.

Key words:

Community services for older people, integrated care, patient experience, care transitions, hospital utilisation, health services research.

WHAT IS KNOWN ABOUT THIS TOPIC

- Care "closer to home" services can reduce older people's demands for acute based care and improve patient experience.
- The ability of community-based services to improve patient care depends upon them being linked in a well-coordinated network of care options.

WHAT THIS PAPER ADDS

- Patient, carer and staff perspectives on the integration of services offered when patients experienced health crises in three English settings that were actively promoting closer service integration at an organisational level.

- An examination of whether more integrated governance structures lead to more integrated patient care.

INTRODUCTION

Older people are the main users of acute hospital beds in England (Lyratzopoulos et al. 2005, Downing & Wilson 2005). Research which estimated that "avoidable" acute bed days used by older people ranged from 24-48% (McDonagh et al. 2000) has led to the development of services that involve health and/or social care teams delivering care "closer to home" in non-acute settings. The aims of these services include: preventing an emergency attendance in the longer term (e.g. falls prevention schemes (Beech et al. 2010); schemes to provide more proactive care for people with long-term conditions (Russell et al. 2009, Sheaff et al. 2009)); diverting hospital emergency referrals/ attendances (e.g. rapid response teams (Stevenson & Spencer 2002, Beech et al. 2004) ; reducing acute lengths of stay (e.g. residential intermediate care (Young 2002) and early supported discharge schemes (Beech et al. 1999)). Whilst this growth in services has increased the options available for patient care, it has also increased the complexity of the patient "journey" as the new services often span health and social care organisations and settings. It is therefore important that as new services are implemented, they are woven into an integrated network of health and social care.

Efforts to improve the integration of services can take place at different levels (horizontally across care settings, vertically within single organisational structures) and in different ways (for example, altering communication and information sharing pathways and work relationships between providers) (Ling et al. 2010, MacAdam 2008, Wistow et al. 2010). This paper presents research that examined the integration of services offered at the patient/ practitioner interface (referred to as meso- and micro-level integration by Ling et al. 2000 and also as continuity of care (Heaton et al. 2012)) and in particular the extent to which the

actions of frontline staff working within and across organisations supported the drive to reduce the use of emergency hospital bed days by older people. This issue was approached by exploring the experiences of patients regarded as eligible for care "closer to home" services, at the point of and following a health crisis, and building up a wider picture of their care 'journey' through the eyes of carers and relevant health and social care personnel. The research was undertaken in three of the health and social care settings covered by the Innovation Forum (IF). In total, the IF included nine councils (and their corresponding health and third sector organisations) who had decided to work in partnership to achieve a 'headline target' of a 20% reduction in emergency acute hospital bed days used by people aged 75 and over during the three years from 2004/5 to 2007/8 (Wistow & Henderson 2010). Hence, a secondary aim of the research was to assess how closer inter-organisational integration was affecting the delivery of services at the patient/practitioner interface.

METHODS

Study design and participant recruitment

Data collection took place between February and July 2008. Qualitative research methods within a case study design were used to map individual patient journeys. This design (see McLeod et al. 2011, Toscan J. Et al 2011) is recommended as an approach for capturing patients' experiences about services (NHS Institute for Innovation and Improvement 2009). The study was designed to follow patients within/ across both service boundaries and across time in order to capture their experiences as they were referred to and discharged from services. Methods used are reported in more detail elsewhere (Henderson et al. 2011).

Eighteen patients (six in each site) with one of three conditions (Chronic Obstructive Pulmonary Disease (COPD), stroke or falls) were recruited. These conditions: are common reasons for visits to hospital emergency departments by older people (Downing & Wilson, 2005); require a coordinated service response because individuals suffer sudden health crises (McLeod et al. 2011);   are relevant for care "closer to home" services (Beech et al. 1999, Beech et al. 2004, Cooper 2004). The identification of the patient sample was purposive. Patients were recruited with assistance from hospital and/or community based staff and use of the modified Appropriateness Evaluation Protocol criteria (an audit tool for identifying avoidable acute hospital bed use (Beech 2005)). If patients met the inclusion criteria, they were approached initially by a member of staff involved in their care to assess potential interest in participation and were given an information sheet giving details of the study. A researcher then contacted the patient, answered any questions and arranged a suitable time and venue for the initial interview. Patients were given at least 24 hours to consider their participation before the researcher sought written consent.

Data collection procedures

Researchers conducted up to three semi-structured interviews with each patient using a topic guide devised to elicit patient experiences of care. The guide was informed by consultation with a public involvement advisory group convened by one of the participating research organisations. The first interview, at a time close to the participant's health crisis, covered the events leading up to it. The second covered clinical interventions received (generally in an acute hospital) and the third, on-going care following discharge from an acute hospital or care "closer to home" service. Interviews were arranged at a date and time and in a place

convenient to participants. As many patients were frail, researchers tailored the length of interviews according to any signs of tiredness or anxiety.

Where possible, if the patient agreed, an additional interview was undertaken with an identified carer. Also, "snowballing" out from the patient participants, researchers carried out semi-structured interviews with a range of key personnel involved in the patient's care: e.g. members of the hospital nursing, allied health or medical team and, in community settings, intermediate care or rehabilitation team members. Interviews were conducted face-to-face or by telephone, and were tape-recorded with the participant's consent.

Research participants

In site 1 the six patient journeys covered health crises due to COPD (two patients) and falls (four patients), in site 2 crises due to COPD (two patients) and falls (four patients), and in site 3 crises due to stroke (one patient) and falls (five patients). In total, 112 interviews were conducted (see Table 1). The target of three interviews per patient was not always accomplished: in site 2, one person died unexpectedly before follow up interviews; in site 3, discussion related to the complete patient journey was condensed into fewer interviews as the acute part of the journey was covered retrospectively, participants having been recruited from community-based services. In some cases carers were not available to be interviewed or patients indicated that they did not want their carers to be contacted.

Data analysis and ethics approval

Tape-recorded interviews were transcribed and anonymised. Themes were identified, and categories developed and refined inductively, employing the constant comparative method of grounded theory (Glaser & Strauss 1967). The researcher responsible for each site (SA, AD, CH) independently coded the data for their site line-by-line. During a series of face-to-face and teleconference meetings to enable sharing of data and ideas, the joint coding-framework was agreed. Themes common to all sites as well as differences were discussed, compared and developed as analysis progressed. Emergent findings were also informed by other data such as interviews with senior managers and documentary analysis. Themes that were substantially present in the data from all three sites remained in the final analytical framework.

Ethics approval for the study was granted by the Eastern MREC. Research governance approval was obtained from the relevant Primary Care Trust and Local Authority committees.

RESULTS

The care delivery experiences of patients are grouped into the three key phases of their journeys: pre-crisis, crisis, and rehabilitation (including discharge from acute care). Where appropriate, issues raised by patients are explored further using findings from the interviews with carers and health and social care staff. Participants have been assigned pseudonyms to preserve anonymity.

The pre-crisis phase

While some patients had been relatively well prior to their health crisis, many had experienced significant periods of ill-heath. In particular, patients who had fallen and patients with breathing problems gave instances of having delayed seeking support or reporting accidents, being reluctant to 'bother' professionals (in particular GPs). These decisions delayed or averted contact with primary and community care services at a point at which they might have acted to prevent crises. For example, fourteen of the eighteen individuals stated that they had suffered a previous fall but in many cases had not reported these to health professionals:

I've had a couple of bad falls. They've maybe put me in bed for a few days, but nothing like this! But it's just one of those things – you trip, or you sort-of stumble. [Mrs P, Site 3]

Blockages to connecting "closer to home" services to patients could also occur because of the way that mainstream primary and community services were organised.   The interviews with staff members indicated that GPs had a key role in offering care during the pre-crisis and crisis phases but they thought that changes to the GP appointment system had created barriers. For instance, a member of a COPD team explained that patients found it difficult to arrange timely home visits as they had to phone the GP between 8 and 8.30am; telephoning later meant that they had to wait until the next day for a home visit, which could be too late to prevent an admission. Some staff praised out-of-hours rapid response teams for being typically faster to respond than out-of-hours GP services but rapid response staff argued that it could be difficult to obtain vital health information out-of-hours, with community matrons and a patient's own GP not always being available and there being limited access to centrally held notes/assessments.

A few patients linked their current health crisis to an episode of "inappropriate" care in the past. For example, Mrs I (who suffered from COPD) thought that her current re-admission was due to her being discharged from hospital too soon:

I suffer with a breathing problem and I know what I can do on a day to day basis, what stretches me and what I just have to pace myself at. But it wasn't any of that – my whole being felt dreadful. It was an effort to get out of bed to walk to the loo, it was an effort to go back to bed. I had no interest in eating anything, I just felt totally lifeless, drained and that was the way I was when I came out in January. [Mrs I, Site 2]

Mrs J who suffered from COPD and heart failure, had a similar experience. Her daughter stated:

The first time we took her in, it was horrendous waiting eleven hours [in A&E] – and they had to discharge her after three days ... You could see she was ill! And then four days later she's back in again. [Mrs J (daughter), Site 2]

The crisis phase

It has been estimated that up to half of those people who fall and are attended by the ambulance service do not need to be taken to hospital (Snooks et al. 2006). In this study, very few people were diverted at the point of making an emergency call. Mrs N's patient journey illustrates a rare example of a successful 'diversion' by paramedics from acute care, but also illustrates the patient's response to a perceived poor service from her primary care provider. She used her community alarm when she fell:

If I press that [alarm], then it answers in the hall there. That's how I got the paramedics you see, because – not being unkind – you can be on the phone for hours trying to ring a doctor and you don't get anywhere. So I ring now for the paramedics. [Mrs N, Site 3]

The call centre contacted the emergency services and the paramedics decided that there was no need for her to go into hospital: instead referring her to an intermediate care service. The decision appears to have been aided by patient-held notes kept in her home.

A&E staff are key in ensuring the timely referral of patients to care "closer to home" services. Efforts in A&E to avoid admissions to the main hospital were not always successful from the patient perspective. Two patients recounted episodes in which they were treated in A&E for fractures and discharged home, but apparently without adequate arrangements for follow-up care and support. Mrs R recalled that A&E staff did not discuss with her how she would manage at home with one arm in a cast; Mr H, that he was wheeled to the taxi area with a pair of crutches without having tried to walk with them first. In both cases family members contacted community services which were then able to provide appropriate support and treatment. Mr H's daughter arranged for home care from his social services department, which subsequently referred him on to community rehabilitation, and Mrs R learned about adult care services from a family member. Her GP subsequently referred her to the intermediate care team:

I got a phone call within 24 hours from adult care [actually intermediate care] asking me what was wrong – and maybe two days later I was all set up; they were marvellous.[Mrs R, site 3]

In other cases, acute care did provide a route to an alternative service. Mrs P fell in the street and a member of the public called "999". Her speedy discharge to a community-based intermediate care service was arranged by acute hospital therapists.

I had to go to hospital, really... they took details in the ambulance and passed me over (laughter), as a parcel ... I went to the hospital and they x-rayed the hips and my elbow, because I made a mess of the elbow. I had to stay overnight because I couldn't walk. And then they brought me home, because the care team were willing to look after me and see that everything went OK. Otherwise, I'd have probably had to stay in hospital. [Mrs P, Site 3]

Staff working for care "closer to home" services in all the sites argued that current referral patterns meant that opportunities were being missed to prevent "avoidable" acute bed use. A key challenge was to ensure that the existence and function of these services was known to potential referrers. Just as patients and their families tended to dial 999 when faced with an emergency, many community health and social services staff reportedly often saw this as the obvious first step. However, one care worker defended the decision to dial 999 as reasonable, arguing that they did not have the clinical expertise to diagnose injuries, or assess whether or not referral to acute care was justified.

The patient journeys demonstrated the important role that family and friends play in providing follow-up care. For instance, one woman who lived alone received help from her son and friends for two days until a rehabilitation bed became available. However, such requests could put considerable pressure on informal carers. One patient's niece was asked to come at short notice to prevent an admission and felt guilty about her reluctance to do so:

I got a phone call at about 6 o'clock from one of these OT women saying 'In my opinion [Mrs D] should not have been discharged home on her own – given her fracture in her arm, she can't get up out the chair… Could you come over and stay with her and look after her?' I said: 'Well, you've placed me in a very difficult position. It won't be tonight will it? I'm sorry, I can't'. That made me feel terrible. [Mrs D (niece), Site 1]

Another patient had a network of support from older neighbours, but felt they then became imposed upon by professionals:

She's [neighbour] not a carer, she's not a helper – they started ringing her up 7 o'clock in the morning, so I had to have her name scrubbed off. I never tell anybody her name… The last time I was bad they said they wanted to ring [the neighbour] and I said 'No, I'm not giving you permission' because she'd just had a broken shoulder herself. [Mrs L, Site 2]

The rehabilitation phase

In some cases, decision-making about on-going care following an acute attendance or admission resulted in timely transfer and patient satisfaction with the process. For example, Mr K was screened in the hospital's observation ward by intermediate care staff, offered a six week package of intensive physiotherapy and transferred to the rehabilitation unit the next day:

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

a suitable candidate and that I could benefit from what they could offer. [Mr K, Site 2]

Similarly, a respiratory rapid response team assessed Mrs I after receipt of a referral from the hospital's observation ward, arranging immediate community follow-up after her brief admission.

I just couldn't believe it. It all sort of clicked into place. I thought this is actually going to happen… I came home and I just couldn't believe it, the phone rang and [they] said 'We'll be here in half an hour' – and they were. [Mrs I, Site 2]

However, many patients and carers were concerned with the quality of acute hospital discharge planning, particularly their lack of involvement in this process. Two patients from different sites, both frail women in their eighties with COPD, experienced unsuccessful discharges and thought that this was because they were not feeling well enough to go home. As one said, it was difficult to argue with the doctors:

I was astonished when the young doctor said 'I think you can go home tomorrow'. I said 'I don't feel fit. … What about me going to the [rehabilitation unit] for a bit?' And he said 'Oh no, you'd be much better at home, get back to normal'. And so it was against my will. I suppose they would say I finally agreed, but there didn't seem any option but to go home – and it was then I found I wasn't able to cope. … With hindsight, I was a bit weak to go with it, but I was so weak.' [Miss E, Site1]

Other patients who required extended periods of rehabilitation encountered bottlenecks in access to bedded rehabilitation with the choice of discharge destination appearing to be

driven by the availability of community hospital and intermediate care beds. One woman had hoped to go to the local community hospital but eventually went to a rehabilitation unit:

I was supposed to be going on the Friday and then one of the family rang up and they said 'She won't be going on Friday, she'll probably go on Monday'. And then later on, my grandson came and [...] asked where I was going and they said [community hospital]. And then the next visitor that came asked and they said 'There's no room at [community hospital], she's going to [rehabilitation unit] on the Monday'. [Mrs B, Site1]

Acute hospital staff agreed that there were many delays arising for a number of reasons. These included a lack of suitable placements for on-going care and conflict between the multi-disciplinary team's duty to make a safe discharge and patient preferences for discharge timings and destinations. However, some staff argued that assessment processes were now undertaken too quickly. For instance, while home visits were seen as important to identify future hazards in patients' homes, a social services staff member observed that pre-discharge visits were now less common.

Communication problems between staff working in different settings were also seen as causing of delays. Hospital staff highlighted difficulties in obtaining information about any community based services that a person was receiving prior to admission and that might support on-going care at home. Staff from community rehabilitation teams similarly argued that communication difficulties could delay patient discharge from acute care.

Many of the patients who received on-going care from rehabilitation services welcomed the fact that they were treated as individuals and the holistic and integrated person-centred approach. As one daughter put it:

It was a whole package. ... It wasn't just my mum, they actually thought about my dad as well, because he's 81 and he's got breathing problems. ... They came up with good ideas. [Mrs M (daughter), Site 3]

Those receiving home-based rehabilitation (and their relatives) were also very positive about being able to have this care in their own home.

I'm a lot happier at home, because you can be your own person, you can do what you like, as far as you're able to, and there's no restrictions. I can have my meals when I want them and go to bed when I want to and simple things like that. It makes a difference. I don't like being regimented. [Mrs Q, Site 3]

However, staff interviews again revealed ways in which communication difficulties affected the on-going care of patients. Primary care professionals expressed concerns about the discharge summaries sent by acute hospitals and some community staff deplored the duplication of assessments by acute and community therapists. However, other community based therapists gave reasons for re-assessing patients following a referral from an acute hospital including the need to identify the therapy required, the patients ultimate discharge destination, and whether social services had been notified.

DISCUSSION

English NHS policy regards timely and appropriate access to an integrated network of services that aim to prevent ill health and/or offer alternatives to care in an acute bed as a crucial way of addressing the health needs of older people (Age UK 2012, NHS Future Forum 2012). This research generated a "patient's eye" view (supplemented by inputs from carers and providers) of the integration of frontline services received at the time of and subsequent to a health crisis and offers an insight into how integration at an organisational level affected care at the patient/ practitioner interface.

Key findings

Examples of well integrated care and positive patient experiences were observed. However, across each of the three sites a number of challenges affected the extent to which service delivery was coordinated. Although the field work for this study was undertaken in 2008, more recent reports (Age UK 2012, NHS Future Forum 2012) suggest that the types of problem observed are still present. Services for preventing health crises were under-used because individuals were slow to access care following accidents or when feeling unwell and because health professionals failed to inform patients about preventative services. For example, frequent fallers were not always directed to falls prevention services even though they can reduce the burden of recurrent falls (Beech et al. 2010, Dickinson et al. 2011).

At the time of a health crisis, there was a reliance on 'traditional' referral patterns and services, partly due to a lack of knowledge about care "closer to home" services amongst key frontline professions and because out-of-hours rapid response services were not always available (mirroring research by Sheaff et al. 2009). Patients also remarked upon a lack of

information and signposting about services that they could themselves use before, during or after a health crisis.

Some patients felt that a "premature" discharge from acute care had led to a subsequent hospital re-admission. Others thought that adequate follow-up arrangements for their care had not been made. Although scarcity of resources can have an impact on the outcome of hospital discharge plans, this issue may not be actively discussed with patients (Huby et al. 2004): a similar lack of information-sharing with patients was found here. Family members also felt excluded from discussions about discharge arrangements, again confirming findings from elsewhere (The Comptroller and Auditor General 2003). Carers also expressed concerns about the roles they were expected to play when a patient left hospital: a view corroborated elsewhere (Pickard 2004).

Communication between professionals, particularly across organisational boundaries, remained problematic. Patients described experiencing multiple assessments but some staff indicated that they only trusted assessments carried out by themselves or a close colleague (as found by Dickinson (2006). There was a lack of compatible technologies to facilitate information sharing.

Finally, because this research was conducted in three IF sites, its results allow an assessment of the extent to which closer organisational integration was affecting the integration of services at the patient/practitioner interface. A poor fit between strategic goals and operational practice emerged.

Implications for practice

Delivering care in response to a health crisis is particularly challenging. Frontline staff need to make rapid decisions yet also achieve an appropriate balance between risk, access to health care resources and a patient's preferences (Poncia et al. 2000). Maintaining continuity of care can also be difficult when a patient moves between different care providers and settings (McLeod et al. 2011). However, the findings of this study do offer support for many current policy guidelines and recommendations (e.g. Department of Health 2010, NHS Future Forum 2012).

Better access to same-day appointments with GPs and services for people with long-term conditions could help to ensure timely use of services for preventing or addressing a health crisis. Health professionals also need to be more active in identifying a person's needs for preventative services (Hippisley-Cox et al. 2007). Single-point-of-access telephone numbers (such as the proposed NHS 111 service in the UK) and better signposting could also facilitate access to community care and other alternatives to acute care. Systems for sharing patient information might also improve communication between professionals (this research highlighted the role of shared patient held records in preventing an acute attendance). Research elsewhere has also found that co–locating staff from different organisations and/or establishing care teams can facilitate information sharing, referral processes and staff morale (Davey et al. 2005, Roland et al. 2012). Joint learning events (Zwarenstein & Reeves 2006) might also help acute and community-based staff to develop networks and share learning as a means of establishing Communities of Practice (Ranmuthugala et al 2011).

CONCLUSIONS

Policymakers and practitioners in England and elsewhere are looking for ways to improve the integration of services for health and social care (MacAdam 2008, Rosen et al. 2011, Thistlethwaite 2011). If patients are to experience the benefits of this process, inter-organisational integration needs to be coupled with vertical integration within organisations to ensure that strategic goals are communicated to and influence the actions of frontline staff (see, for example, Wistow 2011a, 2011b). It is important that, as the only stakeholders present for the complete care journey, health and social care service users are able to inform the service re-design agenda.

REFERENCES

AgeUK (2012). Agenda for Later Life 2012. Policy priorities for active ageing. Retrieved 5th September 2012 from http://www.ageuk.org.uk/Global/AgendaforLaterLifeReport2012.pdf

Beech R., Rudd A.G., Tilling K., Wolfe C.D.A. (1999). Economic consequences of early inpatient discharge to community based rehabilitation for stroke in an inner-London teaching hospital. Stroke, 30 (4), 729-35.

Beech R., Russell W., Little R., Sherlow S. (2004). An evaluation of a multidisciplinary team for intermediate care at home. International Journal of Integrated Care, 4 October 2004 – ISSN 1568-4156. Retrieved 5th September 2012 from http://www.ijic.org/index.php/ijic/article/view/113/226

Beech R. (2005). Identifying the need and scope for intermediate care. In: Roe B, Beech R (Eds). Intermediate and continuing care: policy and practice. Oxford: Blackwell, pages 19-32.

Beech R., DeVilliers R., Thorniley-Jones H. et al. (2010). Promoting evidence informed service development: a study of falls services in Cheshire. Primary Health Care Research and Development, 11 (3), 222-232.

Cooper S. (2004). Early supported discharge at exacerbation of COPD: safe and cost effective for some. Thorax, 59 (10), 869–869.

Davey B., Levin E., Iliffe S., Kharicha K. (2005). Integrating health and social care: implications for joint working and community care outcomes for older people. J Interprof Care, 19, 22-34.

Department of Health (2010). Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care. London: Department of Health. Retrieved 4th September 2012 from

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/d igitalasset/dh_116675.pdf

Downing A. & Wilson R. (2005). Older people's use of Accident and Emergency services. Age Ageing, 34 (1), 24–30.

Dickinson A. (2006). The Single Assessment Process: Operationalising the policy, opportunities and challenges. Journal of Interprofessional Care, 20 (4), 365-79.

Dickinson A., Horton K., Machen I., Bunn F., Cove J., Jain D., Maddex T. (2011). The role of health professionals in promoting the uptake of fall prevention interventions: a qualitative study of older people's views. Age and Ageing, 40 (6), 724-730.

Glaser B. G. & Strauss A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine Publishing Company.

Heaton J., Corden A., Parker G. (2012). "Continuity of Care": a critical interpretive synthesis of how the concept was elaborated by a national research programme. International Journal of Integrated Care, Volume 12, 13 April 2012: ISSN 1568-4156. Retrieved 7th January 2013 from http://www.ijic.org/index.php/ijic/article/view/794/1533

Henderson C., Sheaff R., Dickinson A. et al. (2011). Unplanned admissions of older people: the impact of governance. Final report. NIHR Service Delivery and Organisation programme. Retrieved 5th September 2012 from http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1618-136_V01.pdf

Hippisley-Cox J., Bayly J., Potter J., Parker C. (2007). Evaluation of standards of care for osteoporosis and falls in primary care: Final report to The Information Centre for Health and Social Care. London: QRESEARCH and The Information Centre for Health and Social Care.

Huby G., Stewart J., Tierney A., Rogers W. (2004). Planning older people's discharge from acute hospital care: linking risk management and patient participation in decision-making. Health, Risk and Society, 6 (2), 115–132.

Ling T., Bardsley M., Adams J., Roland M., (2010). Evaluation of UK Integrated Care Pilots: research protocol. International Journal of Integrated Care, Volume 10, 27 September 2010: ISSN 1568-4156. Retrieved 2nd January 2013 from

http://www.ijic.org/index.php/ijic/article/view/513/1069

Lyratzopoulos G., Havely D., Gemmell I., Cook G.A. (2005). Factors influencing emergency medical readmission risk in a UK district general hospital: A prospective study. BMC emergency medicine, 5 (1), 1. Retrieved 5th September 2012 from

http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=548275&tool=pmcentrez&render type=abstract

MacAdam M. (2008). Frameworks of Integrated Care for the Elderly: A Systematic Review. Ontario: CPRN Research report. Retrieved 5th September 1012 from

http://www.cprn.org/documents/49813_EN.pdf

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

McLeod J., McMurray J., Walker J.D., Heckman G.A., Stolee P. (2011). Care transitions for older patients with musculoskeletal disorders: continuity from the providers' perspective. International Journal of Integrated Care, 11, 18th April. Retrieved 5th September 2012 from

http://www.ijic.org/index.php/ijic/article/view/555/1240

NHS Future Forum. (2012). Integration: a report from the NHS Future Forum. London. Retrieved 5th September 2012 from

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132023.pdf

NHS Institute for Innovation and Improvement (2009). The ebd approach guide and tools. Retrieved 5th September 2012 from

http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=index&cPath=84&Joomcartid=v0j8o5s6biqcsfas1dta3k9ec4

Pickard L. (2004). The effectiveness and cost effectiveness of support and services to informal carers of older people. A review of the literature prepared for the Audit Commission. London: Audit Commission.

Poncia H.D.M., Ryan J., Carver M. (2000). Next day telephone follow up of the elderly: a needs assessment and critical incident monitoring tool for the accident and emergency department. Journal of Accident & Emergency Medicine, 17 (5), 337–340.

Ranmuthugala G., Plumb J.J., Cunningham F.C., Georgiou A., Westbrook J.I., Braithwaite J. (2011). How and why are communities of practice established in the healthcare sector? A systematic review of the literature. BMC Health Services Research, 11, 273. Retrieved 5th September 2012 from http://www.biomedcentral.com/1472-6963/11/273

Roland M., Lewis R., Steventon A., et al. (2012). Case management for at-risk elderly patients in the English integrated care pilots; observational study of staff and patient experience and secondary care utilisation. International journal of integrated Care, Volume

12, 24th July 2012 – ISSN 1568-4156. Retrieved 2nd January 2013 from

http://www.ijic.org/index.php/ijic/article/view/850/1772

Rosen R., Mountford J., Lewis R., Shand J., Shaw S. (2011). Integration in action: four international case studies. London: The Kings Fund.

Russell M., Roe B., Beech R., Russell W. (2009). Service developments for managing people with long term conditions using case management approaches, an example from the UK. International Journal of Integrated Care, Volume 9, 23 Feb 2009 - ISSN 1568-4156. Retrieved 5th September 2012 from http://www.ijic.org/index.php/ijic/article/view/303/605

Sheaff R., Boaden R., Sargent P., Pickard S., Gravelle H., Parker S., Roland M. (2009). Impacts of case management for frail elderly people: a qualitative study. Journal of Health Services Research and Policy, 14(2), 88–95.

Shepperd S. & Iliffe S. (2002). Hospital at home versus inpatient hospital care (Cochrane review). In: The Cochrane Library, Issue 2. Oxford: update software.

Snooks H.A., Halter M., Close J.C., Cheung W.Y., Moore F., Roberts S.E. (2006). Emergency care of older people who fall: a missed opportunity. Qual Saf Health Care, 15 (6), 390–392.

Stevenson J. & Spencer L. (2002). Developing Intermediate Care: a guide for Health and Social Services professionals. London: The Kings Fund.

The Comptroller and Auditor General. (2003). Ensuring the effective discharge of older patients from NHS acute hospitals. London: National Audit Office.

Thistlethwaite P. (2011). Integrating health and social care in Torbay: improving care for Mrs Smith. London: The Kings fund.

Toscan J., Mairs K., Hinton S., Stolee P. (2011). Integrated transitional care: patient, informal caregiver and health care provider perspectives on care transitions for older people with hip fractures. International Journal of Integrated Care, Volume 12, 13 April 2012 – ISSN 1568-4156. Retrieved 2nd January 2013 from
http://www.ijic.org/index.php/ijic/article/view/797/1531

Wistow G. & Henderson C. (2010). Anticipating the New Health Act: Messages from the Innovation Forum. Journal of Integrated Care, 18 (5), 4–14.

Wistow G., Waddington E., Kitt I. (2010). Commissioning Care Closer to Home: Final Report. London: Association of Directors of Adult Social Services. Retrieved 2nd January 2013 from http://www.ijic.org/index.php/ijic/article/view/513/1069

Wistow G. (2011a). Integration this time? 'Liberating the NHS' and the role of local government. London: Local Government Association.

Wistow G. (2011b). 'Integration and the NHS reforms'. Journal of Integrated Care, 19(4), 5-13.

Young J. (2002). The evidence base for intermediate care. Geriatric Medicine, 32 (10), 11-14.

Zwarenstein, M., & Reeves, S. (2006). Knowledge translation and interprofessional collaboration: Where the rubber of evidence-based care hits the road of teamwork. The Journal of Continuing Education in the Health Professions, 26 (1), 46–54.

Table 1: Participant interviews by research site

Site	Number of patient interviews	Number of carer interviews	Number of staff interviews
1	18	5	14
2	16	4	24
3	12	4	14
Total	46	14	52