

# Care coordination: translating policy into practice for older people

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## Abstract

**Purpose** – *The authors aim to present findings from their research on the implementation of Unified Assessment (UA) policy and the work of care coordinators who oversee the delivery of support to older people with complex needs.*

**Design/methodology/approach** – *A mixed methods approach included staff interviews (n = 95) and focus groups (n = 3).*

**Findings** – *The care coordinator role is controversial and the lack of common terminology across health and social care obscures its importance. It is seen as a social care responsibility. Limited ownership amongst healthcare professionals leads to tensions in practice. The challenges of breaking down silo thinking embedded in established professional practices are highlighted as are infrastructural and capacity deficits. Disparities between policy intentions and practice means that UA is failing to meet core objectives relating to the delivery of seamless support.*

**Research limitations/implications** – *Further research is needed to develop and evaluate evidence-informed interventions that test solutions to the problems faced in practice and support the delivery of more effective arrangements.*

**Practical implications** – *Practice development may be supported by: guidelines that are more prescriptive and include a formal role definition; joint training to promote shared understanding of key concepts; investment in administrative and IT infrastructures; and more coordinated direction at strategic level.*

**Originality/value** – *Over a decade has elapsed since the publication of UA Policy Guidance; however, there is limited published evidence on the effectiveness of UA policy and its translation into practice.*

**Keywords** *Unified assessment, Care coordination, Complex needs, Older people, Seamless support, Interventions, Elder care, Elderly people*

**Paper type** *Research paper*

## Introduction

Care coordination is an established policy concern in developed countries (Allen *et al.*, 2004) and is seen as critical to the delivery of effective support to individuals with complex health and social care needs (Bowler, 2006; Coughlin *et al.*, 2006). An extensive theoretical and empirical literature exploring the coordination and integration of care has amassed (Ranade, 2004; Glasby and Dickinson, 2008).

Assessment and care management frameworks across the UK recognise the care coordinator role as key to the planning, commissioning and delivery of integrated care. Policy Guidance supporting the implementation of the Single Assessment Process in England (Department of Health, 2002), Unified Assessment (UA) process in Wales (Welsh Assembly Government, 2002) and Single Shared Assessment Tool in Scotland (Scottish Executive, 2001) specify that where an individual's needs are complex and require the input of several professionals, one professional should be identified as the care coordinator. He or she should provide the focus for communication and take the lead for care planning and the ongoing management of care. Whilst complex needs are not defined, the UA Guidance notes that 'complex' implies the requirement for

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a specialist assessment of all or most of the assessment domains. In Wales there are 12 assessment domains, including the service user perspective; the carer perspective; activities of daily living; personal care and physical well-being; mental health; relationships; and safety.

Key care coordination tasks, as specified in UA Policy Guidance, include:

- acting as a consistent point of contact;
- progress chasing;
- managing conflict;
- coordinating case conferences;
- adapting personal plans of care; and
- health and social care organisations are required to agree local protocols to guide care coordination activities.

UA Policy Guidance specifies that care coordination applies to both health and social care and recommends that where an individual's main needs are health-related a healthcare practitioner should be the care coordinator. Acting flexibly, in the best interests of service users, is considered to be essential (Welsh Government, 2002, 2011). Organisations may establish care coordination arrangements between staff in different disciplines through virtual care coordination teams, though very limited information is provided in UA Policy Guidance about such teams and it is unclear whether this implies that the role might be shared in some circumstances.

Research following the implementation of the Single Assessment Process in England highlights improvements in the ways practitioners capture complex needs (Clarkson *et al.*, 2009). However, it also suggests that promoting shared understanding of key principles amongst professionals and how these relate to practice is problematic (Challis *et al.*, 2007). Whilst it is assumed that there is a shared understanding of coordinated care, the concept is neither clearly defined nor understood and its underlying complexities are often overlooked. The term is used interchangeably to depict the structural and philosophical aspects of care delivery, the process of care delivery and interpersonal issues associated with care delivery (Ehrlich *et al.*, 2009).

There is disparity between policy and practice and only limited evidence of integrated care planning and support (Williams and Sullivan, 2009). Inter-professional information sharing continues to be problematic as there are differences in governance requirements and health and social care IT systems do not provide the functionality that is required (Ward *et al.*, 2008; Sicotte and Paré, 2010). Services are fragmented and often inconsistent with service user expectations (Commission for Social Care Inspection, 2008; Department of Health, 2010a; Walsh *et al.*, 2010). There is considerable potential to adopt more seamless approaches to supporting older people with complex needs and strengthening relationships between health, social care and wider community organisations (Commission for Social Care Inspection, 2008; Chester *et al.*, 2010; Welsh Government, 2011). Further understanding the issues affecting the translation of care coordination policy into practice is critical to realising this potential.

To date, there is limited published evidence on care coordination within the UA policy framework. In seeking to address this and provide evidence to support future policy and practice development, this paper explores the role of the care coordinator. We report findings from in-depth interviews with strategic and operational staff who are involved in supporting older people to live in their own homes.

## Method

Fieldwork was completed in each of the 22 local authorities in Wales. Necessary permissions were secured from the Wales Multi-Centre Research Ethics Committee and the Association of Directors of Social Services.

## Project reference group

A project reference group guided our work and included older people, representatives from statutory and independent sector organisations and academia. Members commented on

interview topic guides, preliminary findings, policy and practice implications and research outputs. Older people were recruited via the Involving People Network, which forms part of the research infrastructure support service funded by the Welsh Government.

## Staff interviews

### *Sample*

We completed in-depth interviews with 95 members of staff, 87 by telephone and eight face-to-face (Table I). Directors and Chief Executives forwarded bilingual information sheets and consent forms to potential study participants. Staff wishing to participate e-mailed completed consent forms to the research lead.

### *Interviews*

Interviews were framed by topic guides that were developed in collaboration with the project reference group; they encouraged staff to contribute their perspective in their own words, paying particular attention to: agreeing and implementing care coordination protocols; defining the care coordinator role; coordinating care in practice; and, infrastructural and resource issues. Interviews took approximately 1.25 hours to complete.

### *Focus groups*

Qualitative data were obtained from three focus groups, spanning eight local authority areas; one in North, Mid and South Wales. In total, 57 participants, nominated by their Director or Chief Executive, attended the focus groups (Table II).

Discussions focused on factors that encourage or hinder the implementation of UA policy; break-off groups, facilitated by researchers, enabled participants to consider these in detail. Each group nominated a spokesperson to share key points during a plenary session.

### *Data recording and management*

Following consent all research interviews were recorded to MP3 and transcribed. During the focus groups a record of participant contributions was maintained by the facilitator; key points were written on a large paper display whilst other researchers made notes. Anonymised data was held securely in accordance with data protection requirements.

<b>Table I</b>	<b>Staff interviewees by employing organisation and designation</b>		
	<i>LHB</i>	<i>LA</i>	<i>NHS trust</i>
<i>Designation</i>			
Unified assessment lead	22	22	
Nurse director/assistant director	1		2
Clinical development director	1		
Community hospital manager			1
Discharge liaison nurse			5
Community nurse	1		
Nurse reviewer	1		
Head of occupational therapy	1	1	
Occupational therapist		2	3
Care manager (community based)	3	17	
Care manager (hospital based)		4	
Review officer		1	
Long-term conditions case manager	1		
Domiciliary care manager		1	
Commissioning team manager		1	
Local authority team manager		2	
Unified assessment project manager	1	1	
Total	32	52	11

**Table II** Focus group participants

<i>Profession</i>	<i>Number</i>
UA lead	3
Care manager (community based)	15
Care manager (hospital based)	3
Occupational therapist	5
IT specialist	2
Partnerships manager	4
Community mental health team manager	4
Nurse (hospital based)	10
Nurse (community based)	1
Re-ablement services manager	1
Continence services manager	1
Chronic conditions manager	1
Discharge liaison officer	2
Community hospital manager	5
Total	57

### **Data analysis**

Detailed readings of the interview and focus group transcripts established a familiarity with the data and encapsulated the emerging themes. An outline coding scheme to highlight units of meaning (Patton, 2002) was devised and a series of codes (free nodes) assigned a conceptual label to sections of transcript. The range and variation of themes was mapped using data displays (Creswell and Plano Clarke, 2007). Further refinement of themes was undertaken in discussion with the project reference group. More detailed analysis allowed the identification of commonalities and contrasts, resulting in a more complex coding framework represented as hierarchical code groups. Team discussion about node definitions and patterns in the thematic analysis facilitated the interpretation of the data. Our initial and continuing analysis considered each data set separately. Final analysis synthesised all the datasets, enabling contrasts and comparisons to be made and the exploration of salient themes. QSR Nvivo software supported the data analysis.

### **Findings**

The findings focus on key themes arising from our analyses. We identify challenges to the implementation of the care coordinator role within the UA policy framework. Some relate to defining roles and agreeing responsibilities whilst others relate to limited strategic direction and others to longstanding infrastructural and capacity deficits. The identification of current challenges may assist the development of future evidence-informed interventions that support the care coordinator role and address problems in practice; we explore this in the discussion section.

We have used quotes from participants to illustrate the findings. The notation below each quote indicates their unique participant identifier.

#### ***Care coordination: whose role, whose responsibility?***

Ambiguity and controversy surrounds the role of the care coordinator:

It's a bit like a hot potato (UA2:20, Discharge Liaison Nurse).

At strategic and operational levels we found considerable variation in the terms used to describe the care coordinator across health and social care. Whilst Guidance emphasises the importance of adopting common terminology, the terms care coordinator, care manager, case manager and care broker were used interchangeably by staff in everyday practice. The lack of consistent terminology appeared to be a source of confusion for practitioners and obscured the importance of the care coordinator role:

[...] there is some confusion about terminology and who does what [...] we need to really get our heads around what it means (UA1:03, Local Authority UA Lead).

Care coordinator – it's never been properly defined who that's supposed to be [...] there's always anomalies in the language [...] you have care managers and case managers and social workers [...] the other one that comes up is they call it the healthcare coordinator. So again, does that mean that that's only for healthcare and not the social care needs? (UA2:28, Discharge Liaison Nurse).

Amongst healthcare practitioners the role of care coordinator was confused with brokerage and advocacy roles. This was compounded by the failure to refer to the care coordinator in key health-related strategies (such as the *Community Nursing Strategy for Wales*, Welsh Assembly Government, 2009) and also by the failure to make explicit that care coordination is a vehicle for addressing core policy objectives relating to integrated care.

After speaking to strategic staff from across Wales, we found no evidence of local, jointly agreed protocols to underpin care coordination, nor the development and operation of virtual care coordination teams nor the formulation of cross-boundary care coordination agreements:

There's no agreement then over who is going to be the care coordinator [...] that process still isn't in place (UA2:17, Health Board Manager, Long-term Conditions).

These protocols should provide a platform for operationalising the principles of care coordination and promoting shared understanding of the structure, organisation and management of virtual teams.

Whilst Policy Guidance specifies that arrangements for care coordination must be recorded in Personal Plans of Care and up-dated as necessary, practitioners reported that a named care coordinator does not always appear in the documentation. It is often assumed that a particular individual acts in a care coordinator role but this is not always made explicit to practitioners, older people or carers. Both strategic and operational staff described an ad hoc approach to the recording of care coordination information, noting confusion at practice level as older people progress along their care pathway:

Basically it's rubbing out one person's name and putting another name there, it's as simple as that on a piece of paper really, but you need to make sure that other people in the team are aware of it as well [...] often they're not (UA2:06, Care Manager).

Practitioners reported that older people rarely experience what Heffernan and Husni (2009) term relational continuity with a named care coordinator. The lack of a consistent point of contact means that individuals continue to repeat information. In this respect UA has failed to meet its core policy objective of reducing duplication of effort for older people, their carers and practitioners.

### *Embracing care coordination across health and social care*

Guidance is explicit in specifying that care coordination applies to both health and social care, and indeed recommends that where a person's main needs are health related a nurse or other healthcare professional should assume the care coordinator role. However, care coordination was seen as a social care responsibility and as synonymous with care management:

I think there is still a presumption in this area that it's going to be the social worker (UA1:05 Care Manager).

We are the care coordinators by default (UA2:9, Care Manager).

A primary concern of the interviewees related to who acts as care coordinator. Health staff reported being neither willing nor able to take on the role. Social services staff felt that they did not have any choice. This may reflect the limited impetus, at national level, to take forward UA from within the health division of the Welsh Government following the publication of the 2002 Guidance. Staff reported:

[...] everybody goes "Ooh" particularly in health [...] it was very much seen as social services (UA2:2, Nurse Director).

This contrasts with the Single Assessment Process in England, where health was a key driver and closely involved at initial implementation. In Wales, staff reported that schedules for the implementation of UA in health lag considerably behind social care. The fragmented approach at

strategic level has impeded progress on the ground. Consequently, local authorities were seen as the drivers of UA at local level and there was limited ownership of the care coordinator role amongst healthcare practitioners:

There is no real sense of ownership or responsibility from the staff (UA2:21, Lead Occupational Therapist).

The importance of coordinated, strategic level support to promote shared goals, expectations and objectives and encourage clarity of roles was highlighted:

The health and social care sides of WAG need to pull together (UA1:02, Local Authority UA Lead).

Leadership [...] for goodness sake get these two portfolios joined up (UA1:06, Local Authority UA Lead).

The potential to lose sight of core UA objectives, in the absence of strategic level support from health, was noted.

Health and social care staff acknowledged that ambivalence about the care coordinator role and the reluctance by healthcare practitioners to take on this role, detracted from the development of more integrated ways of working. The role was described in negative terms by healthcare practitioners. The potential for the care coordinator to make a difference to the everyday lives of older people was not always recognised. For example, encouraging seamless approaches that emphasise problem solving, maintaining independence and responsiveness to changing needs.

### *Engagement of key professional groups*

Research conducted in Wales (Hannigan and Allen, 2011) suggests that government policy is challenging traditional assumptions about the work professionals do. Greater flexibility in working practices is encouraged and roles are becoming increasingly blurred. Set in this context, we identified difficulties engaging some professional groups in care coordination activity, which is not a role associated only with a specific discipline or profession. Occupational therapists in particular were resistant to what they perceived as the blurring of professional roles:

I've become an OT because I wanted to do occupational therapy, not be a care coordinator (UA2:26, Occupational Therapist).

This was noted by other strategic and operational staff, who highlighted the challenges of breaking down established professional practices, leading to compartmentalised, or "silo" thinking:

[...] there's some fear, again, some practitioners are saying "well, I'm not going to be a care coordinator. I just provide therapy" (UA1:03, Local Authority UA Lead).

[...] the person who'll be the care coordinator has been very thorny for OTs and a very anxiety-inducing role because at some stages it was seen that this person would be totally responsible for arranging, for instance, the whole package of care (UA1:02, Care Manager).

Policy Guidance acknowledges that the contribution of occupational therapists to the assessment and management of care is often under-recognised. It suggests that therapists should contribute to all aspects of the UA process, making a specific contribution to the conduct of specialist and comprehensive assessments as well as the development and coordination of care plans that focus on rehabilitation and promoting independence. However, we found evidence of OTs engaging in identity work (Allen, 2000) to support their positions and circumscribe their roles to exclude care coordination activity. For example, they were reluctant to share evidence in support of their professional judgement in ways that comply with locally agreed UA documentation and consistently emphasised their duty to discharge specialist roles and responsibilities. This creates tensions in practice that negatively affect the delivery of seamless support to older people and also disrupts work undertaken locally to enhance trust in one another's professional judgments.

The perceived encroachment of professional boundaries was raised during the focus groups, generating a lively debate between OTs and care managers. The time limited involvement of OTs was emphasised. OTs suggested that traditionally care managers see themselves as the

coordinators of care because of their long-standing involvement with older people. This was disputed by care managers, provoking anger:

[...] there seems to be pockets of other staff that have said they're not going to take this on board and perhaps "force" is the wrong word but it just doesn't seem fair that certain groups of staff can opt out and other staff have had to try it (UA1: Focus Group Participant).

### *Care coordination – infrastructural and capacity issues*

Nurses (community and hospital based) and occupational therapists feared that becoming a care coordinator would compromise time for undertaking preventive work, completing specialist assessments and delivering patient care:

I think it would just clog up our [...] and not allow us to do our specialist assessment [...]. I think it's better placed with the social worker at the moment [...] I don't believe it's a role that I would like to be doing to be honest (UA2:26, Occupational Therapist).

CPNs and nurses, they don't want to touch it with a bargepole [...] it's the responsibility of coordinating all the services, if there's a problem you have to deal with the problem and they know full well the paperwork that's involved and the knock-on effect [...] they're more than happy that social workers exist 'cause that's the last thing they want (UA2:47, Local Authority Team Manager, Older People).

Healthcare practitioners said they did not possess the skills needed to effectively care coordinate, in particular, the administrative skills required to organise case conferences. They made what Allen (1998) terms jurisdictional claims, that is, knowledge-based appeals to control tasks and activities against the claims of others. For example, nurses reported that pre and post qualifying training focuses on the acquisition and refinement of clinical skills and what Culverhouse and Bibby (2008) term profession specific work. Whilst the importance of acting in the best interests of older people by being flexible in relation to who assumes the care coordinator role was recognised in principle, jurisdictional claims acted as a barrier to operationalising care coordination in practice.

Highlighting fundamental infrastructural constraints, all staff across health and social care agreed that healthcare practitioners were hindered by a lack of administrative support to undertake and manage care coordination activities:

Care coordination is more than just collating all the assessments, isn't it? It's about managing reviews, the monitoring process; it's about making sure that reviews happen formally and in a timely manner. So there are lots of issues that they haven't got the infrastructure in health to manage. You know, the District Nurse hasn't got an admin that she can call on saying "well can you arrange this review meeting?" which could entail, to be fair, on the high end, quite a few people (UA1:01, Local Authority UA Lead).

Enduring problems relating to IT systems, which are a critical part of the infrastructure required to deliver UA, as well as longstanding difficulties reaching basic agreements on the sharing of information, were problematic for the care coordinator:

Because to coordinate that you need information with you and currently you can't because the electronics aren't there to support it and the will isn't there either because nobody wants to touch this (UA1:01, Local Authority UA Lead).

Because we can't actually access their computer system and they can't access ours, then we've got in effect two systems going on one person (UA2:6, Care Manager).

We need an electronic system because we will drown in the paper (UA1: Focus Group Participant).

Some fundamental practical issues were raised. For example, hospital and community nursing staff had limited access to networked computers, which compromised their ability to undertake basic care coordination tasks:

Community Nurses, for instance, haven't even got the hardware, you know, if you're talking about electronic transfer of records or access to electronic data, they haven't even got hardware or laptops (UA1:16, Local Authority UA Lead).

The 2002 Guidance acknowledged that fully operational IT systems are unlikely to be in place for some time. Over a decade on, our findings confirm that across Wales timescales for the implementation of robust electronic UA systems are problematic. Electronic information sharing

was not routinely embedded in practice. Whilst it is beyond the scope of this paper to report on IT systems or to profile difficulties relating to the sharing of information across professional groups, it is nevertheless important to note that current operational systems significantly hindered the work of the care coordinator.

## Discussion

UA presents opportunities to implement seamless approaches to supporting older people with complex needs. However, the assessment and management of care falls short of the unified approach overseen by a care coordinator that was envisaged in the 2002 Guidance. Difficulties relating to the implementation of the care coordinator role present a fundamental barrier to realising core policy objectives that require joined-up working.

Experiences related by staff highlight a number of fundamental challenges, including a lack of shared understanding of the care coordinator role and difficulties in coming to terms with the need to work flexibly and traverse traditional professional boundaries. Care coordination appears constrained by restrictive thinking and practices, as well as longstanding capacity problems and difficulties agreeing and implementing shared systems.

Despite differences between Wales, Scotland and England, for example, the shift towards integrated personalised planning and the piloting of a common assessment framework for adults in England, our findings offer insights that are instructive to policymakers and practitioners across the UK. UA shares the same underlying principles as the Single Assessment Process in England and the Single Shared Assessment Tool in Scotland. Similar problems relating to assessment and care management have been reported across the devolved regions (Clarkson *et al.*, 2009). We consider the issues that policy makers and practitioners might find helpful in focusing their efforts on bridging the gap between policy and practice. Whilst this is based on our work with staff involved in supporting older people, the recommendations have relevance for other service user groups.

There is no blueprint for effective care coordination given the diversity of situations that individuals face. However, joint ownership of the care coordinator role is essential, as issues affecting people with complex needs usually transcend the boundaries between health and social care. Key policy initiatives, such as *Building the National Care Service* (Department of Health, 2010b), *Fulfilled Lives* (Welsh Assembly Government, 2007) and *Designed to Add Value* (Welsh Assembly Government, 2008) reflect the need for partnerships across health and social care, as well as between the statutory and independent sectors. Strategic coordinated direction from within the health and social care divisions of the Welsh Government, as well as from organisations representing the various professional groups, is necessary to facilitate a whole systems approach to the assessment and management of care. Organisations need to ensure that:

- effective local partnership arrangements are developed to help achieve clarity of roles and an appropriate balance of duties; and
- the links between care coordination and other policy initiatives are made explicit.

The strategic direction is a critical first step in effecting positive change and reinforcing the shared nature of responsibility and importance of the care coordinator role.

In their work looking at discharge planning and transitional care, Holland and Harris (2007) suggest that the failure to define and use terms consistently acts as a barrier to good practice. Similarly, Ehrlich *et al.* (2009) emphasise the importance of shared understanding of key concepts. The use of different terminology by practitioners to describe the care coordinator should not continue to obscure the importance of the role and associated activities. More prescriptive guidelines, including a formal role definition that offers a common terminology, might help alleviate confusion and raise the care coordinators' profile. Indeed, recent work by Challis *et al.* (2010) suggests that policy initiatives may need to be more prescriptive if they are to realise their intended outcomes.

Building future capacity to undertake care coordination in health is important given the increasing population of older people and the rising prevalence of chronic conditions. In particular, administrative infrastructures within health should be strengthened and must not



continue to act as a barrier to the delivery of seamless support. The perceived additional demands on workload, associated with the care coordinator role, must be offset against the duplication of professional resources and crisis management activity that is often the outcome of a lack of coordination. This is particularly important in the present economic climate given the need to make public spending cuts and achieve improvements in efficiency and systems performance. Indeed, the Welsh Government (2011) emphasises the need for expertise to be used more efficiently and effectively and for greater cooperation across professional boundaries.

Our findings point to the need for improved operational processes to facilitate information exchange. Investment in the IT infrastructure to enable effective care coordination is long overdue, as is further guidance relating to the composition and operation of virtual care coordination teams. Welsh Government acknowledges the need for national direction around strategic requirements and to ensure that IT systems can interface with each other (Welsh Government, 2011). They view this as an issue for local government to resolve.

Addressing fundamental problems of access to IT facilities for healthcare practitioners, in particular networked computers, is a priority if they are to be supported to effectively care coordinate. The care coordinator cannot operate optimally using paper-based systems. Basic steps need to be taken, not least making available the full range of assessment documentation and care plans in electronic format to relevant practitioners. Integrated health and social care records would transform the assessment and management of care and the work of the care coordinator. We do not underestimate the considerable challenges this entails, in particular, agreeing a universally compatible system design and funding the necessary infrastructure and systems development. However, it would helpfully underpin future care coordination practice. Whilst IT is an important tool it is not a panacea. It is essential that staff do not expect it to resolve all difficulties relating to the transfer of information between professionals and the coordination of care.

Research highlights the importance of continuity of the care coordinator (Heffernan and Husni, 2009). Information about who the care coordinator is should be routinely recorded on Personal Plans of Care, updated and communicated, in particular to older people and their carers. Team managers should reinforce the importance of this recording through staff supervision and practice governance arrangements.

Our findings highlight basic training needs to support professional practice. Future training and continuing professional development should build upon the Strategy for Joint Staff Training outlined in the UA Guidance, by focusing on:

- agreeing common terminology;
- encouraging joint ownership of care coordination; and
- making explicit the contribution care coordinators make to supporting older people with complex needs, as this is not always recognised by all of the service providers involved.

Consistent with previous research (Tucker *et al.*, 2009) we found that health and social care practitioners continue to be protective of their territories. Measures to facilitate integrated practice remain poorly developed. Thus, joint training continues to be important in achieving change and supporting high levels of competence. This is particularly important given the increasing requirements for practitioners to work across disciplines, professional boundaries and organisations in order to develop joint roles and integrated ways of working. Training should be reinforced by work place monitoring and encouragement of good practice.

Recent years have seen a focus on evidence-informed practice and the development of tools to support policy implementation and change (Nutley *et al.*, 2007; Rycroft-Malone and Bucknall, 2010). The Welsh Government has committed to a greater focus on evidence-informed practice and disseminating research findings across health and social care (Welsh Government, 2011). Our findings highlight the potential utility of an

evidence-informed intervention to support the role of the care coordinator, in particular to help to:

- encourage shared understanding of the care coordinator role, its importance and purpose;
- assist the development of local care coordination protocols that encourage the adoption of flexible, potentially more seamless and effective arrangements for supporting people, including virtual care coordination teams;
- facilitate improved integration of support across providers and between generalist and specialist care, including the contribution of occupational therapists; and
- strengthen professional practice by meeting identified training needs relating to the integrated management of complex care.

We recognise there are no simple solutions and do not underestimate the complexity of this task. Building on the work reported here, our directions for future research include plans to develop, pilot and evaluate an intervention across UK study sites to test potential solutions to problems faced in practice, assist in implementing the recommendations made in this paper and support the development of more innovative practice that makes a positive contribution to the everyday lives of older people and their families.

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