Short papers

Pilot study of a visitor volunteer programme for community elderly people receiving home health care

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Abstract

There is a need to evaluate community support programmes for elderly people. In this randomized control trial (RCT), we determined the effectiveness of 'friendly visitors' in a volunteer programme of a visiting nurses organization in Southern Ontario, Canada. The Volunteer Friendly Visitor Programme was developed to support elderly people receiving homemaking and nursing care in the community. Volunteers are screened, trained, interviewed and matched to homebound elderly clients for general interest, visit expectations and personality. Volunteers spend three to four hours on average per week with clients socializing in mutually agreed-upon ways. The nursing staff identified clients who were lonely for this additional support. These newly-referred clients were randomly allocated to receive a friendly visitor or not for six weeks. Those receiving the volunteer visitor improved in life satisfaction and two social support measures: worth and social integration. Thus, the addition of volunteer visitors to planned homemaking and nursing care made a difference for elderly in the community.

Introduction

Local surveys of frail elderly in the community frequently cite some problems of loneliness that arise from being isolated from social supports (Chambers & Kirby 1988, Milne 1990). The Volunteer Friendly Visitor Programme at a visiting nurses' organization was developed as an addition to nursing care to support elderly people with health problems who are socially isolated in the community. Visitor need is based on the clinical judgement of the nurses providing service to this group. Volunteers for the programme are screened, interviewed and matched to homebound elderly clients for general interest, expectations for the visits and personality. Volunteers spend 3–4 h on average per week with clients socializing in mutually agreed-upon ways. Community nurses and homemakers give home care as required for the health problem.

A review of the literature indicated that there was only one controlled trial that identified the impact of volunteer visitor programmes for elderly people in the community. From a computerized Medline and CINAHL search of the literature, only one randomized control trial (RCT) (Munson *et al*. 1980, Calsyn *et al*. 1984) was found and 1.5 weekly hours of senior citizen or undergraduate student volunteer visiting reportedly had no impact on the life satisfaction of homebound elderly people over a 12-week period.

The purpose of our study was to evaluate this volunteer community programme by determining the effectiveness of a friendly visitor in the volunteer programme. Specific outcomes thought to be responsive to this programme were life satisfaction and social support.

Methods

All clients who were new referrals to a community nursing agency's friendly visiting programme ($n = 26$) were selected randomly to receive a friendly volunteer, or not. Three subjects in the experimental group and one in the control group were unable to complete the questionnaires themselves; thus 12 experimental and 10 controlled clients, respectively, were followed for 6 weeks. Sociodemographic, health perceptions, activity level, social support, and satisfaction with life variables were measured by independent research assistants before clients received the intervention and health perceptions, social support and life satisfaction were again measured 6 weeks later. Thus, change

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scores before and after the intervention were compared between groups.

Sample

Visitors

All volunteer visitors for this study were undergraduate students studying gerontology at the local University. They had provided references, and attended an interview process with the Coordinator of the Volunteer Programme so as to clarify their goals, assess their suitability and receive an orientation to the organization's nurses' service in the community.

The initial training programme is specifically designed to meet the needs of the individual volunteer and the client. Issues discussed include safety in relation to mobility aids, walkers, canes, wheelchairs and pertinent information related to the client's medical diagnosis. The Coordinator of the Volunteer Programme monitors the client/volunteer match by monthly written reports submitted by the volunteer, contact by telephone calls to client and volunteer, as well as their availability for visiting. Ongoing educational and training needs are met at the monthly volunteer meetings where topics identified by volunteers are discussed and, where necessary, presentations by professionals in the community will add additional information and encouragement. The success of a volunteer/client match depended a great deal upon the clinical judgement of the Coordinators in assessing the volunteer and the client for their suitability, as well as the ongoing support and recognition given to each volunteer. The Coordinators were not involved in the research data collection.

Clients

The clients were receiving the professional nursing services of the organization to assist in their personal needs, e.g. bathing, monitor medications, monitor mobility. The visiting homemaking services were also assisting in the household work activities, e.g. preparation of meals, household chores, shopping for 3–8 h per week. This ongoing assistance is thought to help clients remain in the community and maintain some independence. Eligibility criteria for the study included: (a) able to understand English (b) not cognitively impaired and (c) voluntary consent to be randomized.

Each of the clients included in the research were identified by the visiting nurses as requiring the support of volunteer services. The needs included social support in a lonely and/or isolated situation and the volunteer was expected to provide some physical and emotional support in the clients' own home or during an outing in the community.

Measures

Personal and sociodemographic information were collected by self report and included age, gender, marital status, level of education and income status. These were measured at baseline.

Their functional ability was measured using the Eastern Co-operative Oncology Group (ECOG) Performance Status Scale (Skeel 1982) at baseline. The ECOG is a subjective assessment of how an illness affects one's ability to function.

The Health Perceptions Questionnaire (HPQ) (Davies & Ware 1981) measures people's perceptions of their own health and is intended for use in population assessments of general health status. Three single item measures of general health were used in this study. Subjects rated their health (excellent to poor), amount of pain and concern about health ('a great deal' to 'none') on a scale from 1 to 4.

The Personal Resource Questionnaire (PRQ) (Weinert 1987) is a second generation multidimensional 25 item, 7-point scale measure of social support consisting of five dimensions of support: intimacy, social integration, nurturance, worth, assistance/guidance.

The Life Satisfaction Index (LSIZ) (Neugarten *et al*. 1961, Wood *et al*. 1969) measures the psychological well-being of older people with the goal of identifying 'successful aging'. The LSIZ consists of 13 items, rated from 0 to 2 (disagree, neutral, agree).

Intervention

The nurses referred clients in the programme who were thought to be lonely and socially isolated. The volunteers met their clients weekly and on average visited for 3 h. As hours of visiting were part of their university course work, volunteers indicated their contact hours. Activities included walks around the house, talking, assisting with care activities, reading, writing letters and often just listening. Clients indicated the visitors provided 'company' and gave them 'something to do'.

Volunteers rated the programme as an extremely valuable learning experience and a rewarding activity.

Results

Sample descriptive statistics

Of 26 people who entered in this study, four were dropped from the study due to their mental confusion ($n = 3$) and entering a nursing home ($n = 1$). Participating subjects were mainly females (68%), widowed (68%) with a mean age of 80 years. Their mean education level was grade 9, and most were retired or never worked (73%). Over half (55%) were Canadian-born and they

reported their income at low to medium levels (95%). Their functional capacity level indicated that 86% needed some assistance to look after their personal needs or household work activities.

Group comparability

As indicated in Table 1, sociodemographic variables were found comparable at baseline between groups except the experimental group had more persons born in Canada, whereas most in the control group were born in England ($P = 0.03$). However, this variable had no effect on outcome measures when used as a covariate.

At baseline, levels of health, life satisfaction, functional status, and social supports were not different between groups (Table 2). Subjects indicated, at baseline, only fair health, some pain and some health concerns. Their life satisfaction scores were only moderate and their social support scores were lowest in the areas of social integration and nurturance.

Effectiveness of intervention

The change scores of the group receiving the friendly visitor were compared to the control group change scores (Table 3). The subjects receiving the friendly volunteer showed a statistically significant difference in life satisfaction (Mann Whitney *U*-test = 23, $P = 0.01$) and two social support measures: worth ($t_{20} = 2.41$, $P = 0.03$), and social integration ($t_{20} = 2.38$, $P = 0.03$). 'Worth' indicated a greater feeling of worth and integration as others let them know that they were important and were appreciated as a person. 'Social integration' indicated that they had people to share activities with. It is unknown if this improvement in social integration included others as well as the volunteer visitor. Other clinically important improvements occurred in level of health. There were no statistically significant differences in nurturance, intimacy and assistance or guidance subscales of social support. These results must be viewed with caution due to multiple testing.

Table 1 Comparison of sociodemographic variables between volunteer visiting and control clients at baseline ($n = 22$)

	Total $n = 22$		Volunteer visitor $n = 12$		Control $n = 10$	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Age (years)	79.4	(7.0)	79.7	(7.0)	79.0	(7.5)
Education level (years)	8.6	(2.8)	8.3	(2.9)	9.0	(2.8)
Functional ability 1–5 (5 poor)	3.2	(0.8)	3.3	(0.8)	3.2	(0.9)
	n	%	*n*	%	*n*	%
Gender: males	7	32	5	42	2	20
Widowed	15	68	9	75	6	60
Canada country of birth	13	59	10	83	3	30
Income poor	7	32	4	33	3	30

Table 2 Comparison of health and social variables between groups at baseline

	Total $n = 22$		Volunteer visitor $n = 12$		Control $n = 10$	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Life satisfaction (0–26)	12.0	(5.2)	11.9	(6.0)	12.2	(4.5)
Social support:						
Intimacy (0–35)	23.4	(8.5)	23.6	(8.7)	23.2	(8.6)
Social integration (0–35)	19.1	(8.5)	20.6	(9.6)	17.4	(7.0)
Nurturance (0–35)	19.1	(7.8)	21.6	(8.8)	16.2	(5.5)
Worth (0–35)	23.4	(7.8)	22.9	(8.1)	24.0	(7.7)
Assistance (0–35)	24.2	(7.5)	23.5	(8.1)	25.0	(7.0)
Poor health (1–4)	3.1	(0.8)	3.0	(0.9)	3.3	(0.7)
Pain (1–4)	2.1	(1.2)	2.3	(1.4)	1.9	(1.1)
Health concern (1–4)	2.2	(1.2)	2.6	(1.2)	1.7	(1.1)

Table 3 Comparison of changes after 6 weeks in health and social variables between groups

	Volunteer visitor $n = 12$		Control $n = 10$			
	$\bar{x}$	SD	$\bar{x}$	SD	t_{20}	P
Life satisfaction	2.83	(1.7)	−3.3	(5.6)	3.34	< 0.01*
Social support						
Intimacy	−0.08	(6.5)	0.40	(8.8)	0.15	0.88
Social integration	3.08	(5.3)	−2.40	(5.5)	2.38	0.03*
Nurturance	−0.75	(5.7)	0.70	(6.2)	0.57	0.57
Worth	1.25	(5.1)	−4.80	(6.6)	2.41	0.03*
Assistance	1.08	(5.5)	−2.80	(7.0)	1.45	0.16
Health improvement	0.3	(0.6)	0	(.8)	0.82	0.42
Pain improvement	0	(0.6)	−0.2	(.9)	0.61	0.55
More health concerns	0.4	(1.3)	0	(1.2)	0.78	0.44

*$P < 0.05$.

Discussion

More extensive research is needed to verify the programmes effectiveness.

Although this pilot study was limited by the small sample size ($n = 22$), the short time period (6 weeks), and nonblinded subjective reporting by clients, there were statistically significant improvements in life satisfaction and social support by the subjects receiving friendly volunteer visitors.

The improvement in life satisfaction was contrary to the Calsyn *et al*. (1984) study. It is thought that the studied samples were different as our research subjects also received Home Health Care visits by nurses and homemakers. In addition, volunteer–client matches related to choice and interests of volunteer were a result of a specifically prepared interview process of each client and volunteer, who were undergraduate students studying gerontology. The volunteer time of 3–4 h weekly visits (as opposed to 1–1/2 h weekly in the Calsyn *et al*. (1984) study) on a consistent basis was a requirement that was identified in the friendly visitor job description and reaffirmed during the volunteer interview process.

Although this short-term study of clients who were recipients of careful matching of volunteer to client with a high contact of 3–4 h weekly provided some evidence of the value of a friendly volunteer visitor, more extensive research is needed to verify the programme's effectiveness.

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Collaboration between health and social care: coterminosity in the 'New NHS'

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Abstract

Policy-makers and practitioners have seen coterminosity as a way of enhancing collaboration between health and social care agencies. Its role in promoting such collaboration has varied over time; Labour's reforms suggest a different role for coterminosity in inter-agency collaboration. For example, Social Services' representation on Primary Care Groups highlights the localised nature of collaboration. This article defines coterminosity, reviews recent policy changes towards it, and interprets the role that it might play in the future. The article concludes that coterminosity offers an important contribution, especially at local levels, but is insufficient in resolving all inter-agency issues.

Introduction

Improving collaboration between health and social care agencies has been a long sought-after goal in both organizations. Coterminosity of geographical boundaries has been one measure often proposed to improve such collaboration. However, the context in which coterminosity operates is crucial to its role. This article assesses the contribution that coterminosity is likely to play in health and social care following the publication of the 1997 White Paper, *The New NHS*.

Collaboration: an enduring issue

Ever since the formation of the NHS in 1948 (but especially since the 1974 re-organization), the need to collaborate has been of paramount concern to health and social care agencies at both operational and strategic levels. Various measures have been implemented (and often evaluated) over this period to foster collaboration including shared values/strategy and joint finance (Wistow 1990). However, one measure that continues to preoccupy policy-makers and practitioners is coterminosity and yet its contribution remains elusive.

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Collaboration is significant in terms of the organizational structures and relationships that are formed, the processes that are employed and the variations in (policy and service) outcomes that result. In particular, the relative contribution of different mechanisms to improved collaboration in different areas remains an important (research) issue. Here, we shall consider one mechanism of collaborative strategies, *viz.* coterminosity.

What is coterminosity?

Despite being frequently proposed as a solution to collaborative difficulties, coterminosity remains an ambiguous concept; it has evaded detailed analysis by policy analysts and practitioners. Policy documents at central and local levels have frequently cited the value of coterminosity without ever subjecting it to rigorous scrutiny (Exworthy & Peckham 1998). A re-examination of its role in collaboration is therefore vital given the type of policy changes introduced by the Labour government as part of the 1997 White Paper, *The New NHS* (Department of Health 1998).

It is relatively easy to find statements supporting the concept of coterminosity. For example, in the 1960s, unity of boundaries was an accepted policy goal:

> The best available solution would be to align the boundaries of health and local authorities: the assumption being that cohabitation [i.e. coterminosity] would lead to coordination (Klein 1990, p. 91).

Similarly, coterminosity was promoted in the 1970 Green Paper, a fore-runner of the 1974 re-organization. Although the 1974 changes moved most community health services to the NHS, coterminosity between health authorities (HAs) and local authorities (LAs) was largely achieved. Policy in the 1970s and 1980s still sought coterminosity although in less directive ways:

> [HA] boundaries, either singly or jointly, were to be coterminous with those of social services or education authorities (Ottewill & Wall 1990).

Griffiths's (1988) supported the concept, seeing coterminosity as a self-evident benefit:

> Collaboration and joint planning are admirable provided that … responsibilities are clear … [Of course], this would be helped by restructuring at a local level with HAs, Social Services and Family Practitioner Committees (FPCs) enjoying coterminosity …(para. vi.).

More recently, joint purchasing/commissioning has sometimes looked to coterminosity. Hudson (1995) claims that joint purchasing is capable, *inter alia*,

> securing a better picture of need in the population unhindered by **organizational boundaries** (p. 235; emphasis added).

This policy desirability reflects three benefits that coterminosity is *assumed* to confer: ease of communication between officers in different organizations, clear responsibility for the same population, and a correspondence between service purchasing and provision. The scale and nature of these benefits will depend on the extent of boundary coincidence. It is possible to distinguish between unitary (e.g. one HA to one LA), multiple (e.g. one-to-many) and partial forms of coterminosity (i.e. overlapping HA/LA boundaries) (Exworthy & Peckham 1998). Intuitively, unitary coterminosity would be expected to confer the most benefit to both agencies.

'The New NHS' and recent policy changes

The key antecedent of the reforms announced in late 1997 was the introduction of the quasi-market in 1991 (see Robinson & Le Grand 1994). Perhaps one of the most significant impacts of the reforms upon collaboration and coterminosity was the effect of the quasi-market upon the planned boundaries of statutory agencies. In the NHS, only HAs retained explicit geographical boundaries in the 1991 reforms, their funding being derived according to the size of their resident population. However,

> [HAs] could, in theory, purchase health care from whichever provider was most able to meet the purchaser's requirements. Crucially, the provider need not be located within the HA area (Exworthy 1998, p. 451).

However, despite this potential, strong links remain between HAs and local providers. Recent evidence has shown that 80-85% of HAs' budgets have been spent with providers located within the HA's geographical boundaries (Exworthy 1998).

The 1997 White Paper *The New NHS* set a new direction for the NHS and, in conjunction with other policy developments (such as Health Action Zones and the 1998 Green Paper 'Our Healthier Nation'), the context for health and social care collaboration has been substantially altered. Although implementation of these policies is not yet complete, it is possible to identify emergent themes with respect to collaboration and coterminosity.

The key development is the creation of Primary Care Groups (PCGs), responsible for commissioning services from providers. These PCGs represent (a revised re-emergence of) a locality approach as they will contiguous with each other within each HA. HAs will oversee PCGs and undertake strategic development with all relevant local organizations including LAs. The outcome of this development will be the Health Improvement Programme (HIP), an agreed programme of service development over the medium–long-term. In supporting their collaborative role with HAs, LAs are to have a broader social, economic and environmental duty, thereby emphasizing the partnership approach.

The partnership theme is developed in the Green Paper *Our Healthier Nation* (Department of Health 1998) which sets out the government's proposals for improving public health. The Green Paper seeks to establish a 'contract for health' in each area in which 'government and national players', 'local players and communities', and individuals have responsibilities for improving health, individually and collectively within a framework of national targets (for heart disease and stroke, accidents, cancer and mental health) and locally agreed priorities.

One strategy that combines both White and Green Papers is the Health Action Zone (HAZ). These HAZs are networks of local statutory and/or independent agencies who have been given greater flexibility in the use of financial, material and human resources. Thus, usual regulations and organizational barriers are being eliminated or lowered with the intention of promoting greater effectiveness in tackling interrelated health and social care issues. HAZs tend to cover whole authority areas and, even though the focus may be upon subgroups within those areas (e.g. young and elderly people, diabetes patients), this serves to emphasize the role that coterminosity could play at the local (cf. authority) level.

A more symbolic, but equally powerful, shift associated with recent Labour policies has been the change in language. Markets and competition have been down-played (though not entirely removed) in favour of cooperation. Such a change may augur well for collaboration and possibly coterminosity.

A new focus for commissioning

Two consequences of the development of purchaser organizations in the NHS in the 1990s have been the aggrandisement of Health Authorities (to populations of 500 000 to 1 million) and the renewed interest in collaboration, as manifest through joint purchasing initiatives. The consequence of the former was that HAs sought to introduce 'locality purchasing' schemes to facilitate public consultation exercises or liaison with GPs. The consequence of the latter was that agencies sought ways to work together. One outcome of both trends was the search for coterminosity. Though highly constrained by other factors (such as finance and cultural differences), coterminosity was often achieved at the locality level, if not (always) at the authority level.

A key element of recent health care policy has been the development of primary care as a focus for provision and for purchasing leading to current proposals for PCGs. There are, however, a number of problems with this approach. First, GPs, who play prominent (or dominant) roles in primary care-based purchasing, have traditionally had poor collaborative links with social care agencies (Hudson 1994). The development of PCGs might suggest that such poor collaboration will continue although some proposals (e.g. HIPs) point towards the *opportunity* for greater collaboration between health and social care.

The government has stated that,

> [in developing PCGs] … account must be taken of social services as well as Health Authority boundaries, to help promote integration in service planning and provision (Department of Health 1997: section 5.15).

However, in reality, the geographical basis of PCGs (between 46 000 and 255 000 population) is unlikely to match with the spatial organization of most Social Services (or other LA departments). Whilst PCGs of above 100 000 will be epidemiologically stable (thereby reducing risk), it does not augur well for close collaboration with social care. However, PCGs will be geographically delimited, contiguous units, which may give some opportunity for collaboration. Inevitably, the degree of collaboration in each area will be a function of the particular configuration of authorities and their decentralised units. Moreover, as individual practices are not geographically delimited, collaboration will involve overlapping sets of relationships, thereby hampering joint working.

The Government acknowledges some of these issues and has argued that,

> [PCGs] should develop around natural communities, but take into account also the benefits of coterminosity with social services [and that] . …practices based close to the borders of a Group will be able to join with others in the way which makes best sense locally. (Department of Health 1997: section 5.16).

Unfortunately, the notion of natural communities may not fit easily with the tests for population size and agency coterminosity, as is often the case in boundary determination (Exworthy 1994). Further problems may also arise where PCGs draw together practices that have traditionally used different (possibly nonlocal) health care providers creating contracting tensions within the group.

Combined, these issues do not suggest that the primary care focus of current reforms will necessarily facilitate collaboration, through coterminosity or any other mechanism (Peckham *et al.* 1998). However, evidence from the national evaluation of Total Purchasing Pilots does show that TPPs have been making important operational links with social services at both practice and TPP levels which hold out the potential to create more vertical and horizontal integration of service provision (Myles *et al.* 1998). Total purchasing appeared to be a catalyst rather than an initiator of change and key to this catalytic role was the TPP's control over resources as perceived by themselves and others such as social services.

Service provision

The geographical organization of service provision is highly dependent upon the nature of that service. Some services are (apparently) more amenable to collaboration and coterminosity than others. Even services that are normally associated with provision in fixed locations and/or limited multiagency working have important collaborative connotations.

The notion of a hierarchy of (health) services based upon epidemiology (and by implication, geography) has long been recognized (Curtis & Taket 1996); those services associated with 'rarer' conditions are (generally) not provided on a 'local' basis, and *vice versa*. This reflects the epidemiology of conditions, but also has policy relevance in terms of subsidiarity – the principle where decisions are devolved to the most appropriate local level (i.e. practice, Primary Care Group, HA or supra HA level) (Exworthy 1993). Two examples illustrate this. Cancer services in the UK are being re-organized on the basis of a 'hub-and-spoke' model in which specialist regional centres complement the work of generalist district (local) units. However, such services operate at such large scales that they do not easily correspond to collaboration with other agencies. By contrast, community nursing has strong links with its local communities and in the mid-1980s was re-organized on the basis of neighbourhoods, geographical units of between 10 000 and 25 000 population (Cumberlege 1986, Ottewill & Wall 1990). This facilitated coterminosity, and in turn, collaboration because of the similar spatial scale at which social services (and others) operated.

Community-oriented health services tend to have closest links with social care services although the role of coordination between hospital staff and social workers in terms of discharge planning from hospital to patient's homes, for example, should not be underestimated. Links between health neighbourhoods or localities and LA area offices are perhaps the most easily identifiable form of collaboration in terms of service provision and the most obvious scale at which coterminosity may be achieved. The 'success' of collabora-

tion at this level is dependent on more than just coterminosity as evidenced by the above example from total purchasing.

Conclusions

The current reforms indicate that some signs of progress are apparent but that the nirvana of collaboration is still somewhat distant, if only because acceptable policies have to be put into practical action. Similarly, the role of coterminosity has re-surfaced following Labour's health and social care reforms. The notion that 'joined-up' solutions are required to tackle complex problems might tend to suggest that coterminosity ('joined up boundaries') would contribute to collaboration – the complex problem. Indeed policies based on defined geographical area are prominent in the reforms (including HAZs, PCGs and HIPS) which may facilitate collaboration.

It is noticeable that the scale at which these geographically based reforms are occurring is at both the authority and locality level. Policy change has signalled some re-alignment of agency roles and responsibilities but nonetheless many structural and organizational obstacles persist which hinder full and effective collaboration. For example, general practices are based upon lists of patients who may or may not be resident locally. This contrasts with, say, the praxis of Social Service Departments which tend to be geographically oriented. Likewise, health service accountability has tended to be financial and managerial whereas LA accountability has drawn upon a democratic model. These are fundamental differences which geographical boundary re-alignment may only ameliorate.

In conclusion, coterminosity thus has a continued role to play but, as at other times, it has to be balanced with other imperatives. However, the nature of recent policies highlights that coterminosity will have a small but significant function in the success or otherwise of policies in this 'new' era of collaboration.

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