OUR LAST 1,000 DAYS

STRATEGISING SOCIAL CARE FOR OLDER PEOPLE

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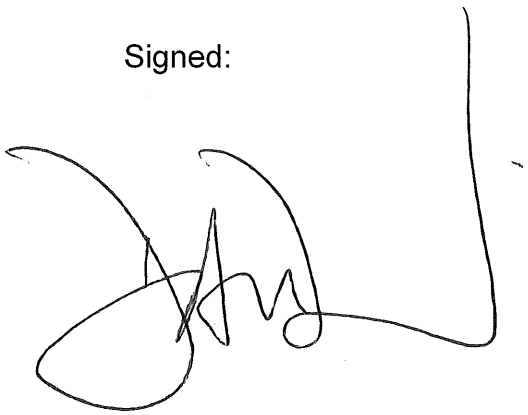
Declaration

This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for an examination which has led to the award of a degree.

Signed:



Dated: 15th February 2020

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The Essence of My Thesis

My thesis uncovers from key field strategists that for many older people there is a 'cliff-edge' of care between care-at-home and care-home. At such an interface, framed as 'our last 1,000 days,' many people face a choice of trading away the vital ingredients of quality of life for their safety. These vital ingredients – powerful contributors to well-being – may be said to be derived from:

- The power that one's ***home*** has to provide identity, autonomy and security,
- The role of independence and ***autonomy*** that enables each to pursue their individual interests and pursue individual happiness,
- The power of community, ***relationships***, family and, where possible, a life partner to enable autonomy, functioning, capability and quality time.

Very understandably, few older people trade away the blend of these ingredients willingly, and as such entry into a care home seems to follow a pattern of unplanned hospitalisation at times of great stress to the individual and considerable health and financial cost.

Instead of this cliff-edge of care, my thesis uncovers from field strategists a belief that there is a place for clusters of housing-with-care environments at this interface between care-at-home and care-home. In England these environments are referred to as Extra Care. Therein, the three contributing elements to quality of life of home, autonomy and relationships may continue to do so, rather than (to a large degree) be removed. These clusters are home-

like, ensure autonomy and are located where the older person has always lived. Coming with the help of an advocate to assist with the navigation through the unfamiliar territory of statutory and other services, an alternative along the dimension between care-at-home and care-home is visualised by the field strategists. A missing alternative to institutional care.

According to the strategists, and given the present unaffordable trajectory of health and social care, such clusters have the potential to generate well-being in ways that are equitable, effective and sustainable. I induce from them a strategy skeleton that matches the resources available to the outcomes desired: namely of home, autonomy and relationships. Onto this skeleton I add flesh from other research as abducted from best empirical practice, personal experience of building over 1,000 homes and the Extra Care literature. This detail considers clusters of homes, their form, number, scale, staffing, tenure and financing. Since Extra Care is becoming ever more widely available in England, and is part funded by the Department of Health there, I advocate that Extra Care be available in Northern Ireland, and my research provides a framework for same – The Extra Care Plus Framework:

- **a focus on communities and relationships that can**
- **provide an Extra Care housing nucleus in domestic clusters**
- **as supported by community navigators, who in turn may**
- **manage a new, mixed economy of care for residents and the wider community.**

Executive Summary

Problem Statement

If each of us knew that we had only 1,000 days left to live, I wonder how we might like to spend such time? The chances are that we might like to spend our time along with our families and engaged, should we so choose, with pursuits that we may find fulfilling. If this is the case, then perhaps a public strategy for the social care for older people might configure the resources that may be to hand in order to best enable these outcomes for us. My thesis examines how a strategy can be configured as to achieve these outcomes better.

That people are living longer worldwide is to be celebrated, but along with this success comes significant challenges for individuals, families and society. To illustrate the scale of this challenge, consider that in the UK, one person in six born today are expected to live to be 100 years old, some 10 million people, rising from some 13,000 today. Such rapid growth has been evident in Northern Ireland where the Northern Ireland Statistics and Research Agency found that between 2007 and 2017, the number of people aged between 90 and 98 grew by 55% from 1,956 to 3,029 (NISRA, 2019). In this cohort, a great many find themselves at the ‘interface’ between care-at-home and care home, torn between their deep-seated desire to maintain their quality of life through remaining in control, and their capability to do so. Many are forced to trade in their independence in return for the security and standardised interventions of institutional care.

Regrettably, such care is not well suited to maximise the individuals' quality of life. Nor is it financially sustainable. Mean care costs for 65-year-olds are £2,000 per year, whereas costs for 85-year-olds are closer to £12,000 per year (Bengoa et al., 2016). Such expense is partially due to unplanned acute care events by older people living at home at this interface, as well as the costs relating to the number living their last 1,000 days in institutional care.

Demographics, costs of institutional care, plus non-elective and extended stays in acute care are significant reasons behind the health and social care system finding itself on an unsustainable trajectory. The resulting pressures on the acute care system mean that a different strategy is sorely needed. Such a strategy may well be an approach that enables older people's autonomy, but with security. It may likely take the form of a housing-with-care environment that enables the well-being contributions of the home, autonomy and relationships.

Accordingly, it has been long recognised that for those older people at the interface between care-at-home and care home, enabling them to remain in control via housing with care both maximises their quality of life and constitutes cost-effective care. Indeed, as I detail within Section 1 of my enclosures companion document, in Northern Ireland, there have been successive policy initiatives for over 30 years that have advocated creating more clusters of housing-with-care. Therein, it has been long recognised that older individuals and older couples may retain control and pursue their own happiness in ways that suit their idiosyncratic needs and desires. As such, housing-with-care has always seemed a promising way to addressing the longstanding strategic

problem of spiralling care costs. However, the problem is that there has been no conceptualisation of an integrated public/private policy nor strategy to procure these clusters of care. My thesis aims to contribute to filling that void.

Research Question

A principal aim of health and social care may be said to be the maximisation of well-being for older people. My enquiry examines the factors that contribute to such quality of life aims, especially at the interface between care-at-home and care-home. The question is how to better match the resources and capabilities which are available against these well-being aims.

In developing these thoughts further, I show that quality of life may be said to be manifested under the three dimensions of the *home, retaining autonomy, and the gift of relationships*. I expose that for older people their home is a representation of success and quality of life. It embodies self-mastery, and the security that it affords enables good well-being outcomes, including those that are derived from relationships. This central contribution that the home has for quality of life has ramifications as older people's cognitive and physical abilities diminish – their last 1,000 days. One repercussion, according to literature, is that older people resist moving as it requires giving up their badge of autonomy and success – their home. They put off apprehending their situation, at the interface between care-at-home and care home until they are forced to, often at a point when they are most vulnerable, perhaps following successive falls and non-elective hospitalisation.

In my enquiry, I encourage the field strategist participants to consider quality of life in Northern Ireland for older people (and their spouse carers) who are navigating this interface between care-at-home and care home. The sample is drawn from the highest levels of executives across the fields of health, social care, and housing. They include a past Minister, a dementia specialist geriatrician, a Chief Nursing Officer, a Director of Older Persons Care within the Department of Health, a CEO from one of the Health and Social Care Trusts and CEOs from charity and housing association sectors.

While being mindful of the contributors to quality of life that are derived from of home, autonomy and relationships as well as socio-political and financial constraints, I ask the field strategists to consider the health and social care system for older people in Northern Ireland and how it might be improved.

Research Motivation

During the financial crisis and great recession of 2008-2010 house prices halved in Northern Ireland and the number of buyers also halved, leading to a drop in the revenue of my housebuilding company of 75% and its existential crisis. Still now, writing in 2020, many of those who bought their first home between 2003 and 2010 remain in negative equity. Moreover, Northern Ireland has (in 2019) yet to get back to its levels of economic output of 2007. Thus in 2009, having built over 1,000 homes and a specialising in homes for second time buyers, I was required to transform my business and the market into which its products were offered, away from those without equity and towards those who were in a position to buy. Such products were outsourced, timber frame built (for better working capital management) and were largely detached to

appeal to those with equity, including older buyers. I designed and built over 20 homes focused on an older cohort that included single storey homes, two storey homes that may be adapted for ground floor living with a carer apartment above, and in an apartment format. Each of the homes were large enough to accommodate a lifetime of memories. However I found that few buyers were compelled to move and sacrifice their existing lifestyle in anticipation of their own cognitive/physical decline and needing personal care. Conversely, those compelled to move were rarely in a position to buy a new-build home – hence, in a nutshell: *90-year olds don't buy houses.*

Accordingly, I set about designing a form of dwelling that could be rented, and it took the form of large apartments in an attractive building as a prototype for Extra Care (see figure 25) and I designed a further cluster of 26 homes in this style along with attributes for staff, guests, communal eating and recreation. Since, as I demonstrate herein, building to rent is not a viable business proposal, such a rental initiative likely requires stimulation by government, similar to the Extra Care stimulation by the Department of Health in England.

I was unable to gain traction with the concept on the ground, partly due to a lack of a cogent strategic rationale. This thesis represents this missing jigsaw piece.

Research Methods

My principal enquiry consists of 25 semi-structured interviews with participants drawn from the fields of health, social care and housing from whom I induce and articulate theory. I ask them with my preconceptions exposed (bracketed)

and as an ‘insider’, meaning one capable of eliciting valuable insights thanks to a career as a volume housebuilder and as one mindful of the success of Extra Care in England. Extra Care is a means of care for older people centred on clusters of appropriate housing and integrated with the community. Therein older people may rent a home with care on hand rather than moving into a care home, and with couples remaining together.

The interviews are given structure by my introduction of the archetype of ‘Conor and Joan’. This vignette finds Conor living with dementia at the interface between care-at-home and care home. It describes Joan as being unable to lift Conor and living with depression. The story, provided in advance, allows participants to expand on their views as to how such a common situation plays out for Conor, Joan, their family, and, when aggregated, for society.

My enquiry methods are phenomenological, and I enquire how the expert strategists make sense of the quality of life of older people at the interface and theorise to improve their quality of life. I ask them to explain the objectives of social care, how they are being achieved, how effective are such methods, and, given the trajectory that they witness, what the future may hold. Under a strategy-as-practice perspective and by using Decision Explorer software, I generate several cognitive maps from each of the mapped participants to present how the complex issues that we discussed interrelate within each participant’s lifeworld. Prompted by the Conor and Joan vignette, these cognitive maps afford an existential-phenomenological analysis into the day-to-day choices that the field strategists make and constitute their explicit and implicit strategic positions concerning the social care of older people.

I use the ‘data structure’ technique from Gioia et al. (2013) to ensure that the maps fairly represent the views of the participants. In so doing, I offer the ‘Relevance/Amplification Score’ (RA) as a methodological contribution when determining which of the many themes mentioned by participants are most relevant. Using the RA, I rank the scoring of the topics based on the number of mentions multiplied by the given emphasis on each occasion.

I then explore each of the 30 most relevant themes hermeneutically by cross-referencing over 150 direct quotations against them, and in so doing, I match the quotes against essential items. By matching the quotes against the 30 themes, I ensure that the richness of the participant’s voice is not lost during aggregation. Moreover, I carry out an additional methodological contribution as I attribute meanings to what the participants were getting at when they said what they said. I have referred to this technique as my asking the ‘so what?’ question to tease out meaning. I do this by my considering a quote in the context of a specific theme and then posing a ‘so what?’ question. This displays my interpretation of the participants meaning and often either provides a valuable insight, or shows links to other issues. In this way, the answers to the ‘so what’ questions become essential building blocks for the induced theory.

I synthesise the participant’s priorities and strategic propositions into two action-orientated causal maps. The first causal map is entitled ‘Change Drivers’. In it I present the reasons behind the care crisis and I map the relationships between the underlying issues. The second causal map that I call

‘Strategy Outputs’ shows the relationships between the ways to improve quality of life for older people and represents a map of social care strategy.

Primary Research Findings

As prompted by the vignette, the field strategists agree that the social care system in Northern Ireland poorly addresses quality of life. Such findings reflect my secondary research into the long-failed efforts of the health and social care system, which for 30 years has recognised that a significant way to improve quality of life for older people is through independence and housing. Yet throughout that time it has consistently failed to implement policies to afford such care models. The field strategists confirm the literature conclusions − that presently the focus of social care is derived from a health model, namely, to make (passive) sick people better rather than maximise their well-being. They consider that better social care must come from affording independence, enabling co-production, control and self-determination. They recognise that, somehow, a housing-based care model will actively contribute to this being achieved in an equitable, effective and sustainable way: the question is, how?

I probe the field strategists as to what would make things better. When synthesised, this articulation represents the field strategists’ framework of strategy proposals to cost-effectively achieve the objective: namely to improve quality of life for older people at the interface. Their framework illustrates how they match the available internal resources and capabilities to hand when seeking to fulfil the objective within a fluid external environment.

The objective is summarised as the maximisation of quality of life for older people at the interface between care-at-home and care home whose quality of life is derived from the three dimensions of *home*, *autonomy* and *relationships*. The field strategists agree that presently the available resources are configured poorly, and I expose how they do strategy when proposing to better match the resources and capabilities that are to hand. The resources and skills that they focus upon centre upon *enabling* each older person's capabilities. *Enabling* maximises control and, in turn, quality of life by using 'enabling structures' such as an older person's housing, their independence, their community, their family, and a community navigator. The strategists consider that each of these enabling structures may be individually configured to achieve the strategic objective of quality of life, and I articulate this within the strategy skeleton.

Abducted Research – Conceiving Extra Care Plus

Onto this strategy-as-practice skeleton I add the flesh of how Extra Care works in the rest of the UK, along with how I have built similar varieties of homes and financial considerations. Together this leads to a theoretical configuration of care: it is within a housing format, it leverages relationships and enabling structures, and it uses private and public finance to cost-effectively produce welfare. As so fused, this conceptualisation is presented as a framework of Extra Care Plus (ECP), where 'Extra Care' means the physical environment of clusters of housing within which care is provided, and the 'Plus' refers to how *housing* becomes a *home,* and, in the process, underpins quality of life. It does this by incorporating the other two domains of quality of life mentioned, namely

autonomy and relationships. These domains are, in turn, contributed to by a reflexive mix of resources and capabilities that match the quality of life dimensions of autonomy and relationships. They include family, friendships, community, social care services and a community navigator (defined below). In all, the ECP framework thus seeks to capture a strategic solution for the stated problem by configuring various resources and capabilities:

- ECP conceives homes for older people where care is provided while maintaining an older person's independence and family unit.
- ECP homes afford the residents security of tenure and enable control over who comes through their door.
- Since older people very often do not consider moving until they are unable to do so, ECP homes are conceived as being available to rent either through a housing association or via private rent (because 90-year-olds do not buy houses).
- ECP is located in each town and community over a certain population threshold (I suggest 10,000).
- ECP facilities range in scale from 20 to 30 households in each.
- Each ECP facility has a full time 'community navigator' (CN) on hand and enabling structures such as restaurant facilities. The CN helps residents and the wider community to be integrated and maintain their independent status by coordinating their formal and informal care. The CN ensures effective use of a person's statutory care allowances via self-directed payments and effectively arranges for these to be topped up as needed. The CN helps an older person to pursue their own happiness, such as through sharing time with people and day trips. Through informal care channels, the CN will also very likely stimulate more family care, such as by including them along with professional carers in an older person's rota, as well as incorporating local volunteer networks.
- Depending on location, the ECP facility will incorporate additional recreation facilities such as affording communal eating, a guest

apartment for relatives to stay, gardening, and other collective managed structures and activities that enable well-being.

At its heart, ECP consists of homes for older people to move into as an alternative to a care home. Couples such as Conor and Joan may remain together, in control, and with help where needed. ECP theorises that by continuing to be autonomous Conor and Joan may maximise their quality of life at minimum cost to them, their family and the taxpayer. Thus, as Joan casts around for her options with Conor falling and as she faces putting Conor into institutional care, ECP is conceptualised as providing Conor and Joan with a valid option for Conor's last 1,000 days. The alternative is the present 'cliff edge' of care.

The context of Northern Ireland

In contrast to the rest of the UK, Health and Social Care are integrated in Northern Ireland (readers may note that I describe its structures within my enclosures document.) Despite this difference, I show that the strains on social care that are being felt in England are felt just as keenly in Northern Ireland.

Now I briefly contextualise the UK system compared with other parts of the world. Broadly speaking, national systems for social care may be said to be a choice between a universal approach with accommodation costs (referred to as 'hotel costs') normally excluded; a social insurance approach (with possible co-payments) or a thirdly, by a means-tested approach.

One analysis that compared the UK means-tested system with the broadly social insurance systems of Germany, France, and Japan, was carried out by

Fernandez and Forder (2012). They found that a social insurance systems had positive effects in fostering an awareness of social care, and that when co-payments were employed, such as the 10% charge applicable in Japan, many of the inefficiencies/perverse behaviours characteristic of universal or means-tested systems were mitigated. On the other hand, the authors found that that the overall spend as a percentage of GDP, was more focused in the UK on the less-well-off sections of society when compared to Germany for example. This was found to be mostly due to the UK 'safety net' characteristics (ibid., p. 354).

Thinking of the role of clusters of care in a housing format for a moment. In my thesis I have detailed relevant research from other countries into the meaning of housing and its role for quality of life. Also, in jurisdictions such as the U.S.A. and Canada, such clusters are broadly available privately, and in European countries broadly available via public provision. However I have been unable to uncover any research that takes the next step that I seek to do – namely by seeking to pinpoint the marriage of private and public capital in ways that can stimulate the widespread creation of such clusters. Despite the same problems existing across the western world, the knowledge gap into which I seek to contribute, seems to be international.

Implications for Policy

In my Enclosures companion document, I show that for over 30 years in Northern Ireland, the health and social care system has recognised that a critical plank of an older person's social care needs to be through maintaining their independence, often via specialist housing with care. However, it has been unable to conceive and procure a scalable model of such housing-based

care. Perhaps this has been due to the system being hard-wired to make sick people better, or perhaps it has been due to it being unable to apprehend procurement outside of the public sector. However, overall the care system's structures presently poorly fit the environment that it faces.

To strategically address this poor fit implies adapting internal processes to fit the external environment better. To do so ECP conceives how to procure a scalable model of care and by using resources and capabilities that are social and personal to better fit the objectives of quality of life that are also social and personal. By so doing my thesis conceives a framework of ECP to better align the system of social care to the environment in which it now operates.

The salient elements of the Extra Care Plus framework are to increase the supply of Extra Care housing for older people to add:

- **a focus on communities and relationships that can**
- **provide an Extra Care housing nucleus in domestic clusters**
- **as supported by community navigators, who in turn may**
- **manage a new, mixed economy of care for residents and the wider community.**

Since Extra Care maintains independence and quality of life, is cost-effective, but is presently absent from Northern Ireland, it seems there is a clear gap in how the quality of life for older people is manifested there. My thesis, forged from the expertise of the field strategists, is one that advocates filling this gap with Extra Care Plus.

Acknowledgements

I wish to thank my wife Hazel, supervisors Alec Morton and Viktor Dörfler, and business partner, Norman Philpott. Without Hazel's unstinting support, I would have been unable to conduct my research. Together Alec and Viktor offered crucial direction as well as welcome encouragement, and Norman's indulgence for the considerable time that I have devoted to the DBA over almost five years has been vital.

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1.0 Introduction

1.1 The Aims and Objectives of the Research

1.1.1 Aims: Their philosophical context

When considering how to capture the overall aims of my research, a useful summary of philosophy that seems to reflect my intentions caught my attention. It was Michael Sandel's recent response to a deceptively simple question: what is philosophy? He replied that philosophy is 'critically reflecting on the way things are, that is to say, the present social, political, and economic arrangements, and to be open to the possibility that things could be both different to how they presently are and could be better' (Sandel, 2010, min. 22.01).

I aim to reflect on the way things are for older people in Northern Ireland during their last 1,000 days, be open to the possibility that things could be better, starting with what factors contribute most towards well-being. Perhaps as a participant put it, 'life is about creating stories together'.

1.1.2 Aims in context

Many older people, due to frailty, isolation or cognitive decline, need some assistance in their later years. Often, for physiological reasons, staying at home becomes problematic, and older people and their families encounter the need to consider residential or nursing care. The problem is that satisfying a person's physiological needs is insufficient for quality of life. Standardised interventions associated with institutional care, such as doing things 'for' older

people and ‘to’ older people, may satisfy physical needs, but are unlikely to afford the well-being that comes from the dignity that independent fulfilment generates. Not only are the quality of life outcomes from state interventions limited in their effectiveness, they are also expensive. In the context of the financial pressures on the health and social care system in Northern Ireland this poor productivity in the production of welfare is regrettable.

In his 2016 report, Professor Bengoa highlighted that the health and social care system requires ‘transformation’. The costs of social care for older people are a significant cause of the system being on an unsustainable trajectory. In turn, some of the causes of cost increases are due to demographic changes: for example, the NISRA report recently found that the number of people aged between 90 and 98 grew by almost 55% between 2007 and 2017 (NISRA, 2019). When these numbers are multiplied by the costs of care, the care costs implied become immense. Bengoa et al. (2016, p.13) presented the relationship between care costs and age in a graph that I have redrawn and present in Figure 1.

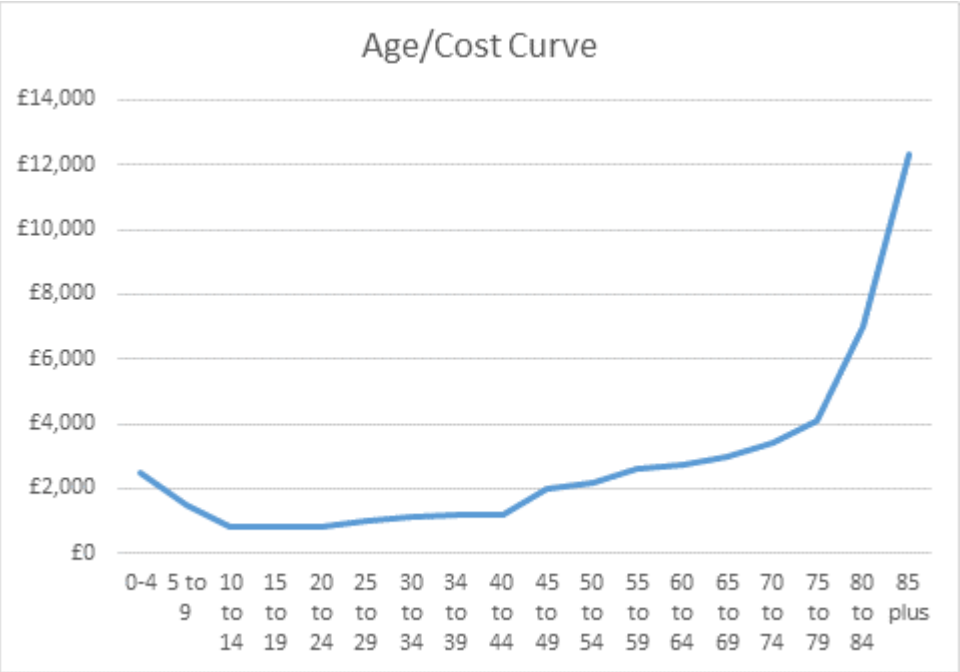

Figure 1: Age/cost curve from Bengoa et. al., 2016

(Adapted from Bengoa et al., 2016)

Professor Bengoa concluded that the quickly rising number of older people multiplied by the dramatically higher health and social care costs is a significant contributor to the system being unsustainable and that it requires transformation. Accordingly, to contribute towards a strategy for the sustainability of the health and social care system, as well as better quality of life for older people, the aim of my thesis is to articulate a better strategy that maximises quality of life for those in their last 1,000 days in a way that contributes to the sustainability of the entire health and social care system.

1.1.3 Objectives

My thesis considers the contributors to quality of life for older people and strategises how to harness these contributors better. I expose three central contributors to quality of life as being across the dimensions of the *home*, *retaining autonomy*, and *the gift of relationships*, and I consider that it is understanding these resources and capabilities more deeply that may lead to them being configured together more effectively. In doing so, I expose the objectives as being how to configure such resources and capabilities that are readily available in order to maximise welfare across these three dimensions of home, autonomy and relationships.

1.1.4 At the interface between care-at-home and care home

Given the central importance of home for those in their last 1,000 days, I explore why it is that older people leave. Is leaving a positive choice? Is leaving one's home of 40 years seen as a success? Or is there a 'cliff-edge' of care, where care is provided at home for as long as is possible, and then, perhaps following a succession of falls and non-elective hospital stays, entry into a care home follows? Possibly at this point, many older people – or very often their family – trade their independence for safety. Perhaps with such a pattern, it becomes inevitable that quality of life becomes a secondary consideration.

Rather than a binary choice of trading independence for safety, my thesis asks, 'Where is the storytelling factory?' This phrase encapsulates how older people's engagement, socialising, and fulfilment needs are central to their quality of life outcomes. Enabling them is likely to have a multiplier effect on well-being, trading them away, the opposite. Furthermore, keeping couples

together can add to this multiplier effect. Thus, when older people consider institutional care, it is likely that having alternatives available where couples may remain together and where autonomy may be maintained is where the quality of life outcomes for many can be maximised.

Such care formats exist, allowing many older people to maintain their quality of life better thanks to being helped to remain independent. These formats are centred on housing for older people and incorporate care features. A commonly used term for such environments is Extra Care, and it has been evaluated extensively. For example, the Personal Social Services Research Unit on behalf of the Department of Health (e.g. Bäumker et al., 2011; Darton et al., 2011) found that Extra Care increased the quality of life for older people, their carers, and their partners at lower costs for government departments. As a result, NHS England/Homes England have increased their investment in Extra Care (Homes England, 2019). Other UK regional governments have also approved the Extra Care projects that they have assessed. For example, Petch (2014) described the benefits of Extra Care for Scottish policy, and regarding Wales, in 2013 their government stated:

> Overall, it was concluded that the Tan Y Fron Extra Care development has the potential to be highly beneficial for the Tudno area, its local people, and support some of the most vulnerable in society (Wright, 2013, p.12).

However, other than in limited pockets of social housing provision, Extra Care is not available in Northern Ireland. Given its success elsewhere in the UK this seems unusual and may likely be a net loss for the collective well-being for any

older people. The Personal Social Services Research Unit (PSSRU) found that Extra Care maintains well-being in a cost-effective way and its absence likely lowers the sum of welfare in Northern Ireland.

The aim of this piece of research is, therefore, to conduct an enquiry into what is going on with older persons' care at present in Northern Ireland, enquire into whether there is an overarching strategy for their well-being, and establish what a better strategy might look like.

The enquiry presupposes that there can be a role for Extra Care within such a strategy, thanks to its success in England and Wales. It enquires how such facilities can contribute to welfare production, and what resources, including financial resources, capabilities, and features, might such facilities have.

1.1.5 How does 'older people's last 1,000 days' fit into the aims?

I chose the theme of our last 1,000 days thanks to the writing of Atul Gawande in his book *Being Mortal: Medicine and What Matters in the End* (Gawande, 2014). Gawande reflects on the quality of life of older people living with frailty, serious illness, or when approaching death. He calls for changes to how health and social care treats patients who are approaching their end of life. Systems, rather than having a physiological focus, should, in his view, focus more on enabling well-being and quality of life. The reference to the last 1,000 days forces one to think: 'If you knew you had 1,000 days to live, what would be the things that matter to you?' This emphasis seems to me to be profound and helpful when I seek to gain attention for those whose voices are weak.

If we take for a moment the following narrow proposition, that the main driver for the health and social care system may be said to be to make sick people better as efficiently as possible, then we may compare such a system's purpose with the wishes of those living their last 1,000 days. Those in their last 1,000 days may well be frail, isolated, and living with multiple chronic issues, but they will very often crave having their social needs and social life fulfilled, every bit as being made less sick. Accordingly, it may be that the central purpose of the health and social care system, to tackle illness, as I have narrowly framed it, is charged with a different agenda to that of Gawande's ideas. If so, it follows that the publicly provided health care system is unlikely to be an effective means to satisfy an individual's need for personal fulfilment. Indeed, this is the case throughout most of our lives, where we strive to achieve our satisfaction existentially and without institutional input.

My enquiry commences from the viewpoint that it is overwhelmingly the case that individuals and couples know what is best in their unique circumstances for their quality of life. Viewed this way, public social care may be most effective when it can help make that happen. Perhaps there are ways of achieving a multiplier effect for welfare production in contrast to the linear status quo. That is to say that rather than a binary system of public provision of 15-minute visits at times not of the individual's choosing, which comes with high logistical costs, people themselves know how their lives are made meaningful. Thus, my enquiry has a focus on fulfilment, concentrating the mind on how to effectively add to well-being, and suggests that achieving this is likely through the health and social care system *enabling* welfare as much as *providing* it. So how might a system help to give an older person purpose? How might it promote

friendships, independence, and personal mastery? Moreover, if such a care philosophy ought to produce more welfare from the same scarce means, how to strategise for this?

1.2 Creating Strategy

1.2.1 Introducing strategy-as-practice

An oft-cited definition of strategy was offered by Johnson and Scholes (1999). They stated that it might be defined thus:

> Strategy is the direction and scope of an organisation over the long term: which achieves advantage for the organisation through its configuration of resources within a changing environment, to meet the needs of markets and to fulfil stakeholder expectations (Johnson and Scholes, 1999, p.10).

My research seeks to apply these principles to the messy problem of the quality of life of older people, covering as it does the overlapping issues of health, social care, housing, independence, and personal fulfilment.

Yet, how does one go about creating a strategy that might achieve the goals of maximising the well-being of older people in their last 1,000 days? Since strategy is an organisation's 'direction and scope … through its configuration of resources', it seems that one must uncover, understand, and command the complex issues, collateral, and competencies in question. Only then, by applying such knowledge across such resources and capabilities that are to

hand, may one configure and concentrate them towards achieving the defined goals.

One framework that considers how to make strategy is that of ‘strategy-as-practice’ (SAP). SAP considers strategy as understanding what ‘people do’ rather than seeing strategy as something that a ‘firm has’ (Jarzabkowski et al., 2007, p.4). It is a socially constructed process. This philosophical lens necessitates a deep understanding of ‘the way it is done here’, the norms of a given industry, and the organisation’s culture. I have used SAP in order to foreground how the field strategists across health and social care make sense of the issue of quality of life for older people.

1.2.2 Uncovering judgement, experience and intuition

To illustrate how to uncover such deep-seated knowledge, several writers have utilised the metaphor of an iceberg. Michael Polanyi (1966, p.4) claimed that most of a person’s knowledge is tacit knowledge, and usually, most of it is obscured. This ‘tacit dimension’ may be thought of as the bulk of an iceberg underpinning everything that we know, and ‘wholly explicit knowledge is unthinkable’ (Polanyi, 1966, p.7).

In parallel, Herbert Simon, whose primary interest was decision-making within organisations, claimed that very often, the particular blend of resources and capabilities that are critical for an organisation’s success are hidden below the surface. He claimed that the most obscured competencies are the essential ones, such as judgement, creativity, experience, and intuition. Despite being hidden below the surface, they may, just like an iceberg, be identical in composition to the parts visible above the surface. Thus, if one identifies the

form of the ice above, one may reasonably interpret what lies below (Simon, 1976, p.69).

These hidden capabilities, being a blend of judgement, experience, and intuition, are very often precisely the factors that are the catalysts for creativity and strategy formation. For this reason, my thesis investigates them, as they have time and again proven to be the most precious resources of all (Stierand, 2009; Stierand and Dörfler, 2013).

1.2.3 The insider approach when seeking tacit knowledge

One way of eliciting such an in-depth SAP understanding is through exploration by an 'insider' (Dwyer and Buckle, 2009, p.55; Guba and Lincoln, 1994, p.106; Stierand and Dörfler, 2013). An insider is a person conversant with the issues with which specific industry leaders grapple. Through the insider interviewing the strategy-maker – who may 'know more than they can say' (Polanyi, 1966) – the insider may best probe and uncover the form of the submerged knowledge 'iceberg'. The insider may expose the 'taken for granted assumptions' (Johnson, 1992, p.30) of industry, of 'how we do it here', and the mix of core competencies that constitute the critical success factors (Barney, 2001; Prahalad and Hamel, 1990). Along with the strategising participant, the insider may be able to facilitate and induce the strategy process. In this way, the insider technique elicits the participant's cognitive landscape, their catalyst issues, and causal links to elucidate their organisation's 'emergent strategies' (Mintzberg, 1998, p.154).

1.2.4 Cognitive and causal mapping

Within the SAP framework, Colin Eden and Fran Ackermann have been prominent in developing tools for creating a strategy. Their techniques and computer software help uncover how members of an organisation make sense of the procedures they encounter, and how they may strategise to improve such arrangements (Ackermann and Eden, 2004; Eden and Ackermann, 2010, 2013).

Eden and Ackermann created techniques to help the insider to ascertain the cognitive views of what they name the ‘power broker’ participant. One tool is the Decision Explorer computer software: it maps the participant’s cognitive landscape and, for clarity, allows the user to link between issues graphically. The software also allows the insider to blend individual cognitive maps of participants into a collated ‘causal map’. This map, synthesised from the others, illustrates the causal relationships between each significant issue across the disciplines investigated. Section 2 of my enclosures document details the 43 cognitive maps formulated from my research participants, and Part 5 within this document discusses the findings.

1.3 Extra Care Plus: blending home, autonomy, and relationships

1.3.1 Autonomy on the continuum between structures and agency

That people are living longer is to be celebrated. However, the consequences pose problems for the individual older person concerned, their family, carers, and society. Lines of responsibility for the quality of life of older people who

need care are opaque, especially between societal structures and individual agency.

An individual's agency, independence, and control are essential contributors to their well-being, but they are also slippery concepts. They are challenging to measure and poorly afforded within the standard health and social care 'offer' where the standard offer for older people in their last 1,000 days consists of a choice between institutional care and domiciliary care. However, domiciliary care is limited and impersonal, and it offers a poor choice (Kelly and Kennedy, 2017). The standard alternative of institutional care is considered by individuals to be expensive, of uncertain quality, and unappealing (Commissioner for Older People for Northern Ireland, 2018). As the field strategists often graphically detail, neither gives significant individual agency for the older person in the arrangement of their affairs. Nonetheless, providing older people's services requires that some structures are in place. The question is, how on such a continuum, may agency as a proxy for quality of life be most effectively maintained?

This continuum between, on the one hand, such structures as are required from the state and, on the other, the freedoms of personal agency is a source of long-standing philosophical thought. From Machiavelli (1513) and Hobbes (1651), and from Locke (1689) through Rousseau (1762), Kant (1781), Mill (1839), and Sandel (2010) to Sen (2010), many philosophers have considered the proper limits of the state when weighed against an individual's liberty, their freedom, and their capabilities. My thesis further elaborates on this

philosophical context across the dimension between agency and structure in what I term the structuration continuum.

Yet, as well as the well-understood dimensions of home and relationships that contribute to the quality of life of older people, the concept of autonomy is one that can guide the strategist when navigating between seemingly incompatible criteria: that a care bargain needs to be simultaneously equitable, sustainable, and efficient. If we consider the continuum between full independence at one extreme and nursing care at the other, enabling independence could be a vital prerequisite for a sustainable care strategy proposal. Enabling independence may more easily afford the competing desires of equity, efficiency, and sustainability than present arrangements where government assesses social care 'needs' and then tries to satisfy them − an emphasis on enablement rather than provision if you will. Thus, a guiding principle may be that strategies that help to enable a person to remain independent and pursue their happiness may prove to be critical in conceiving a more effective care bargain.

1.3.2 Structuration continuum

One means of illustrating such a continuum between government structure and personal agency is 'structuration' (Giddens, 1991). I use the phrase 'structuration continuum' to illustrate this long-standing philosophical tension that is also present within social care.

The continuum between agency and structure seems to me to be useful when considering different forms of intervention to improve the quality of life of older people. Younger, fully able-bodied persons with no cognitive decline may be conceptualised at the agency end of the dimension, needing no

compensations to enable them to pursue their own happiness, whereas those older people with a cumulation of morbidities that dictate that significant interventions are required may be conceived at the structure end of the dimension. Such morbidities may be some or all of old age, frailty, cognitive decline, heart disease, diabetes, and so on. There are therefore likely to be a wide range of health and social care needs for which a 'one size fits all' solution will be ill-suited. Despite an inevitable need for there to be an increasing amount of help for older people, enabling an older person to nonetheless pursue their individual happiness may likely maximise their well-being at the least cost to the taxpayer.

There is a range of resources to help with bringing an individual's arrangements back into balance. Perhaps the most effective way of compensating for an individual's unique needs is enabling them to help themselves; after all, who is better placed to maximise a person's quality of life than themselves? For them, the ever-changing problems set by unique circumstances likely call for unique answers that they, as an agent, are best placed to answer.

Thus, across the structuration continuum between full agency and structure, perhaps dynamic efforts to optimise enablement and maintain agency may be particularly useful. I consider this below.

1.3.2.1 Dynamically generating well-being

In following this train of thought, it is possible that present arrangements are often ill-suited to leverage capabilities that are enabled by a person's autonomy and personal agency. In management theory, configuring skills and

specialisms can become in themselves capabilities akin to discrete resources. Resources developed in this way are termed ‘dynamic capabilities.’ To illustrate, consider a criminal barrister specialising in planning law, for example. Their expertise, as forged over many years of experience, has become a distinct and valuable resource (Barney, 1991; Ambrosini and Bowman, 2009). However, should the individual change jurisdiction, not only would they be less expert with legal precedents and so on, but they would lose their specialist knowledge of ‘the way it works here’, such as the particular nuances of the presiding judges in front of whom they ply their trade.

Thanks to evolving capabilities, resources can be thus developed dynamically to allow an organisation to adapt their resource base purposely. Teece et al. (1994) described this improvement of the resource base as ‘the firm’s ability to integrate, build, and reconfigure internal and external competences to address rapidly changing environments.’

In the context of scarce social care resources, a person maintaining their own ability to manifest their welfare may be akin to dynamic capabilities, whereby the concept of agency is central to an individual being in control, maintaining independence, having scope to pursue their interests and thus to co-create their distinctive well-being. Such attributes seem to constitute a meld of capabilities that, just as witnessed in management theory, may become a distinct resource in themselves. And, just as the barrister removed from their courtroom, these capabilities can be lost. Whereas they may be produced when an agency relationship is enabled, these dynamically created resources can be seen to be at great risk of being lost within institutional care. Thus,

maintaining capabilities could be a critical plank when strategising how best to optimise older persons' well-being and at the minimum cost to the taxpayer.

A care strategy along such lines could be said to be enlightened management of older people's journeys along the structuration continuum, maximising capabilities on the way. Along this journey, there is a need for help and care to be provided, but in a way that maintains agency. Viewed in this way, the control and agency that an older person generates via their home needs to be emphasised, even after remaining in their own home becomes problematic. With this analysis, new home-type staging posts along the structuration continuum may be needed to avoid a 'cliff-edge' of care. Such staging posts are the structures that accentuate agency, enable control, and allow an older person to stay in a domestic cluster model of care for as long as possible. There they may maximise their 'higher needs' (Maslow, 1943 p.12) – that is to say, their fulfilment needs over and above the physiological needs accentuated within institutional care.

My thesis thus claims that higher quality of life may be made available for a given individual by adopting a policy of enabling agency rather than removing it when care needs become more pressing. My thesis highlights that as one travels along the agency–structure continuum, removing independence diminishes the quality of life for older people. Also, as one proceeds along the continuum, personal and societal costs tend to increase. I examine the substantial body of empirical and academic evidence that fusing housing and care via Extra Care maintains independence, and thereby well-being, at a lesser cost. Similarly, postponing a move towards more structured and

institutional care and keeping couples together can afford a higher quality of life for the same cost (Darton et al., 2011).

1.3.3 ECP on the continuum between home and institutional care

Extra Care Plus (ECP) is the phrase that I have coined to capture the fusion of the elements that contribute to well-being. In the name, the 'Plus' refers to enabling structures within each Extra Care facility to compensate for some loss of a person's 'functionings' which risk losing their independence and in so doing, their 'capabilities' (Sen, 1985). A central element of these enabling structures is a staff member whose role is that of confidante and advocate for residents, partners, families, and the local community to collaborate with and de-mystify the complex social care system. Following the name given by Age NI in their successful pilot of such a role, I refer to such a person in such a position as the 'community navigator' (CN). The CN is an additional resource conceived as being available to reflexively configure the unique blend of other resources and capabilities that each older person has to hand. The CN may make people more productive when producing welfare, dynamic capabilities, independence, and their own well-being.

My thesis claims that ECP offers one such staging post along the continuum between agency and structure that may give both individuals and their long-term spouse/partners the necessary support to remain autonomous. In so doing, ECP offers a blend of home and autonomy that directly addresses the aim of maximising the quality of life of older people. In addition, ECP is conceived as a host for relationships that may further optimise their quality of life. When supported by family, informal care, formal care, and with the CN on

hand to assist, independence through Extra Care Plus may be central to self-worth and fulfilment in the last 1,000 days of many older people.

1.4 Thesis Structure

Following this introduction, I present my literature review, where I focus on the role of housing as a contributor to an older person's well-being. I describe how one's home embodies one's quality of life and is a catalyst for many aspects of well-being, as well as the place of sanctuary, especially when a person is vulnerable. After that, I unpick why indeed do older people move, despite their home being such a facilitator for quality of life, and to this end, in the enclosures document, I provide a historical analysis of the Northern Ireland health and social care system. This chapter deals with how the system has seemingly been unable to alter its policies away from a narrow needs-based approach. Under such an approach, the state assesses a person's needs and then seeks to address them. Inevitably, given scarce resources, a person's physiological state is given emphasis, rather than maximising well-being and the chapter exposes the system's abortive attempts to reform in a way that manifests independence. It details that, at the interface between care-at-home and care home, despite continually refreshed policies that seek some form of a housing-with-care solution, no such facilities exist (to all intents and purposes), and the choices for such older people (and spouses) remains bleak. The literature highlights that older people felt most in control when living within Extra Care when compared to those living with provided domiciliary care or those living within a care home.

In Section 4, I unpack the philosophical underpinnings of my research, methodology, and methods. I describe the relationship between my existential phenomenological enquiry, which affords strategy-as-practice insights, and my way of conducting it. The section also details how I have preserved the voices of the field strategists and allow others to see how it is that the theory induced from the participants reflects what was said via an extensive data structure with my enclosures document, and ensure research dependability. Therein I present an analysis of each interview, including many direct quotations, and show the steps that I make to induce knowledge. Moreover, in a methodological contribution, in this analysis I tabulate across the 30 most relevant issues a total of 150 quotations. By asking the ‘so what?’ question against each quote, referenced against the issue, I induce what the participant means and the implications of the point they make. These direct and powerful quotations give rise to some arresting insights by the field strategists that would otherwise be at risk of being lost through aggregation, even with common qualitative research methods.

Within my companion document of enclosures, I detail how 14 field strategists made sense of the social care landscape for older people. I present 43 cognitive maps concerning an issue that they specifically care about and induce from each their contribution to the strategy causal diagrams. I explore in some detail each participant’s lifeworld using the cognitive mapping technique.

The causal maps that follow, and are presented in this document, distil my primary research to synthesise and articulate the strategy-as-practice induced

from the Northern Ireland field strategists. They illustrate the causal relationships between each significant issue present across the disciplines investigated and form a roadmap from which the Extra Care Plus strategy flows.

Section 5 discusses the findings, strategic policy proposals, and next steps to improve the life fulfilment of older people's last 1,000 days. Therein I describe how the strategists believe that care formats in clusters of housing might enable the objectives of quality of life through home, autonomy, and relationships.

Section 6 examines such clusters where, in England, one proven means of affording independence with social care through housing is via clusters of residential, home-like places of care – most often referred to as Extra Care. Extra Care it is defined as facilities for the provision of social care for older people in a custom-built housing-like environment where residents enjoy the security of tenure, and where their care is self-controlled.

In the later sections of my thesis, Section 7 pulls several strings together in order to articulate the strategy conceptualisation of Extra Care Plus, Section 8 locates this theory in its potential contribution to knowledge, and Sections 9 and 10 are concerned with reflections, limitations, and references.

2.0 Literature Review Part 1: What Housing Means for Home, Autonomy, and Relationships

2.1 Structuration and Social Constructionism

I use themes of structuration and social constructionism to illuminate my literature review.

2.1.1 Structuration theory

Structuration theory (Giddens, 1984) is a useful lens in my research as it provides a means of understanding the constant tension within society between structure and agency since neither is enough on its own. For example, to be successful, a country's economy needs agents and agency, very often from the private sector, and, classically, they prosper through their creative endeavours thanks to their initiative, intuition, and vigour. To the extent that wealth is a blunt proxy for quality of life, then such agents are vital for quality of life since they are motivated to create wealth for themselves and others, as well as jobs and taxes that pay for government institutions. Such is the need for agents.

However, as Adam Smith recognised, 'structures' are needed too: 'people of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices' (Smith, 1776, Book 10, Ch. VIII). This quotation highlights how Smith recognised that agents need structures for two purposes: firstly, to provide sufficient regulation to prevent the 'conspiracy against the

public', and secondly, legal structures are needed to provide security and property rights for the benefit of the agents.

Under structuration theory, neither an entirely 'micro' (agent) nor 'macro' (structure) analysis is enough on its own. Both are required, but the balance between the two may be different, as is the case in different countries with different relative levels of state ownership versus private institutions. I find the continuum between these factors a helpful image that frames my research. For example, formal social care for older people exists in predominantly publicly funded settings, whereas most social care is informal and takes place in private settings. My investigation is into how and where this line might be best positioned to better balance the three desired outcomes of 'equity, efficiency, and sustainability' (Fernández and Forder, 2010).

It is possible that to aid well-being creation, and in the absence of wholescale increased public funding, a more successful strategy may be to capture better the resources and capabilities that are available through the 'agency' that individuals, groups, families, communities, and carers offer. That is not to say that the balance needs to be entirely agency-biased – far from it; my thesis is simply that there may be a better balance towards agency to be had, and that such a balance may better generate the three desired outcomes.

2.1.2 Social constructionism

How to do that requires a fuller understanding of the mechanisms of agency, and one valid means of generating such knowledge is through the theory of social constructionism. Social constructionism focuses on the view that

meanings are developed in coordination with others rather than separately. As Herbert Blumer put it:

- Human action is grounded based on the meaning that things have for people;
- the social interaction that one has with others underpins meaning; and
- the person interprets such meanings (Blumer, 1986).

In common with others such as Merleau-Ponty, Blumer considered that natural science often bypasses humans as a source of knowledge, relying instead on stimuli and causality to give an account of human conduct.

Conversely, Blumer contended that meaning is reflexive and interdependent, and that people are essential. Thinking about that, if it is the case that there has, hitherto, been an imbalance away from the micro/agency way of understanding the social world, perhaps one reason for this is that reliably collating microdata is not easy to do. It is hard to grasp the knowledge of the micro/agency side and then aggregate it without losing all its meanings. To do so, according to Blumer, requires one to place oneself in the position of others (ibid., p.51).

Simone de Beauvoir thought similarly and took social constructionism towards research involving older people. She appreciated that the study of older age relies on a deeper understanding of individuals and the reflexive way in which they perceive their world. Indeed, in *The Coming of Age*, she observes:

> The individual is conditioned by society's … attitude towards him. An analytical description of the various aspects of old age is not enough: each reacts upon all the others and is at the same time affected by them, and it is in the undefined flow of this circular process that old age must be understood' (de Beauvoir, 1970, p.9).

When turning to knowledge concerning housing, Jacobs and Manzi (2000, p. 35) take issue with much of housing research and advocate the social constructionism paradigm that they claim has often been missing to date. They posit that over the last 30 years, most policy debates within social policy have developed robust explanatory theories to underpin research, with a notable exception being housing research. They state that 'although the absence of *explicit* theory remains a defining characteristic of mainstream housing research, it primarily relies on a positivist epistemology' (italics emphasis within original). The authors note that one major problem of this approach is that the housing groups and sponsors of research dominate the presentation of 'facts' that are devoid of a robust ontological and theoretical basis.

The authors make a case for using social constructionism epistemology as what constitutes knowledge. They argue that knowledge is contingent and forged in micro-level data that requires extrapolation with caution in order to avoid losing the micro meanings through aggregation. Researchers need to find ways of retaining the cogency of subjective experience when inducing theory.

To conclude this train of thought, social constructionism is an epistemological school used across many disciplines of social science. Used with care, it is helpful for me to illuminate the required micro and agency concerns as I investigate the gaps in knowledge over the structuration continuum as it pertains to housing, agency, and social care.

2.1.3 What does the literature say about the meaning of housing, and in what way is it important to older people?

When considering housing from a social constructionist viewpoint, a significant issue is that there is a profound difference between ‘housing’ and a ‘home’. Helpfully, the social constructionist view emphasises the role of housing in its role as a home for the people who live there, rather than as an objective in itself. Such a view contrasts with widespread positivist viewpoints that tend to only consider housing as a commodity (Heywood et al., 2002, pp.31–33).

Via his book *The Meaning of Housing*, David Clapham (2005) further elaborates on this point. He notes that most current approaches to housing ignore or downplay the perceptions and attitudes of individuals and households. When they are considered, they are assumed to have simple, rationalistic, and universal aims (p.9). Elaborating on the traditional view of housing, Clapham (pp.7–11) highlights the four traditional means of viewing housing and the limitations of each.

Firstly, he describes the view of housing as one derived from government interventions. He notes the limitations of this view as it ignores the rates of homeownership that for older people often surpasses 70%. Moreover, he also notes the long-standing withdrawal of the state in matters of housing.

He describes the contrasting second view of housing, which has a neo-classical standpoint: this view marginalises state support as an (unwelcome) 'intervention'. Simplistic assumptions of human behaviour and profit maximisation by organisations and utility maximisation by consumers underpin this approach. While this is a reasonable approach for price determination in cases where demand and supply are plentiful, it is less applicable in housing arenas, and especially those that incorporate care. The approach ignores that the essential elements that underpin a fair exchange are absent – such as low barriers to entry, plentiful supply, and a high degree of participant information. Also, the validity of the neo-classical approach is further diminished by its failure to recognise the role that government must play in the supply of housing through control of the planning functions, both in terms of zoning and determination of individual planning applications.

Thirdly, there is a geographical approach that begins to account for the complexity of human behaviour. Nevertheless, it attempts to generate universal propositions without a full appreciation of the details of attitudes and behaviours. Another problem is that there is little focus on how constraints come about, such as the planning function.

A fourth view is a sociological one that concerns power in the vein of Marx and Weber. Clapham highlights that this view explores the structural inequalities of housing, where writers such as Marx and Weber underscore the constraints on choices that less affluent people have. However, by concentrating on the restrictions on choice, Clapham observes that sometimes choice itself becomes squeezed out by political dogma. As such, the approach ironically

can miss the point by virtue of the advocates' politics often diminishing the role of choice and agency that the Weberian view is designed to enlighten.

Another view, in addition to those presented by Clapham, is one that notes the limitations of the conventional binary choice between the established narratives of either needing more state interventions or more market-based solutions. Jacobs and Manzi have written several pieces in this regard (e.g. Jacobs and Manzi, 2000) and believe that a more reflexive means of understanding than the conventional binary approach is required. They claim that housing research needs to acknowledge the preconceived idealisations of state or market that too few housing researchers make explicit.

I note Clapham's four approaches in aspects of my research, notably the positivist interventionist views that dominate the literature, and how they often seem to combine with a Marxist sociological perspective. For example, Dickens et al. (1984) compared housing policy, provision, markets, and distribution in both the UK and Sweden. In contrast to a social constructionist approach, the authors claim that in both countries, housing is provided as a commodity. Their claim is that housing providers solely aim to make profits and bizarrely state that 'this must ultimately depend on the exploitation of labour' (pp.8–9). The authors employed a social structuralist approach, drawing heavily upon writings of Marx and Engels in favouring the predetermined nature of housing supply that they found in Sweden. However, the implication of housing as being something entirely state-determined seems to fail to account for the meaning that the home has for individuals. Such positivist approaches seem excessively narrow as they tend to ignore the individual;

they tend to overly emphasise housing as an objective reality that is uncontentious and is perceived as the same thing by policymakers and inhabitants.

Conversely, the social constructionist approach attempts to address the widespread lack of a convincing focus on the behaviours of the actors within a system by making the perceptions of individuals and households the principal foci. For such actors, the meaning is the sum of the interrelated meanings that their home has for them as household members. With a view that meanings are socially constructed, housing, rather than being commodified, is more a means to an end, with the end purpose being personal fulfilment, well-being, and life satisfaction.

2.1.4 Housing as a means of fulfilment

Throughout their books, both Heywood et al. (2002) and Clapham (2005) advocate approaching the meaning of housing as a means of fulfilling a household's lifestyle ambitions. Over recent decades, according to them and other writers such as Giddens (1984, 1991), social and economic changes have changed the context within which people, including older people, make housing choices, with housing being increasingly a means of personal fulfilment rather than simply providing shelter. For private homes, such a narrative poses few policy questions. Private sellers and housebuilders alike are adept at emphasising a compelling value proposition for buyers who could easily buy elsewhere. Such sellers will very often highlight the advantages of their dwelling in terms of the benefits of the area for schools, parks, and amenities as mediums through which a prospective buyer may enjoy fulfilment.

However, it represents a significant challenge for community care to emphasise fulfilment. Instead, community care has more emphasis on state provision and allocating hours against assessed ‘needs’, coordinating such arrangements, minimising cost, and concentrating services in locations suitable for support delivery. Giddens notes that ‘the more tradition loses its hold, the more individuals are freed to negotiate their lifestyle choices amongst a diversity of options’ (Giddens, 1994 p.5). Doubtless, this continues despite some members of a household living with increasing age-related disabilities, but with care structures, as they stand, their thirst for life fulfilment may go unquenched.

Heywood et al. (2002) and Clapham (2005) expand on the theme by noting that social changes since WW II have afforded opportunities for people to construct their own lives through a positive choice using two closely linked factors of identity and lifestyle. They posit that housing is thus bound up with these two characteristics of a postmodern society: fulfilment and lifestyle. They go on to highlight that such insights open the notion that, for many, housing not only encompasses a place to achieve satisfaction and self-actualisation but is a badge of personal achievement and a reflection of their identity. Such a notion has a ring of truth for me as a housing developer who has built over 1,000 homes across Northern Ireland. It reflects the hoary old adage, beloved of estate agents, that the three most important features when achieving higher house prices are location, location, and location. As such, the home and its place have a role in telling other people about how one perceives oneself.

The authors argue that such notions of fulfilment, lifestyle, and achievement through living in a lovely house in a pleasant street start to highlight the role that a home has as a badge of accomplishment and a means of self-categorisation. Moreover, people self-identify by their postcode and street, are more likely to be open to 'people like us' as identified by subtle social signalling and can be prone to be suspicious of 'outsiders'. When viewed this way, housing binds up our identity, achievement, sense of self, and whom we perceive ourselves to be. American philosopher William James is widely attributed to have summed up this psychology of success in the statement: 'By and large, people become what they think of themselves.' He is emphasising that free will, choices, and the achievement of aspirations are central to well-being, and it seems that housing is key to such a badge of both success and identity. For my research, it is undoubtedly the case that at no stage do such characteristics 'switch off' as one passes a particular age milestone. Indeed, this appreciation could be fundamental in the creation of improved adult social care policies and geographies of care. As notions of life success and the home are thus inextricably linked, then moving – or worse, being moved – to a non-home environment may be the antithesis of success. At this point, when care needs become problematic at home, other housing-based options as an alternative could maintain many of the factors within a home that contribute to well-being.

Next, I introduce elements of a deeper understanding of what home means for older people building on the notion above, that the home is a badge of success and that success and status are manifestations of power.

2.1.5 Housing as a means of exerting influence, control, and normalcy

Thus far, I have explored how housing may be something of a badge of self-achievement and as a category of identity; for example, being a homeowner within a particular postcode brings with it an identification of success. Such a viewpoint reflects the pattern of homeownership that changed as a percentage of households from 30% in the 1950s to over 66% in 1990 (Gurney, 1999b) – a sea change that brought with it a socio-tenurial polarisation. Homeownership became the norm, normalised, and normalising; to an extent, the alternatives became, by definition, abnormal. Gurney (1999c) underlined such a schism in normalisation within his paper entitled: 'We've got friends who live in council houses': power and resistance in homeownership.'

Gurney observed evidence of cultural, linguistic, and psychological prejudice against and excluding householders who rent. Such households were subject to a Foucauldian 'normalising judgement', meaning that if something was not 'normal', then somehow it must be 'abnormal', and the fear of being exposed or embarrassed has a normalising effect (Foucault, 1975).

Saunders (1989) ascribes this notion of normalisation to owner-occupiers, as the 'nation of homeowners' is somehow prejudiced against those who are renting, especially those paying social rent. Similarly, Gurney (1999a p.173) analyses the 1996 Housing Act and companion documents where the word 'home' is used as a normalising discourse in the texts, venerating the model of owner-occupation 'through ideas of love, comfort, pride, warmth, independence, and self-respect. The chapter concerning homeownership is dripping with such ideas as normalisation through repetition and association.'

He demonstrates how the word ‘home’ is used 400% more often in the homeownership chapter of the policy documents compared to the social rented section, where the word ‘stock’ is used extensively instead.

The contribution that Gurney makes is to provide a framework to explain how ‘housing’ and the ‘home’ are symbolic of status. Similarly, Pannell and Blood (2014, p.6) found a strong attraction to be in control in ways that social housing cannot always deliver. Gurney (1999a) reflects, thus, that power, status, and wealth come not only through a Weberian analysis, where wealth is a proxy for power, but via a Foucauldian view that sees power as net-like, pervasive, and associated with homeownership. This unseen discipline, power, goes part of the way to explain the existential hold that homeownership has for older people, and their reluctance to give that up. This deep-seated cultural phenomenon is continually reinforced − for example, Vasara (2015) describes the canonical cultural ideal of the hard-working Finns as pioneers and homeowners. English-speaking cultures are replete with similarly powerful and mythical role models of Wild West settlers and *home*steads, as well as the cultural imperative of an island nation and its military duty to defend the *home*land. These images are provocative and hard to resist.

Gurney (1999a, p166) cites Foucault (1975, p.194) in this framework to understand power: ‘We must cease once and for all to describe the effects of power in negative terms … in fact power produces reality … and rituals of truth.’ Gurney cites examples of this pervasive relationship between instinct, home, and the power afforded by being in control. For example, he cites the Department of Environment and Welsh Office (1977, p.50), which stated that

‘a far more likely reason for the secular trend towards homeownership is the sense of greater personal independence that it brings. For most people owning one’s home is a basic and natural desire.’ The same document quoted a typical respondent, who alludes to the normalising influence of owner-occupation: ‘It is just a fact of human nature; you look after it better if it belongs to you.’ This Foucauldian analysis thus highlights how tenure seems to have an observational disciplining power in the manner of the Bentham panopticon that normalises prison inmates. I also reflect on the UK’s ‘right to buy’ council housing policies of the 1980s and 1990s. Founded on the political/social calculation that owner-occupation brought with it a normalising influence, the government likely used the right-to-buy project in part to engender ambition and social mobility. It may also have helped some households have the feeling that they had ‘skin in the game’ and the government may have calculated that they would thereby be less likely to cause social problems.

In addition to one’s address and one’s tenure being subtle social indicators and a medium to ‘normalise’ people, Gurney also notes some more explicit social indicator ‘conformity tests’ to categorise people, such as how insurance applications ask applicants whether they own their home.

To summarise, power and social conformity are manifested through housing in a deep-seated way. The home, address, and community hold powerful meanings for people that must exist irrespective of age. These matters contribute to maintaining a regular and fulfilled life: harnessing them may be a fruitful way of producing welfare.

2.1.6 Constructionism and fulfilment through housing

Several contributions from the literature clarify this Foucauldian framework to explain why, for older people, the home provides such an existential extension of one's self. These Foucauldian topics of power, control, observation, and what he terms as 'normalcy' are themes that are illuminating for the meaning of housing and have been the subject matter of several authors.

One paper that explores the meaning of housing for older people, which uncovers a projection of one's self to the world, was written by Paula Vasara (2015). She carried out an in-depth ethnographic study of older people in Finland to establish the meaning of housing for them. In parallel to policies in Northern Ireland, social policies in Finland encourage older people to remain at home where they are entitled to cost-free (for the user) domiciliary care. Vasara conducted a narrative analysis on 11 interviewees living in age-related housing, with interesting findings that have implications for my research. One point is what she calls the 'socio-temporal' context of the participants, who were born in the 1920s, grew up in an agrarian economy and had their lives shaped by the rapid growth of consumerism and welfarism. She notes the considerable uncertainty that marked the lives of this generation, how they appreciate their gifts, and how the generation appreciates hard work. She notes the group members' ability to continue to contribute to their well-being through their independent attitudes. She found among respondents a common approach to a housing pathway that was culturally expected. Her participants stated that the norm is to be independent early by renting while young and then buying a home for family living. Being able to advance to homeownership was

a significant success milestone in life's trajectory and intertwined with hard work. For the participants, housing is knotted up with industriousness, resourcefulness, and relying on oneself. In older age, the individual embarks on a journey as independent living becomes complicated: 'nowadays, the path is commonly perceived as one that leads from a house to a more easily managed apartment closer to services, and finally to age-related housing with more services available' (ibid., p.59). (Paula Vasara's inference is that age-related housing with care services is available, whereas in Northern Ireland this is not widely the case.)

Vasara further found that homes are more than dwelling houses; they are places of comfort, autonomy, and security, filled with personal meanings. Her participants viewed their home as a social place that encompassed the participant's relationships with others as well as personal effects that converged into a profound sense of identity. This identity mirrors the qualities of the residents as a representation of self and chosen lifestyle. Vasara found that for her participants, the home had great connections with quality of life, which included 'deposits of halcyon days'. Their homes were full of memories and worth preserving.

A final significant finding was that the home was emblematic of independence. Much in the vein of the phrase 'an Englishman's home is his castle', it provided an ability to choose life agency, to take charge of who was afforded entry, and was a manifestation of control and power.

A different slant to exploring the meaning of housing and home is that, for many people, it is the home that gives sense to life. Two authors who illustrate such

an approach are Young (1997, pp.161–164) and Milligan (2012). Young emphasised the significance of home giving meaning to life from a feminist viewpoint, whereas Milligan concluded similar findings from older people's perspectives.

Both authors highlighted firstly the feelings of protection that the home generates in crucial ways. The home provides security through physical safety, and through second-order effects of cognitive reassurance where the householders benefit psychologically from feeling secure. They also highlighted the advantages that a home has for privacy – giving the residents their own space – and they also highlighted the satisfaction attributed to the achievement of homeownership. They noted the value that the home has for individualisation: giving residents autonomy over admission and freedom as an outlet for self-expression through home decorations and personal contents. Young expressed the view that, in many ways, the home is an expression of a person's body.

Both authors highlighted the role of home as a place where one performs the basics of one's life and the highly personal nature of such actions. From lovemaking and family disputes to dressing and toileting, the home affords a safe place for all such deeply personal activities. Milligan (2012) develops the point that, for older people, the home is a safe place where there can be a transgression of social taboos. Specifically, she refers to the intimate acts of a male child carrying out personal care for and with his mother and the vice-versa case for adult women aiding their fathers. Wanless et al. (2006) make the point that in the UK between 2.4 and 4 million people are providing care to

those aged 65 and over, with more than a fifth of carers providing care for 100 or more hours a week, and that this critical issue gets little coverage. Such poor understanding lessens the potential scope of the home for the carrying out of such everyday intimacies. Young also highlights the role of the home for constructing and reconstructing one's self, whereby the home affords people the space to refresh and emerge re-energised following convalescence.

Similarly, Milligan (2012) devotes a chapter to the meaning of home for older people following an incident such as a non-elective hospital admission. She highlights the attachment of home, being in control, and giving a positive sense of self for reconstructing one's social self. She cites Wiles (2009, p.655) when stating that the home 'helps the adjustment to the contingencies of ageing and enhanced well-being'.

This construction of one's social self is not only grounded on the familiarity that one has with one's own home; it is deeply intertwined with relationships with other people. This construction of our being, our being-in-the-world, and our very embodiment as an individual are, therefore, profoundly and reflexively concerned with social interactions. In recognising such a key element within the meaning of housing, Young assigns value to the home as a place for rituals as an embodiment of family tales, incidences, culture, and remembrances.

This analysis has therefore unpacked several profound ways in which the home has essential meanings for people, including as a categorical badge of success, as a seat of power, as a place for recuperation, as a place where social taboos may be broken, as a place of refuge, and for embedding meaning through family and social interactions.

2.1.7 Autonomy through ownership

A Foucauldian analysis that posits that there is a relationship between power, control, well-being, and ownership, gives rise to research questions that would likely require some form of research into housing situations where quality of life is measured when tenure is controlled. However, few researchers seem to have responded. As such, housing academia is far from replete with research sceptical of public housing provision.

Two papers that have explored this area were written by Hiscock et al. (2001) and Saunders (1989). When examining the significance of housing, Saunders demonstrated that the home becomes more important to people as they grow older, and in that context, he reviewed the importance of tenure. Here, Saunders found that homeownership creates the basis for a stronger sense of 'ontological security' than he found among tenants thanks to people feeling more in control and being free from surveillance. Thinking about these findings, the feelings of vulnerability that Saunders found among younger adults would very likely be exacerbated among older people. Hiscock et al. examined just this area.

Hiscock et al. unpicked this point of 'ontological security', found to be more prevalent among older homeowners as opposed to similarly aged home renters. Drawing upon Giddens (1991, p.92) – who defined ontological security as 'the confidence that most human beings have in the continuity of their self-identity and the constancy of their social and material endowments. Reliability of persons and things' – they sought to find whether such 'reliability of persons and things' was better and more reliable when the householder was in direct

control, rather than having to action issues through a housing manager or committee. Intuitively, such a proposition seems likely. Through in-depth interviews with 43 adults, the authors explored the 'extent to which home-owners and social renters in the West of Scotland attained psycho-social benefits from their homes' (ibid.). Several participants considered that owner-occupation offered less protection than social renting due to the threat of losing the home, due to the risk of repossession. Most, however, believed that owner-occupation offered residents the most control and protection, especially for those with mortgages long since discharged. For the most part, the authors confirmed 'owner-occupation was thought to be more prestigious than social renting'. Interviewees also discussed ontological security in terms of the home as a site of constancy (Hiscock et al., 2001, p.50), finding it 'reliable' in Giddens's terms and so further leading to ontological security.

2.1.8 Summary: the meaning of housing

Knowledge of what contributes to older people enjoying a fulfilled last 1,000 days is vital for policymakers. Since their home forms a critical plank of such fulfilment, understanding what their home means to older people is, in turn, vital for policymakers. Surely it is only when armed with such an understanding of the aspects of the home that policymakers may compose valid recommendations for housing as a site of caregiving. It is for these reasons that this section has explored what the literature tells us about the meaning of the home for older people.

I have emphasised that the meaning of the home is vital for agents as a micro counterbalance to the macro mainstream of housing research. By using

Giddens's (1984) structuration theory and the theory of social constructionism, I have illuminated the little-heard micro side to better give voice to the actors.

I have explored what the literature can tell me that may be relevant to my area of research as to the meaning of housing and home, especially for older people. The conclusion emphasises how older occupants view their home as an extension of how they construct their lives and present themselves in the world. Their home represents power, achievement, as a badge of success, and provides ontological security, especially for owner-occupiers. How people construct themselves is intertwined with the dwelling. The home is where a person feels safe and in control and represents a deeply personal place in which adult children perform some of life's deepest intimacies. These meanings are compelling, and it is therefore vital that they are correctly understood by those involved with the creation of a strategy of housing with care.

3.0 Literature Review Part 2: Support, Option Recognition, and Decisions about Moving

3.1 Introduction

This section of the literature review explores what literature tells us about what happens at what I term the ‘interface’ between home care and institutional care. The research describes this point as the period of ‘option recognition’ when it becomes apparent that the support available in an existing home setting has become inappropriate.

Given the importance that the home has for people, this section also unpacks why else older people might move. To recap on the meaning of home, I found that the literature widely explained the significance of housing as the embodiment of what gave meaning to life thanks to home, autonomy, and relationships.

Under the domain of the home, a home:

- is a means of delivering fulfilment;
- is an embodiment of social standing;
- is a badge of success (thus, any change may be a failure).

Under the domain of autonomy, a home:

- provides physical security;
- is a manifestation of Foucauldian power and control;
- provides ontological security;
- in cases of owner-occupation, provides financial assurance;

- is a place that normalises the social world, assuring one of not being ‘abnormal’;
- is a place safe from surveillance.

Under the domain of relationships, a home is a place:

- for conducting social interactions, which are in turn vital for life meaning;
- for sharing pleasures with family and friends;
- for personalisation and adornment with memories that give existence value;
- where intimate personal care to be performed.

Since their home has a special meaning for older people, it is unlikely that they will be willing to change from that steady state of living at home. A sound policy should account for these micro-level concerns.

I have also described how the home gives life meaning in ways that are not available in institutional care settings. Thus, this section drills down into the interface between home and institutional care, since, if it is apparent that older people value home so dearly, why would they move? And what does the literature say about the issues surrounding such a move for the older person, their carer, their partner, and their family?

3.2 The Competence/Environmental Press

A powerful depiction of the suitability of an older person’s environment by reference to their competence is the Lawton and Nahemow (1973) competence/environmental press model. The model, illustrated below, highlights the dynamic interaction of individual ability and the demands of their environment.

To explain the model, consider an older person who has returned from acute care − their competence is low. To be within the maximum comfort zone, their environmental demands should also be minimised. Hence, for example, it would be best if they are not asked to deal with the stress of very young grandchildren. When the older person regains strength, and their general competence improves, they may cope with higher environmental demands and their grandchildren, as illustrated in Figure 2 below.

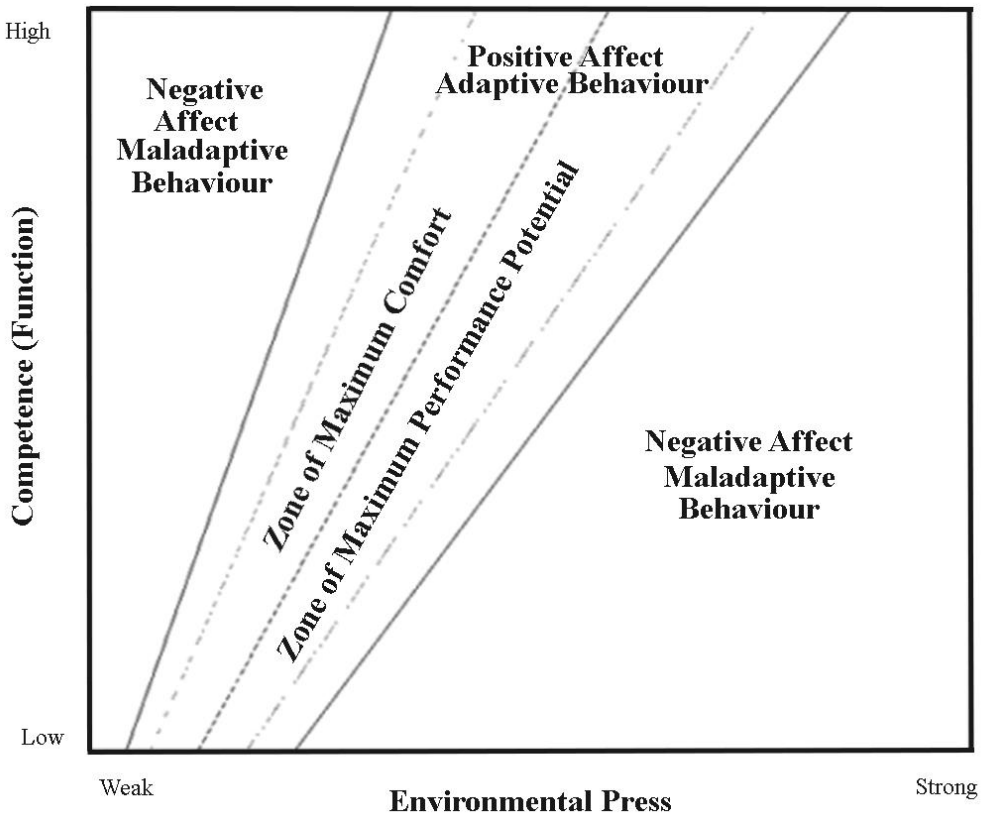

Figure 2: Competence/environmental press model
(Adapted from Lawton and Nahemow, 1973)

The model illustrates how the environment enriches lives via the zone of maximum potential. Being challenged by young grandchildren, for example, is likely to stimulate an older person and improve their quality of life. The model helps focus on the relative mix of factors that can be configured to provide performance potential for any given level of capability. Viewing the matter this way illustrates the contribution to a person's quality of life that stimuli have. This insight highlights how social interventions can have powerful results in allowing older people to realise their individual quality of life potential.

3.3 Voluntary versus Involuntary Moves

Robert Wiseman (1980) created a model to highlight the 'push' and 'pull' factors affecting the decision-making of retired persons to move. He graphically demonstrated these, as I have adapted in Figure 3, where on the face of it, the 'pull' factors seem weaker and less numerous than the 'push' factors and would intuitively seem correct.

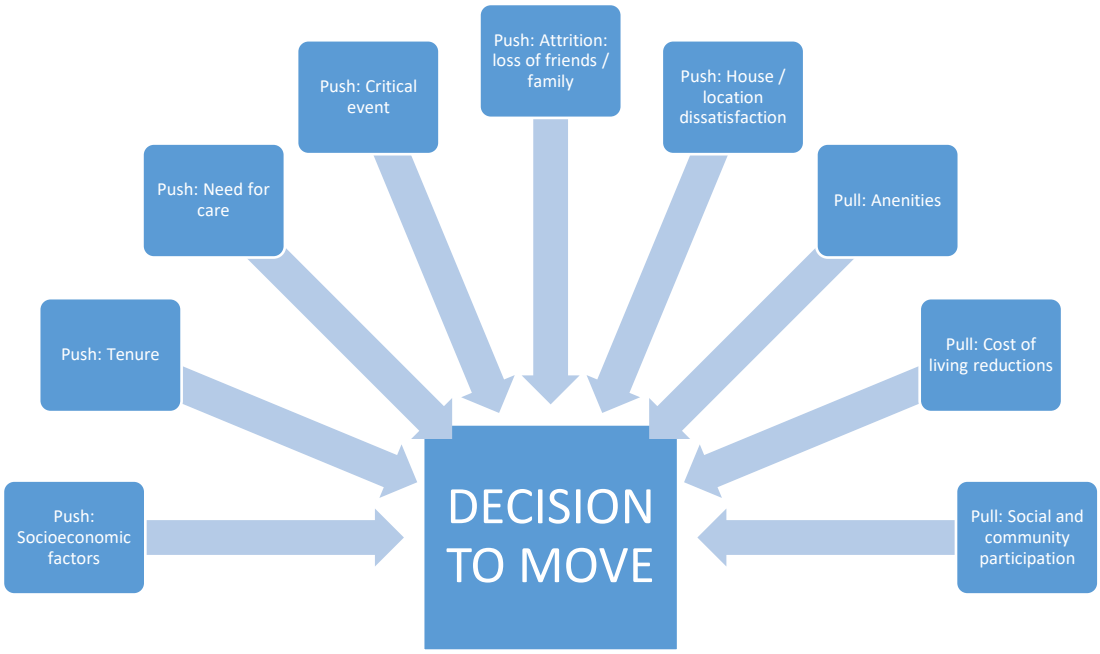

Figure 3: Wiseman push/pull factors

(Adapted from Wiseman, 1980)

Where they are the main reasons behind moving home, the 'pull' factors seem to typify the 'voluntary' types of a home move at a time that some scholars refer to as the 'third age' (Gilleard and Higgs, 2011; Litwak and Longino, 1987). With such voluntary moves, retirees may maximise their quality of life, as typified in Wiseman's context by retiring to the Florida sunbelt. It is for this reason that the model is perhaps less relevant in a Northern Ireland context, and not just due to the weather. Instead, in Northern Ireland, moves are potentially more likely to be 'push'-related. Another factor is the mean house price in Northern Ireland being less than £150,000, meaning that liquidating one's principal asset is unlikely to be enough to acquire a purpose-built retirement home. Moreover, the Wiseman model has little to say for those that

are the focus of this thesis — namely those whose last 1,000 days are at the interface between care-at-home and care home.

3.3.1 Social construction of the interface between home and institutional care

Instead, interest concerns the involuntary movers at the interface between home care and institutional care. Here, ‘movement outcomes range from health care institutions to congregate housing situations offering assistance and to reside with or near to primary kin’ (Wiseman, 1980). These are very often the result of a ‘trigger event’ such as a sudden loss of functional ability or the loss of a partner. The moves happen at a time of high stress and are very different from the notion of the third-ager planning their retirement years. They are much more associated with chronic cognitive and physical changes for the older person or one person within a couple. Such moves are centred on what Gilleard and Higgs (2011) describe as the ‘fourth age,’ and are typified by the loss of agency (Lloyd et al., 2013).

Some authors consider the notion of the very old and infirm disappearing from social consciousness (Heywood et al., 2002; Gilleard and Higgs, 2011; Lloyd et al., 2013). Here, society looks away, rather like the parable of the Good Samaritan, where the priest and the Levite ignore the stripped and beaten traveller. Gilleard and Higgs (2011) describe how those in the fourth age are marginalised and concentrated in long-term care, making ‘old age an undesirable social imaginary’. They liken this to the impact of a black hole, ‘distorting the gravitational field surrounding it, unobservable except for its traces’, which forms an event horizon beyond which there can be no return

and where the absence of light renders it unknowable (Lloyd et al., 2013). Such a theatrical metaphor stresses the fear of being institutionalised and of 'passing beyond the possibility of agency, human intimacy, or social exchange' (Gilleard and Higgs, 2011). These authors highlight the apprehension of older people fearing infirmity, disability, and the loss of agency likened to falling into the black hole. In contrast, they emphasise the value of the home as a real extension of their self, and its totemic value for remaining in control, secure at home, where older people feel safe against being sucked into the void.

Viewing these findings from literature through a social constructionist lens underlines the deep-seated nature of such social attitudes that are reinforced by government policies. Taylor (1998) picks up this theme when noting the dialectic between social policy and identity: 'Social policy, whether as a set of beliefs or services, a form of governance … is deeply implicated in setting the ideological and material conditions for the realisation or foreclosure of particular identities.' Taylor posits, thus, that the state is 'deeply implicated' in the abandonment of the very old into a metaphorical black hole. Heywood et al. (2002, p.15) describe the 'sustained assault on the welfare state' over the past decades that has continued through successive governments, as the failed implementation of the Dilnot (2011) proposals and Care Act 2014 bear witness. Aronson (2002, p.414) offered 'a glimpse of the complexities and tensions of home care receipt in the face of its retreating public provision' and in this complex and idiosyncratic picture, how older people's voices were most often silent. Policies that withdraw community support while simultaneously encouraging older people to remain at home (e.g. Compton et al., 2011) represent an irony not lost on writers such as Milligan (2012). She forged her

account following her experiences of seeking to maintain her mother's quality of life at home. Even as a gerontologist academic, she found the process to be a minefield.

In a seminal paper, Peter Townsend (1981) argued that dependency is being socially manufactured: modern culture, social practices, and implicit and explicit policies all conjoin to exclude the frail from sight and from what he terms the 'social imaginary'. Back then, Townsend claimed that better integration of older people is needed. That is very likely to remain the case since, as older people enter the interface between home care and institutional care, they are too often on their own and without help: according to Aronson, 'responsibility for their well-being is left in the hands of individuals who are expected to navigate through the mixed economies of care as self-interested and atomised consumers, rather than as citizens with shared interests, rights and obligations' (Aronson, 2002, p.400). The dominant imagery of successful ageing compounds this fear of entering the interface – images of the forever-young horizon-gazing while together on a faraway beach – would seem to taunt those trying to maintain dignity when being aided with toileting.

Similarly, the authors also contrast the social imaginary where successful ageing is idealised at home, meaning that dependency and entry to a care home can only mean failure. In Aronson's account, such older people are located precariously among part social provision and complicated institutions of public, private, formal, informal, independent, and state provision. He cites Twigg (2000) in painting a picture of society that often demonises those who

succumb to dependency after being unable to navigate between the islands of a complex and disjointed support system.

Moreover, the inchoate nature of care services seems to encourage wider society to switch off from the debate, pushing those in the fourth age still further away in the social imaginary. Hence Taylor (1998), echoing Townsend (1981), debates how the state and society iteratively forge meanings and together lead to a closing of the collective mind towards the very old. Since moving is to lose it all and to 'fail', such a culture reinforces an existential need for older people to retain identity, remain in their homes, and stay in control.

By virtue of the home itself and by support networks, older people may maintain their autonomy that in turn is a catalyst for quality of life. However, at the interface, this breaks down. Individuals entering the interface know little of its practices at a time when they are most vulnerable and need help most.

3.3.2 Option recognition

Several authors refer to the period when continuing to live at home becomes increasingly difficult as the time of 'option recognition'. Gabriel and Bowling (2004) relate this point to the competence/environmental press model of Lawton and Nahemow (1973). They conclude that measuring is difficult through positivist scales of mental and physical impairment. Irrespective of whatever deficiencies older people have, what was critically important for their sample of 1,000 participants was an emphasis on improving life via enabling support structures. They compensate for physical and cognitive deterioration, irrespective of setting.

The Lawton and Nahemow model exposes how the more competent the person is, the less dependent they are on their environmental circumstances. Environmental proactivity may also reinforce autonomy, such as with micro adaptations such as handrails and macro adaptations such as housing with care environments. Gabriel and Bowling (2004) tell us that such compensations allied with family time and storytelling characterise what makes life good at the interface.

The authors argue that over time, many older people have their attachment to their home compromised by declining competence, or a change in their environment, or both; thus, when adaptive behaviour can no longer bring the micro and macro environment into balance, a point of option recognition is reached. They found that any strategic response that comes after that point has an inevitable impact on self-identity and self-esteem, and thus they stress the psychological importance of this period in countering the fear of the 'black hole'. They identify the importance of self-definition and of being independent compared to the risk of dependency. The authors' methods were ethnographic across 54 interviews with older people with a mean age of 80, where 39 were living in mainstream housing, most commonly in flats or bungalows. They found striking associations between 'independent adulthood' and 'a place of their own' where even the 'last resort' of a care home was deemed superior to being a burden on their adult children (Gabriel and Bowling, 2004; Peace et al., 2011). Interestingly, Katz et al. (2013) and Vasara (2015) also note that this 'reluctance to complain generation' of individuals who are presently in and approaching old age may be replaced by a less stoical generation and that this further implies added pressure on services.

Peace et al. (2011) also explored what moves were considered by their studied cohort, finding that across the three interview locations across England, there were significant differences in participant responses. They and Park et al. (2016) lamented the ‘chronic shortage’ outside South East England of housing with care facilities. In London, participants widely contemplated a move to sheltered housing thanks to it being plentiful and it being well understood. However, in the other two locations, one urban and one rural, where sheltered housing was less available and much less known about, few participants volunteered that they were contemplating such a move. Most felt the expensive and disruptive prospect of moving in later life with possibly poor health challenging to consider, though most had thought about it. Indeed, Bligh et al. (2015) found that 66% of those over 76 wanted to move to someplace where they would have added security of tenure in a home-style care environment. Some, however, did not wish to talk about it at all, the authors commenting that the topic is bound up with uncertainty about older people’s future self-identity, and required ‘facing up to the end of their life’ (Peace et al., 2011). Quite understandably, a great many were unwilling to do that.

In pinpointing the point of option recognition, Peace et al. mark the keen awareness of their respondents as to their diminishing levels of control and their ‘contraction of personal space’ (Peace et al., 2011, p.748). Respondents were opposed to the concept of a care home environment: being in a place commonly conceived to be where one has nothing to do all day long, and being forced to mix with people with whom they would not ordinarily mix, and leading to what they described as impoverished person/environment interactions and a predominance of micro-level concerns. For example, they quote respondent

‘Naomi’ who stated: ‘I couldn’t sit there, you know, arguing about whether the windows should be open or closed’ (ibid. p.748). Other authors report similarly: Walker and Paliadelis (2016) note the significant themes of care home entry as a resigned acceptance of the loss of home and autonomy, recognition of mortality, a value of support from essential relationships being foregone, and a fear of boredom that was also stressed by Brownie and Horstmanshof (2012).

A significant conclusion that these authors come to is that when forced to face up to options, older people evaluate their options subjectively. At this point, which the authors refer to as the point of ‘option recognition’, older people, rather than objectively weighing up the pros and cons of the options on offer, evaluate their choices much more in terms of how they would be able to maintain their self-identity. In such a calculation, it seems the importance of preserving self-identity is hard to overstate.

Other authors highlight what factors constitute the actual tipping point for moving into care, chief among which is trading independence for safety, especially following a succession of falls (Walker and Paliadelis, 2016). However, seemingly by the time many older people recognise that a purposive move to an environment of housing with care, or even a bungalow close to an adult child, is desired, it is often beyond their strength to do so. Abramsson and Andersson (2015) found precisely this point when their longitudinal study showed a spike in the desire to move among participants after they reached their late 70s matched with a lack of apartments available for them to rent. Buying a home at such an age is unusual. Croucher (2008) also noted that the

support of a warden or scheme manager was a major ‘pull’ factor for these older people who would consider moving. She found that the thought of having someone on hand for ontological security and perhaps that little bit of help was an ‘integral’ part of sheltered housing in the minds of older people. However, as Paris (2010) among others notes, such set-ups are becoming increasingly rare, as there has been a shift towards ‘flexible’ approaches of managers working across several schemes, thanks to funding limitations and to the detriment of the sheltered housing philosophy.

3.4 Decisions about Moving: Discussion

This section of the literature review has used Lawton and Nahemow’s competence/environmental press model to frame how older people have been found in the literature to rebalance their environment such that it is better in balance with their competence. The model exposes how adding to the older person’s capabilities through additional social resources can have a powerful multiplier effect to maintain an older person’s life balance and in so doing be a catalyst for well-being. The model demonstrates that avoiding isolation and loneliness can prevent the need for clinical interventions and prevent the need for moves to institutional environments.

I introduced the Wiseman model, also seen as a primary means of interpreting moves in retirement. However, when the model is viewed from the UK, it highlights that such steps for lifestyle-seeking ‘third-age’ retirees are perhaps not commonplace. ‘Pull’ factors seem weak, not least because of a lack of awareness and supply. However, for everyone, there is the universal truth of

‘push’ factors that stem from our inevitable cognitive and physical decline – eventually leading to the point of option recognition.

The literature finds that later in life, moves are very often feared. I introduced the ‘black hole’ metaphor that several authors have used to highlight the deep fear of the fourth age that some authors found in their research of older people. The black hole metaphor captures the fear of having to give up autonomy, control, independence, and personal agency. This socially constructed ‘bogeyman’ is co-created by policies and society and is a cause of a care cliff edge — where maintaining independence is a success, dependency and moving to institutional care is a socially constructed failure. As the social care debacle before the 2017 general election bears witness, these taboos of care may have deepened since both Townsend’s paper in 1981 and that of Taylor in 1998. It perhaps reflects a continued failure of strategic policy. As both authors noted, solutions lie with both better integration and the smoothing of the cliff edge between care at home and institutional care.

Presently, when older people and their families face up to ‘option recognition’, moves are very often beyond their strength and energy, and older people find that there is often no supply of suitable single-storey homes in bungalows or flats for them to rent. Furthermore, the support of a scheme manager, a critical attribute of sheltered housing that can add to a person’s quality of life, has been removed as a service offering.

To conclude, older people push the thoughts of moving away until forced to do so. Indeed, very often, older people stay on at home overlong, to the detriment of their welfare. One reason that explains such behaviour is due to the

negativity within the social imaginary of care homes. I also observe that since the costs of institutional care are overwhelmingly paid for by the relevant HSC Trust in Northern Ireland, the Trusts have the perverse incentive of trying to dissuade residents from moving there.

When forced to consider the issue, called the point of option recognition, older people (or their families on their behalf) seem to be forced to trade their independence and their self-identity for their security. Often following a fall, possible unplanned hospitalisation, a lack of support, and at a time of high stress, older people may capitulate by suddenly giving up their fight for home and autonomy, and they consent to a hasty move into care. A cliff-edge of care results, a cliff edge that older people too often topple over.

In Northern Ireland, this cliff edge remains, and this leads to the question of how strategic policy could help smooth such a care cliff edge as has been done in England and Wales, where Extra Care constitutes an essential element of their system.

4.0 Methodology

4.1 Philosophical Underpinnings

This section maps the ontological and epistemological underpinnings of my research. Such foundations inform the research methodology and the methods that I have chosen, the subjects of subsequent chapters.

In truth, the philosophical underpinnings, methodology, and methods are inextricably linked, making discrete separation difficult. As with my research into the quality of life and well-being for older people (Law, 2017), there are multiple overlapping layers in a continuous feedback loop, rather than being separate philosophical subjects. Below, I revisit the topics that arose within the literature review and continue with the philosophy of my investigation.

4.1.1 Structure, agency and housing philosophical underpinnings

The continuum between, on the one hand, the structures required from the state and, on the other, the freedoms of personal agency is a source of long-standing philosophical thought. From the time of Plato's 'Republic,' philosophers have considered the proper limits of the state when weighed against an individual's liberty, their freedom, and their capabilities. Structuration theory (Giddens, 1984) is one means of illustrating this long-standing philosophical tension. Structuration theory demonstrates the need for there to be structures to help older people; however, the approach also highlights the need for the older person to have agency, be in control, and pursue their own happiness.

An individual's agency, control, and independence are essential contributors to well-being, but these are also slippery concepts. They are challenging to measure and poorly afforded within the standard health and social care 'offer'. Previously, I highlighted the agency literature, which explained that many older people have their existential sense of self under threat and a deep-seated fear of being helpless and losing independence and control. Earlier, the literature exposed how it is that many older people hold on to their home overlong thanks to it being an embodiment of their agency and the belief that their homes afford higher well-being than institutional care. When I interviewed older people for my MRes dissertation, I heard more than once the phrase 'they'll be taking me out of here in a box'. However, for many of them, their present home may exacerbate dependency. Examples might include poor insulation (leading to fewer rooms being habitable), steep stairs, and being remote. Thus, Extra Care may be a step along the structuration continuum, still generating well-being through the existential sense of self, but within a supportive environment that may compensate for an individual's frailties or deficiencies during their last 1,000 days.

The standard offer for older people who need care during their last 1,000 days is a choice between domiciliary care and institutional care. Domiciliary care is limited, impersonal, and offers poor choice (Kelly and Kennedy, 2017), and institutional care is considered by individuals to be of uncertain quality, and unappealing (Commissioner for Older People for Northern Ireland 2018). Neither seems to give significant individual agency in the arrangement of an older person's affairs and yet these are precisely the features of housing that the literature says are most crucial in dynamically generating well-being.

4.3 Researcher Positionality: From ontology to epistemology

According to Sikes, 'researcher positionality' encompasses the researcher's ontological position, assumptions of beliefs, values, and epistemology. Such positionality is crucial to methodological decision-making since all research is subjective: it requires choices. As such, recognising the researcher positionality is vital (Sikes, 2004, p.17).

Ontology is the philosophical study of reality with two principal ways of considering it. One way, very often referred to as a positivist view, examines the nature of reality as one where the researcher 'thinks about issues such as whether the world exists independently of your perceptions of it' (Greener, 2011, p.6). An alternative view, often referred to as an interpretivist view, considers instead that there is not a single universal truth 'out there' to be discovered. Instead, reality is often what we, as social actors, determine it to be.

I am engaged with the second approach, where reality is socially and culturally composed, and it is open to interpretation. A simple question helps me to illustrate this question clearly, namely: are Liverpool the best team in the history of English football? Such a question is a contested one and will likely have different sets of beliefs as to the 'truth' whether the question is asked in Liverpool or Manchester. The example highlights that social interpretation affects how reality is perceived.

Schwandt (1998) expands on the positionality of constructionists and interpretivists, who believe:

> To understand the world of meaning one must interpret it. The inquirer must elucidate the process of meaning construction and clarify what and how meanings are embodied in the language and actions of social actors… to prepare an interpretation is itself to construct a reading of these meanings; it is to offer the inquirer's construction of the actors one studies (Schwandt, 1998, p.222).

We may, therefore, conclude that individuals have a constructivist view of the world, and when it is put together, it creates a constructionist reality that is real for their being and may be examined and interpreted. According to Martin Heidegger, questions of being and its nature lend themselves to being considered phenomenologically. In *Being and Time*, in the chapter entitled 'The Phenomenal Method of Investigation', Heidegger states:

> With the question of the meaning of Being, our investigation comes up against the fundamental question of philosophy. This is one that must be treated <u>phenomenologically</u> [emphasis in original] … The more genuinely a methodological concept is worked out … it is rooted … with the things themselves … and … removed from technical devices (Heidegger, 1962, p.278).

(Martin Heidegger capitalised the word Being when used in this primordial way of one's existence. As is convention, I shall follow this approach.)

Gioia et al. (2013) echo the scope of such Heideggerian ‘genuine’ qualitative research to uncover knowledge of Being. They state that rather than adding polish quantitatively to accepted theory and assumptions, a phenomenological study has the potential to discover actual new theoretical ‘concepts’ that may lead to later ‘construct’ refinement, but concepts need to come first. Indeed, ‘studying social construction processes implies that we focus more on how organisation members go about constructing and understanding their experience and less on the number or frequency of measurable occurrences’ (ibid., p.16). What I take from this is that in terms of epistemology – that is to say, how do we know what we know – phenomenology is a means by which I might uncover knowledge. I may also interpret as an ‘insider’ (Dwyer and Buckle, 2009) what is going on, and compose a construct based on such findings (Gioia et al., 2013). The philosophical tradition of phenomenology itself is also contested, and I am required to uncover which paradigm I am to use.

4.4 Phenomenological Research

Phenomenology allows the researcher to illustrate, identify, and illuminate phenomena through how social actors in each situation perceive them. It does this by affording the researcher in-depth information and perceptions thanks to inductive methods such as discussions and interviews (Lester, 1999).

Established by Edmund Husserl (1859–1938), phenomenology is a far-reaching way of doing philosophy where the approach is to describe the world of human experience and from that to try to work out its essential structures. Morris (2016) points out that phenomenology adds to the world of space, time,

and causality by elaborating on them in ‘wonderful detail’. By seeing others as an essential part of human existence and being embodied in the world its epistemology emphasises:

1. the importance of personal perspectives and interpretations;
2. how we make sense of the world into which we are thrown;
3. how we interact with others; and
4. how we pursue the things that matter to us.

I made mention of the fact that phenomenology is a contested tradition; this is broadly between the ‘transcendental phenomenologists’ and the ‘existential phenomenologists’, and it is worthwhile up-front to lay out the philosophy of both to contextualise my means of enquiry.

4.5 Transcendental Phenomenology

Husserl used the phrase ‘back to the things themselves’ to emphasise the transcendental, cerebral, and detached methods of investigation that ‘culminated a Cartesian tradition,’ according to Dreyfus (2008 min. 03.29). For Descartes, the subject knows substance through a causal theory of perception: an approach that has been central to philosophical thought since Plato, and one that is sceptical as to how things appear, since we may misperceive how reality is (such as in the Plato cave allegory). Following this Cartesian approach, Husserl recognised that appearances might mislead us into thinking that reality is in some way *other* than it is. His contribution, however, is that despite being misinformed, for perceivers, such as the dwellers in Plato’s cave, it is nevertheless *their* reality. Husserl phrased it that one must go ‘back to the things themselves’ (Husserl, 2001, p.168) meaning, as Mulhall tells us, that if

we want to build our knowledge of social reality on solid foundations, the place to start is the accepted meaning that phenomena have for social actors in different circumstances (Mulhall, 2015, min. 03.30). These meanings, derived from shared versions of reality, thus offer the strategy researcher the ontological opportunity of finding what exists and the epistemological opportunity to develop further knowledge.

Transcendental phenomenology is a description of things as they appear, rather than being explanatory, and it aims to provide a clear, undistorted description of the way things seem. Following Husserl (1970), Giorgi (1994a) holds that phenomenology must be rigorously descriptive and utilise methods of both reduction (epoché) and bracketing. These methods, despite being often conflated, are different, if similar steps. According to Christensen and Brumfield (2010), epoché is a process of blocking assumptions and biases that one must assume before commencing a study so that a phenomenon can be explained through its inherent meaning, whereas bracketing is when the researcher acknowledges his or her personal biases. Both involve setting aside assumptions and beliefs about a phenomenon to clarify how it presents itself within the lifeworld (*Lebenswelt*) of the participant. For my part, the transcendental tradition struggles to answer some of the ‘so what?’ questions that arise when seeking to interpret and apply knowledge. As I further explain, this has led to my posing the ‘so what?’ question against my data structure of direct quotations to afford a more explicit interpretation of the strategist’s own words.

4.6 Existential Phenomenology

By contrast, existential (often referred to as hermeneutic) phenomenologists are those who operate within a tradition of not only describing phenomena but interpreting them by using their own experience and knowledge. Within this tradition, it is only necessary to admit preconceived understandings and inevitable biases rather than trying to bracket them entirely out of play. Finlay (2008) makes the point that researchers would deny it is possible, or even desirable, to set aside their experience and understandings. Instead, 'researchers need to come to an awareness of their pre-existing beliefs, which then makes it possible to examine and question them in the light of new evidence'. This method, therefore, highlights what belongs to the researcher and what belongs to the research (Finlay, 2008 p.12). The original proponent of this form of philosophy, formed in no small part as a reaction to the Husserlian tradition of phenomenology, was Martin Heidegger, with the 1927 publication of the opus *Being and Time*, which stimulated the French existential school of Sartre, De Beauvoir, Camus, and Merleau-Ponty. It is from this school of interpretative, existential, and hermeneutic phenomenology that I take my lead.

Heidegger considered the Cartesian construct of one's subjective self, as it studies and interacts with the so-called objective real world, to be a false one. He believed the notion that one would doubt everything, including whether one truly exists at all, to be absurd (Paskin, 2015, min. 43.44). In contrast to the notion of causation and 'intentionality' that Brentano and Husserl claimed was a mark of consciousness, Heidegger focused on the subconscious and what it

means for Being, where one only directs awareness on something when it is worth doing so. Most of the time, no conscious thought of objects is needed at all. Heidegger contrasted intentionality with his notion that the world is continuously there as background. Under his account, one exists and makes sense of things through 'Being-in-the-world' (*In-der-Welt-sein*), and in such a world, one is familiar with one's existence – what he refers to as one's '*Dasein*'. Morris (2016) interprets this notion as the idea that we would not be human beings unless we were in the world, and the world would not be how it is, as a lived world (Lebenswelt), unless it were a human world. Thus, while Husserl sought to bracket 'out of play' the 'natural attitude' – Heidegger, followed by Merleau-Ponty, had a 'style of thinking' (Merleau-Ponty, 1962, vii) that was suspicious of this Western philosophical tradition. They explored the meaning of Being where one is 'embodied' in the world, and one develops 'habits' to exist without having to be conscious of the object at all. That is to say, you do not need to consider the angle of the hammer when hammering a nail, you just hit away (Dreyfus, 2008 min. 08.43). Merleau-Ponty notes that one does not have intentionality when one is driving a car, one just drives – the vehicle is absorbed into our body 'schema' with nearly the same exactness as we have with our senses: it becomes an 'area of sensitivity' (Merleau-Ponty, 1962, p.143). Both examples also underscore the importance for our existence (Dasein) that caring about something has, and how we purposely strive to achieve specific long-term goals, often via a succession of multiple small steps and often unconsciously. For example, when hammering a nail, the carpenter is at one with the hammer and does not doubt whether the hammer exists at all. Nor does he need to calculate the cause and effect of the angle of his arm

when hammering, he hammers away. However, the act is also a small part of caring about and building a much larger project, possibly a dwelling house. Such an example is analogous to researching strategists, such as when strategists strive in small steps to achieve higher goals. They often do so unconsciously.

Accordingly, the Heideggerian approach to phenomenology is not detached from Being-in-the-world; rather, it understands that one is embodied in it. It is not a cerebral, intellectual study of pure consciousness, but an understanding of how things appear to us, subconsciously, and in the course of everyday use. As Sadala and Adorno (2002) put it, human behaviour is not only a reaction to stimuli and is neither exclusively objective nor subjective. Rather 'there is a dialectic relationship between a person as a body and the world where it is located… people are in charge of determining themselves through their own choices. (Sadala and Adorno, 2002, p. 286).

Some scholars consider that investigating the Dasein of participants requires the researcher to be-in-the-world as an insider – an approach that I turn to now.

4.7 The Insider Method within Phenomenology

Finlay (2009) explains that a 'particularly divisive issue for researchers is how much attention they should pay to bringing their own experience to the foreground'. Some writers firmly deny the interpretative role: for example, Giorgi, following a Husserlian school, posits that 'one simply refrains from positing altogether' (Giorgi, 1994a, p.212); whereas other researchers such as

Stierand and Dörfler (2012) deny that it is possible or even desirable to put out of play their own experience and understandings. Similarly, Linda Finlay (2008) titled an article to highlight this dialectic tension as ‘A dance between the reduction and reflexivity: Explicating the “phenomenological psychological attitude”’, where, as the title suggests, the researcher needs to be ever conscious of their privileged role as one having the potential to influence the data. I am aligning my study to Finlay’s balanced approach as I am confident that if I can foreground my own biases candidly, I will be able to ensure dependability, better clarify the issues, and provide a more worthwhile output.

As an ‘insider’ (Dwyer and Buckle, 2009; Gioia et al., 2010; Stierand and Dörfler, 2012), I pursue how strategy-makers choose when considering how to maximise the well-being of older people. Dwyer and Buckle (2009), for example, describe the insider role as one where the researcher occupies the ‘space between’ – somewhere between an utterly objective outsider view, but lacking intimate insider knowledge, and a complete insider view, carrying an excessive risk of ‘going native’ and excess bias.

4.7.1 Using the insider approach: Macro-existentialism

Using this insider approach that has an existential-phenomenological epistemology, I investigate how strategy-makers choose. The anguish of choice has been a topic that has occupied a pantheon of existentialist writers such as Søren Kierkegaard, Simone de Beauvoir, and Jean-Paul Sartre. Each of these authors considers that the act of choosing is a significant mark of authenticity but is a standard that many fail to meet. Kierkegaard described the choices made in the Bible by Abraham (Kierkegaard, 1985, pp.76–77) when

agreeing to sacrifice his son Isaac. Simone de Beauvoir (1964, vii) chose as an epigraph in the novel *Blood of Others* the quotation ‘each of us is responsible to everyone and for everything’. Sartre believed that people have a habit of deluding themselves into thinking that they do not have the freedom to make choices. By not going beyond their status quo and not recognising the array of options available, a person puts themselves at the mercy of their circumstances. They adopt value systems and social roles that are outwith their nature. Sartre highlighted examples of those living in a state of bad faith (*mauvaise foi*), such as the example of the waiter in *Being and Nothingness* (Sartre, 1956, p.59). Sartre describes his behaviour as exaggerated, as play-acting and conforming to a stereotype. For Sartre, while a person may pretend not to have the freedom to make choices, they cannot deny them: to pretend so is actually to choose between having the liberty to choose or to choose to give it away − it cannot be escaped. In Sartre’s words, man is condemned to be free.

Those living with bad faith disown their freedom because of social pressures, adopt false values, and live inauthentically. In his 1943 lecture ‘Existentialism and Humanism’, Sartre describes the anguish of choice that his pupil has when torn between loyalty to his mother and his country when facing the choice of whether to remain to look after his mother or to leave for England to join the Free French and fight for liberation from the Nazis. His mother lived only for him and if he left, her life would be made worthless; however, if he left to join the Free French, he might not be successful, and his actions could ‘vanish like water into sand’ (Sartre, 1972 p.35). Sartre did not recommend a course of action: his pupil faced the anguish of choice alone.

Methodologically, my research as an insider is to appreciate and help elucidate, at a macro level, the field strategist's 'anguish of choice' – potentially the welfare and economic trade-offs implied when choosing among competing interests with a claim on scarce resources. Sartre did not suggest which way his pupil should choose, and the case highlights the difficult choices that those living authentically must carry out when selecting a policy. His approach is also applicable for individuals living freely and making the most of whatever circumstances they are thrown into; we might call this micro-existentialism.

4.7.2 Micro-existentialism

At a micro level, the existentialist approach has a further role as one where individuals are encouraged to reject 'off the peg' stories. For example, in *The Second Sex* (1972 p.267), de Beauvoir rejects the 'off the peg' conflation of femininity being equal to womanhood when stating: 'One is not born, but rather becomes, a woman.' Nor, she claims, does being older inevitably equate to dependency: she (de Beauvoir, 1970, p.288) notes that 'since it is the "Other" within us who is old, the revelation of our age comes to us from outside – from others. We do not accept it willingly.'

4.8 Blending Micro- and Macro-Existentialism into Strategy

Age is something that happens to other people. De Beauvoir's pithy insight reminds us that people tend not to think about their last 1,000 days and this adds a profound responsibility of choice on the shoulders of field strategists. They do, or ought to, appreciate the inevitability of decline and it is they who

are charged with strategising in the face of it. It would seem natural that when responding to this responsibility, interventions that policymakers would propose would commence with maintaining an individual's agency as opposed to a wholesale takeover of their lives. Similarly, my admitted bias in my investigation is one that calls for enablement – when interventions are needed, they are available in an effective way as interventions which compensate for people's losses of cognitive and physical ability. With such help, older people may maintain their dignity, pride, and freedom. Micro-existentialism may be a powerful way to help expose how older people wish to live freely even when they find themselves in diminished circumstances. Their concerns are unique, and thus individual exposure may stimulate better arrangements that are not 'off the peg' and enable them to pursue their own happiness.

My positioning within a philosophy of existential phenomenology has a focus that acknowledges the tensions between, on the one hand, being human, vulnerable, and frail, and, on the other hand, self-actualisation, life fulfilment, and freedom. Heidegger describes this tension as 'situated freedom' (Heidegger, 1962, p.435), where existentialists consider that there is a responsibility to be authentic whatever the context. Some scholars, such as Dahlberg et al. (2009), describe this as an 'existential view of well-being' where health is 'conceptualised for its possibilities for human existence', and a philosophy of care is required that understands how well-being and illness are intimately bound up in the human condition. Indeed, without 'an explicit understanding of well-being' (ibid.) that includes the existential dimensions of freedom and vulnerability, health care systems may view well-being as simply not being sick. Such an approach to social care appreciates that a nuanced

range of interventions are needed to maintain quality of life and is prepared to facilitate them, leading to questions of the extent, scope, and funding of adult social care provision.

At the other extreme is a view where older people are viewed solely as consumers. Dahlberg et al. (2009) cite Heidegger (1975) and the notion of ‘letting-be-ness’, where such a philosophy of older persons’ care believes everything is subordinate to personal agency. As ever, truth is contested and lies somewhere between, and it may be at a different place across the structuration spectrum for different people. The challenge is to reconcile people’s personal pride and self-mastery within sustainable structures.

To conclude, this section has exposed and rationalised the ontology and epistemology of my thesis: ontologically as constructionist and interpretivist, and epistemologically by outlining why I consider insider interpretivist existential-phenomenological methods to be an appropriate means of enquiry.

4.9 From Methodology to Methods

My ‘Findings and Analysis’ within the enclosures document exposes in some detail how strategy-makers make sense of the issues that I bring to the surface with them, and in my cognitive graphic at Figure 5, I have highlighted these as ‘sensemaking’ and lying on the green critical path of my methodology. As participants make sense and care about an issue, so they cognitively make a strategy to mould it (Mintzberg et al., 1988). An investigator needs a means of systematically uncovering such strategising, and strategy-as-practice (SAP) is

one means to do so as I move from methodology to methods. Below, I elaborate further.

4.9.1 From sensemaking to strategy

When we consider strategising as part of how we may make sense of a socially constructed world, how it progresses may be said to flow from an understanding of the essence of organisational experiences, and the ways and processes by which these experiences unfold. For example, Gioia et al. (2013) explain that since people who construct their organisations are 'knowledgeable agents', they may be assumed to know what they are doing and may also be able to explain (with help perhaps) what they are doing. Accordingly, scholars posit that it is essential to 'foreground the informants' interpretations' (ibid.), how they make sense of their world, and to make sense of how they strategise (Balogun and Johnson, 2005). One discipline that has emerged over the last number of years as a means of uncovering empirical strategy is strategy-as-practice (SAP). Its advocates consider a strategy to be a living discipline continually engaged with by senior management in the field – agents I refer to as 'field strategists'. Such an approach contrasts with viewing strategy as a remote set of policies that corporations have, resulting in an imposed doctrine upon the leadership team with which they must comply. Instead, with a strategy-as-practice view, managers 'do' strategy, as well as 'have' a strategy (Jarzabkowski, 2008, 2019; Jarzabkowski et al., 2007; Johnson, 2004 Whittington, 2006). If strategy might be defined as a pattern within a stream of decisions (Mintzberg, 1978), we can research strategy formation in a broad descriptive context, encompassing how managers make sense of their milieu

cognitively, reflexively, and purposively. In Figure 4 below, I interpret this strategy-as-practice methodology as a flow from sensemaking to strategising, and I explore each in turn.

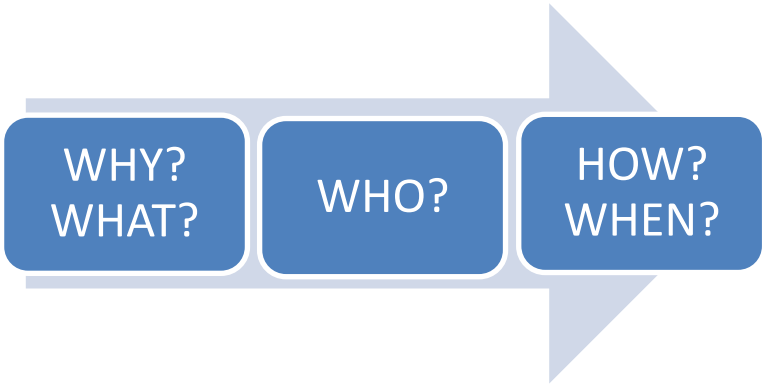

Figure 4: From sensemaking to strategising

Source: Author

4.9.2 Why/What?

In the graphic, I have chosen to foreground the purpose of decision-makers in terms of what they are trying to achieve. This approach echoes Knapp's (1984) 'production of welfare framework' as well as the philosophy of Heidegger that sees the strategists as caring entities. By caring, they are choosing among competing demands within the confines of scarce resources to pursue their purpose authentically. Very often, however, the goals of a strategy are fuzzy and are wrapped up in how people have made sense of their environment and packaged it into 'simple rules'. Mintzberg (1988, p.161), following Polanyi (1966) and Weick (1979), and more recently followed by Kahneman (2011), explains that how humans act is based on the meanings that things have for

them, their inherited background of culture, norms, shared understandings, common language, and procedures. These ‘mental models’, ‘frames’, or ‘schema’ guide and enable actors. This interpretation resonates with Blumer (1986, pp.3–5) and Eisenhardt and Sull’s (2001) novel article ‘Strategy as simple rules’ when illustrating how individuals process information as heuristics to guide actions, often using a mental (or real) map as a guide. Mintzberg (1988, p.161) relays Weick’s example of a Hungarian army unit bravely finding their way in an Alpine snowstorm thanks to their having a map to guide them: however, only latterly did they discover that the plan was not of the Alps, where they were lost, but of the Pyrenees – the point being that sometimes even having the wrong map is good enough.

The implications are that, as I carry out my investigation of *why and what?* as an insider, it is vital to pay close attention to the context, culture, background of the participant as well as what they care about, as that may be analogous to the map that guides them.

4.9.3 Who?

Strategy-as-practice scholars agree that there has been little research into how people within organisations pursue strategy. To the extent that strategy research focuses on people at all, it has tended to concentrate on senior executives and chief executives. For example, Johnson et al., citing both Pettigrew (1985) and Mintzberg et al. (1978), note that ‘we have long known from much research into strategy process that this is a false picture; that strategy development is not so dependent on an individual or even a small group. There are many influences, such as middle managers, consultants, and

even investment bankers' (Johnson et al., 2007, p.560). Among others, Johnson et al. (2007) note that there are very few academic examples of small and medium businesses strategising, let alone for an SME business strategising to create new policies (such as is the purpose of this thesis.)

The method of causal mapping is one practical way to give an insight into the schema of practitioners and to visually map the expert intersubjective views in order to recognise commonalities in understandings and indeed conflicts (Eden, N.D., 1992, 2018).

A premise of cognitive mapping is that the individual participant's graphic has the potential for insight in viewing how the matters that concern management tie together. Moreover, synthesising the cognitive maps from a variety of senior actors across the industry may illuminate the entire subject area by presenting a causal map, with a position agreed by many strategists, requiring skill on the part of the researcher and an element of industry knowledge.

However, with aggregation comes the risk that the results become excessively generalised. With generalisation, the power of the meanings, which are irrefutable when reading quotations in context, can become lost. Hence my methods attempt to retain the authority of the personal through references along with the causal map strategies by overlapping with the Gioia (2013) method. When combined, these methods capture the musings of actors of strategy-as-practice, thus maximising meanings and their transferability that I derive from a collective of strategists and their specific and often arresting quotations.

4.9.4 How/When?

The third element of strategy formation may be said to be the ‘how’ and the ‘when’ of goal attainment.

Matters of the ‘how and when’ begin to get to the nitty-gritty of strategic decision-making. ‘How and when’ starts by finding out what drives the attention of management, be it acknowledged or not acknowledged as the drivers of strategy making, since most often, managers are pursuing the goals of the firm incrementally and such actions cumulatively add up to being strategic (Mintzberg, 1998). As such, the How/When? question is being answered continuously in ways that make the firm and its outputs more ‘VRIN’ (Barney, 1991), that is to say, more valuable (V), rare (R), inimitable (I), and non-substitutable (N). In following this ‘resource-based view’ of the firm, Ambrosini and Bowman (2009) consider that managers are most often more narrowly engaged, rather than, as some kind of deity, considering corporate strategy from on high. According to these scholars, managers operate within a ‘path dependent’ context of ‘adapting, integrating and reconfiguring internal and external organisational skills, resources and functional competencies’ (ibid.), all within a changing environment. Following Teece and Pisano (1994), Ambrosini and Bowman (2009) consider that the ‘how and when’ consists of actually improving the resource base, and that resource base includes capabilities and the core competencies (Prahalad and Hamel, 1990) of the organisation as well as the traditional view of resources as land, capital, and labour. With echoes of Senge (1997) and Argyris (1977), they emphasise a view of management where continuous learning improves the capabilities of

the organisation. Under this view, a strategy is a reflexive endeavour where managers modify their goals and decision-making rules in the light of experience.

In this way, capabilities evolve, are improved for strategic gain and are thus shown to be ‘dynamic’ and a powerful resource in their own right. Such a dynamic view of how managers may improve effectiveness and profitability may be compared with the more static Porterian positioning approaches to strategy creation (Porter, 1980, 1985) and illustrates the role for management itself to be dynamic and authentic to improve the resource base.

The implications of considering the role of management in this way are to foreground the skills, experience, and knowledge of managers when applying themselves to doing ‘what works.’ In my research, I attempt to follow in this tradition of Penrose (1959) and Pettigrew (1985) to illuminate cultural and deep-rooted industry knowledge across the discipline to formulate a strategic contribution for the well-being of many older people.

As noted, a proven technique for mapping the surfacing of goals and objectives, intersubjectivity, and interrelationships is the causal mapping technique of Ackermann and Eden (2011).

4.10 The Method of Causal Mapping: From Theory to Practice

In their book *Making Strategy – Mapping Out Strategic Success*, Ackermann and Eden (2011) also follow the pattern that I have outlined above of Why/What?, Who?, How/When? They state that strategy ‘is about agreeing

priorities and then implementing those priorities towards the realisation of an organisation's purpose' (2011, p.5). It is done by those who can make it happen, rather than by an identikit, or imposed from outside. They stress that strategy is incremental and achieved through small wins. It starts fuzzy. They aim to aid clarity when deciding the 'what and how' of strategy making by using cognitive and causal maps.

4.10.1 Sensemaking

The cognitive and causal mapping techniques are a means of bridging the gap between theory and practice. The authors note that the methods are a package of process tools that they used in 200 strategy interventions. The tools guide management when constructing a workable strategy that is both politically feasible and that exploits the distinctive competencies of the organisation (Ackermann et al., 2004). They note that many strategic planning efforts are not a success since they fail to engage senior strategists, as well as often taking an idealised view as to what is achievable. As a socially constructed practice, policies and practices are culturally ingrained – and thus, the institutional memory of 'the way it is done here' cannot be changed quickly.

The cognitive mapping techniques are a way of getting managers to surface, define, and then graphically illustrate the critical issues, as well as the interrelationships between such matters and the organisation's goals. In so doing, the underlying taken-for-granted assumptions can be examined along with the systems and structures that are in place to achieve (or not) such goals.

4.10.2 The process of cognitive and causal mapping

A conventional means of collecting research data is through semi-structured interviews, which are a ‘pervasive form of learning about the world’ (Atkinson and Silverman, 1997, p.304). However, few techniques satisfactorily capture and analyse the ‘interdependencies between the themes of the coded material, causal relations, and feedback structures’ as well as cognitive and causal mapping techniques (Pyrko and Dörfler, 2018, p.2).

4.10.3 Cognitive maps versus causal maps

Cognitive maps capture the individual’s interview material, whereas causal mapping refers to mapping multiple interviews from different people on one diagram (Ackermann et al., 2004). Cognitive maps may be used to analyse any spoken word or text and share many characteristics with mind maps. Since people and systems deliver strategy, they are part of a cognitive school of strategic management that brings to the surface issues that concern managers and how the responses feed into emergent strategy. Eden and Ackermann (2010, p.232) credit George Kelly in his writings of 1955 as having developed, explained and used ‘Personal Construct Theory’ as a way of better understanding how people make sense of the world ‘*in order to act it*’ (emphasis in original). Kelly, they note, saw people as problem solvers, making sense of the world through shortcuts, heuristics, and agreed constructs. These constructs enable people to define the everyday situations that they face. As such, Kelly recognised the need for him to learn about the constructs that people used and map them for clarity.

It follows that cognitive mapping is the process by which the mapper captures certain aspects of the participant's construct system. The participant and mapper may then reflect on the elucidated maps to develop a better understanding of the issue (Eden, 2018). Following Weick's (1979) theory of organisational sensemaking, we can assume that the constructs that Kelly refers to in fact guide people's everyday thinking and doing – even if the person is initially unable to articulate them when challenged.

Over the last number of years, cognitive and causal mapping has been more easily afforded by specialist computer software such as 'Decision Explorer.' The software allows the graphics to be altered as participants develop how they make sense of the issues. Colin Eden (N.D.) within the Decision Explorer instructional videos describes cognitive maps as 'transitional objects' in that their purpose is to aid a deeper understanding of the messy factors at play, rather than being fixed. The Decision Explorer computer software is a digital version of the traditional 'Oval Mapping Technique', of round-edged Post-it notes stuck to a wall with connections between issues hand-drawn.

4.10.4 Clarifying some methodological detail

One theoretical issue to highlight is the extent to which the map is a fair representation of the participant's construct. The mapper is seeking to expose peoples acknowledged and tacit knowledge graphically. Under this view, according to Polanyi (1966), people know more than they can tell. However, the participant may not recognise their own interpretation, even when they see it.

Great care is therefore needed when putting words into people's mouths. My supervisor, Viktor Dörfler, is, along with Marc Stierand, an authority on interpretative research and made a recent contribution to this problem. In 'Bracketing: transpersonal reflexivity for a phenomenological enquiry in an interpretivist framework', these authors recommended a form of Husserlian bracketing to expose possible researcher bias (Dörfler and Stierand, 2018). They cite Finlay (2009, p.13), who suggests that the researcher may oscillate with a 'dialectic movement between bracketing preunderstandings and exploiting them reflexively as a source of insight'. I note that Finlay's work reflects just such an insider view where the pre-existing knowledge of the researcher cannot be shut away even if one wanted to do so, nor should it dominate: she cites Merleau-Ponty (1962) in her text when noting (2009, p.13) that 'one way of avoiding this trap is to embrace the intersubjective relationship between researcher and researched. "There is a reciprocal insertion and intertwining of one and the other," says Merleau-Ponty.' Dörfler and Stierand (2019) further expose the relationship between such intertwining with the 'major advantage' (ibid. p14) of an 'insider' researcher. They explain that by bracketing through transpersonal reflexivity, an insider may learn together with participants to draw out profound knowledge and where the whole of the induced knowledge may be greater than the sum of its parts.

However, while being drawn to these ideas, I must note that such an approach is at odds with the Giorgi approach (1994a; 1994b) that is commonly cited as a mainstream approach of phenomenology (e.g. Dörfler and Stierand, 2018). My reading is that Giorgi denies that interpretation is needed or is indeed valid. Instead, he notes (1994b, p.242) that 'a descriptive approach would limit itself

to what is given, and the argument is that a sufficiently rich description would include an intrinsic account of the phenomenon'. I thus find no help from Giorgi in supporting the interpretative approach. But notwithstanding whether Giorgi would approve, my research does seek to follow the Finlay (2009)/Dörfler and Stierand (2019) method.

My methods are to re-interview a significant sample of my participants to seek to ensure sound data in Finlay's 'reciprocal and intertwined' manner, to refine their cognitive maps following feedback. I further maximise efficacy by taking contemporaneous notes and completing a research diary to expose my thinking and my choices made. Furthermore, I cross-reference the content of the causal maps with the critical quotations in a data structure that I have developed using the Gioia method discussed below.

4.10.5 The maps themselves

As outlined above, the cognitive plans are partial and reflect the thinking of the mapper as much as the participant. Indeed, Eden (1992, p.262) notes that cognitive maps 'can be seen as a picture or visual aid in comprehending the mapper's understanding of … elements of the thoughts of an individual'. Despite this limitation, they may, however, 'also be a representation that is amenable to analysis by both mapper and others' (ibid).

The approach can add theoretical rigour to social enquiry. Ackermann et al. (2004) posit that the outcomes of the process can be:

1. To provide a cognitive map for each individual

2. To bring to the surface issues and aspirations from individuals to afford the merger of individual interpretations into a group strategy causal map
3. A means of accessing knowledge and wisdom
4. To create a curiosity about others.

Also, when compared to jotting down issues in a disconnected way, a cognitive map allows the participant to provide graphic links between problems, make sense of their operational world, and see and explain causes and effects.

4.10.6 Mapping techniques and in practice

Eden et al. (2018) advocate a structured approach to create cognitive maps that can convey meaning more easily. They recommend the following:

1. Use short statements of six to eight words in length
2. Look for actions (imperative words)
3. Use participants' original language
4. Use contrasts, such as 'do as XXX *rather than* YYY'
5. Do not aggregate statements
6. Avoid judging
7. Be alert to key issues and outcomes.

Below, in Figure 5, I introduce my cognitive methodology map that reflects how I made sense of the topic and how I planned to express it.

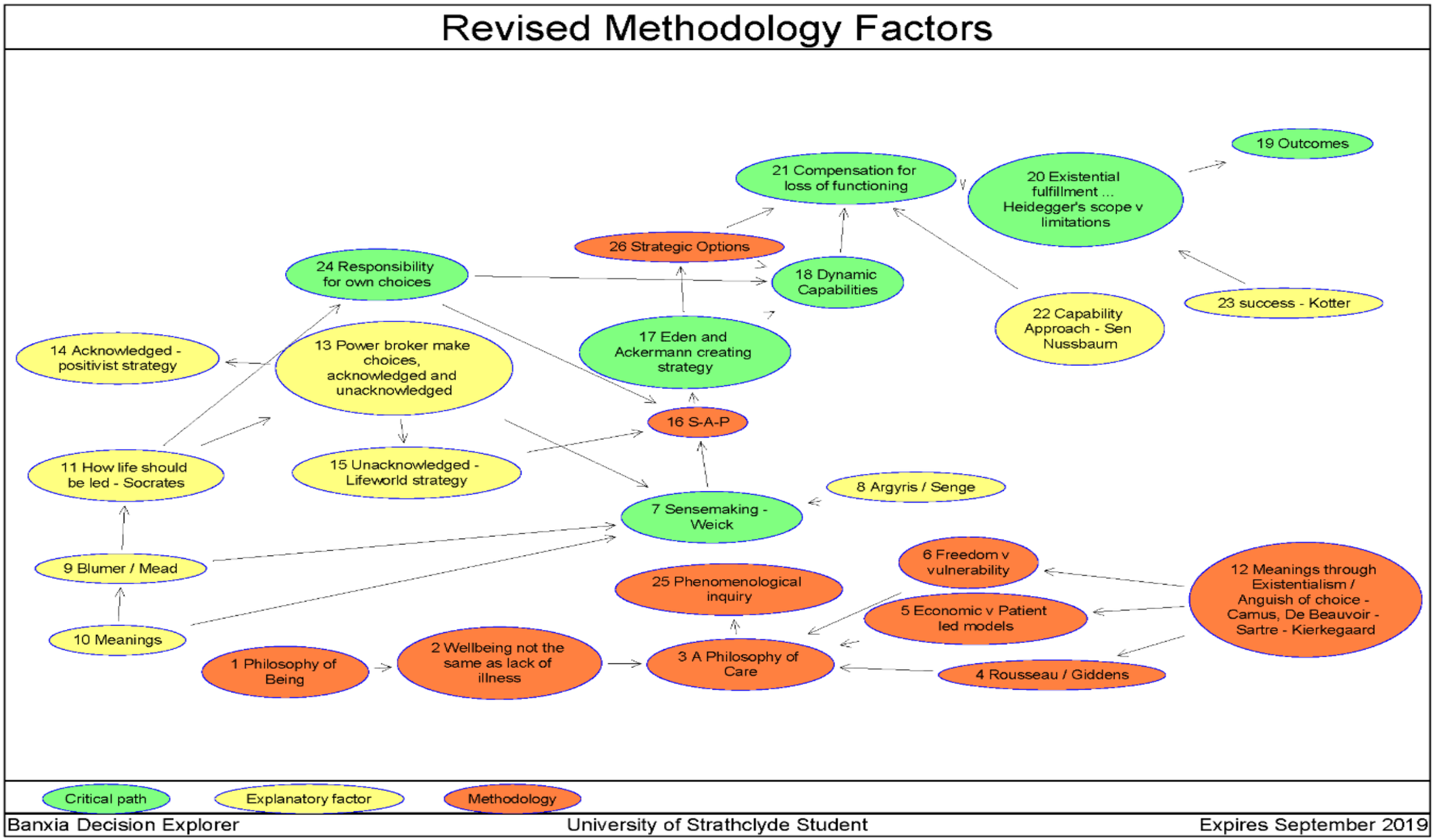

Figure 5: Sensemaking of methodology

Figure 5 illustrates how I wish to convey my methodology. At the bottom, I have coloured in orange my philosophical underpinnings that drive upwards. I have represented these fundamental driving issues that commence with:

1. A philosophy of ‘Being’
2. That well-being is not the same as the absence of illness.

It is from such an ontology that the above matters all flow, driving my philosophical approach, my research epistemology, and leading upwards to my choices of methods. I have chosen to colour in green the critical path where causal relationships overlap the philosophical approach, highlighting what I consider to be a causal relationship between philosophy, method, and the potential outcome. One interesting point is that since the map has a meaning for me, it is natural that there are some words and phrases in it that space does not permit me to detail in this text lengthily. I am comfortable with that.

4.10.7 Gioia method

Gioia et al. (2013, p.15) introduced a ‘systematic approach to new concept development to bring quantitative rigour to the conduct and presentation of inductive research’. Philosophically, the method parallels how I have introduced the methodology with a view of the world as being socially constructed, and that people are knowledgeable agents able to explain their realities. The method foregrounds the interpretation of the informants and goes to great lengths to voice the informants’ views. It recognises the ‘insider’ researcher’s knowledge and ability to figure out patterns and formulate a relevant theory.

The authors recommend a ‘general, but well-specified question’ that opens the door to the ‘Dasein’ of participants using semi-structured interviews. My question is:

> *With reference to housing with care as one means of improving well-being, and with ‘Conor and Joan’ in mind, how do field strategists make sense of social care for older people and strategise to improve their well-being, independence, and control?*

Following Lincoln and Guba (1985) and Strauss and Corbin (1998), Gioia et al. suggest stratifying the interviews with 50–100 open codes, before parsing this down by removing duplicating similarities to some 25–30 labelled topics composed into a ‘data structure’. The structure is a visual aid that may aid the researcher to turn many terms into discrete themes. The researcher may then ‘cycle’ between emerging data, topics, and the literature to better ground the research as ‘abducted’ research rather than pure ‘induction’. The authors posit that this approach, where the researcher has intimate knowledge of the data and relationships, holds the potential for theoretical insights that would not be apparent from merely inspecting the data structure, as done with traditional qualitative analysis such as that presented by Miles and Huberman (1994).

The Gioia method also compliments the causal mapping technique as it allows the researcher to draw out longer quotations less easily afforded in the maps.

4.11 Bringing It All Together: My Methods

In October 2017, I set out in a diary entry how I aimed to approach the forthcoming interviews, and I summarise it below.

The approach philosophy that I believe is most appropriate is phenomenology. Phenomenology has been described as ‘the unprejudiced descriptive study of whatever appears to consciousness’ (Moran and Mooney, 2002, p.1). Martin Heidegger (1975, p.237) developed phenomenology beyond observation and description. He framed it as ‘retaining experiences of consciousness as its thematic realm, but now in a systematically planned and secured investigation of the objects experienced’. It is this strand of phenomenology that resonates with my research as being as much interpretation as an observation.

Central to my ‘systematically planned and secured investigation’ (Gioia et al., 2013, pp.15–31) is the ‘Gioia methodology’, a widely accepted approach for qualitative reliability. The method offers a ‘systematic approach to new concept development and grounded theory articulation’ and brings ‘qualitative rigour’ and transparency in conducting inductive research. The methodology assumes that the participants are ‘knowledgeable agents’ and can explain their thoughts, intentions, and actions, and then brings out from the participants their interpretation of a world that is socially constructed, and how they make sense of this: in Husserl’s term, their ‘lifeworld’. In focusing on the sensemaking of individuals, the research is phenomenological and ideographic (Stierand and Dörfler, 2013) in that it specifies the individual as a unique agent, how they make sense of their role and the symbols and

assumptions that go along with their lived experience (Blumer, 1986). Rather than solely being a 'thick description' of business in the manner of Penrose (1959) and Pettigrew (1985), the ambition is a conceptual grounded theory in the style of Glaser and Strauss (1967).

Gioia et al. (2013) state that the research area ought to be well specified if somewhat general, giving an example: *'*How do top managers of academic institutions make sense of their environments?*'* I have thus sought to specify my thinking within the arena, namely: *With reference to housing with care as one means of improving well-being, and with 'Conor and Joan' in mind, how do field strategists make sense of social care for older people and strategise to improve their well-being, independence, and control?*

The question has four parts:

1. The issue of housing with care.

2. The introduction of Conor and Joan.

3. How strategists make sense of the current system of social care for older people and whether it achieves quality of life objectives.

4. What sort of strategy would improve the quality of life for older people?

Three of the elements within the query enquire how older people's well-being is manifested. Part one explicitly foregrounds how housing and the home may contribute to well-being. The second part of the question is an effort to ground

the interview by making the problem seem more immediate and more personal. It refers to the archetype of Conor and Joan, a vignette that I present below.

The strategic role of housing with care for older people's health, well-being and quality of life.

'CONOR AND JOAN'S STORY'

Conor is 87 years old and has been married to Joan for 60 years. Joan is 84 years old. Conor is also a big man who worked in the construction industry for over 40 years before sustaining a back injury that contributed to him retiring aged 60. Conor is a diabetic and suffers from Alzheimer's disease, which has progressed to the extent that Joan fears for his safety.

Joan is Conor's carer and some factors combine to make the care burden difficult: Conor and Joan live in a suburban semi-detached home in a medium-sized provincial town, itself within 25 miles of Belfast, Northern Ireland. Their home is almost exactly one and a half miles from the town centre, 400 metres from the arterial route and the nearest bus stop. Joan takes medication for depression and an eye condition that prevents her from driving. The couple's adult daughter and grandchildren live in New Zealand and their adult son and his family live in the East of England. Conor and Joan's social activities have narrowed considerably due to isolation and the burden of care.

Financially, the couple own their home, which is worth some £140,000, have a small occupational pension, a small amount of liquid investments and savings, and the state pension.

With significant sacrifices to her own health and well-being, Joan has managed to care for Conor as his condition has progressed. Recently, however, Conor has become increasingly incontinent and the local health and social care trust has responded by providing an increased package of care comprising three 15-minute daily visits to help Joan with Conor's personal care. Joan sometimes questions whether the intrusion is worth

it for the sake of 15 minutes but appreciates the company. The domiciliary personnel regularly change, and Joan feels she must be on hand so that things are done the way that Conor likes it. The domiciliary personnel usually must drive over ten minutes for their next call and mention to Joan that their travel times can amount to a third of their working day. With static wages and no career progression, some who leave have commented to Joan that they may not be back next week if they can find other employment. Others born in continental Europe are worried about their lives post-Brexit.

That Conor is now doubly incontinent is the 'life event' that has fundamentally changed the lifeworld for Conor and Joan: Conor's social interaction is now next to zero, his care package is insufficient, and his overall well-being is much worse than it might be. Joan is both guilty and distressed anytime she is required to leave Conor – she abhors him being uncomfortable in soiled absorbent underwear, and guilty that he is on his own much of the day. Joan is considering whether nursing care would be better for Conor but is petrified at having to lose her house in order to pay for Conor's care. Joan is emotionally distraught, is sleeping poorly and her depression condition is worsening. Conor and Joan's well-being and life satisfaction are poor. Joan has reached the point of 'option recognition' and is petrified because all their options seem to be bad.

Figure 6: The archetype

Source: Author

In social care, there may be a problem with factoring in the role of a spouse, and yet it is Joan who is likely to be the single most significant factor in contributing to the welfare of Conor, and possibly vice-versa. Arguably, however, it is Joan's quality of life that is impacted most in the vignette, yet her story may be often overlooked.

The story allows the participant to empathise with Conor and Joan's situation, focus on their quality of life, and seek how they make sense of social care and housing. The story serves as a proxy for older people across Northern Ireland as I ask how strategists strategise for their well-being outcomes when I first ask them: 'How does this story finish?'

4.12 Conducting the Research: Putting Methods into Practice

4.12.1 Ordering the data for causal mapping

Following initial interviews, I struggled with the transcription process since it took an extraordinarily long time to type – partly due to my limitations as a typist and partly due to submersing myself into the interview recording while re-reading my contemporaneous notes. The interviews averaged 75 minutes in length and some 10,000 words. As such, the first interview took me over five hours to transcribe, which was too long and risked my becoming frustrated with the exercise. After that, I used an online transcription tool that used 'machine learning' to transcribe the interview. The device proved sufficiently accurate, the transcriptions could be easily 'tidied up', and it saved an extraordinary amount of time.

When re-listening to each interview, I was then able to amend the text 'in script' such that I could understand it when re-reading without the audio concurrently playing. I highlighted quotations and added margin notes where the meaning needed clarification. I used the notes that I contemporaneously took as an

aide-memoire, and they, along with the tone of voice and context, added great depth to the meanings within the data. In Figure 7, I present an example page from the 150,000 words transcribed.

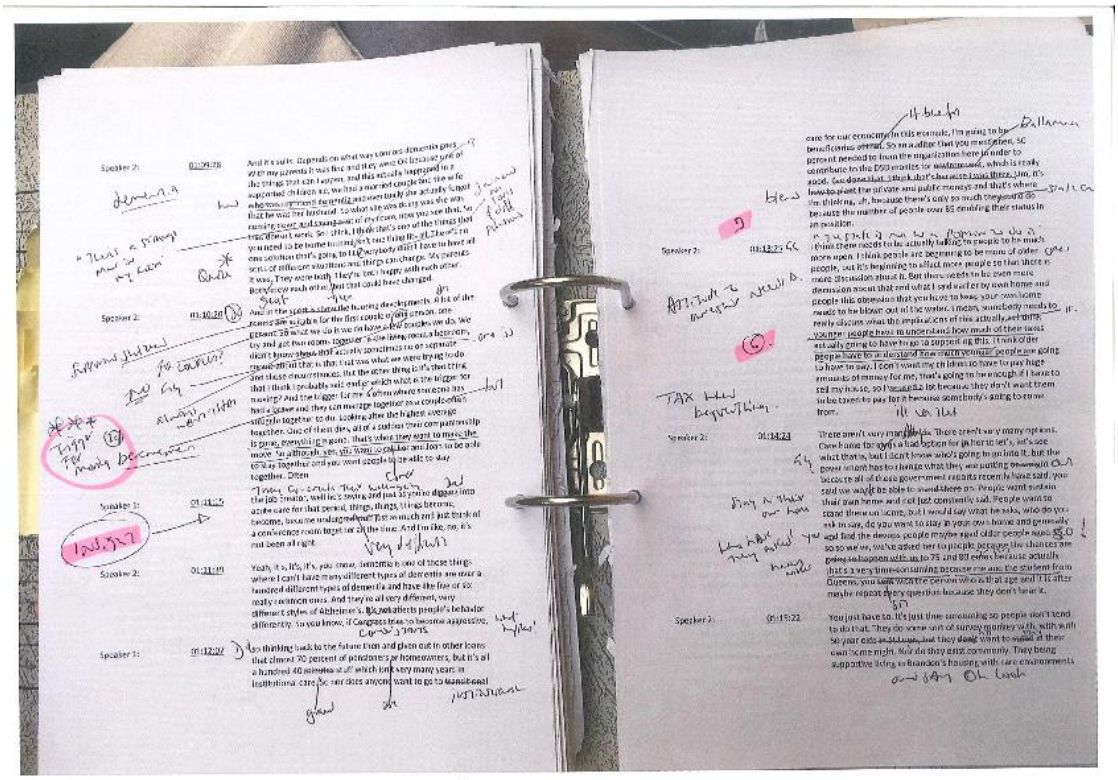

Figure 7: Example of 'in-script' issue coding and quotation surfacing

My method of arranging the interviews with a gap between each allowed me time to transcribe them.

When transcribing my pilot interview, the depth and amount of information that I had not picked up while being present at the meeting struck me. There were sentences from the participant with added meaning that I had not recalled, perhaps due to being distracted when note-taking or thinking of the previous

point within the discussion. My revisiting of the data methodically and several times over ensured that I extracted the full data from the interviews.

My method when re-listening to each recording for a third time was to highlight the issues that the participant stressed as necessary and any quotations that I consider to be particularly illuminating. I linked these issues, along with their causal relationship with other matters concerning the participant in order to cognitively map their views within the original data. By doing this while listening and reading the transcript, I was able to carry out the individual cognitive mapping by hand on their transcript pages. I found that having the map drafted on paper made the process of cognitive mapping on the computer using Decision Explorer software considerably more straightforward since the map has been produced in real-time while listening to the interview and reading the transcript, rather than attempting to navigate the computer software simultaneously. Since I was initially not fully competent in using the software, such a technique dramatically simplified my creating the cognitive maps. Figure 8 is an example of the ‘in-script’ cognitive mapping.

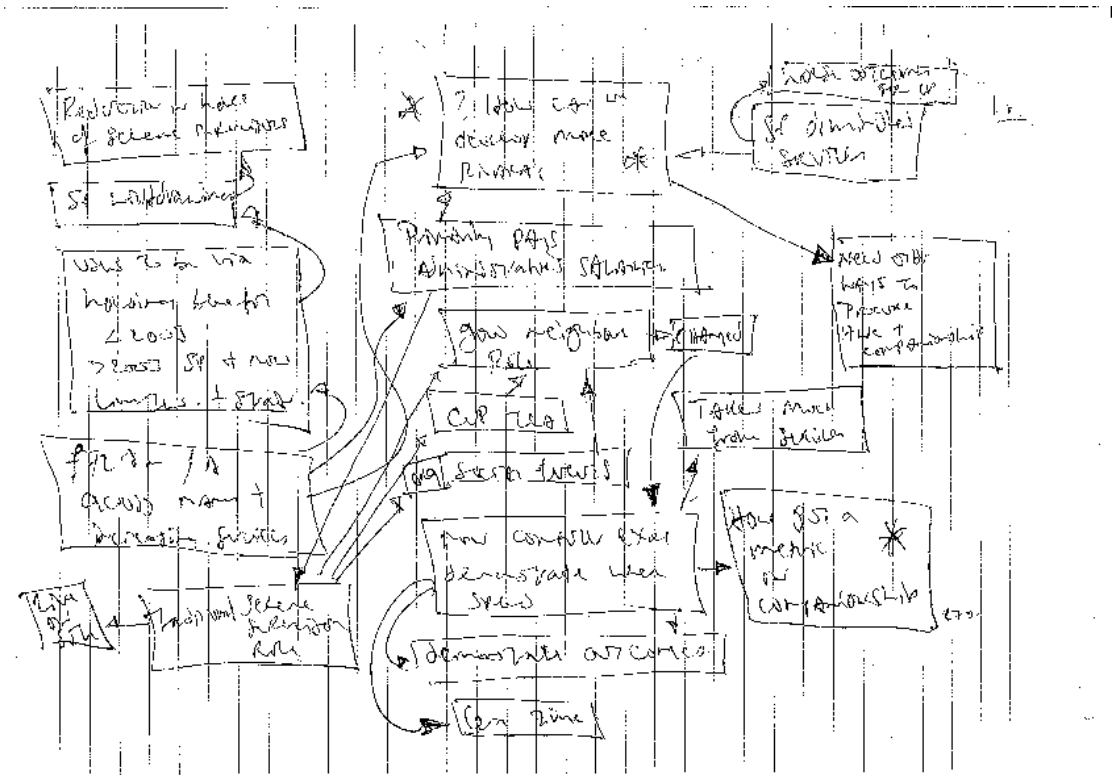

Figure 8: Example of 'in-script' cognitive mapping

4.13 Ordering the Data for the Gioia Method (Part 1): 'The Relevance/Amplification Score'

My method here was to create a numbered list of the issues that were important to the participants as the interviews progressed, mirroring the Gioia first-order coding technique. I was able to then code in the margin of the transcript (for each participant) the relevant number for each issue. Figure 9 below shows the code list.

RAW ISSUES

Issue No. **Issue Name**

1. Is the system sustainable?

2. How to procure liberty, choice, and personal options? Synonymous with Q of L.

3. Demographic change.

4. Empowerment, importance of independence, and personalisation.

5. Carers role: prevention of acute care interventions.

6. Where formal care and informal care start and finish.

7. Focus on communities. The role for quality of life.

8. Appreciation of professional social care workforce.

9. Honesty needed in the market for care.

10. Silos in government / care / health / social care / housing associations.

11. Greater role for housing with care (HWC).

12. Option recognition – when an older person and family truly consider institutional care as an option.

13. Compare younger disabled with older disabled.

14. A future focus for those over 75.

15. Vulnerable, alone older people. Social isolation issues.

16. Pressure on acute care and step-down care.

17. Conservation in the system.

18. A lack of functioning NI Executive.

19. Can domiciliary care manage complex morbidities?

20. Issue of poor-quality care delivered via 15-minute calls.

21. Negative comments re large care homes. Issue of conformity – registered care.

22. ‘Conor’s’ future.

23. Couples together.

24. Dementia issues.

25. Difficulty negotiating care system.

26. Importance of home for well-being and quality of life.

27. Family tensions over money and care arrangements.

28. Need for people to pay for care?

29. Conformance impacting on performance and quality of life.

30. Trigger for movement.

31. NI handout culture.

32. Need more proactive health service?

33. Last 1,000 days of a person; quality of life.

34. Quality end of life aspects.

35. Crisis moves are bad.

36. Spouses/partners do many more times caring than adult children.

37. People do not think about their end of life / needing care / someone assisting with their toileting.

38. Proposing changes to NHS / health and social care is political suicide.

39. Problems finding a (good) care home.

40. The complexity of domiciliary care package issues.

41. Older people worrying about money.

42. Prophylactic care in care homes needed.

43. Older people need a little care – a lot.

44. Advocacy / community navigator / help with thinking ahead.

45. Demands upon females; working lives nowadays; often caring for two sets of parents, teenage children?

46. Older people have a weak voice.

47. Steady reduction in care offered – meals on wheels long gone.

48. Safety issues regarding older people.

49. 'Never going' into institutional care: 'take me out in a box!'

50. Direct payments issues.

Figure 9: Raw issue coding

4.13.1 Secondary coding for 'relevance/amplification score'

I created a systematic means of determining which of the 50 issues are most pertinent, by tabling each issue and referencing when and how the participants referred to it. When it is mentioned, I marked the emphasis given on a scale of one to three, with one representing the issue being mentioned in passing, and three referring to where the participant emphasised the point forcefully. I have named this scoring system the 'relevance/amplification score', as it attempts to capture both. Afterwards, I used this as a systematic means to ensure that

the cognitive maps reflect the issues and themes that are important to the participant.

I present the scoring for participant 12 in Figure 10 below, and this shows how I have numbered the 50 subjects, re-listened to the interview and scored each issue accordingly.

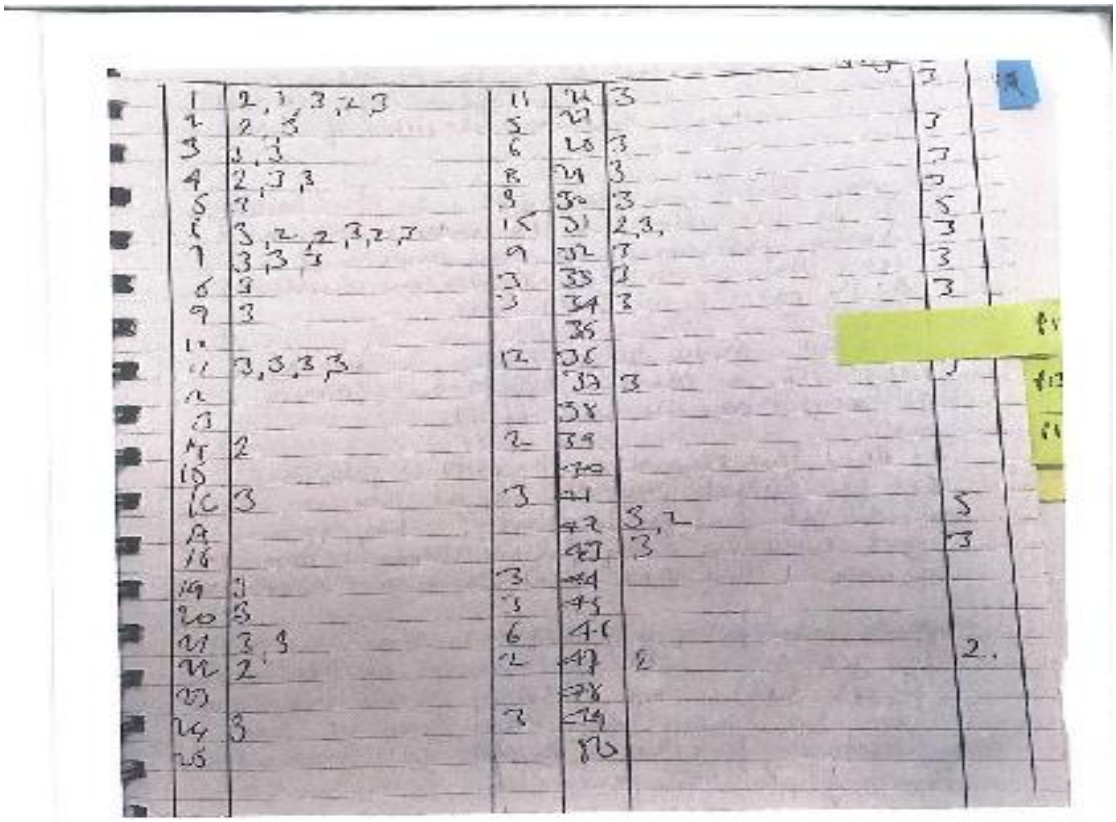

Figure 10: Participant 12 – example of secondary coding of themes

In the above example, and referring to issue one, I have calculated a relevance/amplification score for this participant regarding issue number one, namely: ‘is the system sustainable?’ where a score of 11 may be seen.

The most important theme for this participant (number 12), with a score of 15, was issue number six: namely ‘where formal care and informal care start and finish’.

In Figure 11 below, I map out the total ‘amplification score’ for the top 50 issues across each participant. I have highlighted the responses of participant 12 above to complete the illustration.

RAW ISSUES															
Listed by issue number against participant "amplification score"															
Issue No.	Issue Name		Participant Code												
		P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14
1.	Is the system sustainable?	6	11	9	3	0	0	5	0	12	10	0	11	0	0
2.	How to procure liberty, choice and personal options? Synonymous with quality of life.	14	13	13	9	2	0	12	7	12	13	13	5	3	5
3.	Demographic change.	6	3	13	1	0	3	0	0	3	6	3	6	0	0
4.	Empowerment, importance of independence and personalisation.	4	9	11	8	0	0	3	3	19	2	21	8	6	5
5.	Carers role: prevention of acute care interventions.	8	7	0	3	0	0	3	0	14	6	8	3	2	0
6.	Where formal care and informal care start and finish.	14	4	5	3	0	0	1	5	13	5	8	15	0	0
7.	Focus on communities. Role for quality of life.	8	3	9	5	3	3	0	6	11	7	10	9	3	2
8.	Appreciation of professional social care workforce.	0	9	3	6	0	11	5	0	0	14	4	3	2	3
9.	Honesty needed in the market for care.	10	10	15	3	0	3	3	7	17	9	14	3	3	12
10.	Silos in government / care / health / social care / housing associations.	8	10	0	3	6	3	0	4	0	6	3	0	0	5
11.	Greater role for housing with care (HWC).	4	2	4	3	4	0	2	5	11	10	9	12	3	13
12.	Option recognition. When an older person and family truly consider institutional care as an option.	12	5	0	0	0	0	0	0	5	0	13	0	0	0
13.	Compare younger disabled with older disabled.	2	0	2	0	0	0	0	5	0	2	0	0	0	0
14.	A future focus for those > 75	2	3	2	0	0	0	0	0	0	0	2	2	0	3
15.	Vulnerable, alone older people. Social isolation issues.	0	2	0	3	0	0	0	4	5	17	2	0	0	3
16.	Pressure on acute care and step down care.	12	0	0	0	0	0	3	0	0	0	0	3	0	3
17.	Conservation in the system.	0	0	0	0	3	0	0	12	3	5	6	0	0	0
18.	A lack of functioning NI Executive.	0	5	4	0	6	0	0	3	0	6	0	0	3	7
19.	Can domiciliary care manage complex morbidities?	8	2	0	4	3	2	0	2	9	2	3	3	0	3
20.	Issue of poor quality care delivered via 15 minute calls.	2	9	4	3	0	0	0	0	19	17	7	3	0	8
21.	Negative comments re. large care homes. Issue of conformity – registered care.	4	9	0	6	0	0	3	0	8	5	12	6	0	0
22.	"Conor's" future.	9	0	0	1	0	0	0	0	5	0	6	2	3	0
23.	Couples together.	5	0	0	0	0	0	0	0	6	0	8	0	0	0
24.	Dementia issues.	8	0	3	0	0	0	3	0	6	2	18	3	4	2
25.	Difficulty negotiating care system.	11	0	0	0	0	0	0	3	0	7	14	0	0	5
26.	Importance of home for well-being and quality of life.	7	5	2	6	3	0	0	5	3	3	8	3	0	6
27.	Family tensions over money and / or care arrangements.	3	4	0	3	0	0	0	0	0	0	3	0	0	3
28.	Need for people to pay for care?	0	2	0	1	0	0	0	0	0	0	3	3	0	3
29.	Conformance impacting on performance & quality of life.	0	0	8	4	0	3	3	0	4	0	10	3	5	0
30.	Trigger for movement.	6	0	0	2	0	0	0	0	0	0	0	3	2	2
31.	NI handout culture.	0	0	0	0	0	0	0	0	0	0	0	5	0	0
32.	Need more proactive health service?	4	0	3	0	0	0	3	2	0	0	0	3	0	0
33.	Last 1000 days of a person; quality of life.	2	0	0	0	0	0	2	0	0	0	0	3	0	0
34.	Quality end of life aspects.	4	3	0	0	0	3	3	0	3	3	0	3	0	3
35.	Crisis moves are bad.	5	3	0	3	0	0	0	0	0	0	0	0	0	0
36.	Spouse / partners do many more times caring than adult children.	7	7	0	6	0	2	0	0	5	0	5	0	0	3
37.	People don't think about their end of life/ needing care / someone assisting with their toileting.	3	5	5	3	0	1	0	0	0	0	0	3	0	6
38.	Proposing changes to NHS / Health and Social care is political suicide.	0	2	7	0	0	0	0	0	0	3	0	0	0	2
39.	Problems finding a (good) care home.	5	0	0	0	0	0	0	0	0	1	0	0	0	0
40.	Complexity of domiciliary care package issues.	3	0	0	2	0	2	0	0	0	0	0	0	0	2
41.	Older people worrying about money.	4	3	0	0	0	0	0	0	0	0	0	0	0	3
42.	Prophylactic care in care homes needed.	5	0	0	0	0	2	0	0	0	0	0	5	0	0
43.	Older people need a little care – a lot.	6	6	0	6	0	0	0	0	0	0	0	3	2	3
44.	Advocacy / community navigator/ help with thinking ahead.	4	4	0	3	0	5	0	6	3	3	0	0	3	6
45.	Demands upon females; working lives nowadays; often caring for 2 sets of parents, teenage children	0	3	0	3	0	3	0	0	0	0	0	0	0	0
46.	Older people have a weak voice.	0	4	0	0	0	0	0	0	0	3	0	2	0	3
47.	Steady reduction in care offered – meals on wheels long gone.	4	0	0	0	0	0	0	0	0	0	0	0	3	3
48.	Safety issues regarding older people.	5	0	3	5	0	0	0	0	0	0	0	0	0	2
49.	Rather die than go into institutional care.	4	2	0	2	0	0	0	0	0	0	2	0	0	1
50.	Direct payments issues.	0	4	2	0	0	0	0	3	3	0	0	0	0	3

Figure 11: The 'relevance/amplification score' for issue and participant

After that, I calculated the mean relevance/amplification (RA) score for each issue, as presented in Figure 12 below, where issue number one may be seen to have a score of 4.86, and issue number two has the highest RA score of 8.79.

Calculate the mean "Amplification Score"

Issue number mapped against each participants frequency and stressed importance of issue

ISSUES AS NUMBERED 1-50

Participant Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
P1	6	14	6	4	8	14	8	0	10	8	4	12	2	2	0	12	0	0	8	2	4	9	5	8	11	7	3	0	0	6	0	4	2	4	5	7	3	0	5	3	4	5	6	4	0	0	4	5	4	0
P2	11	13	3	9	7	4	3	9	10	10	2	5	0	3	2	0	0	5	2	9	9	0	0	0	0	5	4	2	0	0	0	0	0	3	3	7	5	2	0	0	3	0	6	4	3	4	0	0	2	4
P3	9	13	13	11	0	5	9	3	15	0	4	0	2	2	0	0	0	4	0	4	0	0	0	3	0	2	0	0	8	0	0	3	0	0	0	0	5	7	0	0	0	0	0	0	0	0	0	3	0	2
P4	3	9	1	8	3	3	5	6	3	3	3	0	0	0	3	0	0	0	4	3	6	1	0	0	0	6	3	1	4	2	0	0	0	0	3	6	3	0	0	2	0	0	6	3	3	0	0	5	2	0
P5	0	2	0	0	0	0	3	0	0	6	4	0	0	0	0	0	3	6	3	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
P6	0	0	3	0	0	0	3	11	3	3	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	3	0	0	0	0	3	0	2	1	0	0	2	0	2	0	5	3	0	0	0	0	0
P7	5	12	0	3	3	1	0	5	3	0	2	0	0	0	0	3	0	0	0	0	3	0	0	3	0	0	0	0	3	0	0	3	2	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
P8	0	7	0	3	0	5	6	0	7	4	5	0	5	0	4	0	12	3	2	0	0	0	0	0	3	5	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	3
P9	12	12	3	19	14	13	11	0	17	0	11	5	0	0	5	0	3	0	9	19	8	5	6	6	0	3	0	0	4	0	0	0	0	3	0	5	0	0	0	0	0	0	0	3	0	0	0	0	0	3
P10	10	13	6	2	6	5	7	14	9	6	10	0	2	0	17	0	5	6	2	17	5	0	0	2	7	3	0	0	0	0	0	0	0	3	0	0	0	3	1	0	0	0	0	3	0	3	0	0	0	0
P11	0	13	3	21	8	8	10	4	14	3	9	13	0	2	2	0	6	0	3	7	12	6	8	18	14	8	3	3	10	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	2	0
P12	11	5	6	8	3	15	9	3	3	0	12	0	0	2	0	3	0	0	3	3	6	2	0	3	0	3	0	3	3	3	5	3	3	3	0	0	3	0	0	0	0	5	3	0	0	2	0	0	0	0
P13	0	3	0	6	2	0	3	2	3	0	3	0	0	0	0	0	0	3	0	0	0	3	0	4	0	0	0	0	5	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3	0	0	3	0	0	0
P14	0	5	0	5	0	0	2	3	12	5	13	0	0	3	3	3	0	7	3	8	0	0	0	2	5	6	3	3	0	2	0	0	0	3	0	3	6	2	0	2	3	0	3	6	0	3	3	2	1	3
Total	68	123	47	103	59	79	86	68	118	58	93	47	24	28	51	37	46	52	60	92	74	48	42	73	65	77	43	40	69	45	36	47	40	59	46	71	63	52	45	49	51	54	69	81	54	58	57	63	60	65
Mean	**4.86**	**8.79**	**3.36**	**7.36**	**4.21**	**5.64**	**6.14**	**4.86**	**8.43**	**4.14**	**6.64**	**3.36**	**1.71**	**2**	**3.64**	**2.64**	**3.29**	**3.71**	**4.29**	**6.57**	**5.29**	**3.43**	**3**	**5.21**	**4.64**	**5.5**	**3.07**	**2.86**	**4.93**	**3.21**	**2.57**	**3.36**	**2.86**	**4.21**	**3.29**	**5.07**	**4.5**	**3.71**	**3.21**	**3.5**	**3.64**	**3.86**	**4.93**	**5.79**	**3.86**	**4.14**	**4.07**	**4.5**	**4.29**	**4.64**

Figure 12: Calculating the mean amplification score

As shown in Figure 13 below, I have ordered the issues into the 30 points that have the highest RA score.

Rank	Issue No.	Mean Score	Issue
1	2	8.79	How to procure liberty, choice and personal options? Synonymous with quality of life.
2	9	8.43	Honesty needed in the market for care.
3	4	7.36	Empowerment, importance of independence and personalisation.
4	20	6.57	Issue of poor quality care delivered via 15 minute calls
5	11	6.64	Greater role for housing with care (HWC).
6	7	6.14	Focus on communities. Role for quality of life.
7	44	5.79	Advocacy / community navigator/ help with thinking ahead.
8	6	5.64	Where formal care and informal care start and finish.
9	26	5.50	Importance of home for well-being and quality of life
10	21	5.29	Negative comments re. large care homes. Issue of conformity – registered care
11	24	5.21	Dementia issues
12	36	5.07	Spouse / partners do many more times caring than adult children
13	29	4.93	Conformance impacting on performance & quality of life.
14	8	4.86	Appreciation of professional social care workforce.
15	43	4.93	Older people need a little care – a lot
16	1	4.86	Is the system sustainable?
17	50	4.64	Direct payments issues
18	25	4.64	Difficulty negotiating care system
19	48	4.50	Safety issues regarding older people
20	37	4.50	People don't think about their end of life/ needing care / someone assisting with their toileting
21	49	4.29	Rather die than go into institutional care
22	19	4.29	Can domiciliary care manage complex morbidities
23	34	4.21	Quality end of life aspects
24	5	4.21	Carers role: prevention of acute care interventions
25	46	4.14	Older people have a weak voice
26	10	4.14	Silos in government / care / health / social care / housing associations
27	47	4.07	Steady reduction in care offered – meals on wheels long gone
28	45	3.86	Demands upon females; working lives nowadays; often caring for 2 sets of parents, teenage children
29	42	3.86	Prophylactic care (in care homes) (and HWC) needed
30	18	3.71	A lack of functioning NI Executive

Figure 13: The ordered top 30 issues

The RA method provides demonstrable dependability since it ensures that the data within the cognitive maps is an accurate reflection of the views of the participants. Another advantage of this method is that it is a useful way to quickly present which issues are the most pertinent, especially since some participants find the causal maps initially hard to follow.

4.14 Ordering the Data for the Gioia Method (Part 2): ‘So What?’ Quotations

Quotes are a powerful way of ensuring sound qualitative research if a clear way can be found to present them. A methodological contribution that I offer, which illuminates issues that strategists care deeply about and preserves the power of such findings, is the hypothetical ‘so what?’ question that I pose against each of the 150 quotations across 30 relevant themes. For example, in Figure 14, issue 7 refers to the contribution of communities towards well-being. Some of the quotations stand alone: for example, participant 13 in quotation number 3 notes that ‘it is very hard to put a metric on companionship’. Here the strategist means that existing procurement tends to ignore the vital need for companionship. The point is clearly made, and I have not chosen to add any elaboration. Conversely, participant number 13 in their quotation number 6 refers to a care home that has a partnership with a creche and the ‘lease of life’ that this gave to the older residents. In the ‘so what?’ question column I emphasise that there is a need within Extra Care for other elements to be close to the domestic cluster, such as perhaps having a nearby creche and post office. I have therefore carefully added inductions by asking the ‘so what?’ question against the data to aid clarity and for possible operational implications. While on its own, such points are small, cumulatively they add to the richness and likely success of ECP. The ‘so what?’ question therefore shapes my conclusions in a way that is wholly grounded in the data. Indeed, linking actual quotations to the ‘so what?’ question allows me to

present my interpretations transparently, and brick by brick, the interested reader may follow how it is that I have induced from the actual quotations the foundations and superstructure of the theoretical framework.

To do this, I cut across the 50 themes and over 150,000 words analysed to select the 200 most impactful quotations and I matched them to the 50 identified topics. I abridge issue number 7/50 in Figure 14 below. The example shows that by presenting the issues with the relevant quotations, I can powerfully highlight how the participant views the reality of care across each of these 50 dimensions. Sometimes, it may be noted, the same quote adds emphasis to more than one theme.

In total, there are 185 pages of interpretation in the form of the example, where each quotation provides essential evidence as to the strength of the participant's views. This technique ensures that the power of the quotes is not lost, as can often be the case when aggregating themes. It also allows me to clarify the induced trail of strategy theory to ensure further qualitative transferability. The conclusions that I draw demonstrate the belief systems of the strategist and add provenance to the strategy conclusions.

7. Focus on communities. Role for quality of life.				
Participant No.	Quote No	Quotations	So	What? What interpretation / What can be done?
4	13	Working with carers, consistently what comes up is a need for a one stop shop, so **there needs to be some sort of peer support.**		
8	13	Ideally what we would like to get to is a **housing association and private partnership.**		
9	1	If the person has dementia, it's about maintaining routine and supporting routines. The other bit of it is that **the vast majority of them are coming [to day care] because there is no-one to look after them.**		
9	3	We notice if people are unwell in our 13 day-centres	x	example of low key keeping people well will constant contact
9	5	You have a **sense of well-being because your family is around you.**		
9	14	You lose community support through a large provider coming over from England, mopping up all the hours, you then lose all the connectedness of a local provider, in a local area, in the local community. That was the success of domiciliary care.	x	importance of local carers
10	1	Your **home** where you live is fundamental and **the anchor stone upon which other aspects of your life are held together**		
11	2	He has been living on microwaved meals for the last few years. All of a sudden he has come to somewhere where you can smell the food cooking because food is very much associated a family environment		
12	8	We need to define what quality looks like, If we had 12 months to live what would the things be that we would want? Independence, as much contact with our friends and family, being able to pursue our interest...a sense of fulfilment...I think we have to redesign the model...part of that is **housing and maintenance of independence.**		
12	11	When you do traditional tendering procurement you are trying to get economic scale by bringing in a huge provider that people in the area don't know. The wealth goes to the main company based outside the area. With a social enterprise model we can actually get them a double whammy, because you get the care for people who need it, but you also provide some income for the area which is one of the main determinants of health...then it will also build social engagement.	x	probs with extg. Procurement. Way to improve is via local, social: need on the ground help to make that happen = community navigator
12	13	**People have transformed so much since moving into housing with care**...I have witnessed people completely blossoming [from SEHSCT website video on Cedar Court]		
13	3	It's very hard to put a metric on companionship.		
13	6	**Best when there is a greater interaction with younger people.** For example I know of a care home that partnered up with a crèche, with toddlers coming through on a daily basis. That brought a whole new lease of life for the older person.	x	need other elements within / close to HWC like crèche, restaurant, shop, post office...
14	13	Somebody needs to be in that [community navigator] role for that couple [Conor and Joan] to navigate through the situation...get help.; know what's available, what can we get them.	x	"Conor and Joan's" story highlights the need for community navigator
15	17	Communal areas are important because of the social engagement function; they just want people to talk to and share stories	x	importance of communal areas

Figure 14: Issue 7 (abridged) showing participant number, quote number, quotation, and interpretation

4.14.1 Interview strategy

My privileged insider position allows me to meet with key decision-makers and hear the full scope of the limitations of the present social care arrangements.

My methods were to conduct 25 interviews averaging 75 minutes in length, and I transcribed and analysed 14 of the first 18. I then revisited four key participants thereafter to check that they accepted my presentation of their cognitive views, and I secured their agreement of my interpretation, making 22 interviews. In the remaining three, I presented the emerging findings to additional political and institutional leaders to best position the results into policy and assist with the strategy gaining traction.

4.15 Achieving Ethical Approval

I composed the ethics application for my investigation, which made clear that I was proposing to interview field strategists and industry leaders across the fields of health care, social care, and housing. I made it very clear that I was not proposing to interview anyone vulnerable. I applied to the university in early November 2017 and gained approval on 12 January 2018.

I sent potential participants a short introduction to my research, the archetype, participant information sheet, and participant approval form. During the interviews, I stressed that I proposed to record the meetings, but I would be destroying the recordings upon completion of my research. Also, I ensured that each participant was aware that the study is anonymous, and I ensured that each participant was content at the close of the interview before I asked them

to sign the consent form. As such, they knew what it was that they were agreeing to, rather than asking them to sign the form at the start. I also offered the participants the chance to review the material; several did so by email and, in the case of four participants, by follow-up interviews.

4.16 Participant Selection and Sampling

I developed a long list of potential participants and collated them using MS Excel software. The software allows me to quickly add information uniformly and monitor my contact with the participants, their responses, and dates of interview. It further allows me to link through to a file in each case relating to the policies of the individual's organisation and their published views since the broader agenda of their organisation/views are valuable contexts. I reviewed the material in advance of each interview.

I am a trustee and board member of the charity Age NI, the Northern Ireland branch of AGE UK. I have become well acquainted with the Chairperson, CEO, and Policy Director thanks to this role. After creating my draft, I was able to visit the Policy Director and fine-tune my initial long list, to balance key personnel across the fields of health care, social care, and housing. The sample selection may thus be described as a mix of positive sampling and snowball sampling, since, as the investigation developed, some participants recommended I interview other people who were not on my initial list, some of whom I did indeed meet. The 'long list' included:

1. Politicians across the political divide, including six past ministers of the NI Assembly, four of whom were Ministers of Health, one previous Minister for Finance, one past Minister for the Communities, and the most recent Chairperson of the Health Committee.

2. Participants from different relevant government agencies, such as the Department of Health, Social Care Trusts, and Patient and Client Council.

3. Several professional representative bodies such as the Housing Association and Social Care bodies.

4. Academics.

5. Senior civil servants, including the head of the Northern Ireland Civil Service.

6. GPs and clinicians.

7. Chairpersons/CEOs from the charity sector.

In all, there are some 41 on the initial long list that I kept under review as the research evolved, as I was aiming to achieve 20 interviews across the range of disciplines.

In the event, the long list grew to 65, and I conducted 25 interviews with 21 different field strategists as I re-interviewed four to ensure my interpretations were valid. From these, I transcribed and carried out 14 cognitive maps, at

which point I achieved saturation. I used the remaining interviews to cross-check the findings and seek to progress the strategic aims of the research.

4.17 Contact

Rather than attempt to arrange all the meetings at once, I approached an initial ten potential participants in January 2018 via telephone and follow-up email. Typically, I engaged with the individual's assistant to provide some background and to ask that they 'look out' for the future email. I then copied the assistant into the correspondence and followed up the next day by telephone. Even where the participants were known to me, this technique of engaging with the field strategist's representatives achieved a high 'hit rate' in arranging the interviews.

Along with the email request for the interview found in Figure 15, I included the archetype, as previously presented in Figure 6, and the participant information sheet/participant approval form found within Appendix 3.

Dear XXXX

Further to our conversation, thank you for being open to meeting.

Herewith below and attached the introduction to my PhD research. The nature of the research is such that I as the researcher, whilst having some expertise in aspects of the research area, am open to the opinions of the informants, rather than my having a pre-determined hypothesis that I seek to test.

As mentioned, I would be very pleased if it were possible to have an hour with you at a time of your choosing.

Best wishes,
David

My research seeks to find how leaders in the fields of older persons Health, Care and Housing make sense of these disciplines and the role and strategy of housing with care therein.

The specific research question is:

"With reference to housing with care as one means of improving well-being, and with "Conor and Joan" in mind, how do power brokers make sense of social care for older people and strategize to improve their well-being, independence, and control."

As you see the question has 4 parts:

1. The wider concepts of health, social care and housing and
2. how they overlap in the opinion of the informant given the introduction of Conor and Joan.
3. The role of housing with care within the current and
4. The future strategy of social care for older people.

I have "Conor and Joan's" story attached along with further details.

David W.S. Law MBA FRICS CDir

Figure 15: Typical email covering letter request for an interview

I conducted a trial interview with a senior consultant geriatrician whom I know well, and this allowed me to road-test my interview technique in a supportive environment. In my research diary, wherein I made comments following each interview, I reflected that 'some of the most interesting responses occurred whenever I introduced contested topics within health and social care.' I concluded that deriving better data will likely come from having contested topics to hand ready for discussion'.

I was successful in interviewing a broad spectrum of field strategists, including:

1. CEO one of the Health and Social Care Trusts
2. CEO Age NI
3. CEO Commissioner for Older People NI
4. Past Minister of the Department for Communities
5. Director of Mental Health, Disability & Older People: Department of Health
6. CEO Regulation and Quality Improvement Authority (RQIA).
7. Director of Older People's Services within one of the Health and Social Care Trusts

4.18 From Cognitive Maps to Causal Maps

I created several cognitive maps per participant using the triangulation methods described of:

1. listening and reading the transcript while sketching the cognitive relationships 'in script'
2. data structuring via frequency/amplification
3. data structuring via 'so what?' quotations.

The mean number of maps per participant was three, and I present all 43 of them in full within the enclosures section. I found that typically in the mapping process, I was able to isolate an issue to offer the meanings that the participant took from their three most pressing concerns. The Decision Explorer software also allows the user to examine discrete problems in this way, rather than

viewing their entire cognitive map, which may have 100 matters raised on it. Figure 16 is an example of such a detail.

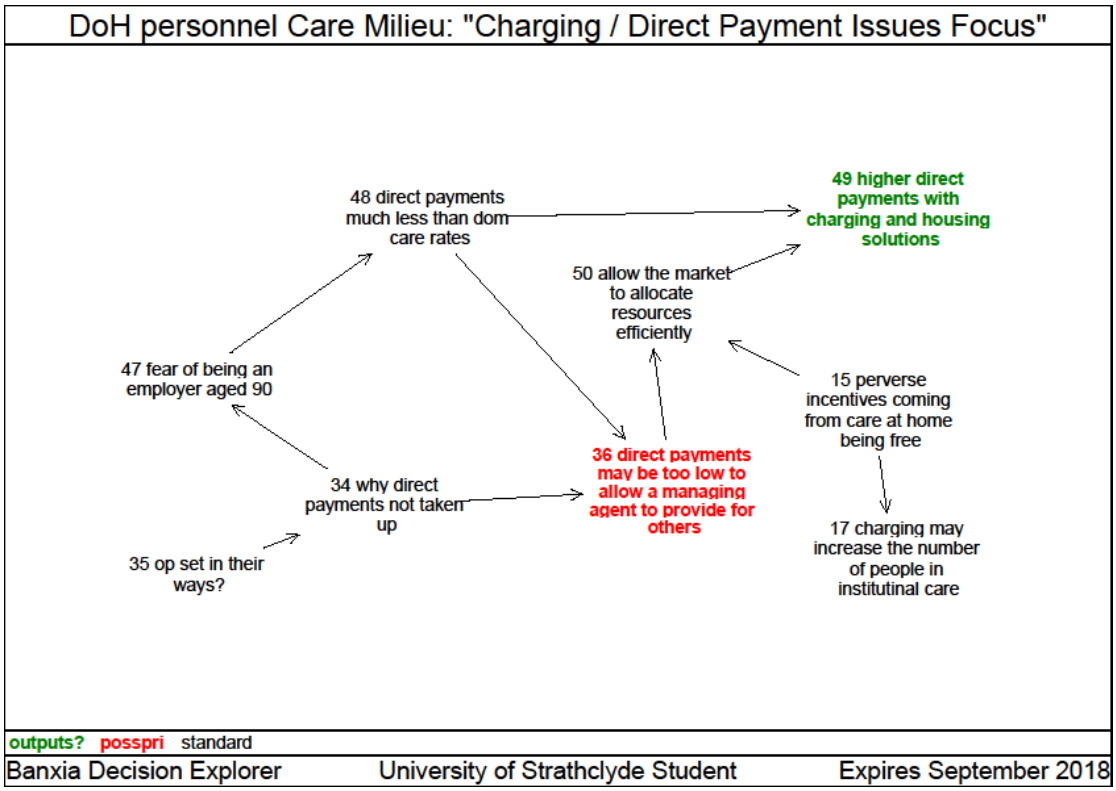

Figure 16: Participant 3 – issues of charging and direct payments

Figure 16 above also highlights my use of the 'style selector' tool within the software, which allows the user to colour issues and label them, such I have done in black, red, and green. This approach follows the Colin Eden instructional videos (Eden, N.D.). In Figure 17 below, I enlarge the issues that I have labelled as follows:

1. Standard (in black font)
2. Posspri, standing for possible priorities (in red font)
3. Outputs, standing for strategic outputs (in green font).

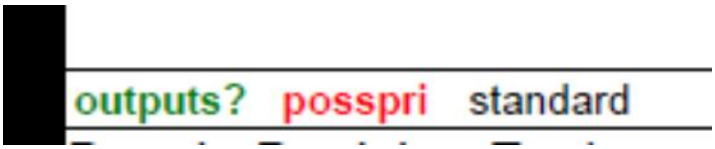

Figure 17: Enlarged style selector

The red issues represent the second-order themes within the data structure, and the green issues identify the strategic outputs of the research. I was able to synthesise these second-order themes and outputs into two graphic images: 'Change Drivers' and 'Strategic Change Outputs.'

4.19 Change Drivers and Strategic Change Outputs

As described in the literature methodology, the causal mapping technique allows a visual representation of how a group collectively considers and makes sense of the many factors within a messy problem. In my data presentation, I conclude with two graphics found within the text in Figure 19 and Figure 20. They are entitled 'change drivers' and 'strategy outputs'.

Change Drivers Map

In this causal map, I have been able to synthesise the most important factors that are driving change from the data structuring methods. I graphically illustrate these drivers working from the bottom up, with four critical factors placed at the top that flows from the drivers below. These four factors then

appear at the bottom of the second causal map, namely ‘Strategy Outputs’, and in turn, drive the causal relationships shown above.

Strategy Outputs Map

The four factors that emerged as the principal drivers for strategy appear at the bottom of this strategy outputs map, and these drive the relationships between the issues synthesised above. They show the causal relationship between strategic steps for change as synthesised from the 43 cognitive maps and data structure. As such the two discrete strategic causal maps highlight the pressing issues firstly and strategic options thereafter. I analyse and present the research findings from individual participants in full within the enclosures companion document, and I discuss the results in the next section.

5.0 Synthesising the Data, Discussion of Findings, and Next Steps

5.1 Causal Map Content

In the companion enclosures document, I detail each of the 14 transcribed interviews with their 43 cognitive maps described. I articulate how each participant strategist makes sense of their lifeworld as it relates to the quality of life of older people at the interface of care-at-home and care home. By using the cognitive mapping process over 43 maps, I illustrate the relationships between the salient issues as they appear to and make sense for each participant. This section now discusses such findings as overlaid with the 'Data Structure' and now synthesised into two summary causal maps.

- **Change Drivers.** The first map, displayed in Figure 19, captures the underlying factors that coalesce such that change is needed.
- **Strategy Outputs.** The second map, displayed at Figure 20, takes over from the context of the Change Drivers map and presents ways to improve the quality of life for older people.

Both maps are grounded in the data. Below I summarise the top ten issues from the data structure: I have coloured the points yellow and blue to denote whether the problem is one that is driving change (yellow) or is an induced strategic output (blue). Since issue number one straddles both categories, it is presented in both colours.

		DATA STRUCTURE SUMMARY: TOP TEN ISSUES
Rank	Mean Score	Issue
1	8.79	How to procure liberty, choice and personal options? Synonymous with quality of life.
2	8.43	Honesty needed in the market for care.
3	4.36	Empowerment, importance of independence and personalisation.
4	6.57	Issue of poor-quality care delivered via 15-minute calls.
5	6.64	Greater role for housing with care (HWC).
6	6.14	Focus on communities. Role for quality of life.
7	5.79	Advocacy/community navigator/help with thinking ahead.
8	5.64	Where formal care and informal care start and finish.
9	5.5	Importance of home for well-being and quality of life.
10	5.29	Negative comments re large care homes. Issue of conformity – registered care.

Figure 18: drivers of change (blue) and strategic outputs (yellow)

5.2 Causal Map One: Change Drivers

In Figure 19, I present the Change Drivers causal map. It draws together all 25 interviews to give a snapshot of the significant issues that are driving changes in social care arrangements for older people. The matters noted prompt some reflection across the quality of life domains of home, autonomy and relationships that I consider below.

(It should be noted that in the remaining elements of section 5 phrases that are presented in bold type represent a ‘node’ to be found on the causal map. My accompanying text explains the causal relationship between nodes.)

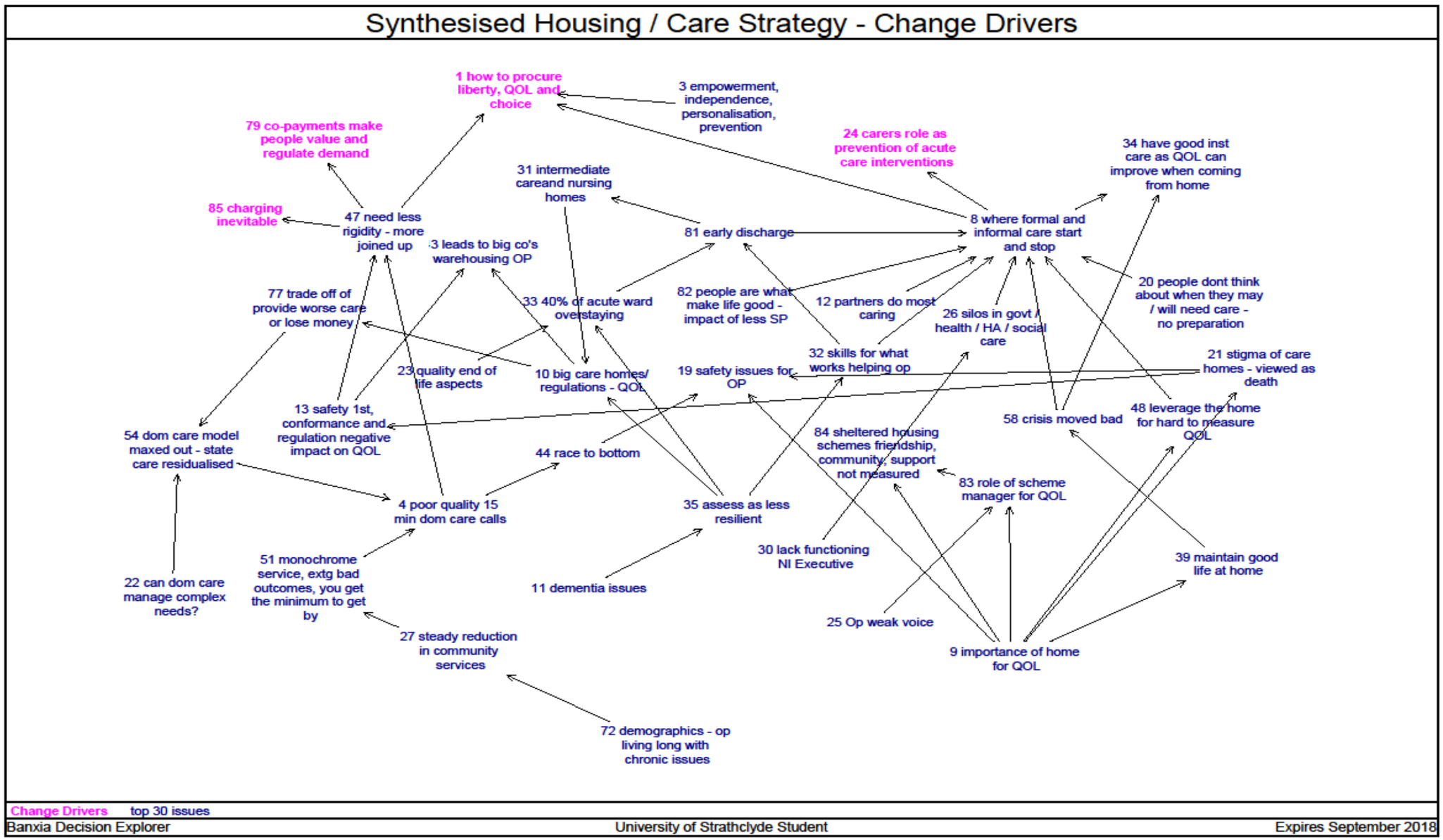

Figure 19: Causal map: Synthesised strategy – Change Drivers

5.2.1 The change drivers viewed through the lens of home, autonomy, and relationships

5.2.1.1 Home

The map gives prominence to the importance of home for older people's quality of life; indeed, one of the stem issues that drive the causal relationships above is **the importance of home for quality of life**. For example, the map notes that **older people have a weak voice,** and therefore there is a significant role for older people's needs even within a home context that needs to be amplified. Thus, the map notes the **historical role of scheme managers in sheltered housing schemes for quality of life**. However, the strategists believe that the system fails to measure the quality of life derived from such a set-up and has accordingly made such managers virtually extinct.

A related issue noted is the **importance of maintaining a good life at home.** This summary statement encapsulates the wealth of data to be found in the enclosures document, and it highlights how the dimension of the home is a crucial contributor to quality of life. One strategist, for example, makes the following point when linking home, autonomy, and relationships to well-being:

> We need to define what quality looks like. If we had 12 months to live, what would be the things that we would want? Independence, as much contact with our friends and family, being able to pursue our interests, a sense of fulfilment. I think

> we have to redesign the model. Part of that is housing, and the maintenance of independence.

The graphic summarises these quotes from the data structure and cognitive maps within the enclosures document when summarising how the strategists consider how to maximise well-being via the dimension of the home when compared to care home living. One manager of a housing-with-care facility compared residents in a new HSC Trust managed housing-with-care facility with the situation that occurred within the care home that it replaced:

> With more independence they take care of themselves because they are given the opportunity. In the care home we bathed them; their meals were made for them. I think it helps them greatly being here compared with residential care.

The graphic states that it may be possible to **leverage the home for hard-to-measure quality of life** outcomes.

The map also however notes that sometimes quality of life outcomes can improve when an older person leaves home. Often, possibly through lack of alternatives, a person stays overlong at home, to their and perhaps their spouse carer's detriment.

When considering the role of the home within change drivers, the causal chain nears its conclusion with an emphasis on home and its role for **'empowerment, independence, personalisation, and prevention**'.

Following this, the map culminates with the quality of life themes of **how to procure liberty, quality of life, and choice?**

5.2.1.2 Autonomy

The map highlights an important issue for the strategists as **where formal and informal care start and stop**. The strategists were emphatic that an older person's quality of life is best maintained whenever they remained autonomous and in control, but the problem is that the structure of care services is arranged the wrong way around when administering *to* someone. The map picks up the symptoms of these sub-optimal arrangements in domiciliary care, such as **you get the minimum to get by**, and there is **a race to the bottom** and, in the case of formal care, that **big care homes are associated with a compliance regime** with diminished quality of life outcomes. Arrestingly, two participants used the same phrase to describe when the system removes autonomy: they both described the process as the

*'**warehousing of older people**'.*

A related theme in maintaining independence is the role of carers, which the strategists highlighted: for example, that **partners do most of the caring** and that **less rigidity and more joined-up care are needed**. These points accentuate that maintaining independence requires the support of relationships and perhaps professional support on the ground to compensate for functional loss to maintain autonomy. The strategists also highlighted the cost of acute care and the cost-saving implications of maintaining independence.

Maintaining autonomy is central to how the strategists considered maximising the quality of life of older people. The theme drives upwards through the map and encompassed specific issues on the way. For example, the CEO of one of the HSC Trusts made the point:

> 'We have to get much better and proactive at keeping people well and keeping people independent; and we haven't been very good at that. Whereby the principles of the NHS are to rescue and recover people, to react when people are vulnerable. But actually, all that is doing is that we are increasing the number of people that we are trying to fish out of the water as they flow past. And we are struggling to do that. We need to get upstream and stop them from falling in.'

Their point emphasises the need for autonomy as a more effective means of maximising quality of life than a reactive system.

The graphic culminates in four overarching phrases. The first is that **charging is inevitable**. For the strategists, such a reality blends with a basic tenet of economics, that 'most of economics can be summarised in four words: "People respond to incentives." The rest is commentary' (Landsburg, 2012). The strategists appreciate the insatiable desires of human nature and the need to regulate such demand. They observe that presently many older people have to be caught by the safety net of acute care that is, in turn, now at breaking point. Their point is that having cost-free social care has resulted in a service that is spread too thinly to generate good quality of life outcomes and

sometimes do not even cover basic physiological needs, with resultant increased demands on acute services. The causal map summarises them via a third statement, namely that **co-payments make people value care, and regulate demand**.

A second overarching theme at the top of the map is shown as the **carers' role when preventing acute care interventions'** Indeed, the strategists seem to ally this reality with the knowledge that individuals and their family/carers are best placed to decide what help (state provided or otherwise) is most effective in maximising welfare. Moreover, they claim carers who know the older person well often stimulate better choices and keep the older person in control, and by so doing contribute to their well-being.

The role of autonomy thus pervades the change drivers map, and the causal chain image nears its conclusion with an emphasis on '**empowerment, independence, personalisation, and prevention.'** Under this framework of empowerment, the strategists consider the objectives of quality of life, but all the while they have in mind the critical factors associated with demand regulation: sustainability, optimum resource allocation, and charging. Summarising this conundrum and entire chain below, the graphic asks the question: **how to procure liberty, quality of life, and choice?**

5.2.1.3 Relationships

A second major driver of well-being is derived from relationships and the image exposes how the strategists considered that friendships, community, and support are central to well-being. One example was the MLA party

spokesperson for older people. They had often intervened whenever a constituent had not been able to access services that maintain their dignity. They stated:

> The only people coming in are the people coming to dress their leg ulcer or do their blood or whatever … how do you prevent that social isolation from happening? Where's the storytelling factory?

The graphic summarises this in the quote '**people are what make life good**' and highlights the **critical role that a person's carer has** for their well-being. Related themes, often raised when discussing dementia, note that social care is most effective when it has reflexive skills **for whatever works** for the individual. Such a theme implies that care is best when the carer knows the person well rather than perhaps services being delivered to older people by a continually changing rota of domiciliary care agency staff. These themes underpin the contributions to well-being that relationships and support afford, and point to outcomes being improved whenever the agent is in control of their own care, such as with self-directed support. It lends itself to carer consistency and incentivises the recipient topping up the state-provided sum in order to pay for things like day trips and other quality time events that an entirely state system is struggling to provide. The map captures this aspect as one of the four overarching conclusions of the change drivers and a theme that a sustainable strategy will likely need to afford, namely **carers do most of the caring**.

5.2.2 Additional factors

5.2.2.1 A system under incredible strain

There was an issue on which all the participants agreed – some euphemistic, and some emphatic. Those of a euphemistic persuasion described the system as under incredible strain, whereas more explicit participants described it robustly, saying ‘it is not fit for purpose’ (e.g. Participant 2). Some went as far as describing examples of the abuse of older people and saying that, in their opinion, the system had contributed to these examples. Such views reflect the findings of the recent Department of Health reports such as *Systems, Not Structures: Changing Health and Social Care* (Bengoa et al., 2016) and the *Power to People* report (Kelly and Kennedy, 2017).

Bengoa described the situation as a ‘burning platform’ and concluded that the system is not sustainable in its present guise. Doing nothing is not an option (Bengoa et al., 2016). The participants were in full agreement with that message. *Power to People* emphatically concluded that ‘transformational change’ is urgently required. Their recommendations were to use a blend of factors that empowers older people, around their home, both with their carers, and their community (Kelly and Kennedy, 2017).

However, since these reports were published, there has not been any transformational change, and the production of the welfare of older people remains far from optimised. Given such agreement, the causal maps highlight the strategists’ views of the manifestations of the system being under incredible strain.

5.2.2.2 Institutional care issues

In the Change Drivers map there are a number of issues concerning care homes. There are many **negative comments regarding how care homes** produce quality of life in general, as highlighted by the observation that the participants articulated, that there was a **stigma around care homes**, and this reinforces older people remaining at home and being afraid of what may lie in store for them inside a care home.

A fear of the unknown, hearing frightening stories of ill-treatment, and a natural aversion to considering their own infirmity are combined in the comment that people **put off thinking about** their inevitable physical and mental decline.

The participants articulated a sense of loss of autonomy when moving into care that is exacerbated by the compliance culture that they noted dominates the care home sector. They noted that care homes seemed to very often conflate the need for security with **conformance, regulation, and routine**, with resultant negative impacts. This is off-putting for friends coming to visit and engage with the resident and exacerbates the damage to autonomy and quality of life.

An example of the compliance culture that several strategists gave is the issue of removing the choice of when and where to have one's meals. They highlighted that this is an indicator of loss of independence and a resultant loss of quality of life. Regrettably, the regime of assessment has tended to reinforce a compliance culture where checking metrics are prioritised rather than creating a holistic environment. Participants who manage care homes, such

as Participant 11, candidly noted that the system requires them to trade residents' independence for compliance. The compliance-based approach seems reminiscent of Goodhart's law – the adage 'When a measure becomes a target, it ceases to be a good measure.' One said: 'We were increasing dependency and killing them with kindness.' Perhaps the conclusion is that an alternative care bargain that avoids such conformity may provide higher welfare for a given resource input. As such, the map emphasises independence rather than conformity as a principal contributor towards well-being, and so enabling such freedom becomes critical. The strategists highlight the quality of life available via autonomy outside of care homes, and that housing-based care models could be a crucial medium for enabling independence.

During my interviewing period, the *Home Truths* report was published (Commissioner for Older People in Northern Ireland, 2018). It examined the governance failures between the Department, the HSC Trust, the regulator, and the private provider within a particular care home. Extensively covered in the media after its publication, it described widespread care failures:

> Evidence gathered demonstrates this abuse materialised in the form of physical abuse, psychological abuse, institutional abuse and neglect (ibid., p.8).

The report makes explicit a reality that was more tacitly acknowledged by most participants: namely, sometimes the quality of life of older people is not improved when older people enter institutional care. Moreover, often, such

decisions about moving are made at the stressful time when there seems to be no way of a family knowing whether the care in a certain home will improve an older person's well-being or whether they will be subject to the very abuse that the commissioner uncovered.

I found widespread negative views regarding the quality of life that was produced within care homes which parallel the Commissioner's report. Indeed, two participants used the same challenging phrase when referring to the worst examples of institutional care in Northern Ireland: they called it the '**warehousing of older people**'.

To the extent that a significant function of care homes is to maximise the quality of life of older people, then, according to the participants, the present system makes achieving such a goal unlikely. The following examples (with further detail within the enclosures document) serve to illustrate.

Some participants highlighted the reasons behind the failings. For example, according to a leading academic, the norm is often too skewed towards risk aversion: 'Care homes are very risk-averse … prevention from a fall, rather than promoting independence … If you sit in a chair all day, you're less likely to fall.' Also, 'there are examples of very, very poor care and they're the ones you will hear about … But there are very good homes. We tend not to hear about those.' The HSC Trust CEO followed this theme by putting it that the compliance culture under which they operate is, at best, 'killing them with kindnesses.' The dementia geriatrician lamented the lack of joined-up thinking between the hospitals, family, and community care as an underlying problem.

Some highlight that proper care is next to impossible in large care homes; one stated: ’60–70-bed homes just become institutionalised.’

Another theme that emerged was that there was not enough cash in the system to deliver excellent care. The recent past director for older people’s services in one of the largest HSC Trusts was clear that the homes do not have the budgets to deliver anything other than fulfilling basic physiological needs. Almost all homes need a ‘top-up’ in order to remain in business rather than adding quality of life elements. As they note, ‘they are supposed to be for enhanced services, but they are needed, and it’s something that our department hasn’t really grasped’. A CEO of a body running both sheltered housing and care homes agreed when describing their care pattern as having to choose between providing ‘worse care or losing money’.

Another theme was how these issues led to other problems. The dementia expert geriatrician expressed frustration (thanks to the compliance and risk-averse culture) at the level of over-medication in care homes. They also noted the absurdity that access to care services actually *decreased* in care homes.

Some participants graphically described the effects that the limited nature of care has. The social care MLA party spokesperson described visiting constituents living in care homes, saying: ‘They are drugged just to sit there; they are horrible places.’ The commissioner for older people was very critical of the care outcomes in too many care homes. As they were closely involved with the *Home Truths* report, following publication, they were free to detail some of the examples summarised therein, such as bed sores on the body of

a client living with dementia that were described as ‘ungradable’ and so deep as to be through to the bone. They described the examples of ‘the culture of care’ in Northern Ireland:

> Because so often, we are coming across experiences of care … in fact, you wouldn’t really call it care … you know, it would be more appropriately defined as the warehousing of older people. Or throwing some interventions at somebody. It really didn’t feel like care.

The map interlinks these themes surrounding institutional care and bears out the sentiments of participants that the present arrangements are under considerable strain. Thanks to static funding being spread ever more thinly, the care per individual is at a minimum. The strategists summarise this by the comment, used in the map, that institutional care is **residualised to only being for the very sick** and are clear that systemic changes are needed.

5.2.2.3 Domiciliary care issues

If the set-up of institutional care is sub-optimal, what of care that is provided into an older person’s home? The causal map exposes the issues and links between significant regrettable issues surrounding domiciliary care.

An issue that is symptomatic of the status quo is that of **poor-quality care delivered via 15-minute calls**. For example, one strategist makes the point: ‘There could be four different providers each day, four different sets of people going in. So we can say that it is a very poor experience for someone.’ The

strategists recognised that this is, in turn, caused by resources being spread too thinly thanks to the **demographic changes** ongoing, as discussed, for example by the doubling of the number of older people over 85 in 15 years. Such a profound change to societal structure is happening just at the time when the number of people entering employment is falling. The quickly increasing demand coupled with static supply is creating problems and causing a **steady reduction in community services and leading to a monochrome service**. As one participant put it, 'you get the minimum to get by' and claimed that this was not the way to produce quality of life; moreover, there is a **race to the bottom** where **staff are not valued**, and this leads to **safety problems** since **domiciliary care may not be an appropriate way to manage complex needs**. Thanks to the reluctance of older people to enter institutional care, this manifests in **state care being residualised,** meaning that the minimum is offered by statutory services to maintain physiological functioning, and leading in turn to **increased pressure on acute care**.

5.2.2.4 Wider political issues

The map shows the link from the subject of **demographics – older people living longer with multiple chronic ailments** – through the question of **whether domiciliary care can manage complex needs**, to **poor-quality 15-minute calls**, resulting in the statement that **domiciliary care is maxed out**. These causal links further cause that there is a **steady reduction in community services**.

A constant theme from the strategists is that **honesty is needed in the provision of care.** They confirm that the public widely expect social care to be free, and even while the domiciliary care provided to those over 75 is costless for the individual, there is an inadequate appreciation of how limited this service is. Indeed, when one comes to experience it, one is not in a place to be able to explain the limited service to others. There is an associated view that a lack of resources causes care services to be diminished for individuals since the quantum of money allocated to social care for older people is being spread over more and more older people as each year passes. The limited amount of capital is now spread to the extent that it can very often barely cover physiological lower-order needs, often causing inferior care outcomes and non-elective acute care entry. The strategists agree that since this is the reality, there is a need for honesty in explaining it, especially since most people do not willingly consider how their own inevitable mental and physical decline will look. The causal link in the map summarises these points when noting that **state care is residualised**.

Previously I have uncovered at length the meanings of home and its contribution towards quality of life through security, hosting friendships, and enablement. Moreover, I detailed the results very often are that older people resist moving as they do not wish to trade away their quality of life. The strategists agreed with these findings and explained that the negative implications are that very many people ‘remain at home overlong’ (Participant 4) with adverse outcomes on their and their carers’ health and well-being. The strategists recognised a familiar pattern within the archetype vignette and

extrapolated what happens to very many Conor and Joan's across Northern Ireland. Moves, when they do happen, are undertaken therefore at times of high stress, often following a succession of falls and non-elective hospital stays. The map links this widespread and multifaceted problem, that **crisis moves are bad**, yet people expect good care in their old age but find that when they get there, the reality is different, and at that point, **their voice has become weak**. This situation has worsened year on year as budgets have failed to keep up with cost rises and demographics.

Thanks in part to the **silos in health and social care**, many participants highlighted the perverse incentives caused by the fact that domiciliary care is not chargeable to the user or their family when delivered into the home, whereas residents must pay for care in a care home. Inevitably, such a structure encourages people to seek care services that are free at home for older loved ones, rather than have a possible inheritance quickly diminished.

Incentives to game the system further exist when institutional care becomes unavoidable. For example, in my freedom of information requests I discovered that only 13% of residents within nursing or residential homes self-pay, despite the threshold for people to self-pay being when assets are higher than £23,250: since almost 70% of pensioners are homeowners, owning dwellings with a mean value of £163,000 (University of Ulster, 2019), something does not seem to add up.

As such, the greatly expanded demand on the domiciliary care services has resulted in **a race to the bottom** and older people receiving just 'the minimum

to get by'. The same lack of capital in the system causes other issues, such as the lack of staff and the problems with care procurement.

In the map, these issues drive upwards, causing cognitive responses that were widely agreed upon by the power broker participants. For example, the question of **demographic change** is displayed at the bottom as a common denominator issue, causing (to a very significant extent) the lack of capital per older person, poor care outcomes, and a lack of honesty from politicians and others about care funding. In turn, this caused participants to focus on the issue of **where formal care starts and informal family care finishes**, since the number and duration of HSC Trust-provided visits in the day is lower than all would like.

The strategists recognise the link that **people are what make life good**, but current arrangements neither effectively incorporate people nor are especially good. They consider that in the absence of significant new government funding, the system needs alternative means of care – perhaps the older person co-producing care more effectively, using relationships with friends, family, and other people and also via other financing means. The strategic direction set by the strategists thus combines drawing in very significant amounts of private capital along with *people*, *home*, and *autonomy* to achieve transformational change.

5.3 Change Drivers Summary

5.3.1 Building from objectives of home, autonomy, and relationships

The field strategists were united in having the interests of older people and their quality of life at heart. They discussed what drives them in their workplace and what issues were most relevant for them in their role as advocates for older people. In this regard, the Conor and Joan vignette served well to uncover what captures their daily attention and them elucidating 'what is going on' with social care for older people.

The issues illustrated drive upwards, with the quality of life dimensions of home, autonomy, and relationships pervading the comments near the top of the map. Two particular statements bear reflection: the first that recognises that free, good, and universal social care across care-at-home and care home is unrealistic. It, therefore, poses the structuration question of viability: how much agency and how much structure are optimal? The map poses the question **where formal care should start and informal care stop?**

The second statement is where the map stresses some important watchwords that draw together the quality of life dimensions and may best underpin a viable care bargain by emphasising the important issues of **empowerment, the importance of independence, and personalisation**. According to the strategists, these meta factors would underpin a more successful strategy, and they represent the basis of the transformative change that is needed in contrast to present arrangements. The present arrangements fail to value the

importance of the home, its value for ontological security, and its enabling role for well-being for individuals and couples.

Similarly the summary theme of empowerment and independence highlights the two-fold importance that **being in control** has, since not only are these factors critical for quality of life, but the strategists stress that relatively small compensations that keep a vulnerable person independent, empowered, and fulfilled may be the only sustainable philosophy by which care budgets can hope to be effective. Family and community may likely play a vital role here in maintaining an older person's autonomy.

5.3.2 Change driver priorities: Ways to achieve the objectives of home, autonomy, and relationships

The strategists incorporated the issues discussed above and onwards to four change drivers (coloured red) that represent the change drivers to underpin the next causal map of *strategy outputs*. As such, they are found both at the top of the Change Drivers image as well as at the bottom of the Strategy Outputs map, as they then drive strategic considerations upwards in the second image.

The initial priority in red is that **charging is inevitable**. This conclusion incorporates the recognition that the system is failing thanks to finite capital, spread too thinly. They recognise that, for most people, the price mechanism is the most effective way of regulating demand, feeding into the second priority that **co-payments make people value care, and regulate demand**. The map highlights the third priority when recognising the **carer's role for prevention**

of acute care interventions, and the fourth overarching phrase sitting at the top of the causal map is: **how to produce liberty, choice, and personal options**. I summarise these four priorities below:

- Charging is inevitable
- Co-payments make people value services, and regulate demand
- The carer's role in minimising acute care interventions
- How to procure liberty, quality of life, and choice?

5.4 From Change Drivers to Strategy Outputs: Matching the Internal with the External Environment

Since the strategic objective is to find how to maximise the quality of life for older people at the interface between care-at-home and care home, the first map has articulated the factors that underpin a viable strategy to achieve these goals. With the quality of life objectives of *home*, *autonomy*, and *relationships* consistently referenced, the map illustrates the interplay of essential factors such as the care status quo, social trends, political realities, and human nature, and it melds these complexities into four priorities. These four priorities may be seen, therefore, as akin to stepping stones on the strategising journey from inchoate objectives to a robust strategic proposal, and it is with these initial findings so assimilated that the strategists then conceived how they would use the tools at their disposal to seek to achieve the objectives. This process mirrors the strategic management process of finding a strategic fit between internal resources and capabilities and the demands of the external market (Barney,1991).

Just as a strategising organisation matches the tools of its internal resources and capabilities that are to hand in order to meet the needs of its external environment, so too did the strategists conceive configuring their internal arrangements to match the needs of their external environment. Against the objectives of *home*, *autonomy*, and *relationships*, the resources and capabilities that best match such purposes may well fall under the dimensions of:

- *Housing*
- *Agency*
- *Community*

The next section maps the relationships between the specific resources and capabilities that fall under these three dimensions and how the strategists would configure them to match the needs of their environment better.

5.5 Strategising Social Care: Strategy Outputs Map

Figure 20 represents the strategising considerations of the field strategists. It commences where the change drivers left off, namely, with the meta-theme of **how to procure liberty, quality of life, and choice** as the key question that drives the causal relationships shown above it.

The map also gives accounts for the blue elements from the data structure of Figure 18:

- how to procure liberty, choice, and personal options? Synonymous with quality of life
- a more significant role for housing with care

- a focus on communities and their role for improved quality of life
- the role for advocacy/community navigator
- help with thinking ahead, and how to procure these strategic ambitions.

As a presentation of the strategy-as-practice direction of travel, the map contextualises the relationship between these critical issues with other strategic considerations. Below, I develop the meanings of these bullet points, which, when read along with the map, generate a strategy skeleton that I later add flesh to with operational detail. As may be seen, the strategy map highlights the messy interrelationships between the strategic responses as a meld of resource and capability configurations in classic strategic management style. None of the elements is an elixir individually. However, collectively, such a compelling arrangement of resources and capabilities in this new way may have a profound effect.

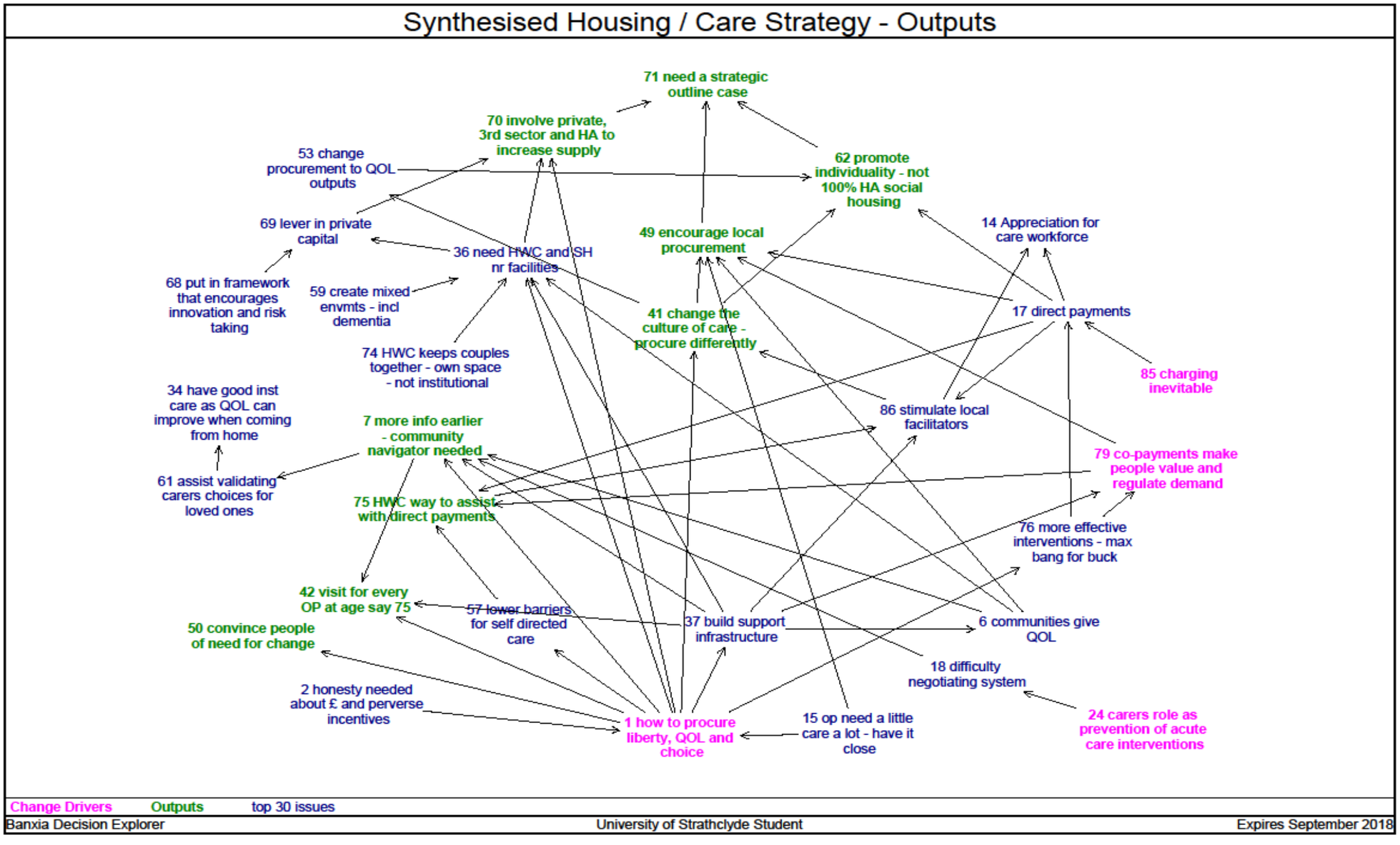

Figure 20: Causal map: Synthesised housing and care strategy outputs

5.5.1 A focus on communities, family, and their role for well-being

Many of the participants acknowledged the part of the family, friends, and the community for an older person's quality of life. Such low-key human interactions contribute to quality of life and compare favourably against the HSC Trust-provided interventions that are often reduced to being only physiological – they are short and set for services and times that suit the provider rather than the individual. For example, the senior management of Age NI strategist bemoaned how domiciliary calls are too often timed to help someone undress and get into bed many hours before they may wish to do so.

The field strategists recognise that older people's social needs are satisfied to a high degree through family, friends, and community. They are less likely to be met either in a care home or where Trust-provided domiciliary care makes up most of an older person's human interaction.

In this regard, the graphic recognises the carer's role in preventing acute care interventions. It highlights the adage that older people need 'a little care, but a lot', that people and communities make for a better quality of life. The image displays these issues as the presuppositions of proposed strategic policy responses, including a need to **build support infrastructure** and to **change the culture of care to promote individuality**. Since there are significant benefits for a local community to have local people employed in interfacing roles, there are additional multiplier effects for local employers and community cohesion. The field strategists highlight this as a contrast to the present arrangements of larger nationwide care providers, who often use staff from

outside the local area to deliver care services. The map thus highlights the strategic output in green to **encourage local procurement** and that **more housing clusters of care are needed.** They create social enablement and enable a more robust community that, in turn, may more effectively take-up self-directed support.

Such themes then underpin the strategy issues presented higher up the graphic.

5.5.2 Advocacy/community navigator/help with thinking ahead

Another presupposition of the strategy proposals is the need for local advocacy. Such a role may smooth the stresses of dealing with the intimidating number and nature of encounters with the health care and social services. These encounters are very often unplanned and at times of fear for the older person and family. The causal map highlights related problems, such as the **difficulties in negotiating the system**, and leads to solutions proposed: a need to **stimulate local facilitators**, and to provide **more information earlier**, such as the **visit for every person** during their 75th year for general awareness. Such an advocate would likely afford the take-up of self-directed support that in turn aids autonomy.

The proposed strategic solution is shown on the graphic as **community navigators are needed (CN)**. This bullet point summarises how a well-placed person is able, in the experience of the strategists, to put in place the small individual things that can compensate for a loss of functioning to maintain capabilities. In turn, they may assist with other strategic outputs in green that

are shown as **procurement becoming more local** and that **older people receive information earlier**.

The strategists visualise the role as a mix of skills. One such ability is social support for the many people whose only human interaction is four 15-minute domiciliary calls per day. The CN is conceived as not only visiting an older person but also prompting other social interactions with the older person's family, partnering volunteers to visit and take an older person out from time to time, and helping a person to mix in with other social opportunities. Presently in some of the Northern Ireland Trusts, there are small-scale initiatives that capture some of these roles, and the strategists with such knowledge emphasised such aspects. Others had good historical experiences of a scheme manager within sheltered housing schemes and how such a person provided a host of services, and they stimulated residents into doing more than sometimes they believed that they were capable of − however they lamented how such a role has largely disappeared.

Several strategists highlighted the role of self-directed payments as a way of enabling independence. Such a manner of care is very poorly taken up due to the service users needing to become employers responsible for PAYE, holiday/sick, and maternity pay. Understandably few vulnerable people avail of this demanding option, but strategists envisioned that a CN could assist with this. One participant who provides payroll services for service users described how these services were critical in allowing their service users (mostly adults with learning difficulties) to engage their own care support that, in turn, is in the

form that generates maximum well-being. They claimed that the freedom that these payroll services provided to their clients was, in some cases, transformational in that it freed the service user from being a recipient of an ill-fitting response to their ‘needs’. Rather than this deficit approach of time slots that suit the providers, service users arranged their support in the form, time, and way that they wished in an asset-based approach and aiding autonomy. The interviewee offered reasons for the poor take-up from older people as a mixture of factors, including a possible culture among older people who may be more stoic than younger people, or that older people believed (in contrast to younger adults perhaps) that the health system should do everything.

In addition to paid services, the CEO of Age NI also provided examples where their CNs matched volunteers, such as an instance where an older person living with dementia had been a cyclist. In a good example of the CN matching resources against their environment in a low-key individualistic way, they were able to match the older person’s lifestyle with a volunteer who helped them attend a weekly spin class

As an ‘insider’, I have fused these disparate strategist considerations concerning the role for a CN: to aid self-directed payment take-up, prevent isolation, and enable older people to maintain autonomy in ways unique to them. Next, I add detail from a mixed economy of care perspective.

5.5.3 How to procure liberty and personal options: Co-payments, direct payments, and a mixed economy of care

A significant number of themes to improve welfare production revolves around how finances work and lead to the conclusion that there is **honesty needed about the cost of care**. In this context, and thanks to demographic drivers, the strategists make sense of the financial direction of travel by concluding that **charging is inevitable**. Following such a conclusion, the strategy-as-practice response is to encourage behaviours that place a value on the services while drawing more capital into the system. Since, by and large, people respond to incentives, the strategists advocate co-payments for social care, shown in the graphic as **co-payments make people value care, and would regulate demand**.

One means to afford co-payments and regulate demand, according to a significant number of participants, is self-directed payments – a means to **procure liberty, quality of life, and choice**. The strategic conclusion is that older people should be helped to obtain their mix of care from social care funding and personal resources, rather than the present system where vulnerable older people are supplicants and given ‘the minimum to get by’ (Participant 14).

In addition to the barriers to take-up previously noted, a further obstacle is that the amount allocated per person falls when the option of self-directed payments is taken up. The policy seems to be based on the erroneous assumption that the recipient can manage matters such as payroll services.

But by definition, the bar that is set for an older person to receive care is set at a height that makes it very unlikely that they will be capable of discharging their duties as an employer. As such, a cut in an older person's level of financial support by virtue of accepting such an administrative burden seemed absurd to the strategists. Instead, what happens when people choose self-directed payments is that they still require the services of an agency, except they are obliged to pay said agency out of the diminished sum. Consequently, the take-up of self-directed support among older people remains very low.

The conclusion is that a policy that expects a frail older person living with dementia to execute such a process, and have the amount provided cut into the bargain, is a poor policy and should be changed. If it changed in conjunction with other policy proposals such as **needing housing with care near to facilities**, and the **need for a community navigator**, then older people might much more easily put their agency into effect, reducing demands on services, lowering costs, and increasing quality of life. Some lessons from the sheltered housing scheme managers and the Age NI community navigator underpin how, in a community, a committed individual can make a very significant impact on older people's quality of life. Helping to manage their domiciliary care, co-funding, and top-up social care interactions sit comfortably in an Extra Care environment.

The cluster highlights several strategic outputs in green that are designed to move the strategy forward, such as: the need to **include private** as well as social housing in order to be sustainable, to **promote individuality**, to **change**

procurement from being largely state-funded only, and to **encourage local procurement** through **direct payments** as assisted by **community navigators**.

5.5.4 The role for clusters of care in a housing format

The home is an integral strand of the strategy proposals thanks to its high contribution to older people's quality of life. As such, if the question is 'How can we procure liberty, quality of life, and choice?', the participants say that the answer often starts with an older person's home. The strategists conceive that at the point when care-at-home becomes sub-optimal for a person and their carer's quality of life, a viable option of care while remaining in control and within in a home-like care cluster would improve an older person's and couple's quality of life.

Such environments exist under the banner of Extra Care, and in the next chapter, I further discuss the empirical findings as induced from the strategists as I examine this format of care and its efficacy.

6.0 Addressing Quality of Life: The Role of Extra Care

6.1 What is Extra Care?

Extra Care seems to be still evolving as a phrase to capture the notion of housing with care, and so definition remains fluid. Notwithstanding that, several authors (e.g. Croucher et al., 2006 King, 2004) have drawn out some common aims found within Extra Care:

- To promote independence
- To reduce social isolation
- To provide an alternative to residential or institutional models of care
- To provide residents with a home for life
- To improve the quality of life for residents
- To allow for flexible care to come to the home environment and enable older people to remain as needs change
- To provide security of tenure for the residents and control over entry.
- Croucher et al., (2006, p.14) also highlighted an overarching ambition to have older people leading better lives than otherwise – either in their previous home or in an institutional care setting – 'via greater opportunities for social contact, barrier-free environments and access to care, and greater independence and autonomy'.

Such agreed themes are still broad, and this seems to cause problems in how Extra Care is perceived and understood. One problem, according to Wright et al. (2010), is that the absence of a clear definition makes it difficult for people, their relatives, and social workers to decide whether a scheme is appropriate. Projects are idiosyncratic, and decision-makers have little to go upon when considering alternatives; for example, these authors found that only a minority of facilities provided an option of a cooked lunch (ibid.).

The Laing and Buisson annual report on housing with care markets (2006, para. 1.1.1) states that Extra Care is, for many, a scheme providing an alternative for older people preparing to enter a care home. This description is very close to the one within the Department of Health (2005) annual report. It stated that for very frail or disabled people, Extra Care provides choice when otherwise their care needs would traditionally have been met by residential care.

A recent review of Extra Care in Scotland (Petch, 2014) attempted to better define Extra Care by seeing it through the goal of keeping older people independent. In the vein of the Lawton and Nahemow competence/environmental press model, Petch noted that Extra Care offered an additional housing option for older people when their previous home was out of balance with their capabilities. As such, the central aspect that seems to give Extra Care its definition is those added resources that allow older people to remain in control and independent.

Petch noted some notable resources and elements that together are fused to support this goal: that support is available 24 hours per day; that there are some meals available; that there are places where social interactions can take place informally; that there is a range of tenure options to give residents security; and that the homes are self-contained. Petch also noted that people moved to Extra Care facilities for emotional support as much as security. Such physical and psychological support is afforded within an accessible environment and aided by social contact with other residents, community, and staff. His phrase that captured these benefits was ‘autonomy with security’ (ibid., p.14), and the deep-seated need for these contributors to quality of life resonated with the field strategists.

6.2 Is Extra Care a Success?

6.2.1.1 The objectives of older persons social care

Throughout my thesis, I have summarised objectives as being the well-being of older people during their last 1,000 days and I have used the Knapp (1984) explanation of quality of life as being centred on the three dimensions of home, autonomy, and relationships. I illustrate these Knapp quality of life elements in the graphic below:

Figure 21: Knapp (1984) Elements of quality of life.

6.3 The Impact of Extra Care on Quality of Life

6.3.1 Literature scope

This section is an in-depth review of the significant corpus of literature where I have uncovered the themes that connect Extra Care and its scope for quality of life improvements.

In Figure 22, I illustrate the relationship between my research areas and 93 selected papers categorised against four broad themes. Category 4A refers to 'What is Extra Care?' and Category 4B refers to the impact of Extra Care on Quality of life. Within category 4B there are three themes that expose how and

how well Extra Care addresses quality of life. In the image, these themes are coloured red, yellow, and blue:

- Care philosophy (shown as red in the figure below)
- Social aspects (shown as yellow in the figure below)
- Care environment and other factors (shown as blue in the figure below).

Literature Review: Paper / book reference list

Paper ref:	1: QOL	2: Meaning of Housing	3: Moving decisions	4A What is EC?	4B: Impact on QOL	5: Business Case	6: e.g.s / design	Section 4 themes	No.	Meta Themes	Paper ref
1						1		Independence	1	A	3,10,13,16,18,71
2		2	2					Dementia	2	A	3
3					3			Fall in use of health care services	3	C	3,31
4			4					A home for life	4	C	6,18
5			5					Social well-being and family	5	B	9,18,30,31,48
6					6			A sense of purpose and self-mastery	6	A	9,30
7			7					A philosophy of care	7	A	9
8						8		Gender issues and couples issues	8	B	9
9					9			Design	9	C	9,10
10					10			Camaraderie and social interaction	10	B	9,10,18,48
11							11	Environment	11	C	9,41
12						12		Active lifestyle	12	C	9,10,18
13					13			Costs and compare to Residential care	13	A	30,31,36
14				15				A range of residents	14	A	31
15					16			An alternative to a care home	15	A	36,37
16				17				Measures of quality of life	16	A	78,79
17					18						
18					18						
19			19					**Meta themes grouped**			
20							20	Independence	1	A	Care Philosophy
21						21		Dementia	2	A	
22			22					A sense of purpose and self-mastery	6	A	
23	23							A philosophy of care	7	A	
24						24		Costs and compare to Residential care	13	A	
25							25	A range of residents	14	A	
26	26							An alternative to a care home	15	A	
27			27					Measures of quality of life	16	A	
28			28					Social well-being and family	5	B	Social Aspects
29			29					Gender issues and couples issues	8	B	
30					30			Camaraderie and social interaction	10	B	
31					31			Fall in use of health care services	3	C	Care Environment / Other
32			32					A home for life	4	C	
33						33		Design	9	C	
34							34	Environment	11	C	
35			35					Active lifestyle	12	C	
...											
Documents			36-93 not shown for clarity								

Figure 22: Extra Care literature review: 3 meta-themes grouped

6.3.1.1 Care philosophy (shown red in Figure 22)

Perhaps a philosophical enquiry into the relationship between Extra Care and quality of life starts with uncovering some of the taken-for-granted assumptions as to what we mean by quality of life, welfare, and well-being.

Several authors, such as Moons et al. (2006), highlight the problem of there being poor definitional agreement on well-being and quality of life. Vanleerberghe et al. (2017) note that 'quality of life' is regularly used as an umbrella concept, and the phrase refers to health care relating to both the physiological and psychological components of well-being. Evans and Vallelly (2007) further point out that in the literature, the term 'well-being' is widely interchangeable with quality of life, often without further definition. Nevertheless, they and other authors such as Bowling (1997) note that there is a consensus about some aspects of what quality of life means. For example, they include that it is dynamic and may vary both from individual to individual and within individuals during their lifetime. It is also multidimensional, as it consists of both objective and subjective components. As such, the World Health Organization (WHO) has adopted a holistic approach when offering a definition that captures the personal and social constructionist nature of this slippery concept. It notes that quality of life is

> an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, and standards and concerns. It is a

> broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationships to salient features of their environment (WHO, 1995).

A person-centred philosophy towards well-being has been recognised within a body of literature and applied to Extra Care. One contribution offered by Dahlberg et al. (2009) contended that the best person-centred social care policies will have regard to their conceptual foundations and will articulate three aspects: a philosophy of the person, a view that quality of life is more than the absence of illness, and a philosophy of care that is consistent with that. To incorporate such a holistic approach, the scholars introduce a 'lifeworld' approach. Such a method includes an 'existential view of being human, and an existential view of well-being' (ibid. p. 266), and highlights agency as being critical for quality of life. Nonetheless, and following a structuration approach, they highlight the tension between how people are limited and how they are free. Moreover, they advocate an understanding of the debate of health as an enabler of fulfilment and that such attainment is often a catalyst for further well-being improvements.

The philosophy of Extra Care in literature enjoys these philosophical underpinnings whereby enabling fulfilment is believed to lead to older people maintaining an existential purpose in life. To illustrate, several authors commence a consideration of life purpose by considering the alternatives for older people who are at the interface of care-at-home and care home. They

broadly report a lack of stimulation for care home residents. For example, Evans and Vallelly (2007) cite Nolan et al. (2004), who concluded that in long-term care, the situation is particularly bleak since activities are focused on meeting minimum physiological needs. As an alternative, Nolan et al. recommend an approach of six 'senses': a sense of security, a sense of continuity, a sense of belonging, a sense of purpose, a sense of fulfilment, and a sense of significance – they, too, emphasise the 'philosophy of the person'. With this benchmark, Evans and Vallelly (2007) cite Nolan et al.'s contention that a failure to provide such a philosophy of care is tantamount to abuse. In contrast they claim that a philosophy of care incorporating the six senses is potentially more available within Extra Care than institutional care.

Recurring themes within the bounds of care philosophy are matters of independence, control, and what Golant (2011; 2015) describes as 'normalcy'. He makes the point that being *normal* does not equal being the *same* when he states: 'Except for their disdain for institutional settings, older people are open to ageing in place in many different residential settings' (Golant, 2011, p.208). Instead, he claims that older people's most pressing demand is to maintain 'normalcy', even as they are affected by chronic conditions and declining cognitive and physical capabilities. Recalling the Lawton and Nahemow competence/environmental press, Golant notes the wishes of older people to 'fit in' and this strongly implies living in places where they feel competent and in control, and where they do not have to surrender mastery of their lives to others. In turn, this requires that older people can live in communities with independence and support services that enable them to maintain autonomy,

manage vulnerabilities, and enjoy the quality of life *autonomy* dimensions that Extra Care tries to afford. Thus, Extra Care, with its emphasis on enablement, both helps older people compensate for their physiological decline and adds social support that is very often otherwise absent.

A large body of research on Extra Care (including Callaghan et al., 2009; Darton et al., 2011 was carried out by the Personal Social Services Research Unit (PSSRU) based at the University of Kent. It reported that an older person's quality of life is centred on how they may retain control of their lives within an Extra Care environment.

The scholars evaluated 19 Extra Care schemes allocated funding from the Department of Health's Extra Care Housing Fund. The researchers collected information about the expectations, experiences, demographics, and care needs of 1,182 residents and carried out follow-up interviews after six, 18, and 30 months. The authors reported that, even after controlling for health, age, and dependency, when care was provided in Extra Care settings, 'the residents reported being more in control than older people living at home receiving home care' (Callaghan et al., 2009, p.1443). These findings complement those found by Croucher et al. (2006), in whose study residents reported a determination not to be a 'burden' on their family as they aged. For her respondents, moving to Extra Care was a statement of their independence.

The PSSRU (Callaghan et al., 2011) also considered the concept of control within an older person's home where they have domiciliary care personnel visiting daily. Whereas they found widespread confirmation that the older

person was in control of their care within Extra Care, they found significantly less confirmation of feelings of control among their matched cohort remaining in their homes. As Gabriel and Bowling (2004) further noted, when they are the ones deciding on the care, people value it highly, irrespective of where it happens. My own strategist respondents described a domiciliary care service that is limited. They also claimed that it is a system characterised by older people's advocates engaged in a constant war with their local HSC Trust in trying to get allocated additional 15-minute calls. They did not report a sense of feeling of control by care recipients.

The insight, therefore, is that people do not have to 'stay-put' to benefit from the feeling of independence and a sense of being comfortable in their own home. The PSSRU authors found that by moving to Extra Care, older people achieved added quality of life via a 'philosophy of ageing in place and maintaining independence' (Callaghan et al., 2011, p.1443).

Some studies have sought to rank independence against other criteria as a contributor to well-being. The sentinel piece of research in this area was carried out by Bowling et al. (2004), who enquired of almost 1,000 older people what made their life good, finding that issues of retaining control exceeded in importance the issue of having good health as a contributing factor for quality of life. These results were echoed by Beach (2015) and Orrell et al. (2013). The latter scholars enquired across 23 Extra Care schemes and a sample of 187 respondents, asking them to describe what made their lives good. In their results, they found that 'maintaining independence', with 167 specific

mentions, was only exceeded in frequency by ‘maintaining relationships family/friends’ (187 mentions, or 100%), whereas, interestingly, in the study, the 11th most frequent response as to what contributed to making their life enjoyable, with only 13 mentions, was ‘physiological health’. These factors highlight the relatively low importance that the respondents gave to health per se, compared to the importance of independence, family, and friends to enabling fulfilment.

A further aspect within this philosophy of care area that Extra Care affords was the enabling role that independence in such settings has for the take-up of ‘personal budgets’. These are amounts of money allocated by a local authority to ensure the older person or their family can appropriately meet an older person's assessed needs in a self-directed way. Such a means of support should enable better control for the service user, but many studies have highlighted the very low take-up of such support (e.g. Netten et al., 2012). Some studies have commented on the role of Extra Care in enabling such a take-up. For example, Callaghan and Towers (2014) emphasised the ‘feeling of control’ afforded by Extra Care and noted that a ‘drive towards personalisation of services and giving service users a personal budget to spend as they wish to meet their needs should result in increased control over how and when care is delivered’ (Callaghan and Towers, 2014, p.1445). They acknowledge the barriers that exist for the take-up of personal budgets, such as the regrettable need presently for older people to be employers providing payroll services, holiday cover, and PAYE responsibilities. However, they suggest that Extra Care can act as a ‘hub’ to provide such support to older

people in the Extra Care scheme and to surrounding older residents, who may also come to the environment for communal activities.

To summarise, under the heading of care philosophy, I have selected a range of research to illustrate the breadth of dimensions of quality of life for older people and how Extra Care feeds into that. The contributions under this care philosophy banner add a holistic depth to the presented dimensions of quality of life: the *homes* themselves afford more opportunities for stimulation, enable *autonomy* and independence that, in turn, generates a broad scope of well-being outcomes through *relationships* and support mediums. I may summarise, therefore, that through such depth, the literature positively supports the claim that Extra Care makes for quality of life under the banner of care philosophy and within the three quality of life dimensions of home, autonomy and relationships.

6.3.1.2 Via relationships and social aspects (shown as yellow in Figure 22)

Figure 22 also displays a corpus of Extra Care literature that concerns how Extra Care contributes to the quality of life of older people via social aspects (e.g. Bäumker et al., 2011; Beach, 2015; Darton et al., 2011; Petch, 2014). The literature has investigated this in different ways; for example, I have noted that Orrell et al. (2013) found that 100% of their older person respondents highlighted ‘maintaining relationships with family and friends’ as a factor that made their lives enjoyable. Similarly, Kingston et al. (2001) found that over

91% of retirement community residents had made new friends since moving into Extra Care.

By way of contrast, some studies compare the relatively low levels of social interaction within long-term settings (e.g. Clark and Bowling, 1989) and highlight that Extra Care does afford such relationships (e.g. Croucher et al., 2006; Evans and Vallelly, 2007). The scholars widely agree that achieving the aim of quality of life through relationships is thanks to the settings having facilities that encourage social interaction. Examples given are the opportunity that Extra Care affords for communal eating and a reduction in the likelihood of social isolation (Bligh et al., 2015; O'Malley and Croucher, 2005).

However, several contributions also acknowledge that within all settings, some residents seek solitude, and some find that the encouragement offered to socialise feels forced and even alienating (e.g. Evans and Vallelly, 2007). Furthermore, there is the problem of isolation among older people that comes from many of an older person's friends having passed away, making it challenging to make new friends late in life. Recognising both phenomena, Croucher (2006) cites studies within the literature of Extra Care design that advocate stimulating an increased likelihood of unplanned encounters in and around the communal facilities. Moreover, she cites studies that have reported characteristics of being 'friendly' as ones that often have observational triggers, such as residents opening curtains every day as a signal that all is well.

Several studies have explored the relationship between quality of life and marriage across different care settings, and such research may likely be relevant for Extra Care philosophy and design. Unsurprisingly, Bernard et al. (2004) reported higher levels of loneliness from single Extra Care residents. Less obvious were the findings of Carmel and Bernstein (2003). They found that single older people experienced faster-declining functioning than comparator couples. They discovered that widowed men who were experiencing functioning losses were less able to maintain being in control than those living with spouses/partners. Indeed, their findings were that they seemed to suffer psychologically compared with married men, who were able to avail of their wife/partner to compensate for their loss of functioning.

Moreover, those with wives/spouses were found to be encouraged by their partners to socialise, whereas widowed men were found to socialise less often. Many gentlemen may compensate for losing their partner in other ways, yet as a married unit, having spent many decades together, couples seemed to be likely to be able to pursue their happiness better. Such an insight sits well within the Lawton and Nahemow competence/environmental press model and highlights how a life partner likely adds a continual daily stimulus and challenge for the older person – keeping the chaps on their toes as it were.

Also, an Extra Care environment may not only compensate for a loss of physical capabilities, but such compensations will likely have wider second order social and psychological benefits too. As, for example, older women are able to maintain their social lives and derive quality of life benefits, then thanks

to reflexive and mutual support, they will likely collectively aid other's functionings. In doing so they may enable them to pursue their happiness, and they do likewise, forming a virtuous ripple effect.

In addition to the central PSSRU evaluation of Extra Care, the Joseph Rowntree Foundation funded Callaghan et al. (2009) to study how social well-being developed after older people joined the new Extra Care schemes (as stimulated by the Department of Health capital initiative). The outcomes were very positive. A year after moving in, most residents had made new friends, enjoyed a good social life, and valued the events and social activities that were on offer. They noted that communal facilities were instrumental in achieving these outcomes, such as restaurants and shops, plus they emphasised the importance of social activities being available as soon as the schemes opened. A further key finding was the importance of the staff, and especially that there were enough numbers of staff to support the social activities, including aiding the frail residents.

To summarise, in literature, Extra Care scores highly under the collated research within the area of social aspects. As described, it seems likely to contribute to older people's quality of life under the dimension of *relationships*, as well as such relationships enabling quality of life via the dimension of autonomy.

6.3.1.3 Well-being via care environment and other factors (shown in blue in Figure 22)

In Figure 22, the category shaded blue highlights the number of papers that describe the contributions towards quality of life in Extra Care that are derived from 'environment and other factors.' Some papers describe what I might call macro factors and they describe broad themes such as how Extra Care might be a valid alternative to institutional care and within the facilities themselves, there are also micro elements that to older people's quality of life.

Consider environmental factors, where it is worthwhile recalling that at the interface between care at home and institutional care, older people are often frail. Darton et al. (2011) referenced the delicate condition of many residents, pointing out that over 50% could not go outside or use steps. As such, they state that the internal environment is required to be both pleasant and level. Nevertheless, they found that residents, their life partner in many cases, and their families were anxious that the entire environment would be pleasing, despite many being unable to avail of the exterior.

Golant (2011) considered the phenomenon of older people moving house less compared to younger people. He highlights that in 2007, 73% of homeowners in the USA lived in homes built before 1980. Accordingly, Extra Care should be judged against the counterfactual of such old homes. In the study, previous living conditions were often characterised by poor insulation, deteriorated exterior, failed windows, leaks, impractical room design, steep stairs, and over-large gardens. (In passing I note that in Golant's research, the subject housing

stock is very likely to be younger than corresponding housing in the UK and it follows that Extra Care in the UK ought to be compared with an even less appropriate comparator than in the USA-based study.) Golant notes that older people may also experience adverse psychological effects thanks to a feeling of ‘failure’ brought on by being unable to cut the grass and keeping up appearances. Also, such homes pose risks from exposure to cold and dampness, leading to respiratory issues, as well as the physical dangers of falls from trips, poor lighting, uneven paths, clutter, poorly arranged layout and furniture, insufficient grabs, and steep stairs.

Two recent systematic literature reviews (Calkins, 2018; Chaudhury et al., 2017) examined the environment across a range of care facility settings and addressed its impact on residents and staff. Both reviews were concerned with the effect on the quality of life of those living with dementia. For example, Chaudhury et al. synthesised 94 empirical studies and nine reports, focusing mainly on environments aiding the quality of life for those living with dementia. Both studies highlighted the difficulty in accessing those whose needs are most significant, leading to their subject studies being based on small samples. Both papers thus highlighted the risks when generalising their findings. Despite such reservations, both reviews strongly indicate that the built environment is a crucial component of the care provided in residential care settings, even ‘serving as a prosthetic for various changes in cognition’ (Calkins, 2018, p.113). Likewise, Chaudhury et al. (2017) conclude that there is a holistic link between the quality of life dimensions of cognition, behaviour, and well-being, and environmental characteristics.

They found several specific means to improve a person's quality of life. Chaudhury et al. (2017) noted that outdoor gardens were linked to positive outcomes such as reduced stress, falls, and depression among those residents living with dementia. They report on a corpus of research covering facility size and unit size, noting that smaller facilities were found to be optimum for frail residents as well as those living with dementia. Their review also found that exposure to both natural and artificial bright light can aid the 'circadian rhythm' among older people, with many possible benefits including better sleep and lessened agitation.

In consideration of matters of the environment that contribute to quality of life, the PSSRU offered conclusions following their evaluation of 19 Extra Care schemes (e.g. Callaghan et al., 2009). They noted that the most significant successes were when there was active involvement by residents in the activities and scheme committees. The authors recognised that to best achieve such participation, a substantial proportion of Extra Care residents needed to be quite able-bodied, and this further contributed to their conclusion that Extra Care was most successful whenever the community had a balance between able and less able residents.

Other environmental attributes were concerned with a body of literature that has enquired whether Extra Care may be fairly said to be 'a home for life'. In their enquiry into this subject, the PSSRU scholars carried out repeated visits to the 19 facilities to study what had happened to individual residents over that time. After 30 months, about a quarter of the residents had passed away,

usually after a stay in hospital, with the overall mean survival time being 18 months; ‘however, compared with care home residents with similar characteristics, mortality was only around 70% of the predicted level’ (Callaghan et al., 2009, p.79). Outside of this loss of residents, just 10% of residents had moved on, most frequently to a nursing home. On balance, therefore, the PSSRU, along with other studies such as Kneale (2011), conclude that Extra Care may be said to be a home for life, albeit best suited to a range of frailties among residents, and best suited to older people and couples conducting a planned move rather than a move prompted by a sudden deterioration of health.

Evans and Vallelly (2007), in their review of the literature, separately considered exercise and social activities as contributors to quality of life in Extra Care settings. Since there is a relationship between a reduced ability to perform everyday tasks and worsening life satisfaction, they conclude it likely that physical exercise has more benefit for the physically frail as it can be the critical factor that enables their ability to carry out activities of daily living. At the margin, a small drop in physical capability was found to cause a significant diminution in well-being. Other studies support the insight that it is not poor health per se that reduces quality of life; instead, it is when poor health reduces independence that well-being suffers, that is to say, that whenever poor health reduces older persons’ capabilities, the literature (e.g. Bowling et al., 1997) finds that the damage to their pride quickly affects their psychological health. Sen (1985) describes such a relationship as one between ‘capabilities’ that, in turn, afford ‘functionings’, and similarly echoes the Knapp and

Lawton/Nahemow approaches. According to Sen, being capable of doing certain things empowers an individual — whether they choose to utilise such capabilities is, importantly, their choice. Thus, just having the opportunity to *not* exercise adds to the quality of life of older people. Bäumker et al. (2011) also found improved quality of life outcomes from Extra Care when compared with residential care, often as a direct function of enhanced feelings of independence and control. Evans and Vallelly (2007) also posit that Extra Care has nuanced second and third-order effects, where exercise can aid compensation for losses of capabilities, and in so doing, maintain independence and the opportunity to maintain quality of life.

A characteristic of Extra Care is the provision of a broad range of activities that are generally received positively by residents, including those living with dementia (Evans and Vallelly, 2007). Such stimulation seeks to prevent the risk of apathy within those living with dementia and contrasts with what the literature has commonly found within institutional settings (Massimo et al., 2018). Activities that are carried out within Extra Care include those related to family, church, charity, singing, and appreciation of the gardens. Evans and Vallelly (2007, p.17) note similar second-order effects on well-being such that 'as with physical exercise, there is some evidence that the impact of social activities may be most significant for people with physical frailties.' What seems to be critical is that whatever elements enable an older person to remain autonomous in individual cases are crucial and that these are afforded in Extra Care settings.

To summarise, the literature finds that compared to the counterfactual of their previous home, or residential care, Extra Care seems to support the quality of life of older people in a considerable number of ways. These cross-cutting ways (under the banner of environmental and other factors) include the scope for Extra Care to stimulate exercise, stimulate socialising and hobbies, and maintain autonomy. Other benefits derive from being within a pleasant environment that is damp-free and in good condition and having level access.

6.3.2 Extra Care impact on the well-being of older people: Conclusion

To conclude the assessment, one PSSRU evaluation of Extra Care (Darton et al., 2011) determined that Extra Care provided better outcomes than alternative means of care for an older person's last 1,000 days for a similar or lower cost. They stated that Extra Care is an: 'appropriate response to the housing and care needs of an ageing population', and concluded that Extra Care is: 'the embodiment of many of the core principles of social care policy, such as prevention, personalisation, partnership, plurality, and protection' (ibid, p.77).

7.0 Pulling the Strategy Strings Together

7.1 The Strategising Process: Matching Internal Resources and Capabilities to External Needs

If the objective is to maximise the well-being for our older people's last 1,000 days, then, according to Johnson and Scholes, an organisation needs to configure its resources and capabilities in a way that achieves such an objective. They state:

> Strategy is the direction and scope of an organisation over the long term: which achieves advantage for the organisation through its configuration of resources within a changing environment, to meet the needs of markets and to fulfil stakeholder expectations (Johnson and Scholes, 1999, p.10).

Other authors from Ansoff (1965) to Miles and Snow (1984) have added to this way of thinking about strategy. They posit that strategy is an exercise of continually seeking to match internal capabilities and resources against the external environment, and it is in this area of management theory that Jay Barney added a significant contribution. In a widely cited paper, under the banner of the 'Resource-Based View', he overlaid the concept of matching internal resources and capabilities against the external environment on top of a SWOT analysis. Under this analysis of strengths, weaknesses, opportunities and threats, he posited that strategists would do well to consider strengths and

weaknesses as internal considerations and that these may be moulded to best suit the contingent external considerations of opportunities and threats.

In my research, the causal mapping technique graphically highlights how the participants positively configure the resources and capabilities that are to hand to strategically fit their external environment (Donaldson, 1987, 2000; Porter, 1985) as well as reflexively, generating new internal resources through their dynamic capabilities (Barney, 1991; Teece, 1994).

Concerning the objective of maximising the well-being of older people, strategy theories point towards matching up the available resources. Notable resources are:

housing, agency, and community

and they may be matched against the objectives of quality of life for older people through:

home, autonomy, and relationships.

The figure below illustrates how the strategists deployed these resources against the well-being objectives.

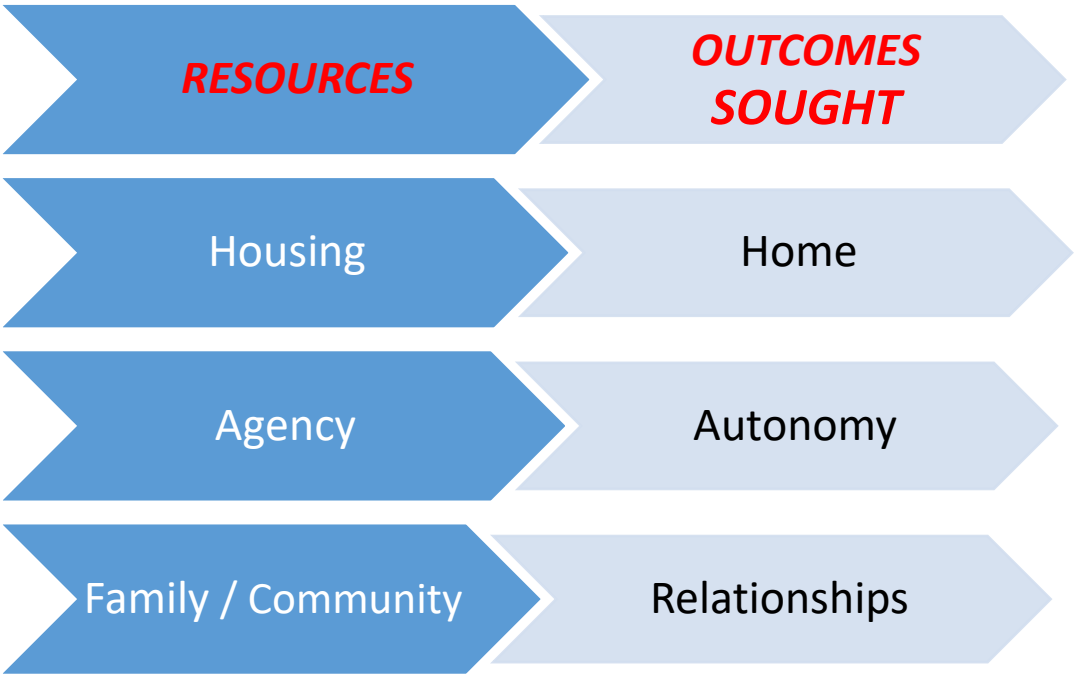

Figure 23: Linking resources to outcomes

Source: Author

The graphic highlights how the strategists considered their objectives and configured their resources and capabilities in order to achieve them. They advocate deploying the resource of housing against the dimension of home; they support using the 'dynamic capabilities' associated with agency in order to aid aspects of quality of life derived from the ambit of autonomy, and they advocate implementing the resources surrounding family and community in order to aid the quality of life dimensions under the banner of relationships.

7.2 Strategy-as-Practice Strategy Elements

This section summarises the strategy induced from the field strategists that constitutes a skeleton strategy, and it has four constituent parts:

1. The outputs from the Gioia data structure
2. The Change Drivers causal map
3. The Strategy Outputs causal map
4. The academic and empirical assessment of Extra Care.

I summarise each of these elements in turn, and it is onto this skeleton that this subsequent section adds the flesh of Extra Care Plus.

7.2.1 The outputs from the Gioia data structure

The blue summary outputs from the data structure summarised in Figure 18 are:

- how to procure liberty, choice, and personal options? Synonymous with quality of life
- a greater role for housing with care
- a focus on communities and their role for improved quality of life
- the role for advocacy/community navigator
- help with thinking ahead and how to procure these strategic ambitions.

7.2.2 The Change Drivers causal map and its priorities

It may be recalled that there are 43 cognitive maps in the enclosures document that illustrate 43 clusters of issues that relate to a particular theme that the strategist cared about. The maps illustrate how the multiple factors interconnected as the strategists considered how to address the objective of maximising the welfare of older people for their last 1,000 days. The strategists each considered the status quo, what concerns them, and the drivers of change. I have synthesised these cognitive maps into two causal maps, the first of which is entitled ‘Change Drivers’. Within it, the strategists highlighted the following key elements that, in turn, drove the strategic considerations.

- Charging is inevitable
- Co-payments make people value services, and regulate demand
- The role of carers in minimising acute care interventions
- How to procure liberty, quality of life, and choice?

7.2.3 The Strategy Outputs causal map and its strategic recommendations

The second causal map exposes how the strategists considered that the quality of life of older people might be maximised. The strategy outputs generated are:

- To convince people of the need for change in the system
- More information is needed and a role for a community navigator (CN)
- A visit for every older person at, say, 75
- To change the culture of care and to procure differently
- To encourage local procurement
- To promote individuality. Also, not 100% social housing
- Involve private, third sector and housing associations to increase supply
- Housing with care communities can assist with direct payments
- Need for a strategic outline case.

7.2.4 The academic and empirical assessment of Extra Care

In addition to the homes that I have built for older people, the literature has shown me that Extra Care seems to offer a promising medium to achieve the objectives of quality of life as summarised by home, autonomy, and relationships: Extra Care provides a home rather than an institution and in so doing, affords couples the opportunity to remain together and to have

independence. Also, Extra Care offers the potential for quality of life through the dimension of relationships thanks to keeping couples together, the role of the community to stimulate well-being, and the role of the CN to assist with such matters as direct care payments, activities, and family coordination. As such the government assessment of Extra Care by the PSSRU (Bäumker et al., 2011) concluded that it provided better outcomes than alternative means of care for an older person's last 1,000 days for a similar or lower cost as an 'embodiment of many of the core principles of social care policy'.

7.2.5 Skeleton summary

Below is the strategy statement abducted from the four constituent parts of my research.

The salient elements of Extra Care Plus are to increase the supply of Extra Care housing for older people to add:

- **a focus on communities and relationships that can**
- **provide an Extra Care housing nucleus in domestic clusters**
- **as supported by community navigators, who in turn may**
- **manage a new, mixed economy of care for residents and the wider community.**

Together, this configuration of resources and capabilities represents a framework of Extra Care Plus (ECP), and it is this framework that forms a missing strand of an efficient, sustainable, and practical policy for the social care of older people in Northern Ireland.

Next, when adding flesh to these bones, I visualise aspects of ECP.

7.3 Extra Care Plus (ECP) Visualised

This section is a description of how ECP may be progressed, and it highlights some practical considerations that will likely be needed to get from a strategy statement to actual facilities being filled with older people maximising their well-being.

7.3.1 Context

This area of my thesis steps beyond the experience of the field strategists and blends their inducted strategy direction into a more extensive abducted theory that is freer to draw upon secondary research insights and my own experiences. Such a process is necessary to provide a more rounded hypothesis that may be tested later through constructs. As Gioia et al. (2013, p.16) put it, ‘concepts are the precursors to constructs’, meaning that to test a theory, one must first create one. To articulate such a thesis, I have drawn upon the explicit and implicit knowledge of the participants, the literature, and my own 20 years of experience of housebuilding that includes homes for older people.

Below I highlight the central elements of ECP.

7.3.2 Description

Within the strategy statement, there is an understanding of how Extra Care has been found to be a successful medium for maximising the well-being of

older people, along with how I have built similar varieties of homes, and financial considerations as detailed within the enclosures document. Together such knowledge leads to a theoretical configuration of care: it is within a housing format, it leverages relationships, enabling structures, and it uses private and public finance to cost-effectively produce welfare. As so fused, this conceptualisation is the framework of Extra Care Plus (ECP), where 'Extra Care' means the physical environment of clusters of housing within which care is provided, and the 'Plus' refers to how *housing* is made into a *home* and in the process underpins quality of life. The well-being dimensions are contributed to by a reflexive mix of resources and capabilities that match the other dimensions of autonomy and relationships. They include family, friendships, community, social care services, and the support of a community navigator (CN).

The term ECP seeks to capture a strategic solution by configuring specific resources and capabilities:

- ECP conceives homes for older people where care is provided while maintaining an older person's independence and family unit.
- ECP homes afford the residents security of tenure and enable control over who comes through their door.
- Since older people very often do not consider moving until they are unable to do so, ECP homes are conceived as being available to rent either through a housing association or via private rent (because 90-year-olds do not buy houses).
- ECP is located in each town and community over a certain population threshold (I suggest10,000).
- ECP facilities range in scale from 20 to 30 households in each.

- Each ECP facility has a full-time community navigator (CN) on hand and enabling structures such as restaurant facilities. The CN helps residents and the wider community to be integrated and maintain their independent status by coordinating their formal and informal care. The CN ensures effective use of a person's statutory care allowances via self-directed payments and effectively arranges for these to be topped up as needed. The CN helps an older person to pursue their own happiness, such as through sharing time with people and day trips. Through informal care channels, the CN will also very likely stimulate more family care, such as by including them along with professional carers in an older person's rota, as well as incorporating local volunteer networks.
- Depending on location, the ECP facility will incorporate additional recreation facilities such as affording communal eating, a guest apartment for relatives to stay, horticulture, and other collective managed structures that enable well-being.

At its heart, ECP consists of homes for older people to move into as an alternative to a care home. Couples such as Conor and Joan may remain together, in control, and with help where needed. ECP theorises that by continuing to be autonomous Conor and Joan may maximise their quality of life at minimum cost to them, their family, and the taxpayer. Thus, as Joan casts around for her options with Conor falling and as she faces putting Conor into institutional care, at a high emotional and financial cost, ECP is conceptualised as providing Conor and Joan a valid option for Conor's last 1,000 days. This conceptualisation can be compared with the present status quo of a 'cliff-edge' of care and a system that, in the words of Bengoa et al. (2016b), is 'collapsing in slow motion'.

7.3.3 ECP finance: Sustainable and effective

A significant aspect of ECP is its financial structure. Thanks to inexorable demographic and social changes coming against finite health and social care resources, care provision has diminished on a per capita basis. With such a phenomenon set to continue if not accelerate, the strategists see the need for significant additional revenue and are sceptical that this will be on offer from the government. As several strategists put it, ‘charging is inevitable’. Whereas this statement was directed at the need for domiciliary care to be better funded with the help of private capital, it hints at the scale of the transformational change needed. It may need to mirror the transformation of 30 years ago in the care home sector, which is now funded by a mix of private and public capital. The very likely proposition is that the present situation of domiciliary services being almost entirely state-funded is unsustainable. Similarly, ways could be found of private and public joining to co-fund the space between care-at-home and care homes. Thanks to their role in maximising quality of life for older people, and the nature of the home as an entity associated with private capital, such care environments will likely encompass clusters of Extra Care housing.

The likely result is that it is only by finding a way to configure Extra Care into a medium that is capable of becoming an institutionally investible proposition that the sufficient capital required for the system to be transformed will become available.

Extra Care Plus may be a promising way to encourage such sufficient private capital inwards as is needed. Such an approach then begs the question of how to pay for such housing clusters.

7.3.3.1 Housing costs

In my introduction, I made the point that 90-year-olds do not buy houses, and I explored why this is through the literature. Now I consider ways in which this statement has profound ramifications.

This point arose with each participant when considering what happens with older people typified by the vignette of Conor and Joan. The chicken-and-egg problem discussed by Krugman (1998) is that when a market does not know about a product, like good food not being known about in England in the 1970s, it is thus not demanded, and it follows, it is not supplied. So it is with Extra Care: since it has not been demanded, it is not supplied.

It follows that when Joan looks around for a housing option of care where she may remain together with Conor, it does not exist. Nor, as the literature makes clear, is there any realistic expectation of changing how older people think about their home earlier. The conclusion is, therefore, very likely to be that such homes will need to be built in advance and made available to rent either privately or with the help of housing benefit. The difficulty with such a proposition is that it does not financially stack up.

Within my enclosures document, I explain at more length why building to rent is rarely a profitable exercise for general housing, and still less so when the

residents are older people. In summary, it is because the investment owners are not confident of having a reliable stream of income, they are unsure of costs, and in contrast to student accommodation, they do not see government policies encouraging investment. Such uncertainty ensures that the investment values of housing rented to older people are low, as I demonstrate.

The worth of an institutional letting is dependent on the rent amount, less running costs, multiplied by a factor that reflects the certainty of the rent being paid and rising over time (known as the covenant strength). The value of leases to older people will be limited: the covenant strength is weak thanks to uncertainty concerning the lease term, and when multiplied by the low level of rent achievable, as reduced by refurbishment costs. The result of the equation is an investment value that is likely to be less than the build costs (and the enclosures document details example calculations). However, there are ways to mitigate these problems.

The principal means to transform the covenant strength is to change the tenant from being that of a direct letting to an older person to a letting of a collateralised asset-backed investment to a highly capitalised institution, ideally the government. A government covenant with the same rent passing would transform the investment value into one that would likely be in high demand by institutions in search of a secure yield. It is for this reason that a means of having a government association with ECP holds the key to transforming housing clusters for older people into a viable investment. Such

a means of transforming the covenant strength happens to be available through Financial Transactions Capital (FTC).

7.3.3.2 Financial Transactions Capital (FTC)

For the reasons given, a government association is very likely to be critical to attracting the quantum of private investment that is needed to procure wholescale Extra Care housing to effect a transformation of social care for older people. As detailed by Participant 8, such an association need not be expensive. This strategist achieved department backing for a housing model that provided adults with learning difficulties with their own homes, and an ability to move out of the home that they grew up in. The initiative utilised UK Treasury Financial Transactions Capital (FTC) loan monies in addition to Northern Ireland department budgets. Being constituted as a loan the initiative is cost neutral. Elsewhere, such as in the case of the new University of Ulster campus, FTC funds have attracted considerable additional private capital when deployed in Northern Ireland.

The FTC concept follows the familiar pattern of a household mortgage. In cases where a homebuyer has a secure job paying sufficiently well to cover the monthly mortgage costs and has a 20% deposit, then borrowing the rest becomes feasible at modest rates of interest. Similarly, FTC has attracted the equivalent 80% of private capital at modest rates of interest and as such, the FTC loan provides the leverage that has attracted the 80% of private capital.

7.3.3.3 Other capital sources

ECP has a theoretical model of financing consisting of several elements. As described, the critical element is likely to be along the lines of UK Treasury loans to Northern Ireland departments under the Financial Transactions Capital scheme that, in turn, draws in additional private capital. However, ECP also proposes that 50% of the funding would be derived from housing association monies, that are themselves partially government-funded.

As a starting point, ECP assumes that 50% of the older persons would be housing association tenants, most of whom receive housing benefit. The reason behind this ratio is that the strategists wanted to avoid any accusations of bias against those who were not homeowners. Moreover, the credibility of a relationship with an established housing association is likely to be helpful in providing confidence to both residents and private investors. After establishing ECP, the 50/50 ratio could be altered in the event that public sector finances continue to tighten. Figure 24 posits an example of how the capital costs could be structured.

- The privately funded capital costs are conceived as being a mix of FTC, equity, and debt capital.
- FTC interest is conceived as being 3.5%, in line with recent examples in Northern Ireland, and rolled up until refinancing in year 10. A reasonable assumption is that the capital value of such housing stock will appreciate in line with a general housing asset class. House price growth of 3% per year might be assumed, that over the term would add some 34% to the value of the building stock. Such capital growth over the term would allow refinancing.
- Debt capital is secured against the asset and serviced from net rental receipts.
- Equity capital is conceived as receiving an annual yield plus an equity share of the asset growth. An acceptable institutional rate of return will depend on the covenant offered by the FTC structure.

Figure 24: Possible capital cost servicing and repayment structure

Source: Author

7.3.3.4 Running costs

Other costs, such as the community navigator (CN) and domiciliary care costs, are theorised as being through revenue expenditure. Presently such costs are funded through HSC Trust provision but are under enormous pressure. A strategic output from the causal maps is that enabling self-directed support (SDS) is likely to be the best way to ensure that the older person is supported to be independent. The older person is in control with SDS and may benefit from whatever care services suit them best, rather than being recipients of a

time slot when it suits the agency and their employers, the HSC Trust. Such a system affords straightforward ‘topping up’, especially with a CN on hand to assist. I envisage the CN to be funded through the 3rd sector, as is the case with the Age NI examples. Thus, while such details need further development, the ECP framework points to ongoing revenue costs being in line with existing levels that, in turn, stimulate private ‘topping up’ and 3rd sector additional funding streams.

7.4 The Built Form: Efficient and Effective

A further major conceptual element of ECP is its physical nature and its locations. In ECP, the built form consists of apartments that are large enough for wheelchair-enabled living and bathing. They include two bedrooms and are thus some 50% larger than traditional social housing sheltered dwellings, and they may measure approximately 900 sq. ft. each. The homes are lift-accessed and built over a variety of two and three floors. There are between 20 and 30 dwellings in each facility, depending on locations, in both edge-of-town and in-fill locations. As per the artist impressions within the enclosures document, they are designed as being vernacularly traditional and incorporate elements that the research found to be critical for quality of life, especially arrangements for informal social encounters and eating. Physically, this implies communal areas and communal eating and café/restaurant facilities. Since older people wish to remain within their communities, the ECP facilities are proposed to be within every community over a certain population threshold. While it is likely that a number of pilot facilities will be required to be built in order to assess

ECP in different settings, to be transformational, an ECP facility may need to be located within every community over 10,000 people.

7.4.1 The built form: A snapshot from the enclosures document

Within the enclosures document in Section 3, I detail some of the different dwellings that I have created for older people. Given the issue that 90-year-olds do not buy houses, I highlight how I have constructed various forms of homes for older people before settling on building a prototype that could work when rented. Several of such buildings together could be an appropriate domestic cluster of care and constitute the built form of ECP. I named the prototype ‘Hawksmore House’, and the Dementia Centre of Scotland assisted with its interior design. I present a photo of Hawksmore House below.

Figure 25: Hawksmore House: A housing with care prototype

Within the enclosures document, Section 3 shows how the clustering of buildings similar to Hawksmore House fit together into a community of between 20 and 30 homes. In the example, located close to Hawksmore House, I acquired the land, achieved planning approval for the arrangement, and christened such a cluster ‘The Pavilions’. Below, I present one of the images of The Pavilions.

Figure 26: The Pavilions: Extra Care conceived in domestic clusters

As the enclosure document details, The Pavilions constitutes one of a form of clusters of domestic housing with care arrangements that have been value-engineered to be an efficient yet attractive format that incorporates a dementia-friendly home setting. The designs have, for example, apartments that are lift-

accessed, have wheelchair-enabled access, are large enough to have separate ‘zones’ for ‘Conor and Joan’, and at 900 sq. ft. are large enough to house such a couple, their memories and ‘deposits of ‘halcyon days’ (Vasara, 2015), as well as space for when bathing needs the help of two carers. The Pavilions also incorporates a reception for the CN, has a safe zone for recreation, an apartment for sons or daughters who may live overseas to stay for short periods, as well as potting sheds, a café/brasserie, and a ‘man cave’.

While the precise configuration of dwellings will naturally likely differ from location to location, I put forward the example of 26 homes, as such a number could be around the optimum number, given the trade-off between having too many homes, which risks the facility becoming institutional, against having too few homes and the CN and facilities becoming uneconomic. The section in the enclosures document reflects on further concerns.

Notwithstanding that there are a number of areas that have yet to be optimised through trial and error in the built form, just as every new theory is conceptual, so too is ECP and its visualisation. Nevertheless, as presented, The Pavilions are a conceptualisation of ECP where the homes form part of a configuration of resources. Here older people may choose to live − rather than presently not having that choice at all.

8.0 Contribution to Theory

8.1 As a Medium to Advance Accepted Knowledge

In December 2017, Des Kelly and John Kennedy published their report into how to transform social care in Northern Ireland. Entitled *Power to People* (Kelly and Kennedy, 2017), it makes clear that the social care system demands transformational change. The report details recommended changes with a roadmap of elements that should be integral to such a transformation. Having now induced from the field strategists a strategy-as-practice skeleton, and further added flesh to such bones with ECP using broader abduction allied with personal expertise, it is of interest to compare such strategising with the Kelly/Kennedy report recommendations. I present them below.

- Self-directed support should be the norm to empower citizens. Markets for care support and provision need to be stimulated.
- Family carers need to be appreciated as the heartbeat of care when transforming into a people-based, as opposed to bureaucratically based, care model.
- Community navigators are needed.
- Councils need to be involved. Their involvement is to include innovative funding models for alternative formats and settings of care.
- Professional carers need a wage structure that incentivises and promotes the profession and good practice.
- People who can afford to pay should do so.

- HSC Trusts have market-shaping duties, especially with a self-directed model.
- HSC Trusts and the Department for Communities need to work more closely together to create specialist housing.

Figure 27: Kelly and Kennedy (2017 p.89-91) conclusions

Gratifyingly, and as may be seen, the Kelly/Kennedy recommendations broadly mirror those of the field strategists. However, while Kelly and Kennedy conclude that transformational change is urgently needed, they were silent as to how. Conversely, I have induced from the field strategists a definitive means of addressing the transformation.

Thus, if the question is, 'What would a strategy look like that improved the quality of life for many older people at the interface between care-at-home and care home?', the answer is, according to Kelly and Kennedy as shown in Figure 27 above. It is these aspects that have been further conceived by the field strategists in skeleton form, and as given flesh by the ECP framework presented herein that represent my theory contribution.

8.2 Strategising Statement and ECP Framework

As previously summarised, Extra Care Plus is a strategy to increase the supply of Extra Care housing for older people to enable well-being. ECP is a configuration of resources and capabilities that constitute 'enabling structures', reflexively deployed for a given individual or couple. ECP and its enabling

structures add quality of life for many older people at the interface of care-at-home and care home.

ECP follows several significant validation steps. These include my methodology, primary research, presentation of the status and history of social care reform in Northern Ireland, an insight into the meaning of home and its contribution to well-being, the reasons why older people do move, the efficacy of Extra Care, and a presentation of my insights gained from a 25-year career of building dwellings for discerning customers.

Together, these elements underpinned my abducted research that includes my data structure and Strategy Outputs map as an induced strategy onto which I have added flesh in the form of Extra Care Plus, a framework to improve the welfare production for older people in Northern Ireland. It consists of a new means of configuring resources and capabilities and, in doing so, takes the Kelly and Kennedy conclusions onwards in an equitable, effective, and sustainable way. ECP is a clear strategic response that articulates how resources and capabilities may be effectively configured to achieve the stated goals of maximising the quality of life for older people at the interface between care-at-home and care home.

Through this thesis I show that in England, Extra Care fills the gap in the care continuum, but is absent in Northern Ireland. This gap should be filled, and I volunteer ECP as a model conceived explicitly for the Northern Ireland environment.

I have herein visualised ECP and summarised it into a strategy statement and to conclude, I restate this strategy statement:

The Strategy Statement

The salient elements of Extra Care Plus are to increase the supply of Extra Care housing for older people to add:

- **a focus on communities and relationships that can**
- **provide an Extra Care housing nucleus in domestic clusters**
- **as supported by community navigators, who in turn may**
- **manage a new, mixed economy of care for residents and the wider community.**

8.3 Closing Remarks

In my introduction, I quoted Michael Sandel's thoughts on what he considered philosophy to be. He stated that philosophy is

> critically reflecting on the way things are, that is to say, the present social, political, and economic arrangements, and to be open to the possibility that things could be both different to how they presently are and could be better (Sandel, 2010, min. 22.01).

I hope I have been faithful to such a definition.

9.0 Limitations and Reflections

9.1 Limitations

Some readers may consider that the sample size of 25 participants is small, and for this reason, the findings may lack the validity of larger samples and thus limit the generalisability of the results. When they countered the risk of such criticism, Gioia et al. (2013) cited Lincoln and Guba (1985) when pointing out that it is possible to extract transferable theory that is fashioned by unique individuals acting within unique contexts. For these authors, even a single sample, such as a case study, may have transferable concepts should the case generate principles of relevance. To aid reliability from small samples, the authors outline their data structure method to create new theory and concepts through 'qualitatively rigorous inductive studies' (ibid. p.26). In overlapping the Gioia method of data structure on top of the cognitive and causal mapping techniques, I believe that I have gone to sufficient lengths to ensure, if not repeatability, then a transferability of my findings. I respectfully consider that Extra Care Plus has been induced with scholarly rigour.

One weakness derives from the operational deliverability of Extra Care Plus, requiring as it does the Department of Health to address the concept of fusing care and housing together, something that they have failed to do for some 30 years. My thesis is that it is only by turning Extra Care into an institutionally investible product that the quantum of capital can be attracted as is needed to transform the system. Again, Northern Ireland departments have a poor record

of managing public/private initiatives and in the aftermath of the RHI problems, the departments are likely to be even more risk-averse.

ECP asks the Department of Health to avail of funding such as Financial Transactions Capital that is earmarked for Northern Ireland by the UK Treasury, and explains how both private and Housing Association funding would be very likely attracted to follow the initial FTC monies and facilitate the transformation that is required. A housing product gives the opportunity for not only an institutionally investable proposition but also a home with care on hand that is needed instead of the present cliff edge of care. I have demonstrated a case for structures to be put in place to enable older people to maintain independence and quality of life. Such arrangements require a balance between structure and agency and between public capital and private capital. ECP conceptualises a sustainable and equitable means of creating domestic clusters of care using money overwhelmingly from outside the public sphere. Such facilities, set to effectively and sustainably produce well-being, may form a core strategy for the Department when implementing their transformation agenda, itself vital for the sustainability of the entire service.

However, ECP may require the Department to be less suspicious of the private arena, and somehow ‘let go’ of control of many older people. It strikes me therefore that a considerable weakness is that, in the continued absence of politicians able to form a local government, there is not the ministerial impetus that might be instrumental in moving Extra Care Plus forward.

9.2 Reflections

For me, my thesis represents a fascinating personal philosophical odyssey in an effort towards contributing to the body of knowledge. Moreover, I am confident it represents a valid theoretical framework, developed using abducted academic rigour, that has the potential to contribute profoundly towards the urgent issue of care for older people.

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ENCLOSURES & APPENDICES TO: OUR LAST 1,000 DAYS STRATEGISING SOCIAL CARE FOR OLDER PEOPLE

David Law

UNIVERSITY OF STRATHCLYDE DBA Thesis

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1.0 Health and Social Care in Northern Ireland: Policy Context

1.1 Broad Arrangements

The Department of Health sets the Northern Ireland legislative and policy context for health and social care (HSC) for Northern Ireland. The Department places ministerial priorities and principal objectives within an annual commissioning plan direction, following which the Health and Social Care Board (HSCB) produces a commissioning plan.

Northern Ireland's model for health and social care is different to arrangements in both England and Wales (as a single region) and Scotland, where social care responsibility is the duty of local authorities. In Northern Ireland, however, the integration of the delivery of services is primarily achieved by dividing care into nine 'programmes of care' into which resources are assigned. These are: acute services; maternity and child health; family and childcare; elderly care; mental health; learning disability; physical and sensory disability; health promotion and disease prevention; and primary health and adult community (Ham et al., 2013). Health and social care in Northern Ireland are almost entirely funded by the government and free for the user at the point of care.

1.2 Health and Social Care Reforms

HSC services in Western countries are being forced to change due to a changing population and demand. Increasing demands are being placed on HSC because of a squeeze driven by constrained resources, populations having an older profile, rising

patient expectations and technological advances. In particular, and due to due to the increasing trend towards longer lifespans, there are many older people who live with chronic health morbidities; they need long-term support from the care system.

Because of such factors, the government of Northern Ireland over the last two decades has sought to strategically change the provision of HSC services and how the sector is governed. My overview concentrates mainly on the attempts to reconfigure the health and social care systems regarding social care for older people, and how housing feeds into that perspective.

A key theme for HSC reform has been an acknowledgement that the acute sector has been the first port of call for too many people with chronic health needs. As such, there has been an aim to shift services towards care in the community (DHSSPS, 2005). Primary care has been recognised as vital to act as an initial contact for HSC services, with GPs acting as gatekeepers for additional care services. The 2005 policy framework prioritised developing alternatives to hospital admission that were community-based (ibid).

Such a process accelerated in August 2011 with the commencement of the *Transforming Your Care* (TYC) agenda (Compton, 2011).

1.3 Transforming Your Care (TYC)

The TYC review concentrated on the outcomes for patients in the community, and how best to achieve them. The review received submissions to their call for evidence from over 3,000 respondents, including members of the public, care providers and interest groups.

1.3.1 TYC philosophy and recommendations

A new and better integrated model of health and social care was to be supported by some fundamental factors (ibid.):

1. That the individual would be at the centre of the model
2. To provide the right care at the right time, in the right place
3. Integrated care – with services better planned
4. Promoting independence and personalisation of care
5. A focus on prevention and tackling inequalities
6. Realising value for money.

Some of the key recommendations were:

- That care be delivered as close to home as possible
- To invest in community health and social care services in lieu of acute care
- To introduce 17 Integrated Care Partnerships (ICPs) in Northern Ireland
- That outcomes would be the factor that determined the shape of services
- That promoting individual responsibility for their health and well-being, along with prevention, would be given primacy.

1.3.2 The Integrated Care Model

The Integrated Care Model within the report was as per Figure 1 below.

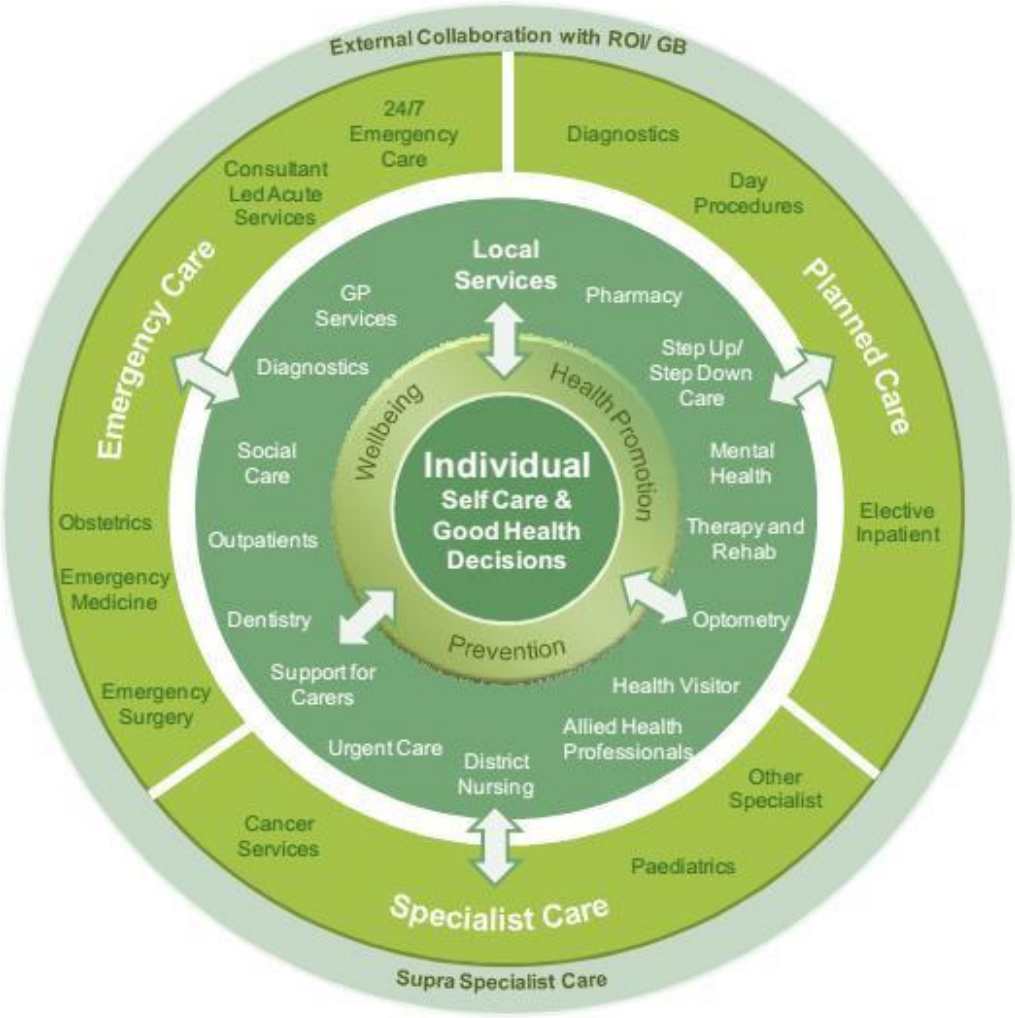


Figure 1: Integrated care model

Source: Compton (2011)

Figure 1 highlights both the multifaceted nature of care and how the ambition was that the person would be, if not in control, then certainly at the centre of their care arrangements and decisions. The HSC would then provide support to individuals in order that they were invested in co-producing their own health and well-being. The model was explained in the report through case studies, including ten major areas of care involving older people, people with long-term conditions, and palliative end of life care. The home was to be the ‘hub’ (ibid.) for care, with ICPs being close enough to

allow individuals to have sufficient primary care support. With so much health care demand coming from chronic health needs and issues of multiple morbidities, the ICPs would also afford a better sense of integration between health and care.

The review anticipated that GPs would form geographical networks and would undertake the critical leadership roles in new ICPs.

1.4 An Approach to Care via Integrated Care Partnerships (ICPs)

The primary care approach proposed was to support a 'hub and spoke' means of care, with hubs having the capability to deliver services that would include X-ray and minor surgery.

The Belfast Trust now has just seven Wellbeing and Treatment Centres (colloquially known as Health and Wellbeing Centres) that, in some cases, have been open since 2005, so the direction of travel may be said to be neither new nor quick to implement. These centres are bases for primary care treatment and information. Outside of Belfast, in addition to new centres located in Omagh, Banbridge and Ballymena, two centres for Lisburn and Newry are planned as a 'pivotal part of the reform of health and social care, as set out in *Transforming Your Care* (DHSSPS, 2013), commencing in Lisburn in 2019.

Delivery of the TYC approach emphasised that five elements would be needed for its success:

- More support for carers.
- More support for staff to implement TYC.

- A more holistic integration of support services, such as engagement with the community and the third sector to help them also to implement TYC.
- Investment in the above to allow change to happen.
- Different departments to work better together in maximising other elements of well-being and health, such as housing, reducing social deprivation and work to reduce health inequalities.

ICPs were thus seen as key to facilitating primary care closer to home in order to limit hospital admissions as much as possible. For example, the 'Acute Care at Home' team is a team of health care professionals engaged in helping people with problems such as urinary tract problems, chest infections, and dehydration. Providing acute care at home via the ICP's avoids the need for older people to be admitted to hospital.

1.4.1 Overall progress of TYC

In 2015 the Northern Ireland Department of Health Committee reviewed the overall progress of TYC by engaging with stakeholders including HSC staff. The Committee heard that TYC 'in its broadest iteration' still enjoyed the general support of the health and social care sector (Northern Ireland Assembly, 2015).

The Committee's review highlighted some problems with the progress of TYC. There were concerns from stakeholders that included implementation detail and performance measures. The Department viewed TYC differently —not as a 'plan' to be accomplished but as an ethos to inform commissioning decisions. The Department stated that 'it is a context for the way in which we think. It is about trying to work from a patient's point of view … there is never an end to this' (ibid.). However the Committee review seemed to rather believe that such a claim actually meant that 'the way it is done here' had not changed and noted that changing from an action plan with specific

targets and performance indicators to more of an aspiration gave rise to concerns over monitoring, governance and funding.

The Committee also found that there was no commitment in terms of how the transformation was going to happen and had concerns that the requisite funding was not being put in place to allow the objectives to be met. Such concerns were not misplaced. The Public Finance Scrutiny Unit of the Northern Ireland Assembly in June 2016 highlighted that the Department, in previous years, had not funded the implementation of TYC, due to overarching funding pressures. TYC received only £39m of the £101m requested for required changes. Stakeholders reporting to the Committee highlighted, for example, a fall in community nurses over recent years and noted that integration and communication between the health and social care sectors had not improved (ibid.).

Since 2015, reform has effectively ceased under the heading of TYC and implementation. More recently, reform has been under the heading of the Bengoa Report (Bengoa et al., 2016 a/b), but the issues remain unchallenged and are unchanged. This stalling of reform seems to follow a pattern of reform initiatives followed by faltering delivery, followed by a new reform initiative and so on, as I set out below. Ultimately, in this section, I provide further analysis as to the reasons behind the phenomenon and what may be done about it.

1.5 Other Health and Social Care Reform Proposals

In addition to the stalled TYC, Northern Ireland has had several other significant reports reviewing the workings of the health and social care system. Together their findings set the scene for my research.

1.5.1 The Appleby Report

Professor John Appleby, the chief economist for the King's Fund 1998–2016, presented his report *Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12–2014/15* in March 2011. He found that by 2015 the budget would be cut in real terms by 2.7% and a funding gap below that recommended to the government via the Wanless Report (2002) of between £1.1 and £1.5 billion. However, the Wanless Report included productivity assumptions, making the funding gap likely to be closer to £2 billion.

Selected further recommendations were:

- Tracking outcomes rather than spending, including the use of health and well-being measures
- Explore and mitigate the very high A&E use and length of stay
- Develop a coherent relationship with the private sector
- Investigate the relatively low productivity and, in conjunction, incorporate incentives for innovation.

As it stands, this £2 billion forecast shortfall seems to have transpired, and the recommendations largely remain outstanding.

1.5.2 The Donaldson Report

Sir Liam Donaldson examined the governance arrangements of integration in 2014 and presented his report entitled *Right Time, Right Place* (Donaldson, 2014). The report found that although social care being integrated was a distinguishing feature of the structure in Northern Ireland and had great advantages, it did fall short on promoting the highest standards of care. The report criticised the excessive number of

acute hospitals that were not funded individually highly enough on an individual basis. This led to a two-tier service between busy city hospitals and less busy hospitals, especially when understaffed out of hours. The report further highlighted an ambiguity of governance and uncertainty over who was in control amongst the Minister, Commissioners, Permanent Secretary, and Chief Executives of Health and Social Care Trusts. Since the report was published, the governance arrangements remain broadly unchanged, exacerbated by the lack of ministers in post to sign off on new policy.

1.5.3 The Bengoa Report

The *Systems, Not Structures: Changing Health and Social Care* document reported on the findings of the expert panel that was chaired by Professor Rafael Bengoa (Bengoa et al., 2016a). The panel was asked to recommend the most optimum configuration of resources across health and social care to deliver the best health and well-being outcomes. The conclusions were stark.

The system is not sustainable in its present guise:

1. The system of health and social care was on ‘a burning platform’
2. Doing nothing was not an option.

> *The Northern Ireland Executive invests annually almost £4.6 billion, or 46% of its entire budget, in providing health and social care services for the people of Northern Ireland. If costs rise as predicted, with a 6% budget increase required annually simply to stand still, then we can expect the budgetary requirement to double to more than £9 billion by 2026/27 to maintain the current system. This is clearly not sustainable given the many other public services needed by the Northern Ireland*

population, many of which also have a significant impact on health and well-being by providing employment, education, good housing, and a safe society (Bengoa, 2016b, p.5).

The report provided 14 recommendations that feed into its triple aims of:

1. Improving the patient experience of care (including quality and satisfaction).
2. Improving the health of populations.
3. Achieving better value by reducing the per capita cost of health care.

The key recommendations of the Bengoa Report are:

- Using the 'triple aims' as a basis for reform, and Accountable Care Systems (ACS) to provide a structure for better patient engagement and patient empowerment for their own care.
- Invest in ACS within Integrated Care Partnerships to allow HSC services to occur in a community setting rather than within the hospital.
- Incorporate an ethos of co-production involving people as assets themselves, with unique skills, who may contribute effectively for their good health and well-being.
- Improve the health of people in Northern Ireland using the most effective social means.
- Communicate a long-term vision covering three areas: towards Accountable Care Systems; to aggressively scale up good practice, and to target rationalisation and stabilisation.
- Create a ring-fenced transformation fund of additional capital.

- A transformation board to supervise transformation and help to transform HSC arrangements to afford decisions best to be made locally and to aid the promotion of evidence-based innovation and best practice.
- Scale up a minimum of two projects per year in cases of better outcomes for service users using innovation.
- Support reforms by continual improvement techniques to strengthen local systems of care, including stronger quality improvement systems.

It can be firstly noted that the thrust of the Bengoa Report is entirely consistent with the principles of Appleby, Compton and Donaldson. While it did stress the unsustainability of the system, it did not make specific recommendations for operational matters. Instead, a ten-year plan for health and well-being – *Health and Wellbeing 2026: Delivering Together* (Department of Health, 2016) – was delivered by a Minister's statement to detail specific changes due.

1.5.4 Delivering Together agenda

The *Delivering Together* agenda represents the current policy change framework in Northern Ireland. The report covers five areas, detailed below.

1.5.4.1 Delivering Together part 1: The context

The ten-year plan set out the challenges faced, specifically from a population rapidly getting older, by noting the number of people aged 85 and over is to grow by 157% from 2014–2039. It noted that the change in the number of persons per 100 over 65 years old increasing in the next eight years would be as much as in the previous 40 years. This presents a great challenge due to increased demands on the HSC.

Furthermore, it noted people's expectations are now higher than ever and that they wish to enjoy fulfilled lives and lifestyles. When it comes to public services, this means

that people wish to remain independent, with choices, and in control of their arrangements.

1.5.4.2 Delivering together part 2: The ambition

The report announced a person-centred care model that was aimed at early intervention, affording independence and promoting well-being. The focus was to move interventions from one of reactive treatment, once an issue arises in acute settings, to preventing crisis where possible in the first place, and managing health care locally.

1.5.4.3 Delivering Together part 3: The change needed

The report highlighted the changes needed:

- Build capacity in communities
- Use primary care for preventive, proactive care and treatment
- Reform hospital and community services to deliver care as it is needed
- Arrange management structures better in order to fulfil the aims.

1.5.4.4 Delivering together part 4: The approach

The report set out a framework for achieving change covering areas of partnership working, workforce, leadership, quality, and e-health, as per Figure 2 below.

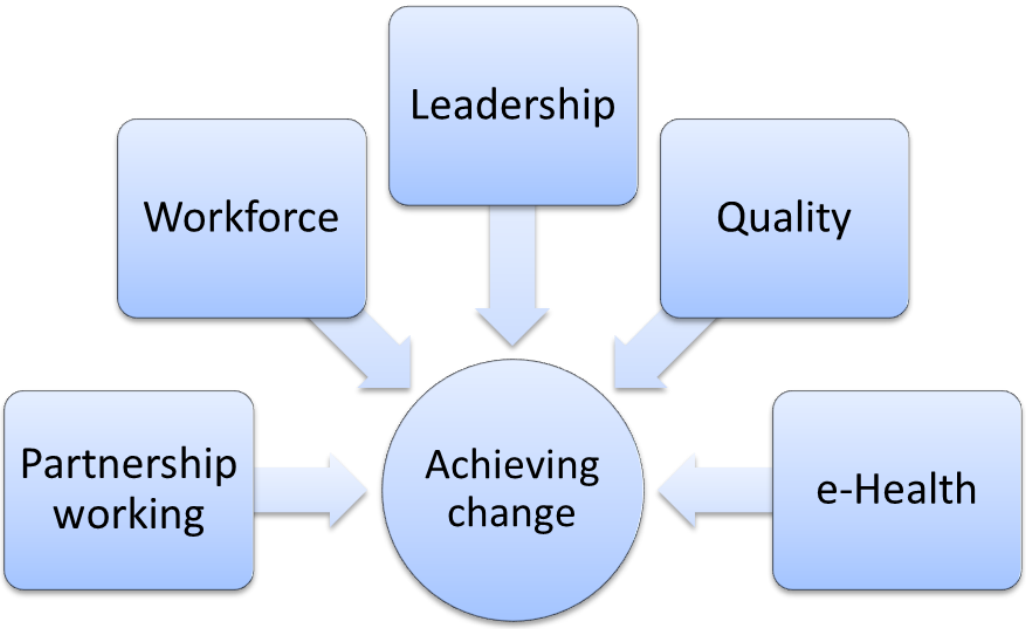


Figure 2: The means of change

Adapted from *Delivering Together* (Department of Health, 2016)

1.5.4.5 Partnership working

The report highlights the importance of co-production of health as an ethos for care whereby the users themselves are a resource that needs to be incorporated as a factor of health production.

Also, partnership working covers working with other service providers to safeguard aspects of quality of life and well-being. The report highlights the claim that HSC has worked along with the voluntary sector, the private sector and community groups successfully over many years. The intention is that such arrangements will be intensified in order to build capacity in this wider resource and in so doing multiply the effects of the HSC spend.

1.5.4.6 Workforce

The report highlights the vacancy rate across disciplines that continue to grow, leading to higher costs thanks to needing to use expensive agency and locum staff, as well as

longer hospital stays than are necessary. The report announces a ‘Workforce Strategy’ to cover retention, opportunities for new job roles, reskilling and recruitment. The report also references the then-upcoming adult social care review (Kelly and Kennedy, 2017: *Power to People*), noting that it was likely to recommend training and workforce appreciation for domiciliary care staff.

1.5.4.7 Leadership

The ministerial plan also highlights a change in the culture of leadership whereby all those working in HSC may be able to initiate changes and means of services improving. Since the model of care envisaged is one powered by multidisciplinary teams, the report empowers teams to deliver care rather than managers micromanaging them.

1.5.4.8 Quality

The plan seeks to assimilate improvements to quality across the HSC, including fostering innovation at a local scale and then to scale up what works. An ‘Improvement Institute’ is announced.

1.5.4.9 e-Health

The plan states that technology is paramount when moving to a person-centred model. The plan announces that a patient portal will be built so that individuals may view their own records securely. This will be in place by 2021.

1.5.4.10 Delivering Together part 5: Action plan targets and delivery

The plan sets out an action plan with dates for implementation of initiatives, and the Department has published several recent updates related to such specified goals. In October 2017, the Department published its most recent update on targets and progress.

The progress states that a Transformation Advisory Board was established, with membership including Professor Bengoa and the Health Minister, as well as a Transformation Implementation Group, with membership including the Permanent Secretary, Chief Medical Officer, Trust CEOs, etc. The update noted that while the Transformation Advisory Board had only been able to meet once 'due to the current political situation', the Transformation Implementation Group had met fortnightly since November 2013. However, while there were occasions during which the group had indeed met at fortnightly intervals, there were, it seems, only six meetings in total during both 2017 and 2012. Unhelpfully, the agenda item 'date for the next meeting' that was noted in the early minutes was excised in early 2017, raising some questions as to whether the meetings were becoming more ad-hoc in their scheduling. Nonetheless, progress was set out, and the next section provides detail on the progress that the Department states that it has made.

1.5.5 *Delivering Together* – 12-month progress report

The October 2017 progress report (Department of Health, 2017) marked the end of the first year of the ten-year plan, with specific objectives listed beneath two stated wider aims:

1. To change the models of care
2. To enable sustainable transformation.

1.5.5.1 To change the models of care

Under the aim of changing models of care, policies are directed towards four objectives, namely:

1. Building community capacity
2. Increasing primary care resources

3. Improving community hospitals' facilities
4. Changing organisational arrangements to afford change.

Each of these four objectives has several initiatives feeding into them. By way of example I examined the *building community capacity* objective to see what actual progress had been made. In the report there are updates on seven initiatives that feed into this objective. One initiative is to build a 'Community Development Framework' that would 'provide the community and voluntary sector with the tools, training, and standards it needs to help grow the sector'. It notes that 'the 'workstream will finalise the framework early in 2018' (Department of Health, 2017). However, notwithstanding the opacity of the language used, a search on the Department website on 1/1/19 failed to reveal any items under the search term of 'Community Development Framework'.

I examined the second of the seven initiatives being the *Healthy Child, Healthy Future* programme where parents are being supported to make healthy choices. However, 'due to workforce capacity issues the programme remains to be fully delivered' (ibid.) A search on the website reveals that the initiative was announced in 2006 and had a policy document published in 2010. Seemingly this is a historic initiative that was brought under the *building community capacity* objective, but this too is dormant, and the pattern of stasis is repeated across the remaining five initiatives within that objective.

1.5.5.2 To enable sustainable transformation.

Some evidence of progress is found under the second major aim of *enabling sustainable transformation.* For example, the co-production strategy was published in August 2018 (Department of Health, 2018b) and reflects best practice in patient-centred care. Also, under this heading, the aim of producing a 'Health and Social Care

workforce strategy' was duly achieved, as well as the 'Nursing and Midwifery Task Group' being formed. However, the 'Patient Portal', set for 'delivery in summer 2018', was not in evidence as of December 2018.

1.5.5.3 'Action Plan Deliverables'

The Appendix of the *Delivering Together* report lists 18 'Action Plan Deliverables' with progress towards said key deliverables noted. Unfortunately, there is no correlation between the 18 deliverables listed and the two overarching aims, their subordinate objectives and categories of initiatives within each objective, as I have detailed above.

For example, while the co-production report is dealt with in detail within the body of the update, it is not in fact listed as a key deliverable. Moreover, the deliverable of the 'Improvement Institute' is not referred to within the report at all; rather, an initiative named the Regional Improvement System is referenced. Regrettably, when I carried out a search for the noted 'Regional Improvement System' on the DoH website in December 2018, this revealed nothing. Nevertheless, but again confusingly, a search for the term 'Improvement Institute' reveals a ministerial initiative dated 2015 that evidently did not gain any traction.

It may be said therefore that progress as evidenced by the 'Action Plan Deliverables' is patchy, with longstanding initiatives somewhat rebranded in a number of cases. Progress is erratic, and there is an ambiguous relationship between the reported initiatives in the text and key deliverables in the Appendix.

If the goal is transformation, commonly defined as a marked change in form, nature or appearance, I can only surmise that the Department is being none too literal in its

interpretation. Also, it may be significant that October 2018, the second anniversary of the ten-year plan, passed without any two-year update.

1.5.6 Power to People report

As noted, the arrangements for adult social care were carved out of the *Delivering Together* agenda, pending the publication of the expert panel. This report has now been published (Kelly and Kennedy, 2017) and is intended to set the direction of travel for social care policy.

The panel came up with 18 recommendations, including the ones below:

- A consensus is needed that transformational change is required. Leadership needs to be explicit. The purpose, contribution and value of social care support needs to be raised.
- Self-directed support should be the norm to empower citizens. Markets for care support and provision need to be stimulated.
- Family carers need to be appreciated as the heartbeat of care when transforming into a people-based, as opposed to bureaucratically based, care model.
- Community navigators are needed (see AGE NI example from the NHSCT in Figure 3 below).
- Councils need to be involved. Their involvement is to include innovative funding models for alternative formats and settings of care.
- Professional carers need a wage structure that incentivises and promotes the profession and good practice.
- People who can afford to pay should do so.
- HSC Trusts have market-shaping duties, especially with a self-directed model.

- HSC and Department for Communities need to work more closely to create specialist housing.

Community Navigator

Working with the Northern Health and Social Care Trust to link older people to services and activities within their local community.

The Community Navigator service is a partnership project, delivered throughout NHSCT area by Age NI, Building Communities Resource Centre and Mid & East Antrim Area Partnerhsip, funded by NHSCT and Public Health Agency.

What is the Community Navigator service?

The Community Navigator service helps older people in the Northern Health and Social Care Trust (NHSCT) area to access local services and activities, to improve their health, wellbeing and independence and supports NHSCT staff by providing links to the community and voluntary sector.

The Community Navigator can:

1. Take referrals from individuals, healthcare professionals and the community and voluntary sector for people over the age of 50.

2. Support community groups to sustain their activities to build capacity through promotion, information sharing, and signposting towards funding and training opportunities.

3. Help raise awareness of older people's issues through attending and participating in relevant forums, meetings, events and consultations

Examples of services the Community Navigator can signpost you to include:

Home Safety Check; Benefit Entitlement check; Handyperson Scheme; Good Morning Call; Community Transport; Social Activity; Luncheon Club; Befriending Scheme; Home Fire Safety Check

The Community Navigator can support healthcare professionals in NHSCT area by:

1. Increasing staff knowledge about support available in each locality through information sharing events

2. Taking referrals and promoting services and opportunities for older people across the NHSCT area

3. Raising awareness of statutory, voluntary and community support

4. Mapping existing services and sharing information

5. Updating the NHSCT Service Directory which provides information on a range of support services.

‘When my husband passed away, I felt down and didn’t want to go anywhere for months. Since I was put in touch with the Wednesday Club through the community navigator, I’ve made new friends and feel like I have got a little bit of the ‘old me’ back.’

‘We received great help from the community navigator about training and funding opportunities. I’m delighted that the support and signposting was available for our group at a time when we really needed it’.

Figure 3: Example of Age NI providing community navigator services in the Northern Trust area

Overall, the proposals are radical and involve older people being empowered via self-directed payments and their housing-based care models giving independence. Innovative funding is recommended, with departments working more closely to achieve housing-based care models.

The present situation is that an action plan grounded on the *Power to People* recommendations is currently being developed and will form the basis of an extensive public consultation during 2019.

1.5.7 Comments on delivery

1.5.7.1 Delivering Together agenda and metrics are tactical rather than systemic

Thus far, I have summarised the five recent expert reports commissioned by the Department, namely:

1. Sir John Compton, 2011: *Transforming Your Care*
2. Professor John Appleby, 2011: *Rapid Review*
3. Sir Liam Donaldson, 2014*: Right Time, Right Place*

4. Professor Rafael Bengoa, 2016: *Systems, Not Structures*
5. Des Kelly and John Kennedy, 2017: *Power to People*

As well as the initial response by the Department:

6. Department of Health, 2016b. *Health and Wellbeing 2026: Delivering Together*

And the 12-month progress report:

7. Department of Health, 2017. *Health and Wellbeing 2026: Delivering Together – 12 Month Progress Report*

I also noted that there was no progress report published on the 24-month anniversary of the ten-year plan.

What is striking when the process is unpacked in this way is how strategic in nature the expert reports are, and it is against their strategic expert recommendations that I weigh the *Delivering Together* plan and 12-month progress update. By way of summary, some of the key recommendations of the five expert reports published by 2017 were:

1. To track outcomes rather than spending, including the use of health and well-being measures
2. To mitigate the very high A&E use and length of stay
3. To develop a coherent relationship with the private sector
4. To improve low productivity and incorporate incentives for innovation
5. To reduce the number of acute care hospitals
6. To clarify who is in control, e.g. removing RQIA and Patient and Client Council from being under the DoH umbrella, including having regulation spot checks from outside Northern Ireland

7. Add a patient-centred approach for a patient experience
8. To reduce the per capita cost of health care.

Comparing the *Delivering Together* agenda against Bengoa and the three previous reports affords some observations.

Firstly, *Delivering Together* does not seem to take on board all the Bengoa recommendations; indeed, *Delivering Together* concentrates on matters that are not actually in the Bengoa report at all. For example, *Delivering Together* gives primacy to the matter of dealing with waiting lists, perhaps for politically expedient reasons. However, that issue, rather than being given primacy by Bengoa's expert panel, was only mentioned in passing and was not prioritised. The four previous expert reports detail strategic changes to the HSC system, whereas tackling waiting lists target the symptoms and not the cause and implies doing more of the same.

Bengoa noted that by 2015 some 77.9% of admissions were non-elective; this compares to 72.6% in 2011 – a rise of over 5% (Bengoa et al., 2016). Such a rise in A&E demand has an impact on the ability of the hospital to meet the demand for elective appointments, meaning more operations having to be cancelled and waiting lists lengthening. Whereas the expert reports seek to uncover the causes of the problem and suggest ways of utilising finite resources more effectively, *Delivering Together* seems to give higher emphasis to the symptoms. Moreover, the fact that just one year earlier there was £40 million of emergency funding deployed to tackle the problem highlights the structural nature of the issue, as the BBC pithily reported in October 2016:

> *The £40m announced in November 2015 to fix waiting lists clearly did not work* (Connolly, 2016).

Primarily, the Bengoa report emphasised a direction of travel: towards a system with the patient at the centre of their care, leveraging, for example, the use of co-production for outcomes-based results. However, it is difficult to discern within the 'latest position for actions' (Department of Health, 2018) that the 'burning platform' noted by Bengoa is being fundamentally addressed. By way of an example of the somewhat narrow issues being addressed, Criteria 6 from the 'latest position for actions' (ibid.) states the metric to be achieved is to:

> *Move forward with the implementation of the new Diabetes Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups. Diabetes Strategic Framework: published November 2013. Northern Ireland Diabetes Network has since been established, and a number of key work streams are underway (including foot care pathway and structured diabetes education). Work plans for 2017/18 for these areas have been agreed and are currently being progressed* (Department of Health, 2018).

Doubtless this is welcome and needed, but it continues to smack of the problem that Liam Donaldson noted when stating that 'silos reign supreme' (Donaldson, 2014, p.11). My observation is that perhaps the existential threat that the HSC system is under is not likely solved through changes such as additional 'diabetes foot care pathways'.

Other criteria benchmarking progress towards the changes advocated by Bengoa are still more impenetrable. Criterion 6, for example, is to:

> *embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of service configuration reviews. These will be clinically led, working in partnership with those that use the services. Consultation on criteria for service reconfiguration completed February 2017, and report drafted for consideration by incoming Minister. Programme of service reconfiguration reviews underway.*

To conclude, it is difficult to say that *Delivering Together* is transforming how care is delivered. The top priority has morphed into reducing waiting lists, implying doing more of the same, rather than implementing transformational change. Nor is there evidence of care being facilitated more in-home environments in the community, and with a 'patient-led' philosophy.

1.5.8 What can be done: a refocus on strategic issues

As often stated, one major factor behind the HSC system is seemingly in a state of continued financial crisis, is demographic. In this section, I seek to highlight some ramifications of such change.

Bengoa notes that:

> *users over 65 account for more than two-fifths of HSC spending – 42%, compared to their population share of 14%. Whereas the average cost of treating a 55–59-year-old stands at £1,970 per head, this rises to over £6,000 for 75–79-year-olds and £14,000 for the over 85s* (Bengoa et al., 2016).

I have adapted these figures into a graph to better illustrate the relative costs of older people on average.

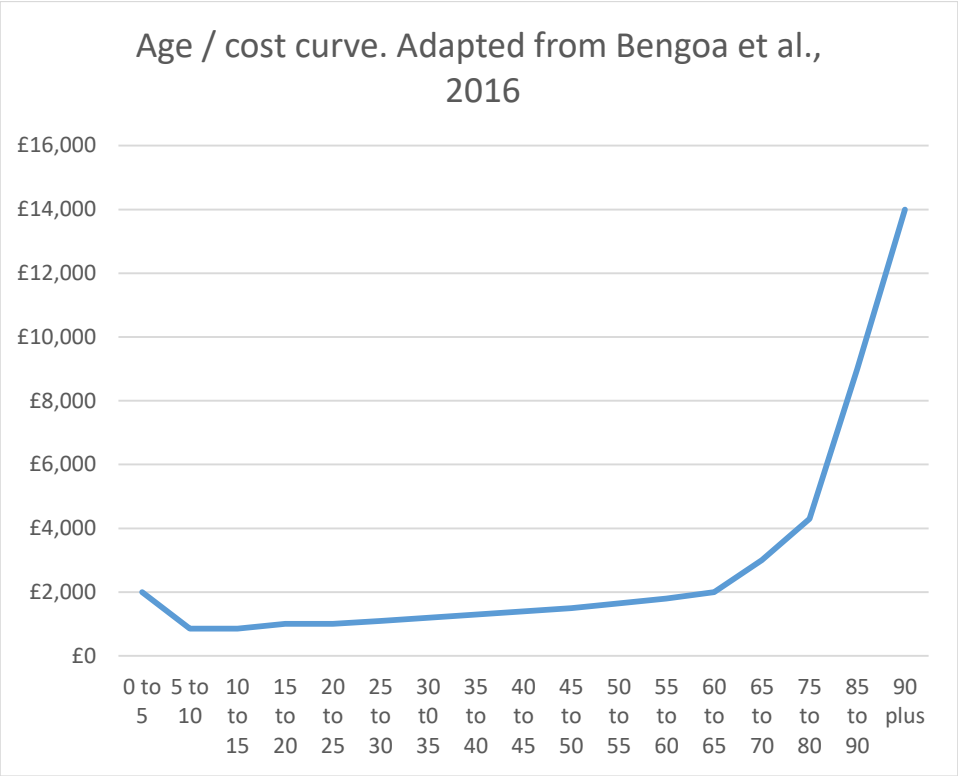


Figure 4: Age/cost curve

(Adapted from Bengoa et al., 2016)

The facts are that older people, on average, cost an extraordinary amount and whereas it may be that Western countries can hope for a 'compression of morbidity', with poor health compressed into a few months at the end of life, evidence on this being the case is mixed (Mathers and Robine, 1999). In the absence of such evidence, the increase in the oldest old simply implies additional high costs.

There is already a £2 billion shortfall in funding (Appleby, 2011, p.4). When one adds the demographic changes underway, the implications are alarming. For example, Bengoa notes that in 2013 the number of people over 85 in Northern Ireland was 33,000, and this is due to rise to 79,000 by 2033, just 14 years from now. Since Bengoa et al. tell us that such older people cost, on average, £14,000; the additional 46,000 older people (79,000 less 33,000) are set to cost an additional £644 million per year.

It is interesting to note that concerns as to the implications of demographics are not new – the *People First* (DHSSPS, 1990) report noted that there were 192,300 persons over the age of 65 in 1990 and set out concerns over the implications of that number being due to rise. Bengoa noted that there were 279,000 such persons in 2013. Both the 1990 and 2016 reports recommended a strategy for community care to mitigate the cost pressures.

Bengoa notes that

> *the pressure this is placing on the HSC resources cannot be resolved by continuing to rely on the current acute care model. The vast majority of care is delivered in the person's home… Acute hospitals are designed to deal with acute illness, not chronic conditions, yet the beds are filled with those whose needs may well be met more effectively and efficiently elsewhere* (Bengoa et al., 2016, p.14).

1.5.9 The key relationship between adult social care and acute care

Bengoa et al. (2016a) explain the relationship between the social care side of the HSC and the health care side. Ultimately, they find that the entire HSC system is at risk due to the acute care sector becoming overwhelmed thanks to the social care demands not being met in the community. These conclusions closely reflect the findings of Appleby in 2005, Compton in 2011, Appleby in 2011, and Donaldson in 2014.

Supporting people to remain in their own home depends on the level and quality of care provided in the community and reduces the need for acute interventions. The more recent reports of Compton and Bengoa stress these points that were also made back in the *People First* report in 1990 (DHSSPS, 1990, p.37). Reducing acute care

interventions is especially important for older people given the high portion of acute care usage by that group, especially for those over 85 years old. As noted, this group costs an average of £14,000 per year at present and the size of the group is presently doubling in a 15-year time period; hence, a means of maintaining the health and well-being of this group away from acute care arenas is vital as well as fundamental in providing a route back from hospital.

Very often, older patients are admitted unnecessarily because they have no other means of their social care needs to be met. Once admitted, very many have no choice but to stay longer than they need to thanks to a lack of care packages or appropriate settings for care. This causes pressure on bed numbers, busy A&E departments, reduced elective care capacity, poor patient experiences and staff cost and pressures.

Presently, as Bengoa et al. (2016, p14) note, the entire HSC system is at risk, and, as such, the case for finding better means for older people's social care is now compelling.

Accordingly, rising social care pressures may be viewed as one major reason behind the entire HSC system difficulties. Establishing this factor clearly points us towards how those same pressures may be eased through community-based care, as has been recognised since 1990 through the medium of housing, care co-production via individual empowerment, community support and aid with social care navigation.

1.5.9.1 Combining housing-with-care and community navigation

Care models based on housing may go a long way in preventing non-elective acute care needs. One means of multiplying the benefits of health and well-being in home-based settings is through the social prescribing role of a community navigator. These can multiply health and well-being co-production by:

1. Older people themselves being more involved in preventative care
2. Coordinating social well-being opportunities
3. Better leveraging and making an older person's own support network more effective
4. Aiding 'help' and 'care' needs to be coordinated in the community rather than in acute care settings.

The next section highlights the Northern Ireland policies in the area of housing-based care, and how it has failed to gain traction.

1.5.10 Uncertain policies for housing with care for older people

The HSC Trusts have been long aware of the demographic pressures squeezing their resources. For example, between 2010 and 2015, the number of persons over the age of 85 was expected to double (Compton, 2011), meaning that there will be many more older people living with chronic conditions needing care, which has ramifications as to how their quality of life is best maintained and in what setting.

The *Transforming Your Care* (Compton, 2011) trajectory was to generate the broader conditions to allow older people to continue their daily lives with independence in their own home or in assisted settings in order that they may co-produce their own well-being better. This route was highlighted in the TYC delivery plan as cost effective for the HSC system and more rewarding for the individual (DHSSPS, 2013). Such a route was seen as thus preferable to care, administered within an acute setting, however such environments do not (to any degree) exist in Northern Ireland. In the implementation plan, the HSC Board confirmed its commitment to expanding choices for increased independent living for older people, including a commitment to divert

funding from savings made from the closure of statutory care homes into fostering expanded choices of care locations including supported living:

> *There is broad support for … promoting independent living at home, and care closer to home... This includes addressing people's social needs to avoid isolation within their communities… We reiterate the commitment to providing greater choice for older people… We also believe that statutory residential care is not always able to provide the best facilities for older people, and better alternatives currently exist and will continue to be developed, such as supported living accommodation. Through this consultation we have not received any compelling evidence that investment in these alternatives, which can be enabled through the closure of some statutory residential homes for older people, is not the most appropriate way forward* (DHSSPS, 2013, pp.65–66).

Accordingly, TYC promised stimulation to additional housing-orientated care settings.

This enthusiasm continued in the months following the publication of the TYC report where there was an emphasis placed on promoting alternative community care models. For example, in 2012, the DHSSPS and DSD jointly published a document entitled *Who Cares? The Future of Adult Care and Support in Northern Ireland* (DHSSPS, 2012). This document acknowledged the role that housing-with-care models would play in the future:

> *We also believe that we need a range of alternative options for people who can no longer be supported in their own homes, such as supported housing, which provides people with that little bit of extra help and security,*

while at the same time enabling people to remain in as domestic an environment as possible (DHSSPS, 2012).

The issue of housing-with-care was also examined in detail by the Northern Ireland Assembly Committee for Health. In its final report on the matter (Northern Ireland Assembly, 2014), the Committee recommended that the HSC Board should:

- Require that each Trust would produce a plan to raise awareness of options for older people's supported living
- Assist other government departments in promoting supported living
- Ensure housing associations and Trusts are stimulated and coordinated when providing supported living.

The Committee recorded that the Department had accepted the Committee's recommendations. It furthermore stated that steps would be made in relation to their implementation in ways that paralleled the implementation report (DHSSPS, 2013). However, as I have noted, the most up to date policy direction, *Delivering Together*, is silent on the matter and the Department has evidently failed to deliver on such commitments.

1.6 Policy Context Conclusions

1.6.1 Where we are

This section of my thesis has been underscored by the implications of the demographic changes being experienced in Northern Ireland. I highlight that an awareness of such pressures is not new, and dates from the *People First* report of 1990 at least. I have detailed some of the key reports that point out that the present HSC arrangements are unsustainable and that wholesale change in the HSC system is needed. A major theme

of such change is that care is best affected away from reactive acute care settings and within this theme, the role of housing-with-care has been emphasised as a valid means of effecting such change.

There is a clear need for a model of care that affords independence, is person-centred and offers some ‘help’ to remain at home rather than have care needs met in hospitals. I have highlighted that such a means of transforming care to being proactive, community-based and associated with the well-being that housing affords is not new. Stretching back to at least 1990, it has been clear that specialist housing models affording care are a valid means of giving older people choice, and of using HSC resources more effectively. It has been long stressed that housing providers and the HSC need to work together with private agency and the voluntary sector to provide the same.

The TYC agenda placed a strong emphasis on community care and care for older people at home and additional forms of care instead of institutional care models. The TYC implementation plan (DHSSPS, 2013) indicated that the Department would stimulate additional modes of care as a ‘quid-pro-quo’ for closing statutory care homes. However, no such initiatives have emerged.

The most recent major reports stress that the HSC system must transform from a reactive model into a proactive model with care provided in the community (Bengoa, 2016); also, that housing and self-directed payments are the means to deliver independence, person-centred care, co-production of health by the individual and support network and higher well-being (Kelly and Kennedy, 2017).

However, I have exposed a pattern of failure over 30 years to implement such proposals. Most recently the Department implementation plans described have no mention of housing. Efforts to shift care to the community seem sporadic at best. Change is in no way 'transformational'. Indeed, change seems to have all but entirely stalled with the one-year update of the ten-year programme being opaque, and the two-year update well overdue. It is difficult to escape the conclusion that this most recent iteration of a change effort is petering out in the same way that *Transforming Your Care* petered out.

I noted how the Northern Ireland Health Committee had previously held the Department somewhat to account, and it may well be that the present (January 2019) lack of political institutions in Northern Ireland is contributing to the lack of change vigour. Whatever the cause, lack of political impetus or the culture of the Department of Health, there is a continued failure to implement the changes repeatedly and clearly articulated. The system remains stuck in a bad equilibrium.

1.6.2 Where we might go to

It may be the case that there have been no valid means available to 'shift care left' into the community and for that reason all efforts have seemed to stall. Presently, community care is envisioned through Integrated Care Partnerships (ICPs), such as the shiny new multi-million-pound facilities proposed in Lisburn. The trouble may well be that this 'top-down' model of moving care to the community is, in many senses, not change, but just doing more of the same facilities-based care. Building a shiny new facility in Lisburn adds a new facility, but it has often been argued (e.g. Donaldson, 2014) that there are already quite enough facilities. That it takes over six years to get just one such a facility commenced clearly does not help.

Perhaps what is needed is fewer ‘structures’ and more ‘systems’, as Bengoa would have it. Accordingly, I posit that a more pervasive means of ‘shifting care left’ into the community is needed, and if the HSC system has failed to find a means of stimulating such a change, perhaps it has been looking in the wrong place: looking at top-down buildings, rather than into people’s homes.

Housing-with-care, now more commonly called extra care, offers the opportunity to stimulate a more pervasive ‘bottom-up’ model of preventative care; however, despite urgent findings in the reports detailed, the Department has been unable to stimulate the supply of extra care facilities. Since they do not exist, the Department has been unable to use them as a coordination point for social interaction, community navigation and well-being co-production. It is quite possible to ask are the particular configuration of resources and capabilities that are needed to drive forward the supply of broad-appeal mixed-tenure extra care to be found within Northern Ireland departments? And if not, how could an exogenous factor be significant enough to shock the system presently failing older people. The primary research of this thesis is an enquiry into precisely these questions.

2.0 Findings and Analysis

2.1 Introduction

This chapter analyses the interview data via the participant perspectives and how they make sense of the issue of the well-being of older people. The data is analyses in three related ways:

- Individual cognitive maps that examine how each mapped field strategist makes sense of a certain theme.
- The 'Data Structure' (Gioia et al., 2013) that matches direct quotations against the top 30 themes to both ensure the following strategy causal maps encompass the most relevant material and to ensure that the power of the direct quotations is not lost in the process of aggregation.
- The Causal Maps – where the above two processes are synthesised into two causal maps. One displays the drivers of 'what is going on' and how the strategists make sense of their world, and the second is a causal map that draws together the strategy proposals made by the field strategists.

Key to this analysis is the process of cognitive mapping as elsewhere described, and I reproduce the cognitive maps for each participant as created by the Decision Explorer software. The software affords a view across the major themes that each participant considers important. It calls such themes 'clusters' as it recognises the importance of some issues via the density of links between specific issues. These are likely to be an essential theme for the participant and worth setting out (Eden and Ackermann, 2010, 2012) and I have thus reproduced these clusters to focus on the important themes

according to each participant, and they show the relationships between the issues within such themes.

Following a participant introduction, this ‘sensemaking’ area for each mapped participant examines the subject via their perspective, their context and I draw out how they make sense of the quality of life for older people, how the care for older people is achieved, their role and how they strategise to improve the quality of life for older people.

In tandem at section 2.3 of this enclosures document, I draw out, through the participant’s contribution to the wider goal of older people’s well-being. I do this through an added technique of ethnographic data structuring and interpretation by cross-referencing the 50 themes that emerged against the 50 most relevant direct quotations. I order the issues into the 30 most relevant through a scoring system. Since this analysis runs to 185 pages, I present the most critical issue in full, namely issue number two ‘how to procure liberty, choice and personal options.’ I also include and samples from the next two most important themes in Appendix three.

Each of these most important issues is displayed with the relevant direct quotations and gives a graphic insight as to why the issue is considered necessary. Thereafter, against each quotation, I apply the ‘so what?’ question, and this transparent interpretation allows the reader to follow how the raw qualitative data has been synthesised within the synthesised causal maps that follow. Such a process not only highlights how the strategic contribution has been interpreted, but it also displays the issues that surround each strategic output and their context. This is important since my interpretations are being drawn from the individual’s tacit and acknowledged

awareness and experience. It follows that the data structure thus demonstrates how I – often along with the participant – have interpreted how these themes interrelate and the possible strategic contribution that can be inferred This gives more validity and a holistic depth to the empirical strategic proposals and academic contribution.

2.2 Individual Sensemaking and Cognitive Mapping – The Participant Perspectives

2.2.1 Participant 1 (P1)

Interview date: 22.1.2018

Profile: P1 is a professor of geriatrics who has been extensively published within the *International Journal of Geriatric Psychiatry*, *Neurobiology of Aging* and the *International Journal of Pharmacy Practice*. The participant is widely thought of as the leading authority on dementia in Northern Ireland. Part of such a role is hosting a memory clinic, and in addition to the interview and subsequent follow up, I was privileged to sit in on one such clinic some months beforehand.

2.2.1.1 Participant (P1) sensemaking

The participant (P1) had read the archetype story and stated that it was a story that was played out multiple times per week in Northern Ireland.

They outlined the areas in which they worked, making the point that their work had three main strands: outpatient, inpatient and research. The outpatient work is ‘very much dementia orientated’, and they stressed the holistic nature of such older person’s social care, such as the importance of

'how you have to build the social support and the infrastructure, the role of carers, the way the situation deteriorates inevitably, how you have got to move with the sort of issue that is relevant at the time.'

They also stressed right at the outset that 'the ultimate, here, is how you stay out of care'. So, here, we have right from the start the tension exposed between the amount of effort that is needed for an older person whose needs are not medical, but social, and different to the next person's, and that those needs are changing. As such, the geriatrician's role is highly reflexive. As a generalist, they must determine which of multiple morbidities is the most urgent, and that should be concentrated upon – while balancing the over-arching need to keep people at home for their well-being.

P1 discussed their role within acute care, making mention that the average age on the ward was 86, that 50% were diagnosed with dementia, and that the ward had 78 beds. They stressed the multi-disciplinary skill involved with seeking to safely discharge patients since they stated that the hospital was not a place where older people achieved much life fulfilment. They noted one problem: that the caring package that usually is in place with the patient lapses after two weeks in acute care and needs to be redone (do novo) after a length of stay. They noted the difficulty with coordinating between the services in acute care and the social care 'package' at home.

Comment: There seems to be a need for more localised centres for older people's social care, avoiding hospitals wherever possible, and easing the path back to the community where a hospital visit is required.

P1 noted on the wards that people are older and sicker when they come in compared with ten years ago. 'The extremes of age' are such that issues with an 85-year-old are

such that used to be seen with those in their 70s some years ago: ‘it’s a fitter population ... there’s just so many older people at the younger end of the spectrum.’ All the same people are also living longer with lots and lots of chronic issues that can impact their health and quality of life. For example, P1 said that with advances in health and health care

‘we are seeing people who have much more morbidity, you name it, some of them have had it. They’ve survived all that stuff: stroke, heart attack, operations, you know all that stuff. So they’re a lot frailer, and they are much older…’

So P1 noted that he is witnessing at once a fitter population, but also a great many older people living for a long time with chronic conditions specific to them.

Thanks to the numbers coming into the wards P1 noted the pressures to ‘move people on.’ And yet P1 stressed the limited places available in dementia homes: meaning that very often there was no-where for people to move to. Occupancy of the ward is ‘probably 100 plus per cent’. One route is ‘step-down’ care that allows older people to convalesce awaiting their package to be put in place for returning home or an opening in a care home. P1 regretted that such facilities had been greatly withdrawn, despite being a cost-effective means of delivering care. Together, we speculated that there was so much pressure on acute spaces that the step-down care was susceptible to being less important and given over to acute space. Notwithstanding that, P1 pointed out that a lower number of people die in acute care than might be thought:

‘it probably wouldn’t be as much as you’d expect, you know, what I mean, given the sort of clientele that come in the doors, it’s amazing. Sometimes, though, you say to

yourself, like, "God, are they going home?" Since some, they look nigh on to death. As they say, hospital is the last resort of the dammed.'

The participant spoke at length about acute care at home as a means of balancing people getting better quicker at home, getting the acute care that they need, and lessening the pressure on the ward beds: 'so that keeps the burden off us … there are lots of studies that show that people do get better at home because they are less confused and have less delirium … this is the direction of travel.' P1 compared this approach with the medical care within care homes, which they considered to be less than ideal and could be easily improved by prophylactic visits. They considered that with the advent of acute care at home, your health care is likely to be better under a wide scope of society and conditions at home compared to in a care home. A geriatrician can be:

'pretty impactful for patients like this … I mean, the nursing home might be just once a week because these people by and large are very stable... you get to know them… and you can take out a lot of (superfluous) medication.'

P1 said, 'if you really nip it I the bud in the nursing home you reduce unnecessary admissions to the hospitals… and the housing environment is critical also'.

Comment: The implications are that a prophylactic approach of 'constant tinkering' has the scope to keep people out of hospital in whatever environment and that the home environment is critical. It follows, therefore, that the two should go together; that is to say, there should be home-type environments with a community navigator prophylactic approach of a 'Community Navigator' who would be more effective if having had training in nurse prescribing.

When considering the complexities of Conor's case, P1 was quick to note the issues that Conor's social worker would need to get to grips with:

'They will be armed with the medical knowledge and everything else so what health conditions do they have … are those fully, really dealt with here we are talking about… So is his diabetes well controlled? What is the state of his Alzheimer's disease? And the safety issue, what's happening here – have they [been] flooding the place or leaving the cooker on or falling or what is it here? So, essentially, the whole lot here that is going to impact from his perspective at his capacity of course as well. What can he decide he wants for himself?'

Comment: The role of the social worker needs considerable expertise and is both complex and time consuming, and the implications are that such time and skills are rationed to the extent that Conor may likely not receive a full wrap-around care package in his home. Usually at home, Joan is just left to cope.

2.2.1.2 P1 cognitive map analysis

Figure 5 below is concerned with care infrastructure. It highlights the multi-disciplinary approach to well-being that P1 continually stressed where the support infrastructure is critical for an older person's quality of life. This is drawn from many aspects as may be seen and is reflexive, insofar as it is 'Conor' who is taking the lead. In the map, priorities are that achieving such well-being usually is best via the home, where home is the first port of call around which to build the support infrastructure. The strategic output from this map is thus to maintain a good life at home.

Thereafter Figure 6 is concerned with the factors underpinning care locations and develops the previous ideas introduced.

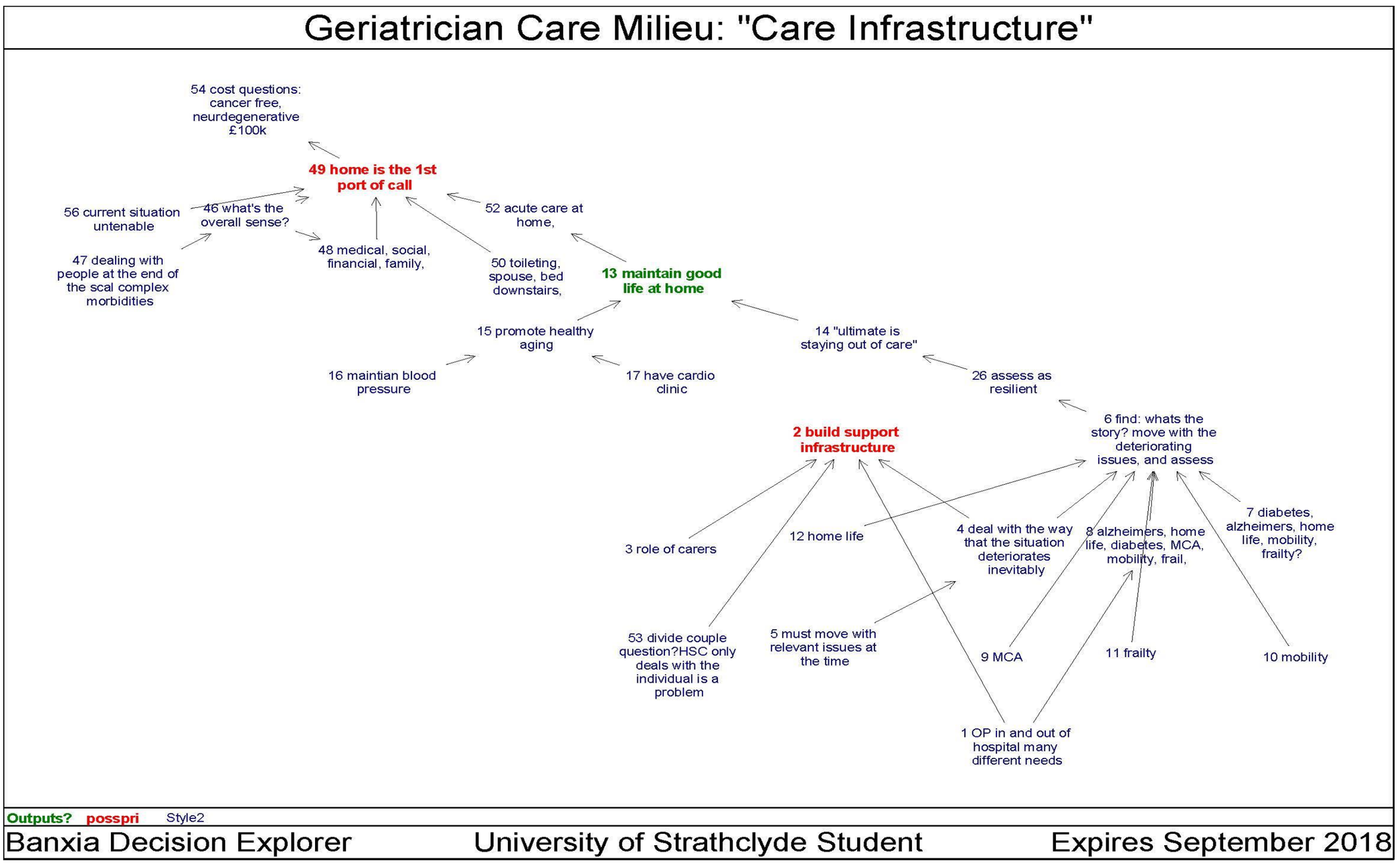


Figure 5: P1 cognitive map of care infrastructure

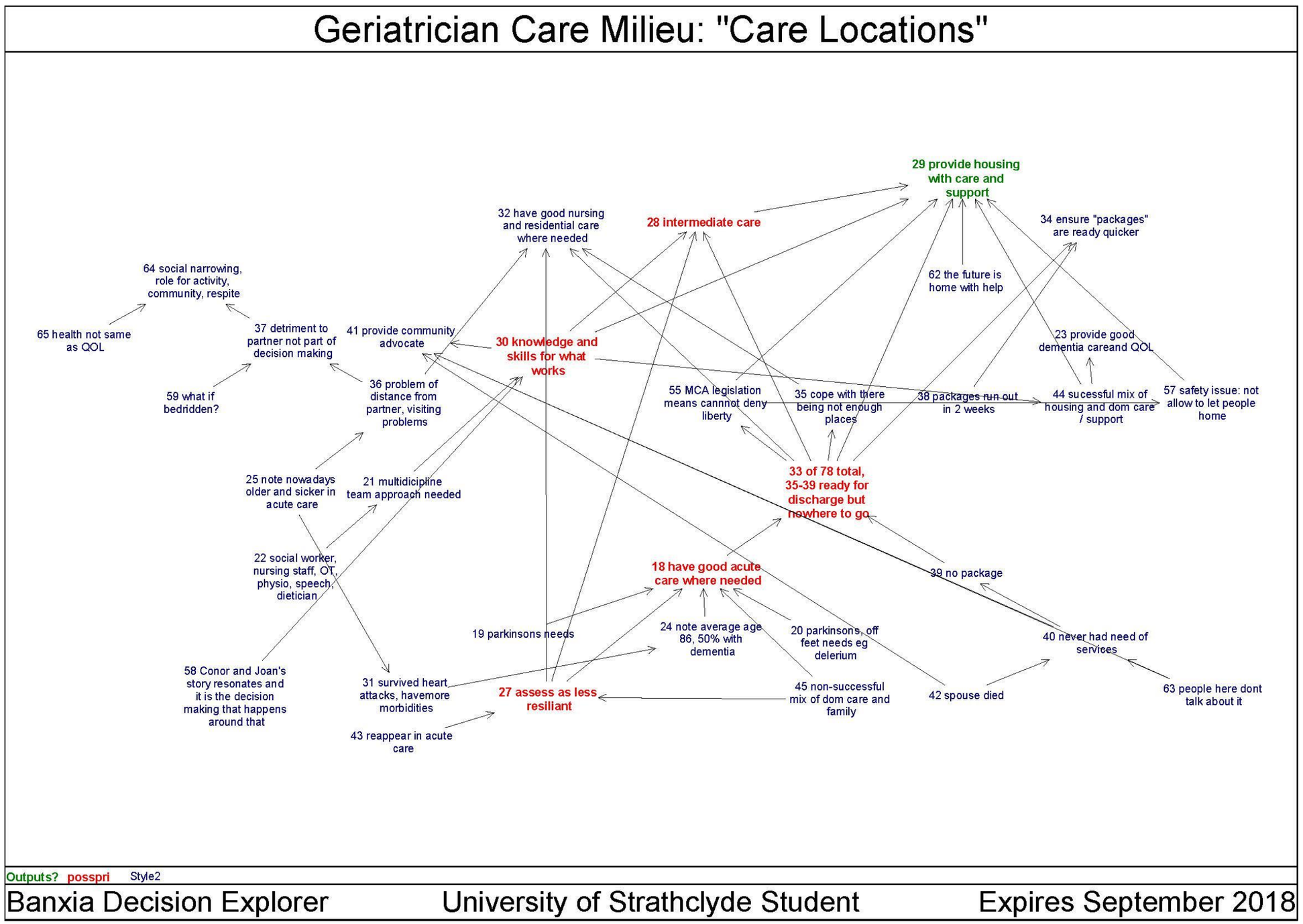


Figure 6: P1 cognitive map of care locations

The map picks up on considerable further detail such as the mental capacity legislation, where Conor has the right to make his own decisions and must be assumed to have capacity to do so unless it is proved otherwise. To undertake this role, the map picks up the possible role for a community advocate

This leads to five possible priorities:

- **Assess as less resilient**
- **Have good acute care where needed**
- **35–39 out of 78 (in hospital) have nowhere to go**
- **Knowledge and skills for what works**
- **(Role for) intermediate care**

The map highlights that the future for care is home-based, with help from a mix of domiciliary care / support specific for the older person and their circumstances and controlled by them / their family or the community navigator. The map has as a strategic output, to **provide housing with care and support**. Along with the 'possible priorities', these strategic outputs are collated and synthesised in the causal mapping of section 9.

2.2.2 Participant 2 (P2)

Interview dates: 07.02.2018 and 10.09.18

Profile: P2 speaks as the CEO of the Office of the Commissioner for Older People for Northern Ireland.

2.2.2.1 Participant (P2) sensemaking

P2 outlined the role of the Commissioner's Office as being based on the principle that older people 'must participate and be active citizens and be afforded the use of services'. The office carries out considerable research and statutory advice for government and almost 40% of the office is dedicated to addressing social care problems, including as a last resort, in individual cases where people have exhausted all other avenues, 'in kind of an ombudsman role'.

Within this ombudsman role, a live topic at the time of the first of two interviews was that the Commissioner was about to publish a report into the review of an infamous care home on the outskirts of south-west Belfast where, following extensive whistle-blowing, the home was required to close due to alleged human rights abuses towards the older residents. The report was subsequently published in June 2018 and at our second interview in September 2018 P2 was able to discuss it at length. During the first transcribed interview, they were vaguer and described the report as a 'very damning report on a particular nursing home'. The report highlighted the lack of accountability within a disparate care system that is spread between the Department of Health, the Trusts, a private provider and the RQIA oversight body. P2 drew attention to the apparent ambiguity as to who was responsible for what; P2 was clear that 'the duty of care cannot be devolved'. P2 stressed some of the findings in the report that were difficult to believe could have really happened. They described one instance of a ten-stone weight loss in 'a time period considerably less than a year,' and another of 'ungradable' bedsores that were through from the skin on the thigh through to the visible femur. In this harrowing light, P2 made the point that the Department, Trusts and oversight body 'would have needed to have been particularly incurious' not to have

been aware of such examples of abuse since they had inspected that home 23 times in a 39-month period.

This example brings attention to what P2 describes as 'the culture of care' in Northern Ireland, which is a significant issue:

'Because so often we are coming across experiences of care… in fact, you wouldn't really call it care… you know, it would be more appropriately be defined as the warehousing of older people. Or throwing some interventions at somebody. It really didn't feel like care.'

P2 concluded that in Northern Ireland there should be a rating for care homes as in England. Families need to know whether their loved one may be subject to the harrowing abuse meted out in the example care home.

Comment: There is a lack of joined-up thinking between different elements of the health and social care system. One way to aid coordination may be through a higher number of eyes and ears on the ground, such as more localised social care facilities, day centres and community navigators. If institutional care becomes inevitable, carers, often under stress and having to make this decision at a time of a significant life event, such as a fall requiring hospitalisation, need to be better informed by a care home rating system or other means.

Another issue that was important to P2 was how much the Department was ambiguous on costs and refused to have a candid approach when clarifying the scope of the growing older population, their social care needs and the costs of delivering on that. Instead,

'they will give you all sorts of figures on expenditure on care, but that is not the same as the cost… We wanted a clear economic analysis so that if, ultimately, it comes to a point of asking older people to contribute to the cost of their care, then it's an honest conversation with older people based on facts. There is no certainty for older people about what they may have to pay, and that's not acceptable.'

P2 detailed the system of self-directed payments. One issue that they pointed out that they consider is not heard enough is that the Trusts can assess for 30 hours of care per week (for example) but only provide funding for 15 hours. P2 gave an example of their own parent with assessed needs of £500 per week, of which the Trusts contributed £250. Again, P2 stressed a frustration with ambiguity in relation to costs, and a system that claims to be cost-free for assessed need, but it either needs to be topped up or is at risk of the care standards falling very short of what may be considered acceptable.

Comment: There is a need for honesty about money since there is evidently not enough to go around for older people's assessed needs.

P2 was most concerned with the related issue of domiciliary care, where a significant number of domiciliary visits are assessed and procured of only 15 minutes in duration, yet that the Trusts in Northern Ireland do not pay for travel time between calls, delivered by carers from outside the community, such calls are not even 15 minutes long and are more impersonal than they could be:

'You cannot provide personal care in the amount of time – often 15 minutes – that is often being awarded to older people. Older people don't want to be put to bed at 5.15pm having had their afternoon meal at 3.15pm. We keep reminding people that

they're not making widgets; we are dealing with the lived experience of an older person in the last few years of their life.'

The evident squeeze on resources has negative implications in domiciliary care as well as within care homes. P2 noted that:

'when we talk to social care workers, they tell us about going into homes where there is no bedding on the beds or having to wash somebody with their bedding because there [are] no towels. Or going into an empty house with no light, no heat, and a person who is lying in bed every day; very often with incontinence. That is some of the lived experience.'

In relation to costs, P2 was also concerned about how the experience of Conor and Joan would play out 'with all kinds of perverse choices' thanks to the way the system is structured.

'At the moment in Northern Ireland, a nursing home costs between £750 and £850 per week. Very few people have that unless they are selling their homes. But it is rarely a pair of spouses going into a care home. Where does the other one live? You can't downsize and have equity. At the moment, domiciliary care is free in Northern Ireland and so you find that families are reluctant to allow their relative to go into a nursing home for fear that their inheritance is being dwindled.'

P2 went on to highlight that not only are many sons and daughters living in England and elsewhere, the demands, especially on daughters, were extreme. Given that females have full-time careers and as a result of related recent social changes are often having children later, the needs of their children and teenagers coincide with

career demands and the personal and social care needs of their own and often their spouse's parents:

'the burden falls to a small number of very stretched, very stressed people, all of whom are susceptible to keeling over… there is no safety net… If you are the lynchpin… if you fall over the whole thing falls over. There is no governing structure that can cope with that sophistication of understanding lives.'

Comment: Good well-being outcomes are very often not generated by the present system of domiciliary care characterised by 15-minute calls. Instead what is needed is someone close to the older person, supporting them to keep their independence, dignity and self-mastery. Such a person may also assist an overstretched spouse or family member when navigating the 'alphabet soup' of services that are (or capriciously not) on offer.

One interesting concrete policy proposal that the Office of the Commissioner is soon to propose is that every older person enjoys the benefit of a visit from a social worker or expert to explain the machinations of the social care system. This proposal follows P2's long experience of older people such as Conor and Joan experiencing a life event, possibly in their mid-80s, never having had to deal with government agencies. The system is complicated, disparate and daunting. The proposal is to have each person offered a 'visit' upon their reaching a trigger age, possibly 75. Naturally, the person may refuse such a visit if they so wish. This example of the need for a 'community navigator' role is very much a concrete strategic output.

Comment: The proposal that every 75-year-old has the default option of a visit to aid their understanding of the system of social care can only be welcomed.

2.2.2.2 P2 cognitive map analysis

Figures 7–9 constitute an insight into the issues that P2 considers necessary, their connectivity and how P2 considers an improved strategy for older people may evolve.

In Figure 7, P2 emphasised the role of the government and how personal freedoms and agency interrelate with societal structures, echoing Giddens' (1984) structuration theory. One direct quotation, for example, is that 'there is no governance structure that can cope with the sophistication of understanding lives'. The cognitive map therefore builds on societal demographic changes and the widespread lack of a 'human touch' when older people interact with government and poor outcomes. As may be seen, the map displays two possible priorities from the issues shown. A summary priority of **Problems with department(s)** and a direction of travel priority being to **Change the culture of care.**

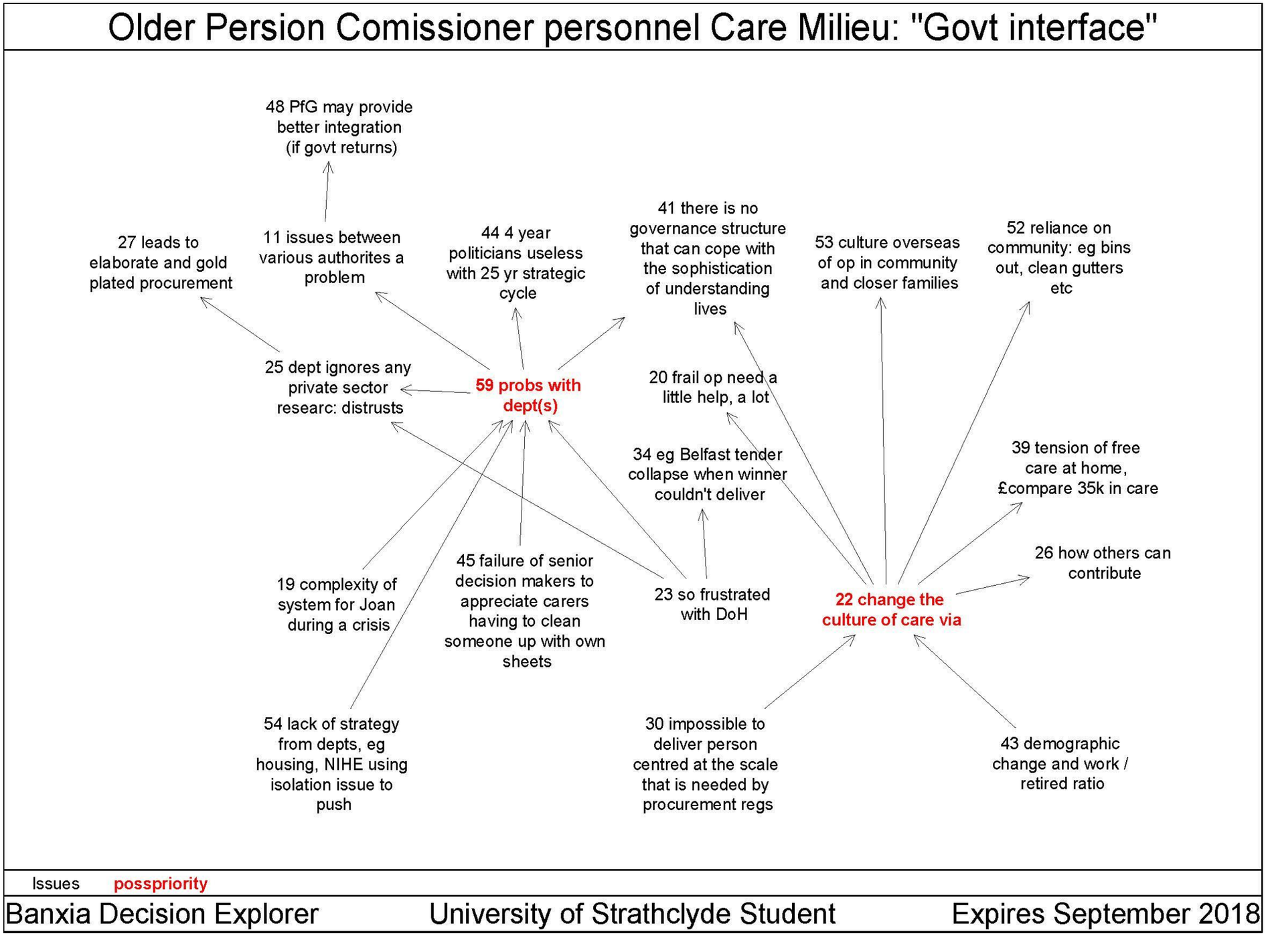


Figure 7: P2 cognitive map of government interface

In Figure 8 below, a more comprehensive cluster of issues is shown, centring on the issue of problems with care and the interrelated issues:

Problems with the Departments: this point encompasses procurement and the **problems with care** and this **leads to big companies warehousing older people** a lack of joined-up thinking between government agencies. According to P2 this has resulted in a **race to the bottom**; good care cannot be procured in such a manner. The outputs that flow from such issues and possible priorities are detailed in Figure 8.

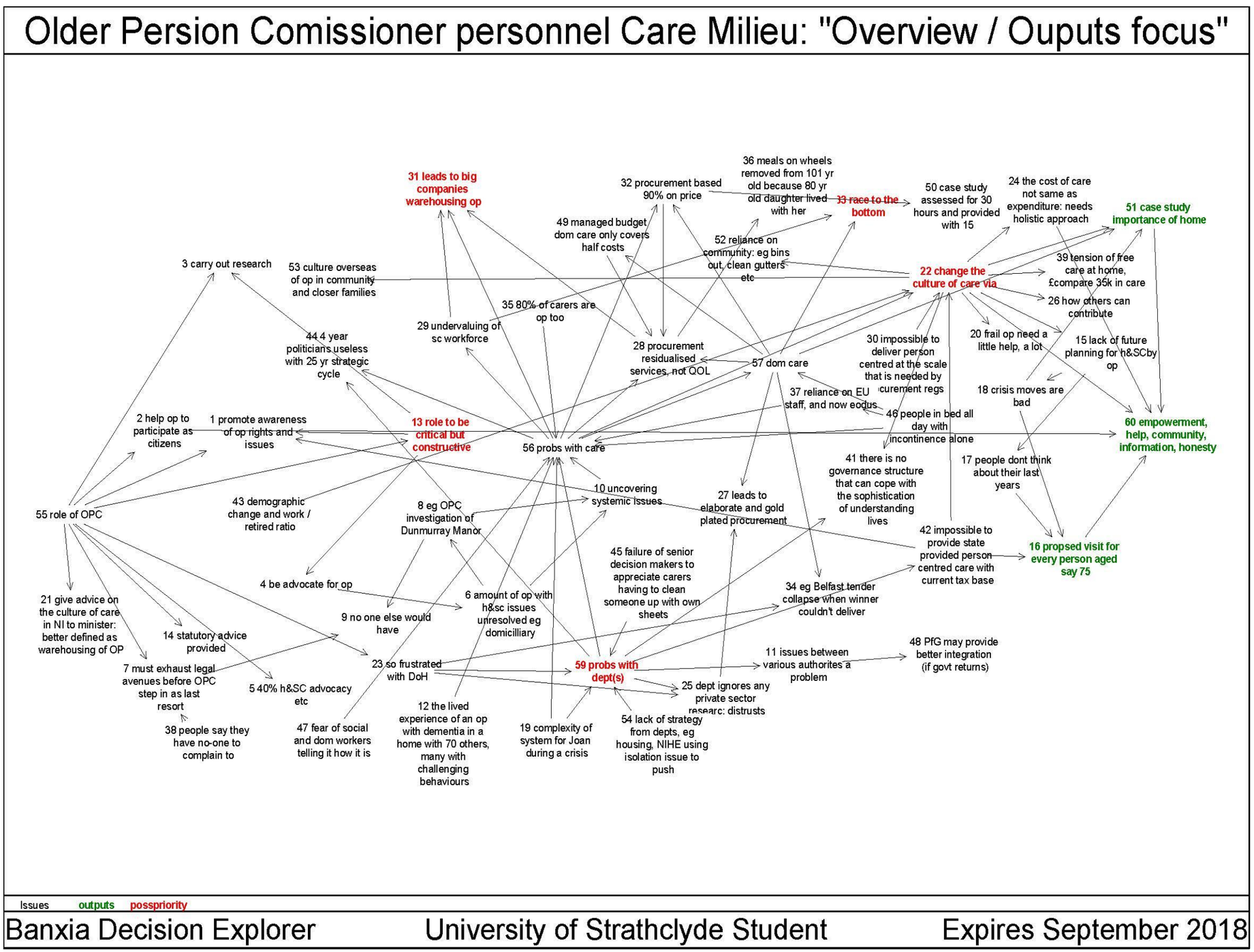


Figure 8: P2 overview and output cognitive map

Figure 9 highlights the relationships between the subsidiary issues that lead to the strategic priorities for participant P2.

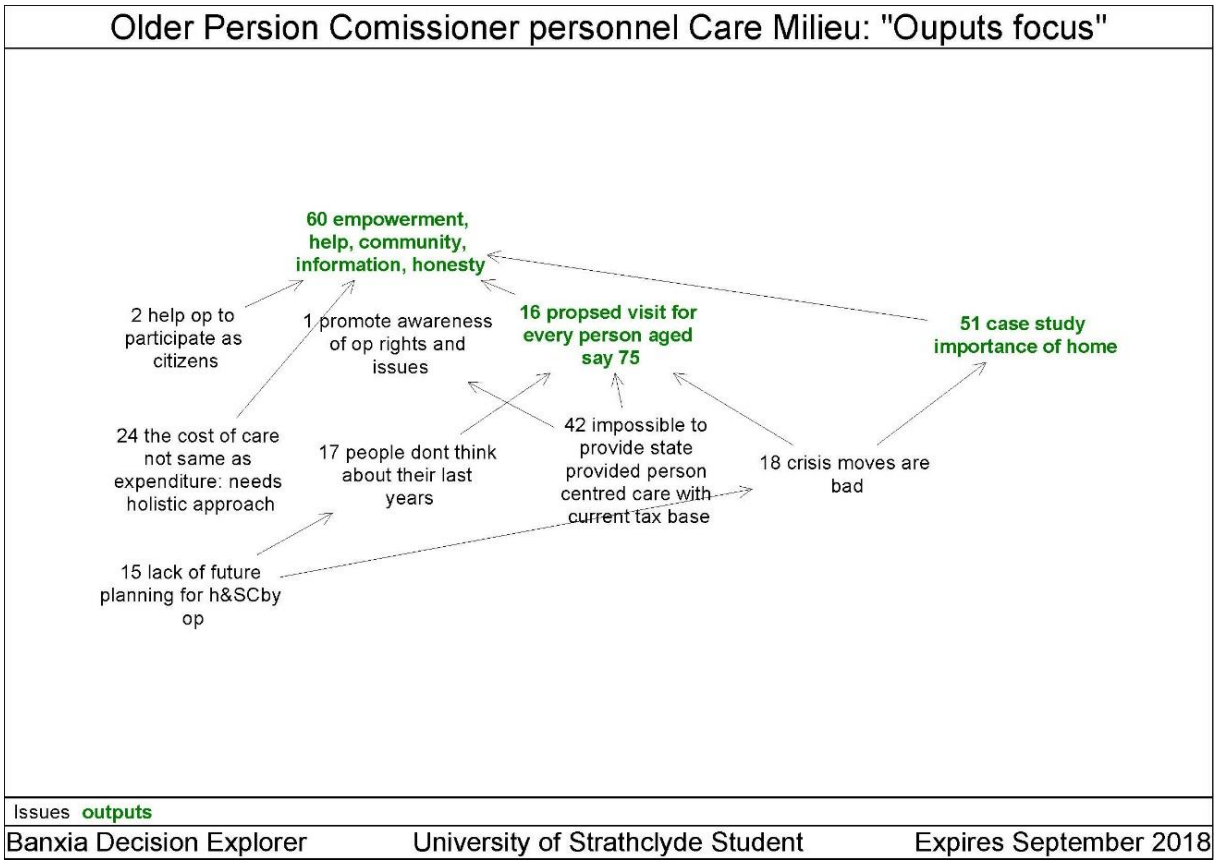


Figure 9: P2 Strategic outputs focus cognitive map

The maps expose the following strategic priorities:

Empowerment, help, community information, honesty. This output seeks to capture the need for honesty in relation to demographics and the cost implications, honesty as to what the state can provide for free, and honesty as to how services are procured: for example, an older person with a wide family support receives a fraction of the government support that others without such advantages have. If this

widespread situation is policy, P2 believes government should say so. Conversely, if finances are such that services need to be directed for those without family support, then this should be clarified more honestly.

The output node also highlights empowerment as critical for older people's well-being, and means of maintaining older people's self-mastery are strategically important. This may take the form of compensating for frailty or cognitive decline via the physical environment, friendship and social support. It is very likely to build upon the contribution that one's home has for maintaining familiarity, control and independence and the proposal that a case study should be carried out to provide empirical evidence to this effect. This leads to the strategic output: **case study / importance of home.**

A related strategic output is a need for community information, community navigator, including the **proposed visit for every person aged 75.**

2.2.3 Participants 3A and 3B (P3a and P3b)

Interview date: 02.02.2018

Profile: The third interview was with the Director of Mental Health, Disability and Older People within the Department of Health (P3a) and this participant was accompanied at the interview by the principal of the Community Care Directorate (P3b) who has responsibility for domiciliary care, care homes and carers.

2.2.3.1 Participant (P3) sensemaking

P3 opened up with the statement that 'the biggest strategic driver in my world has been demographic. We are acutely aware of the increasing population of older people … and that the tax base will shrink in parallel as will the working age population.' They

noted that amongst many strategic drivers this was one central issue: ‘to pick one thing that is kind of above all others it is that, because it really is the end of our current system as it is unless we do something about it … One way or other it’s going to change in the next 30 years radically, and it will be a catastrophic collapse because we have not changed and demographics overtake us … [and] the current model just runs out of steam.’

Comment: P3 confirmed that the Department recognises that the current model is unsustainable and that ‘transformational change’ (DHSSPS, 2016, p9) is needed.

2.2.3.2 Policy change proposals and previous implementation failures

I steered the discussion towards the *Power to People* reforms that were now proposed, and why they believed that these reforms would be different to the previous reform initiatives such as ‘Transforming your Care’, the Donaldson Report and the Bengoa Report (DHSSPS, 2014; Department of Health, 2014; DHSSPS, 2016). In a surprising admission that pointed to the incurious nature of the Department, P3a claimed that the ‘demographic picture only began to crystallise’ in 2012, though ‘probably the academics would have been aware of the demographic development, and way before government became aware of it’. They pointed to the strategy document of 2012 entitled *Who Cares?* that was to ‘get an idea of what people value about the current system to understand at a bedrock level why we do it at all, or what people get out of it; and then the idea was that would lead into the project that we are currently doing. The delay was caused by a lack of funding.’

I probed P3a, reminding them that the flagship Department policy of ‘Transforming Your Care’ initiative had happened in the intervening period. It was to meant to herald

a sea change in older people's care — making it more home-based and built on older people co-creating their own well-being with state support. In response, P3 claimed:

'It's more complicated than this, but the issue has always been funding. You have a health care system that for the first time in a long time is experiencing contraction… in an organisation that has organised itself around endless growth… a system hit for the first time with a contraction in spending: it knows it needs to reform, but it still needs to maintain its services… Where do you find the money? You can only do it by cutting existing services. Now, that's when you've got to convince the minister that "OK, these waiting lists are going to get worse so that we can do this thing with community care." That's a difficult job, because you are asking a minister to trade their personal reputation for the good of the system. And that's pretty tricky stuff… Some do, some don't. It depends what else is going on.'

At the date of the interview, the *Power to People* report (Kelly and Kennedy, 2017) had recently been published. P3a highlighted the means by which the report suggested making the services for people more personal, and that there was an ambition within the Department to deliver on it. P3a mentioned examples such as social enterprises being encouraged to emerge to add an increased community focus compared to Department-delivered services. 'There are some social enterprises doing really interesting stuff, but they are really small.'

Comment: Accordingly, there was an admission that the services were overly mechanistic, but they had no wholesale strategy conceived to increase well-being; rather, their emphasis was on the delivery of services – which is not the same thing. The context seems to be the system is arranged around endless public funding growth,

knows that ‘transformational change’ is now urgent or the system will collapse, yet the participants offered no clues as to their views of how that would happen. Indeed, as below, one did not really believe in the need for change.

2.2.3.3 A divide in the philosophy of the two participants

P3a inferred that the ‘assessed needs’ of people were perhaps overly related to health care rather than social care: ‘you might have people who don’t necessarily need all the visits. What they might need is a trip to the shops, or they may need some kind of social thing – perhaps go to the local café.’ P3a stated that presently these things ‘get lost.’ However, in their opinion the Trust is obliged to consider your health and is overly focused about managing the risks to you: ‘if we get involved it becomes about managing risk, and ‘a lot of the other things are kind of secondary [including] what makes life enjoyable.’ Moreover, ‘if you are going out for a cup of tea with friends … that’s what keeps you active ... mentally kind of agile … Then, the money might be better invested in that.’ Thus, P3a noted that one way to deliver on the *Power to People* recommendations would be to procure differently: ‘instead of going out with a really railed down spec, we say “We have a group of people here, their needs are X, and the outcomes we want are Y, now come to us with ideas for how you think you might meet those needs and outcomes.” It might look very different from domiciliary care at the minute, which we have honed to a point where I don’t think the model is going to give us any more than it’s already given us… I don’t think the outcomes that it produces are going to change very much simply from scaling it up.’

P3a further clarified that in their opinion government was trying to grapple with the need for life to be fulfilled, versus the very binary / medical way in which the Departments were able to help make it so. As P3a phrased it: ‘what can we do to help

you live a good life?' They recognised that this required a shift in the way that the assessments get done: 'So, in the past, someone comes and takes a list of all the things that you cannot do anymore and that's a really dispiriting experience… You can do it the other way: here's a list of all the things you can do, and those that we can help you with.'

P3a was thus well versed in the principles of well-being co-production – something of a buzz word in the broader UK social care perspective, though perhaps P3b less so. The Director of Community Care (P3b) explained that they were aware of the failings within the system, but that rather than transformational change, or procuring differently, improvements for them were more a matter of more resources being needed:

'Our driver is knowing that the system just can't cope… to deliver services to our ageing population which is getting bigger and bigger: along with a shrinking workforce, with a shrinking younger population. So, less people to deliver services and going out to work; creating income. So, who is going to pay for all this? And suddenly it's that dirty word 'charging', isn't it? Who is going to pay to continue all this? At some point charging becomes inevitable.'

Comments: It is therefore a fair interpretation to note that while P3a was engaged with thinking about how change could be implemented, none of these ideas was fully formed. While the most recent expert reports have recommended a sea change in the way that care is conceptualised, the power brokers of the Department were unable to articulate ways that this could look. Moreover, the Director of Older Persons' Care (P3b) did not seem to have the need to revolutionise the model in mind at all, and,

while recognising major deficiencies, viewed these problems as ones that could simply be fixed with more money.

2.2.3.4 A strategy for housing with care?

When I specifically asked whether there was strategy for housing with care, I received only the most general of responses: P3a stating: 'I mean, it will form part of the reform and part of the model of the response, but at this stage the Department of Communities can tell you exactly what they have in mind… we are still talking in the realms of possibility what things might look like… but first of all we need ministers to land and a good bit of analysis to be done before they can get to the point.'

Comment: These findings would seem to follow a 30-year pattern as detailed in section two of policy imperatives to conjoin care and housing withering on the Department of Health vine. P3a has moved departments.

2.2.3.5 Self-directed support

A significant recommendation within the *Power to People* report was that self-directed payments are an excellent way to ensure that people may procure what they want, rather than have government provided domiciliary services delivered to them. I enquired how they thought the Department viewed self-directed payments and what the strategy was for their use to be increased from its present very low level. In response, P3a said 'it's a mystery' why they have not been taken up, whereas P3b said 'it is a mindset out there. A lot of older people are not going to change their ways' and P3a added 'people are just used to the way it is'.

Comments: These responses are somewhat disappointing since the system of self-directed payments does exist and does seem to be a valid and valuable way for older people to have choice. Older people could use such a budget to assist with getting to

the hairdressers, and their vital social needs to be met – needs, indeed P3a previously acknowledged that such activities are vital for well-being and health. Neither mentioned that the monetary amount significantly drops when self-directed support is taken up. Since one needs to be very frail or unwell in order to receive care services, it is bizarre to expect such people to manage the responsibility of being an employer. They will inevitably require professional help with appropriate insurances and expertise: that the costs of such services must come from a diminished sum must result in very few taking up such an offer.

2.2.3.6 Programme for Government

P3a described how the Programme for Government initiative was supposed to afford better integration between departments to seek to remove traditional thinking that is commonly accused of being 'siloed' in nature, and not helped by the institutional arrangements whereby a DUP minister may be less likely to liaise with a department with a minister from Sinn Féin, for example. Progress was seemingly slow: 'we can take it to a certain point… but there will come a time when you need to assign budgets and that kind of thing.'

Comment: Northern Ireland has been unable to set its own budget due to the collapse of the political institutions and consequently the budget had to be imposed from Westminster. Hence, it is most unlikely that there will be progress in the more 'enlightened' approach to government that the 'Programme for Government' anticipated. In addition, P3a and P3b also continually intimated that it is the ministers that are the drivers of change. The civil service may recognise shortcomings, but P3a/b implied that it lacks the will to conduct changes. As P3a noted, 'the challenge for us is to convince people that it's a good thing to change': they evidently have been unable

to do so and has left the department. P3b's views in contrast did not engage with quality of life, instead that more money is needed to deliver services: despite ever more resources being deployed, this approach too appears unmet.

2.2.3.7 P3 cognitive map analysis

Figures 10–11 constitute an insight into the issues that P3a/b consider important, their connectivity and how they consider an improved strategy for older people may evolve.

In Figure 10, the map shows the interrelationship of the issues pertaining to policy, with issues such as the strategic imperative to find a new formula, the lack of a minister, and a sea change of care philosophy to be community-based rather than imposed and procured by way of hours of services being delivered. The results of this are: **leads to monochrome bad outcomes** and **less rigidity is needed.** The map highlights the *Power to People* report as being the current road map to achieve the outcomes. It says that home is the key to be **leveraged for individuality, community and person-centred care**, but while P3 acknowledged the report, and talked in very general terms about social enterprises doing 'really interesting stuff', but no specific ways to achieve the goals other than by charging in order to expand resources: Despite warm words the concrete means of achieving the *Power to People* recommendations seem ignored.

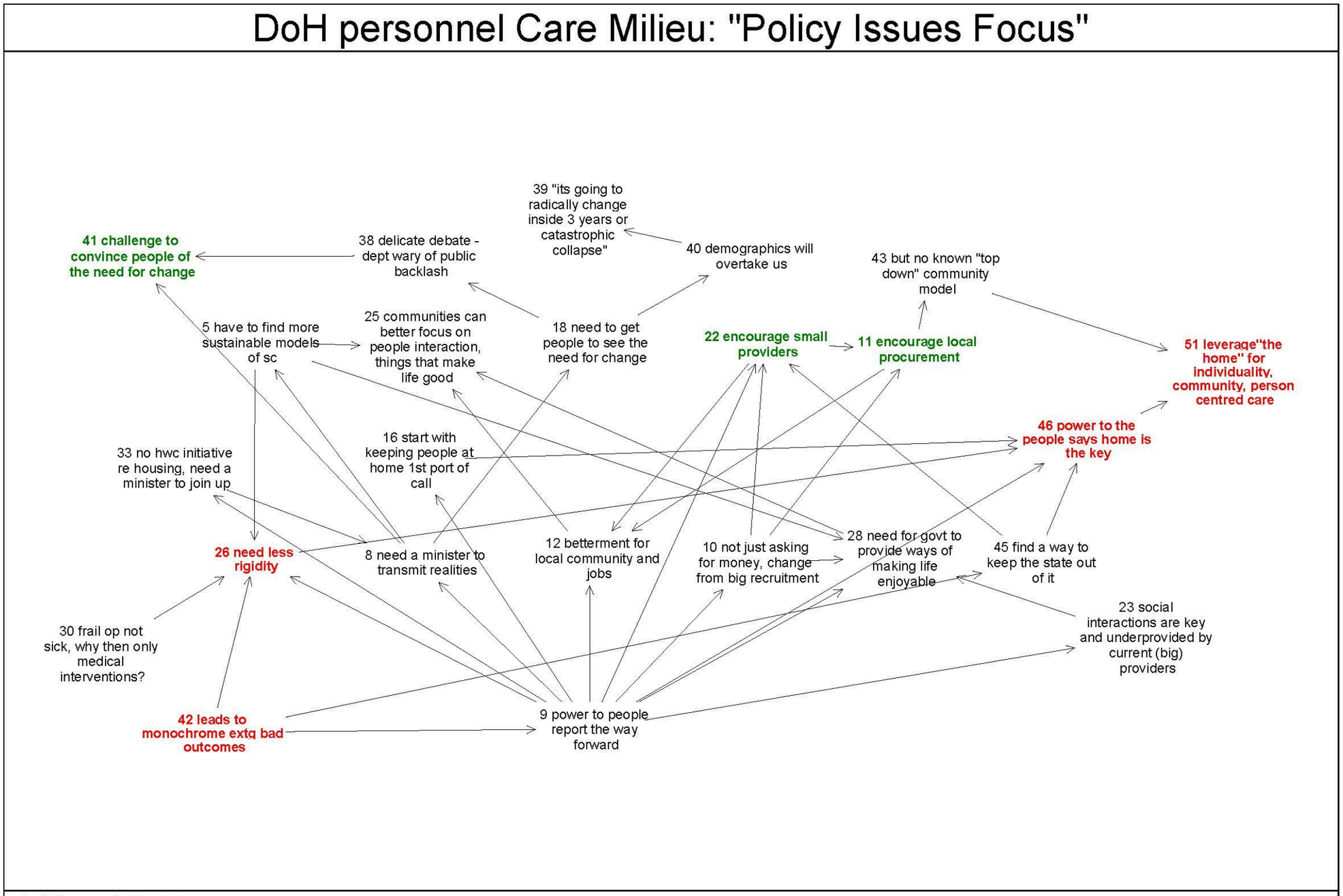


Figure 10: P3 cognitive map 'policy issues focus'

In Figure 11, the strategic issues are mapped. They take account of the existential need for the means of social care being delivered having to change thanks to demographics: **'domiciliary care is stretched to the max'** and it **'really is the end of the system unless we do something'**. The map highlights that 'when the health service becomes involved, it becomes all about managing risk rather than empowering people.' P3 recognised that in the agency–structure continuum, the Department understands at one level that it needs to 'let go', but it may be institutionally incapable of doing so. The map shows that rather than being **procured on physiological grounds, outcomes ought to focus on quality of life, hence the means of procurement need to change.**

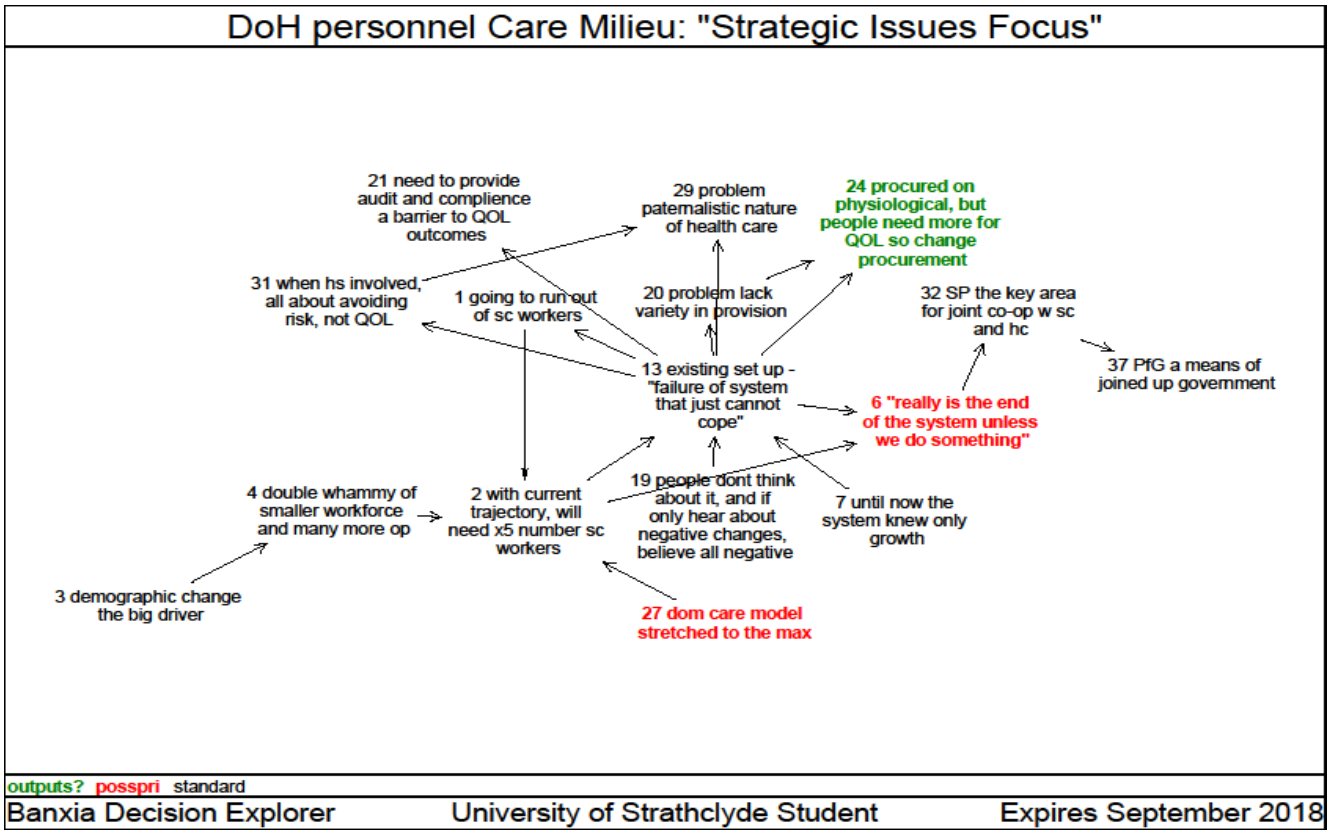


Figure 11: P3 cognitive map 'strategic issues focus'

Figure 12 is the cognitive map relating to charging and direct payment, and the interrelationship of the issues. One possible priority that arose is that presently, when self-directed payments are taken up, the older person receives less than what an agency receives. However, since the older person needs to become an employer and must cover such associated costs, reducing the amount may be a significant reason why the take up has been so low. The map puts this as: **direct payments may be too low to allow a managing agent to provide for others**, and consequently the map highlights the role of the market to regulate demand and focus supply noting **allow the market to allocate resources more effectively**. A further strategic output is shown as **higher direct payments with charging and housing solutions**.

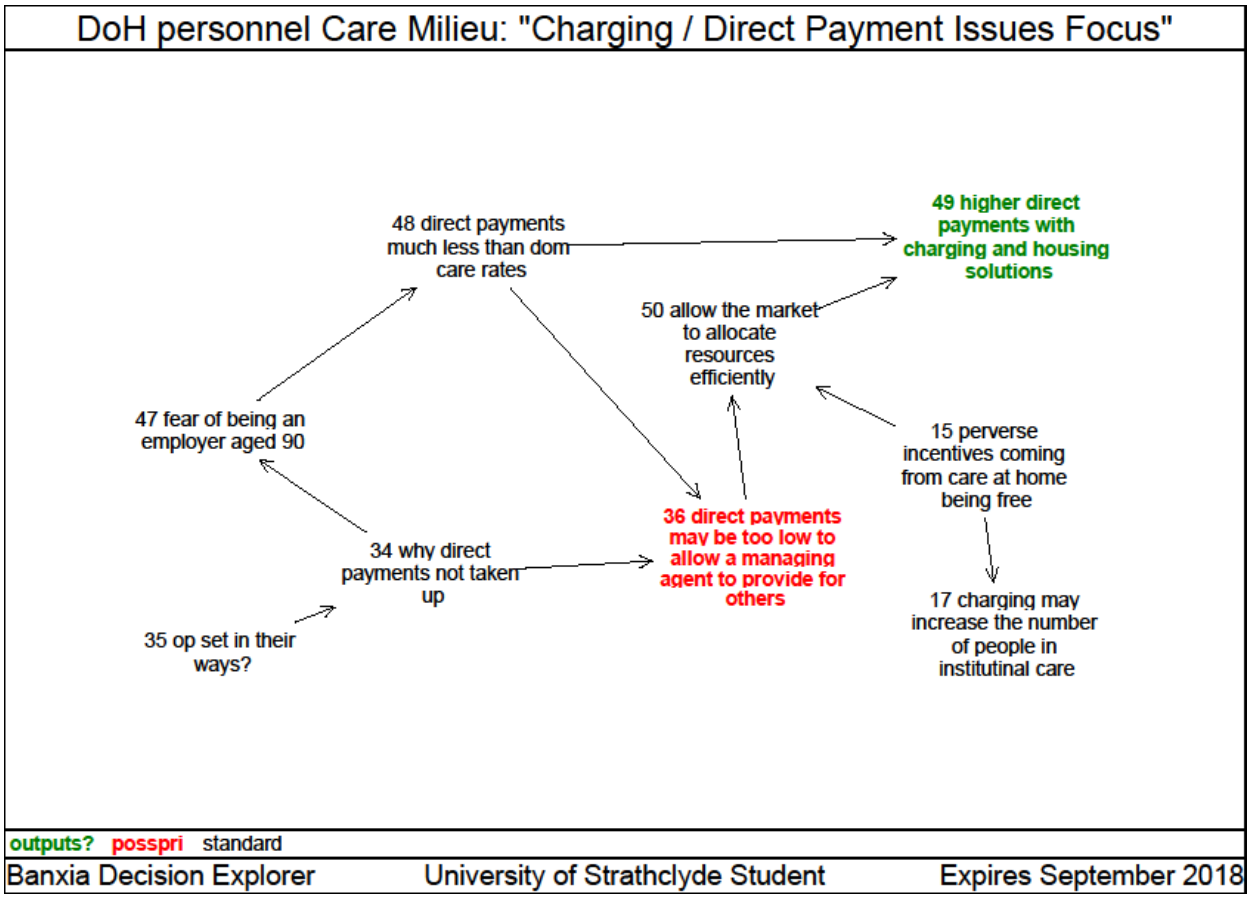


Figure 12: P3 cognitive map 'charging / direct payments focus'

2.2.4 Participant 4 (P4)

Interview date: 19.02.2018

Profile: Participant 4 (P4) is the Professor of Ageing and Health within the School of Nursing at one of the two universities in Northern Ireland. P4 leads research strands into long-term care and into the support for older people living with dementia.

2.2.4.1 Participant (P4) sensemaking

P4 commenced with contextualising the issue in terms of demographics and social changes, especially the changed role of women as carers:

'I think for me the issue is that the system that we have was not designed to address the demographic changes we are facing at the moment – in terms of people living longer, in terms of change in the size and structure of families or women working, smaller families, people immigrating; different people's perception of their roles and their duty to parents have changed. So, we had a heavy reliance on family carers in the past and most of that was provided by females… That is no longer the case.'

In so doing, P4 was directly opening with what they took to be the principal problem, that the system was designed as a top-up for families (they note overwhelmingly females) caring for older people where it was needed. When shorter periods were spent at the end of life with chronic illness and when most females were not in full-time employment, the system could afford to be a top-up service. Now, the underlying assumptions have changed – people are living longer, often with long-term health complaints, often bedridden, and their families are to a much greater degree in full-time employment. P4 noted: 'so, the system that we have is not going to be able to

support an ageing population and that's not just a Northern Ireland issue, that's a global issue. Okay, so I think what we need is some blue-sky thinking, perhaps you are providing it!'

2.2.4.2 The importance of home and issues at the interface between home and care

P4 recounted their research areas. Right from the off stating that their participants across multiple studies throughout Ireland predominantly wished to remain at home in order to maintain control and quality of life:

'They, in fact, want to age in place; and much has been written about the value and the benefit of ageing in place. And, interestingly, in my own research, when I talk to older people … on average between 75 and 80 per cent [of] people, given the choice, [when asked] "Where would you like to spend the rest of your days?" They would say home.'

Some of P4's recent research was into what happens to people and their families at the time when the older person moves into a care home. Sometimes, it is a positive experience: 'very often when people make the move to residential care, if that move is well planned and isn't on the back of a crisis that can be perceived as a positive life (to have).' However, very often, the move is feared: 'but there is that issue around stigma and how people perceive the traditional sort of nursing service residential care that we have at the moment.' P4 also noted the typical situation, in parallel to Conor and Joan, where the move happens following a crisis, and that this is especially hard on the older person and very stressful for the family. One insight was the role that GPs have when validating the family's decision that the older person's well-being would be improved

within a care home: ‘GPs have a huge role, and nurses and social workers, in sort of validating or advocating or taking the decision away from the person taking it. So, then it becomes their decision.’ P3 discussed the shock of the crisis move for all parties – the shock of losing a family member from the home, and the stresses of a stream of powerful emotions that are felt by family members: ‘This… very often can come as a huge shock, interestingly, to the carers involved and that’s accompanied by all sort of other emotions, [from] grief and guilt to a feeling of relief.’

In the context of living at home being of great importance to older people, P4 relayed the widespread fear of being ‘sent’ to a care home. P4 also relayed the problems with how domiciliary care was delivered into homes but acknowledged the ‘massive role played by domiciliary care providers … providing a huge amount of care with very poor training … and largely disregarded or unacknowledged in the system.’ P4 took issue with the way that older people are assessed for interventions on a deficit approach, where the Trusts intervene based on an older person’s assessed ‘needs’.

‘I think that’s an interesting term, “greatest need”. Who is to decide what my greatest need is? … In the main … it tends to be in terms of activities of daily living. So, if you can’t cook a meal, if you can’t eat, if you can’t get to the bathroom, you know, that’s a great need… but (there is) very little emotional support. A little bit of social support can delay, for example, entry to long-term care… improve your mental health and well-being... So, that term, that’s a very sort of biomedical assessment. And resources tend to be directed, if you will, towards the greatest need in terms of a very narrow definition of quality.’

In their research, P4 found that what older people valued most of all was the social engagement, yet this most valuable need is not procured: ‘they just wanted somebody to talk to them, and some human interaction.’

Comment: The strategic take-away from these points is that while the home is very important for well-being, older people value human interaction. P4 was scathing at the HSC Trust assumptions that care can be delivered in a 15-minute call; instead, ‘older people need little, but what little they do need, they need a lot’. This brings into focus the possibility of peer support communities and a role for a community navigator that can assist the carers too. P4 called this a one-stop-shop: ‘working with carers, consistently what comes up is a need for a one-stop-shop.’

2.2.4.3 Bad incentives and a lack of honesty about money

P4 bemoaned the perverse incentives that are at play in the system in Northern Ireland where care at home is costless, whereas a care home can cost well over £30,000 per year. However, despite the expertise of P4, they were unable to provide much detail on how matters work financially. If they do not know, then there must be very few that do. ‘I’m not the right person to ask because this is quite tricky – the whole financial assessment… one is allowed to have £23,000 in one’s account… what it does mostly mean is the family home would have to be sold. I know… you’re actually better off … being poor.’ Also,

‘we were involved with a group [with whom] we were designing the information booklet around the transition from home to care for people and how people would need to think about finance. We just sort of had to point them say because that is so confusing… very difficult to sort of provide information that could be actually accurate… Even

speaking to people who are experts in dealing with this issue, it is very, very difficult and these are the sort of conversations that need to be had much earlier… people plan their long-term care too late.'

Comment: A conclusion that may be drawn from this topic is that there is the reaffirmed need for a community navigator to de-mystify the complex and opaque system of finance.

2.2.4.4 Care home issues

In the light of the highly publicised report by the Commissioner for Older People for Northern Ireland into the very poor care at a particular care home, I enquired of P4 about whether the fear of older people entering a care home was justified, or were the stories of poor care overblown?

'No, there are examples of very, very poor care and they're the ones you will hear about and read about in the media. (But) there are very good homes. We tend not to hear about those, and that worries me, that worries me. If I'm sitting at home thinking "I'm not able to cope anymore" and mum's just sitting beside me… that does very little to instil public confidence.'

In a related point, P4 had done a recent study into the critical role of care home managers, but the problem is getting good people to work in an industry that is demonised and noting that this is a further aspect of the residualisation of care homes, both for residents and staff. Both are spiralling downwards into states of bad equilibrium. They said, 'The manager has a massive role in terms of the ripple effect… and there is a real problem recruiting people into that sector… how on earth are you going to recruit good people? It's a total spiral.'

Once an older person moves to a care home, P4 has found in their research that the younger family re-engage with their lives, but the older spouse came under great pressure. They will 'typically invest their time in the home… five days a week, and very often the home becomes dependent on them… taking a caregiving role … that they never negotiated… Very often the needs of Conor can be at the expense of Joan.'

Another issue is how to balance 'risk' against an older person being able to make decisions. In care homes, the norm is often too skewed towards risk aversion, according to P4.

> *'But a lot of environments, long-term care environments, are very risk averse. It's about keeping you safe, prevention from a fall, rather than promoting independence; I'm writing an editorial around that. If you sit in a chair all day, you're less likely to fall.'*

P4 noted that there is that real danger that these environments can cause a reduction in quality of life, as P4 said: 'I have had nursing residents say to me, "I need to get out this place, get out for a walk at the back garden, you know, without somebody doing a sort of a risk assessment or whatever." P4 also similarly noted that the RQIA oversight tends to lead to a culture of meeting standards in a 'box-ticking' way, rather than empowering older people to create their own lives, even when living in a care home.

Comment: Since it is hard to imagine a social care system without recourse to care homes, it is undoubtedly right that they need to promote well-being rather than solely seek to remove risk. I also interpret the cliff edge between care at home and a care home to be too stark, and that a care environment associated with a housing community can more easily promote independence, rather than trade it away, and that

this would better afford a role for spouses and partners that, from P4's account, are unacknowledged.

2.2.4.5 P4 cognitive map analysis

Figures 13–14 constitute an insight into the issues that P4 considers important, their connectivity and how P4 considers an improved strategy for older people may evolve.

Figure 13 highlights how the underlying issues interrelate.

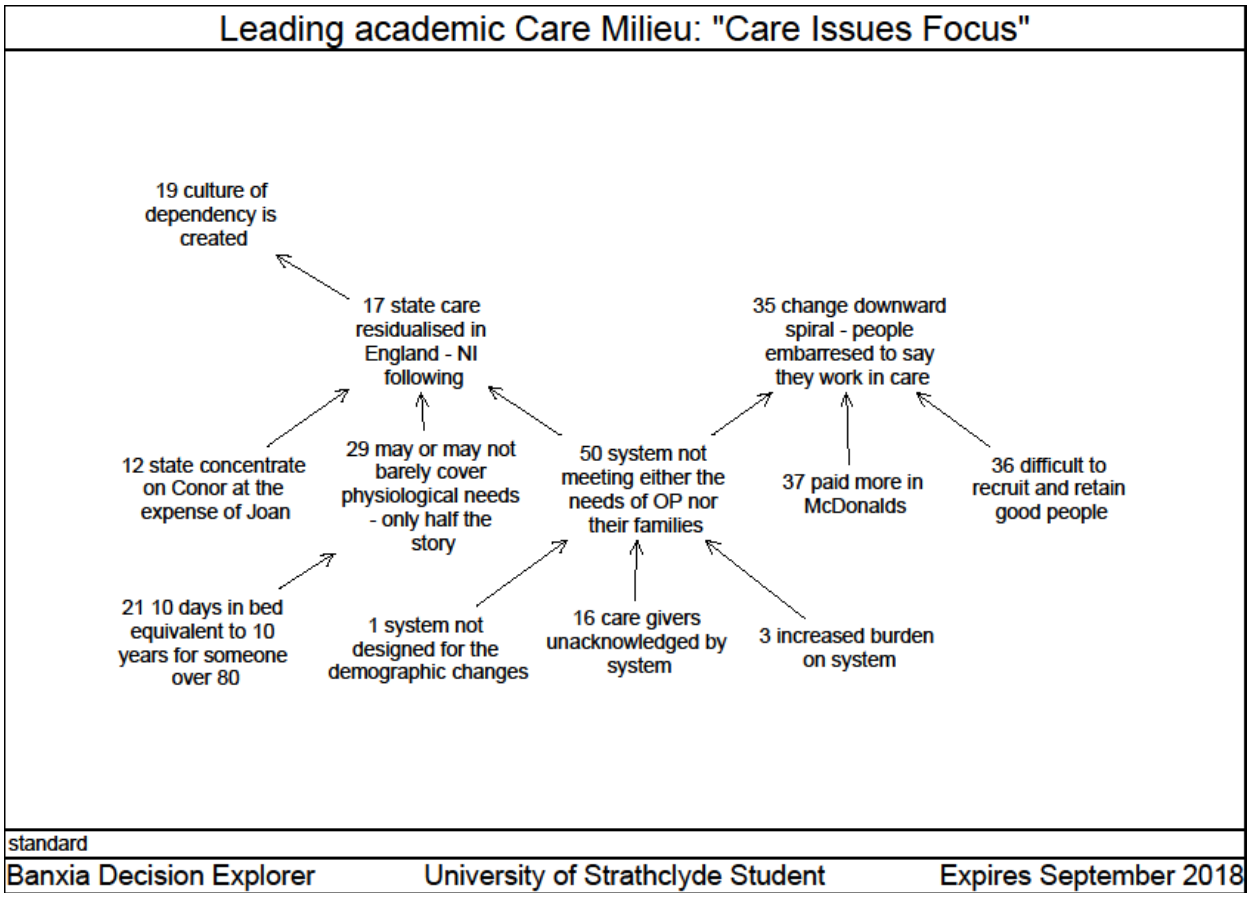


Figure 13: P4 cognitive map 'care issues focus'

The map highlights the following possible priorities:

- **Need to recognise the stigma of nursing homes**
- **Crisis moves to a care home are common but not good**
- **People stay at home too long?**
- **Leads to a need for other options such as housing with care.**

In the graphic these possible priorities then lead to the following strategic outputs:

- **Lower barriers for self-directed payments / self-directed support**
- **A need to emphasise independence rather than prevention**
- **Need to differentiate between good and less good care homes.**

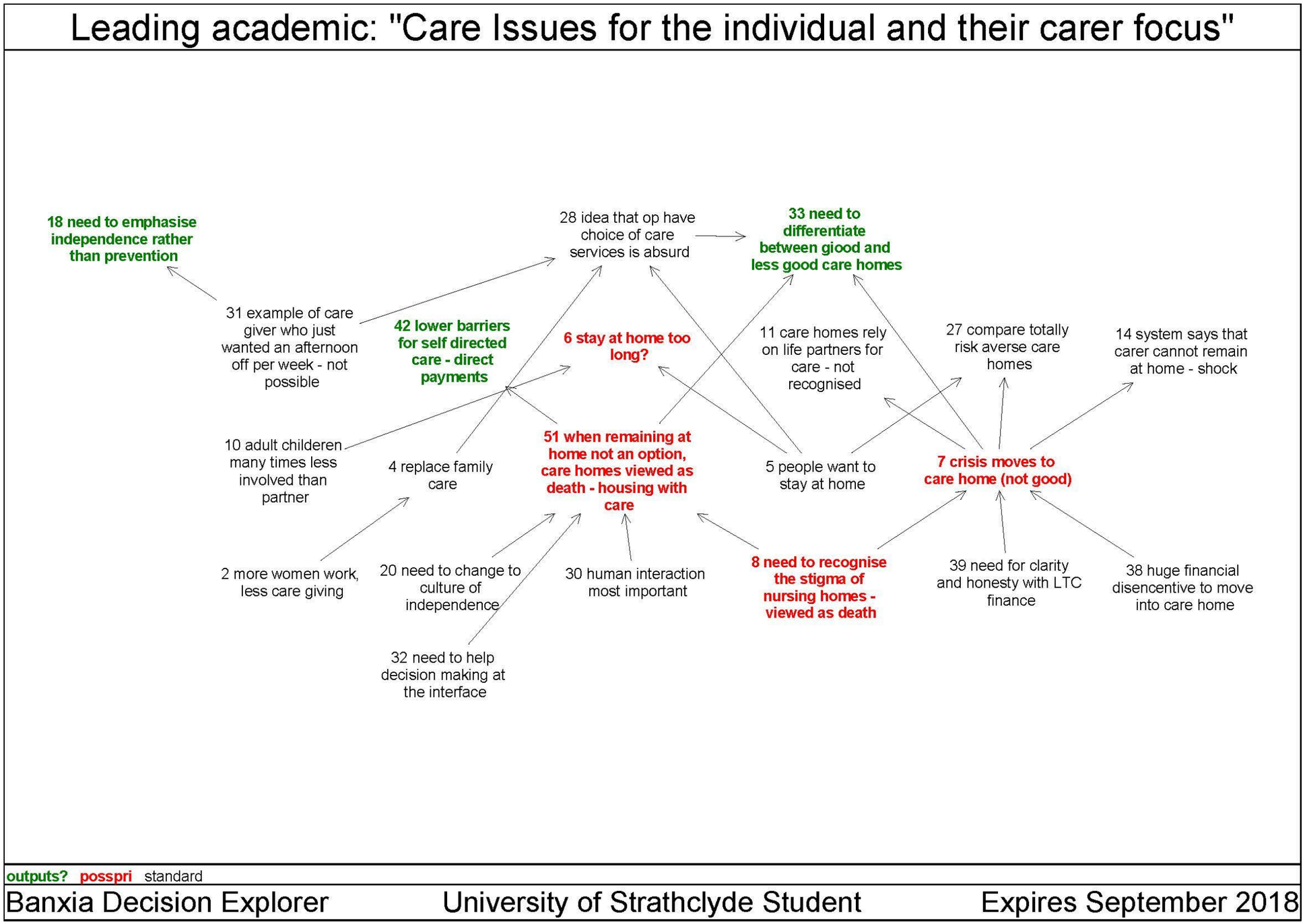


Figure 14: P4 cognitive map 'care issues for the individual and their family''

P4's third cognitive map in Figure 15 takes matters a further step and seeks to synthesise the strategic drivers and strategic outputs. It recognises that it is **often impossible to provide good care in regular homes**; however, there is a widespread apprehension about care homes, and bad disincentives for the family to make that choice, plus a significant number of homes that do not deliver good care and indeed some have been found to be delivering care that has been tantamount to abuse: all leads to a situation where older people are not maximising quality of life, by staying at home, dissuaded away from care homes by these factors.

Moreover, the risk-averse culture within care homes means that it is almost impossible to allow people to be independent and in control, and people's quality of life is thus greatly diminished. Consequently, another option is needed between home and care home. The strategic priority is that care environments be home-like, have couples together, and incorporate social interactions that are so important to people. In the map, it is presented as **a need for housing with care environments instead of / as well as care homes.**

The strategic outputs are mapped showing a need for **more information and earlier conversations**, a recognition that older people **need a little, but what little they need, they need a lot**. A strategy with this philosophy at its core is needed. In the opinion of P4, this means that **social support needs to be close by**, and that there is **a need for mixed environments including for younger people with dementia** and an **emphasis on independence** rather than on assessed 'needs'.

P4 also noted **private providers were demonised** thanks to needing a profit or face going out of business. This is regrettable and given the scale of the issue, meaning that a partnership approach will be needed, **needs to change.**

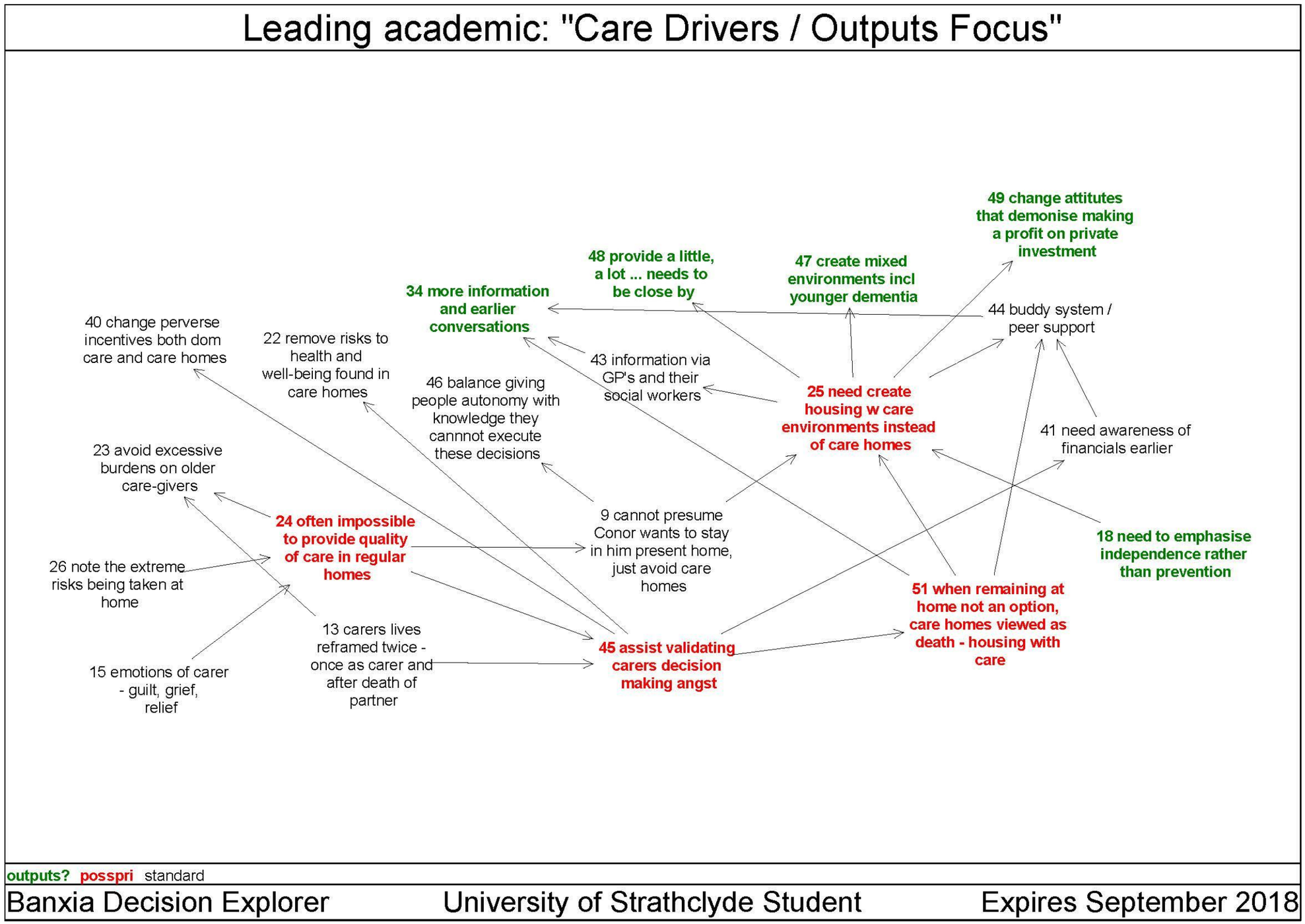


Figure 15: P4 cognitive map 'care drivers / Outputs focus'

2.2.5 Participant 5 (P5)

Interview date: 23.2.2018

Profile: P5 is a politician, MLA, and a recent minister for the Department for Communities. Amongst other things, the Department has responsibility for social housing, in which housing for older people forms a part.

2.2.5.1 Participant (P5) sensemaking

P5 explained that the overwhelming function in revenue terms of the Department is to act as a conduit for welfare payments from the Treasury in London, making up the lion's share of the £7 billion budget. Of this amount, only £1.3 billion was regarded as discretionary and this amount included the £700,000 funding for the 'Supporting People' programme. The Supporting People programme is as an integrated policy that enables vulnerable people to live independently in the community through housing support and other practical services. P5 noted that the budget was always under pressure, and with such a variety of needs from people who have been homeless, rough-sleeping people at risk of offending, teenage parents, people with drug problems, young people at risk, etc., there was very little left for older people.

P5 explained that further sums are allocated to works in the public realm, plans for urban regeneration, including vesting powers, sport and support for the Northern Ireland Housing Executive (NIHE). It is the NIHE that leads the procurement of social housing from Housing Association providers. Accordingly, P5 stressed that the budgets were small and under continued considerable pressure. Housing for frail older

people has for these reasons few resources available to be directed towards it, and is given little priority.

P5 explained the strategic relationship between the Treasury, the Department, NIHE and housing associations, whereby only the housing associations were in a position to leverage their resources through debt capital. There had been some different views of how the NIHE rents had been accounted for in the recent past, which was interesting, since the rents for social housing are derived from housing benefit, a UK Treasury-sourced stream of income, it seems that the Department had been prevented from raising rents to a market level due to Treasury pressure. This has had negative implications such as making social housing look more attractive when compared to private rents, badly distorting the housing picture. Since the Department publishes its advice to housing associations as to what rent to charge, and that this is artificially low, it hampers the housing association's ability to achieve the external funding that is required for the needed additional stock.

A further major issue, according to P5, was how the Department was to shift NIHE and its 80,000 socially rented properties off its balance sheet thanks to a recent ruling. The officials, however, still wanted to remain in control of NIHE and avail of the rents.

Comment: The minister was evidently and understandably concerned with ensuring compliance with UK Treasury and other UK departmental instructions, and not with operational detail. The minister reflected on the Departmental priorities as a conduit for UK Treasury welfare payments. Since housing benefit in order to pay social housing rents comes from the UK Treasury the strategic priority as such a conduit has been to keep such rents artificially low, and this had distorted the market and severely affected

the new supply of social housing. A small portion of such damaged supply is that of the supply of social housing for older people, highlighting the low strategic priority. The strategic attention of the Department for a broad-based housing for older people irrespective of tenure is seemingly microscopic.

2.2.5.2 Thinking about Conor and Joan

P5 noted that 'with those officials involved in it … the culture within the Department was very heavily orientated around purely social housing', and there was not much emphasis on older people's housing; indeed, 'my own assessment is that there wasn't a big priority being placed on that'. Moreover, 'in terms of Conor and Joan, I can't remember there ever being a discussion about how could you meet the need… with housing with some support.'

Comment: I detected a sense that the Department, perhaps due to resource limitations, had little time and resources available to address a great deal beyond day-to-day operations.

2.2.5.3 A remit for a wider role, but not the initiative

Notwithstanding the specific shortcomings in the social needs of older people, P5 noted that the Department did have a role as this department that was to coordinate other departments for joint goal achievements. As P5 put it: a 'role in flagging up all these issues to make sure that there was greater coordination.' Moreover, P5 considered that the Department 'should be looking at the broad kind of parameters of what we would do… for example, producing a social strategy. It is well placed to provide that umbrella-type approach… and, to me, should be leading on it.'

P5 described the ‘Housing Forum’ as one such facilitating medium:

> *‘whenever I would have met (with officials) and we talked about getting the Housing Forum rebooted and having a greater focus on how we are engaging with the private sector, so that they can be doing what needs to be done to meet the housing needs… there was a recognition that this needed to happen.’*

Regrettably it has not.

In addition, P5 recognised the role that housing plays for the health and well-being of older people. They also recognised its role in minimising the need for older people to be forced into acute care after what P5 called a ‘tipping point’. Also, ‘they end up being in some kind of accommodation where they don’t really need to be, and the cost associated with that in either acute care or in care homes’. P5 confirmed that ‘there was a recognition that the department needed to change … recognising that it had become too focused on purely meeting social housing needs’ and better fulfil its role an enabler. However, that change did not happen while P5 was in post.

One reason is the institutional sedimentation, and P5 made the point about how the ministers and politicians may be more open to change than the department(s):

> *‘But just in terms of trying to advance anything in government, getting politicians to say, “Yep… so health is an issue, housing is an issue and it interfaces with housing benefit” … politicians can quite quickly go, “Yep, you have identified an issue”. They then need to commission people on that. But you really need to have champions from within the system that can be strong advocates, otherwise… if you don’t have civil servants that are bought into the concept, then it’s going to be difficult even with a political will.’*

Thus, P5 was saying that it is difficult even for ministers to drive through a change agenda, so in the absence of ministers being in post, progress is unlikely.

'Those conversations, well, if I had still been there, would have been happening.'

Comment: The Department for Communities has made limited progress towards being a proactive agency, and one partnering with private institutions and capital to deliver strategic aims that cut across departments. This reflects a similar lack of strategic progress within the Department of Health in implementing reform. In both cases, the role of the ministers can be seen, in being 'brave' as P3a noted, and P5 similarly stresses that it requires a dynamic minister to achieve change. The apparent belief of the minister is that Departments will not change on their own, and it is thus unsurprising that little of the 'transformational' change cited as urgently needed has happened in the present (2019) absence of ministers.

2.2.5.4 P5 cognitive map analysis

Figures 16–17 constitute an insight into the issues that P5 considers necessary, their connectivity and how P5 considers an improved strategy for older people may evolve.

Figure 16 highlights how some of the underlying issues interrelate, according to P5.

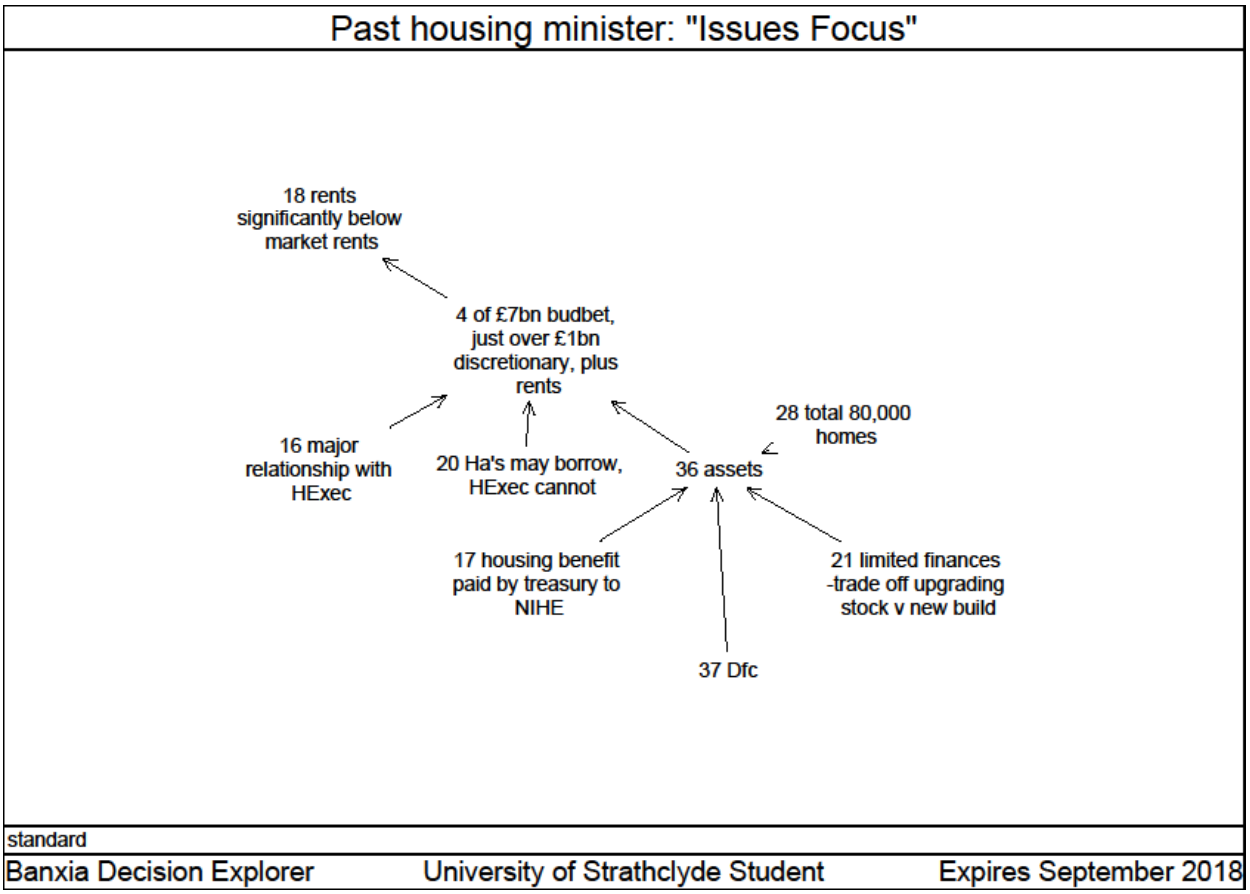


Figure 16: P5 cognitive map of 'issues focus'

Figure 17 then develops how the issues interrelate with policies, touching upon the role that P5 believed the Department must play in coordinating individual aspiration, with cross-departmental and private/public partnerships that are frustrated by the siloed nature of government. As such, the map has a strategic output to

- **promote individuality,**
- **housing other than 100% housing association,**
- **to get more 'bang for one's buck',**
- **to promote communities.**

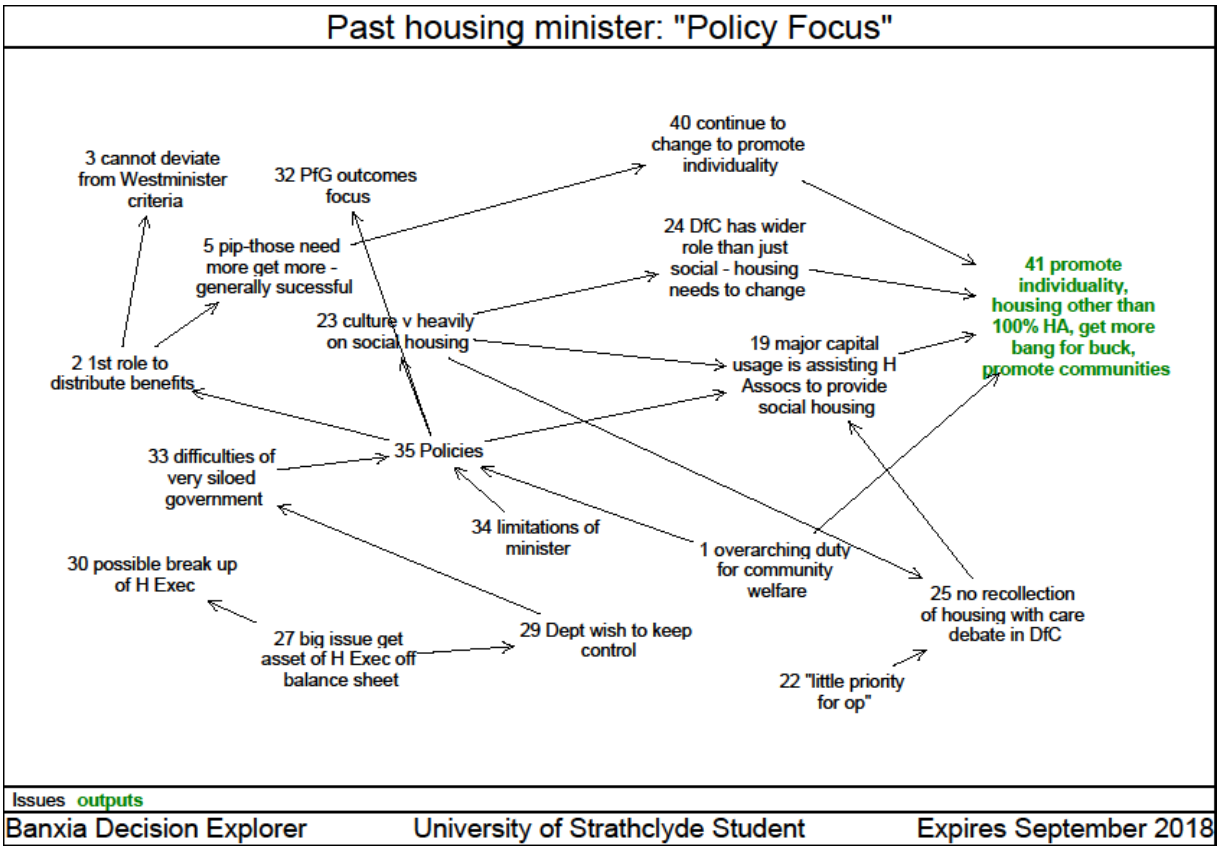


Figure 17: P5 cognitive map 'policy focus'

The third cognitive map for the past minister is a map that has extracted the issues that lead to outcomes. It highlights the possible priorities that are orientated towards getting the Department to be more effective through better engagement and promoting resilient communities to prosper through an enlightened approach, sport, vesting, regeneration and public realm as opposed to a narrow focus on distributing welfare and social housing. They are to

- **maximise 'bang for buck'**
- **a statutory duty to produce a social strategy,**
- leading to **less rigidity, less binary spend, more multiplier effects, promoting individuality,**

- **more bang for buck,**
- **to promote communities.**

2.2.6 Participant 6 (P6)

Interview date: 23.02.2018

Profile: Participant six (P6) is the Director of Registration & Corporate Services for the Northern Ireland Social Care Council (NISCC). The NISCC exists to raise standards in the social care workforce by registering social care workers, setting standards for their conduct and practice and supporting their professional development.

2.2.3.1 Participant (P6) sensemaking

P6 advised that Northern Ireland is 'the first European country to take on registration', and P6 leads this process for 6,000 social workers and 32,000 social care workers to be registered, noting that they add over £800 million to the Northern Ireland economy.

2.2.3.2 Domiciliary care procurement issues

P6 highlighted that due to social and demographic changes, the system as it stands may be unsustainable, based on a changing ratio of people over 65 from 19% to 24% within 15 years coupled with a decrease in the number of those between 21 and 24, as they put it: 'so, in a sense there are not enough young people, coupled with lots of older people. So, in terms of trying to deliver social care in the way that we do, that's a real problem.'

P6 noted that one issue that is becoming clear to an increasing body of people is that with demand increasing at the same time as swift rises in minimum wages in a sector

with no budget growth creates problems. P6 noted that ‘as the regulator, things need to change around procurement’, explaining that presently care is procured not on outcomes but on time increments of 15 minutes. ‘It all revolves around time since time equals cost… currently, we are only one of four countries in Europe’ that procures care in ‘slots’ as short as 15 minutes. Instead, P6 noted that ‘we’ve got to bring in quality factors in terms of how good the care is… and we are working with commissioning bodies to do that.’ However, they noted the financial squeeze remaining acute.

This financial squeeze passes through to the care providers via the set amounts that are offered per visit, resulting in the 15-minute slots becoming increasingly less viable. Increasingly, the amounts being offered are a loss-making proposition for the providers. P6 notes that providers say ‘we can’t continue like this, and one or two of the providers are talking about pulling out of the sector entirely. They are ethical providers, they want to deliver good care, but they are still a business.’

Moreover, since the ‘maximum you get is four calls per day’, of either 15 or 20 minutes, and there is no certainty that each of the four calls is delivered by the same provider. Thus, an older person can easily have four different sets of people coming in each day, with a very high ‘churn’, as P6 describes it. The faces can change literally from week to week. P6 noted how distressing it is to have strangers in one’s house, to say little of having to deliver personal care including toileting and aiding with medicines, dressing and feeding in a rushed 15-minute period. P6 said ‘we can say that that is a very poor experience’, to say little of the recording of what is happening and coordinating between four agencies. Mistakes such as mismedication and ‘no-show’ inevitably occur, according to P6, and are a likely breach of the Trust’s ‘statutory duty for quality’.

P6 stressed the pressures that have been building in relation to domiciliary care staff. There is a shortage of staff, since the profession is not, nor cannot afford to be, valued by the Department of Health. As such, it pays no better than a retail job in 'Next', for example, making recruitment very difficult. P6 seeks to raise the standards of the profession by having a professional qualification, continuous professional development and registration; however, the remuneration is such that there are few incentives to undertake the time and expense to degree qualifications, and in social care, the career progression path is minimal.

Comment: P6 highlighted that the present arrangements are unsustainable, and alternative approaches to social care are needed, such as community care.

2.2.3.3 Community focus

One major topic of conversation that P6 initiated was the role of community in creating well-being for older people. P6 noted that while the focus has continually been on the Department of Health, the Department for Communities has an equally important role to play, as do the councils. P6 referred to the *Power to People* report (Kelly and Kennedy, 2017), which has an entire chapter on community planners that can aid the coordination of social care, rather than always looking to the Department of Health, which can only deliver lumpy health care interventions. P6 painted a picture of community volunteers who agree to visit an older person once or twice per week or take them to an activity once per fortnight. Adding

'I don't think it is one person or department's responsibility… but the Department of Health, they seem to be kind of waiting for community interest groups and non-profit-making groups to spontaneously combust across the province in a uniform way. Now,

it's great that they do in certain places, so there needs to be surely a part that structures and incentivises that. People tend to go where there is the money.'

Comment: P6 highlighted the cross-cutting nature of the issue of maintaining the well-being of older people and expressed how they made sense of the issue and volunteered positive propositions. They did, however, note the reticence of the departments and councils to take a significant lead. It may be that it is a third sector approach to coordinating the community aspects in a uniform way that may be needed. Perhaps a larger charitable provider such as Age NI could take the lead for a pilot.

2.2.3.4 P6 cognitive map analysis

Figures 18–19 constitute an insight into the issues that P6 considers important, their connectivity and how an improved strategy for older people may evolve.

Figure 18 highlights how the underlying issues interrelate.

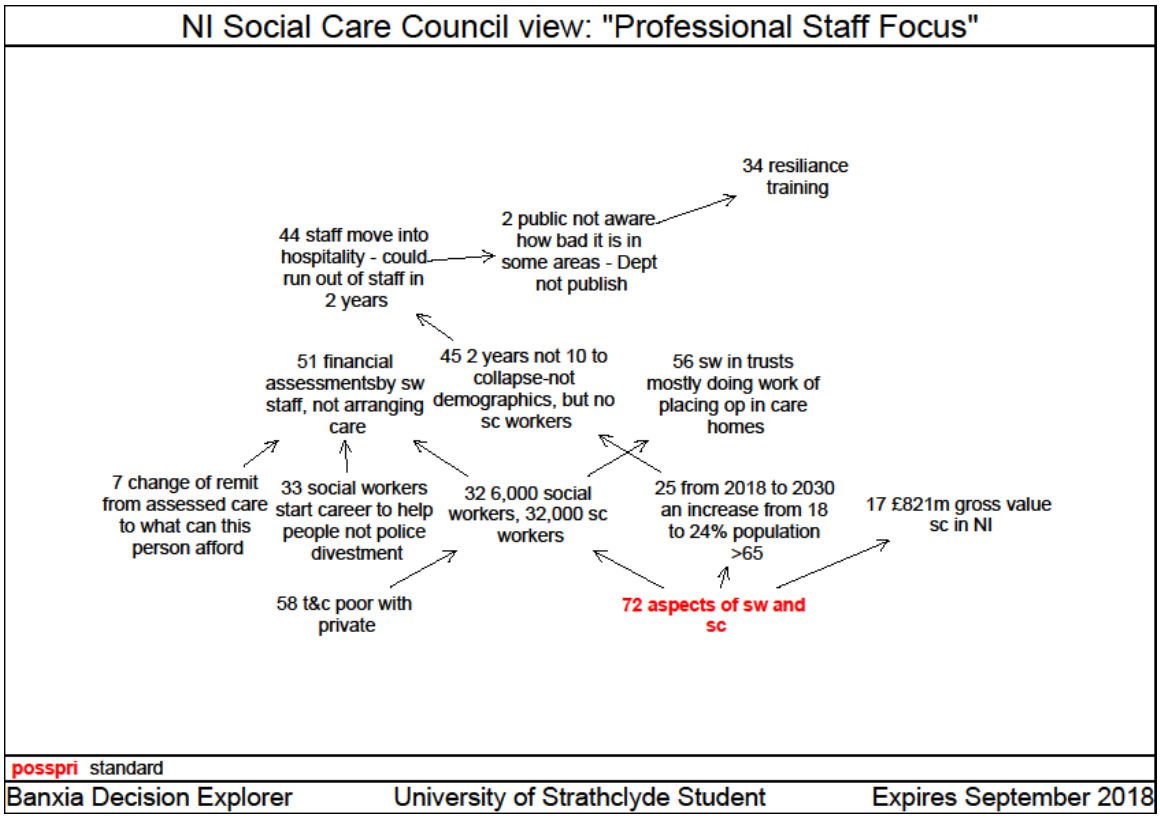


Figure 18: P6 cognitive map 'professional staff focus'

Figure 18 highlights the staffing issues, including that in the opinion of P6, the lack of staff will bring the system to collapse in some two years. Such issues feed into the map in Figure 19 below, being the focus of the major issue. This map notes that the service providers are taken advantage of until they go broke and the stigma in the system about making a profit are factors. Amongst other factors are that:

- **employers and employees wanting to provide good care, but are prevented by the system,**
- it **ensures bad outcomes**
- there are **few incentives to reform it.**

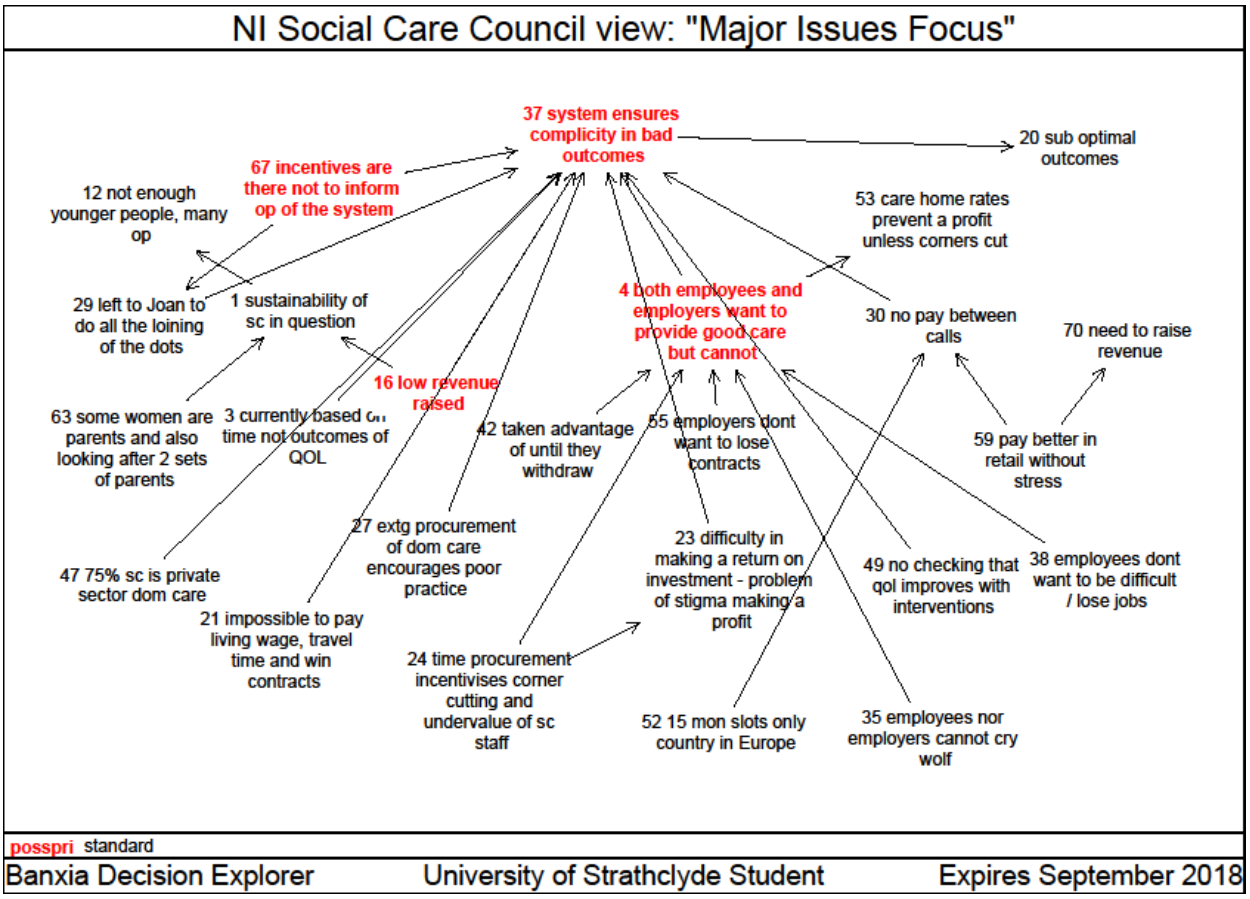


Figure 19: P6 major issues focus

Figure 20 below further develops how P6 views the major issues, priorities and strategic outcomes. The map focuses on the two distinct areas of revenue for the present system and the principles that should be embodied in a reformed system. The key priority that evolved is that there is a need to change attitudes that exist. P6 is clear that providers of risk capital need to make a return for their investment, efforts and risk. Governments can facilitate this as shown in the map by:

- the need to **facilitate partnership**, possibly through councils,
- a **need for community navigators**,
- a building of **connectivity in communities**
- to focus resources on **quality and what is appreciated** by older people.

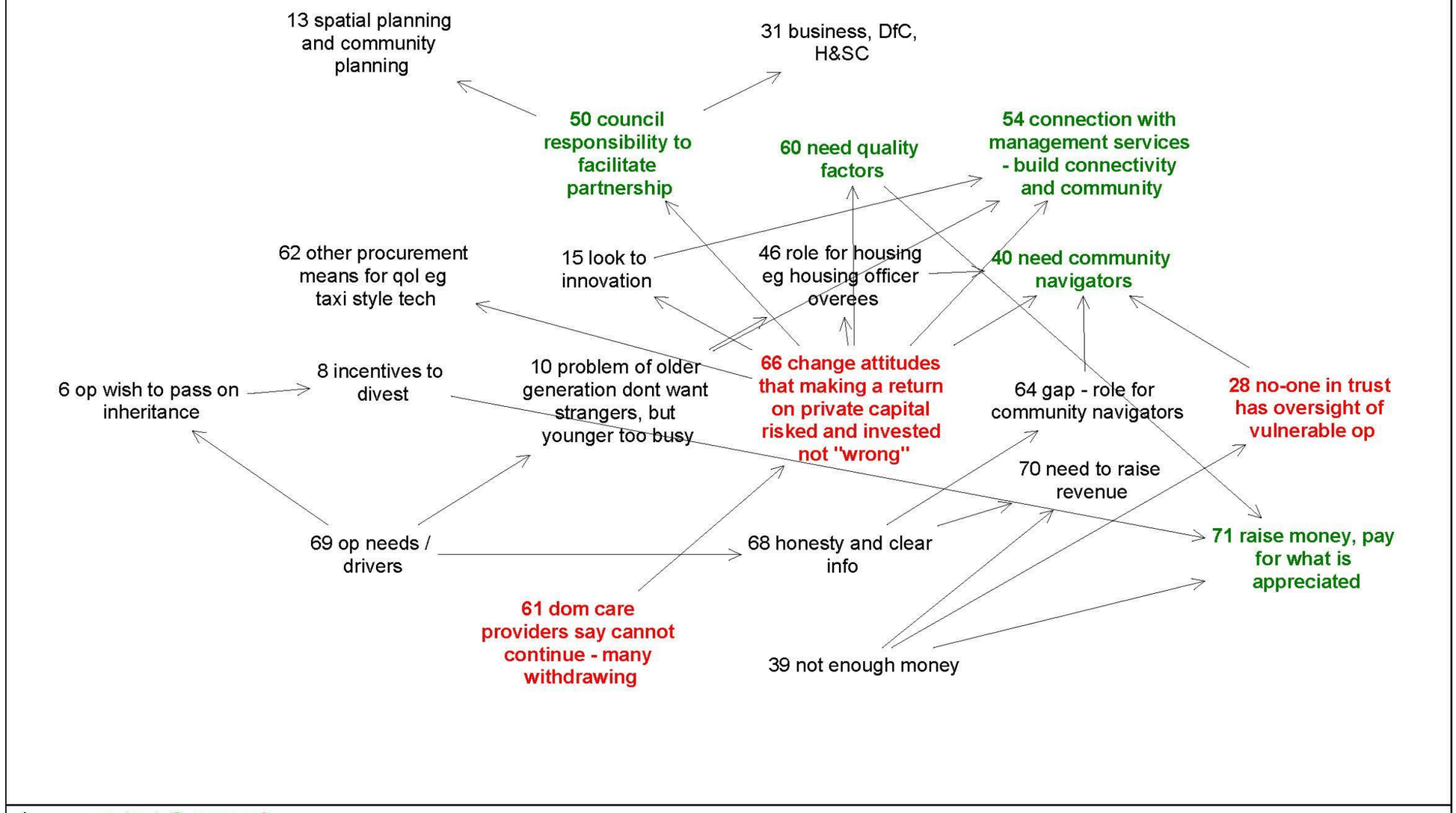


Figure 20: P6 outcomes focus

2.2.7 Participant(s) 7 (P7)

Interview date: 05.03.2018

Profile: Participant 7 (P7) is a group of participants consisting of the CEO and members of the senior management team of the Regulation and Quality Improvement Authority (RQIA). RQIA registers and inspects a wide range of health and social care services based on minimum care standards to ensure the public and the service providers know what quality of services is expected.

2.2.7.1 Participant (P7) sensemaking

Of the broad range of advice to the Department, P7 narrowed the focus of attention to 'regulated services, which is nursing homes, residential homes… and domiciliary care agencies'. The RQIA assess against 'minimum standards'; however, they also confusingly noted that 'some of them are aspirational, they cannot all be met.' Recently, P7 noted that they were moving towards phraseology of 'care standards' rather than minimum standards as a better way of framing their role.

Comment: The remit was not clearly presented to me. I regret not being more critical in asking how standards can be both minimum standards that have to be met while at the same time be aspirational — 'they cannot all be met'.

2.2.7.2 Care home philosophy

They note that their philosophy is one that views the environments, in the following way:

'If it was my mother or grandmother that was going into a nursing home… meeting all those standards, would I be happy with the care? Yes, I would, very much… these are not prisons for old people… I would expect an individualised care plan… a named person (in charge of my care) … all those essential things, so you have a sense of being there and belonging… so you are not just being 'done to'.'

For example, the inspection would seek to ascertain whether good governance is in place:

'What are the oversight arrangements? Is the manager being supported? Do they have the correct number of staff? Do they have the budget that allows for it? Do they have proper monitoring arrangements for care? Are they monitoring the care themselves? Because we are monitoring it … we know exactly what's happening, the number of falls, the number of people that have died.'

P7 noted that it was important that there was a choice for residents, such as 'can you stay in bed and have breakfast in bed because you're just not a morning person.'

Comment: P7 were aware of the genuine risk that standards become standardisation. Moreover, by continually referring to 'not detaining', 'these are not prisons', and concerns of 'doing to' rather than 'being with', there is more than a hint of the lady doth protest too much. It may be the case that standards imply standardisation, and it is only from this compliance-orientated baseline that P7 sought some breadth of choice for residents.

2.2.7.3 Care home inspections

P7 told me that there are 250 nursing and 150 residential homes that are inspected a minimum of twice per year in an unannounced way. Visits are more frequent if there is a need to drive improvement. P7 also noted that the unannounced nature risked being at the home when families were there, so they were seeking to better engage with families. Moreover, they advised that they were considering inviting laypeople along with the visits for greater public appreciation of their role.

In relation to targeting inspections, P7 noted, 'we get lots of intelligence, we get lots of phone calls, letters, emails, we get lots of whistle-blowing about care and we use that intelligence to decide whether we go out, or pick up the phone to providers'.

2.2.7.4 Models of care

P7 highlighted the demographic changes that are presently pressurising the system and such pressures are set to increase further. In this context, they considered the strategic options at one point noting:

'With dementia demographics, certainly in the future, people are either going to need intensive care, perhaps in their own home, or some other setting. So, it's a balance between trying to accommodate those people elsewhere. The models that have been around are pretty traditional, in terms of residential home, domiciliary care with someone coming in. There's not any standards around another model… and possibly the overall reflection of care for the next ten, 15 years. Whether people will come up with something else – that's not what we are seeing at the moment. There are some pockets of supported living, so maybe… Some very difficult people [are] coming out of

hospitals and long-stay institutions who are actually coped with in supported living on a 24-hour basis. So, that can work quite well.'

Comment: The quotation above provides evidence that the RQIA do not see how to provide care other than in either care homes or at home, save for some 'very difficult people' who can be 'coped with'. As such, my first comment is that seemingly the RQIA are not volunteering any awareness of Extra Care as it exists in England. It seems unusual that the CEO did not volunteer to know of other means of care. Secondly, the language is revealing – P7's was at pains to stress that '*these are not prisons for old people'* and the language reveals a way of thinking that seems to imply that receiving care and being in control are mutually exclusive. Also, that a top priority was '*so you are not just being 'done to'*, may well imply that such a situation is commonplace. Similarly, is language such as 'coping with difficult people'. For both reasons, it seems that the culture of the RQIA is one of seeking regulatory compliance rather than a philosophy of well-being and quality of life maximisation for older people.

2.2.7.4 Regulation of domiciliary care

P7 regretted the fact that they were only able to regulate the service provider, rather than individuals. They were aware of the almost impossible task of helping an older person get up, washed, dressed, fed, check medications, and provide a social outlet within a 15-minute period: 'there is no quality of life to that, not at all.' They know the providers and care staff seek to do as best they possibly can but are prevented from doing so by such a system: 'you know, there is a real ethics within the domiciliary care providers.' They were also aware of significant instances of individuals with very poor quality of life, some incontinent and bedridden, who may see no one else in the day.

But staff ‘have no incentive to cry wolf’, not wishing to get a reputation for being ‘difficult’ and their employers are unlikely to complain about their Trust employers.

Comment: P7 was aware of the demographic pressures, shortage of staff and finite finances that contribute to failings in the system and result in very poor quality of life for some older people. Their response defaulted to increases in regulation rather than visualising fundamental changes.

2.2.7.5 P7 cognitive map analysis

Since P7 did not reflect on any system shortcomings, I have added interpretations. Figure 21 presents the cognitive map regarding the inspections of care homes and how the associated issues interrelate. The possible priority highlighted in the cognitive map is presented as:

- **binary method of assessing whether standards are met or not met does not afford an insight into the lived experience and someone’s quality of life**.

A strategic output may be therefore that older people and their families may benefit from a more nuanced approach such as the CQC in England, which provides a rating for homes across several dimensions. Since families often need to make a choice of home at a time of stress and in a rush, the lack of a public means of weighing up one home against another seems an obvious omission. However, P7 simply stated that ‘there is no appetite for rating at the moment’. The strategic output, I thus note for collection in the causal maps, is that

- ‘**a more nuanced reporting is needed to give families information and a means of better decision-making at the time of crisis moves’.**

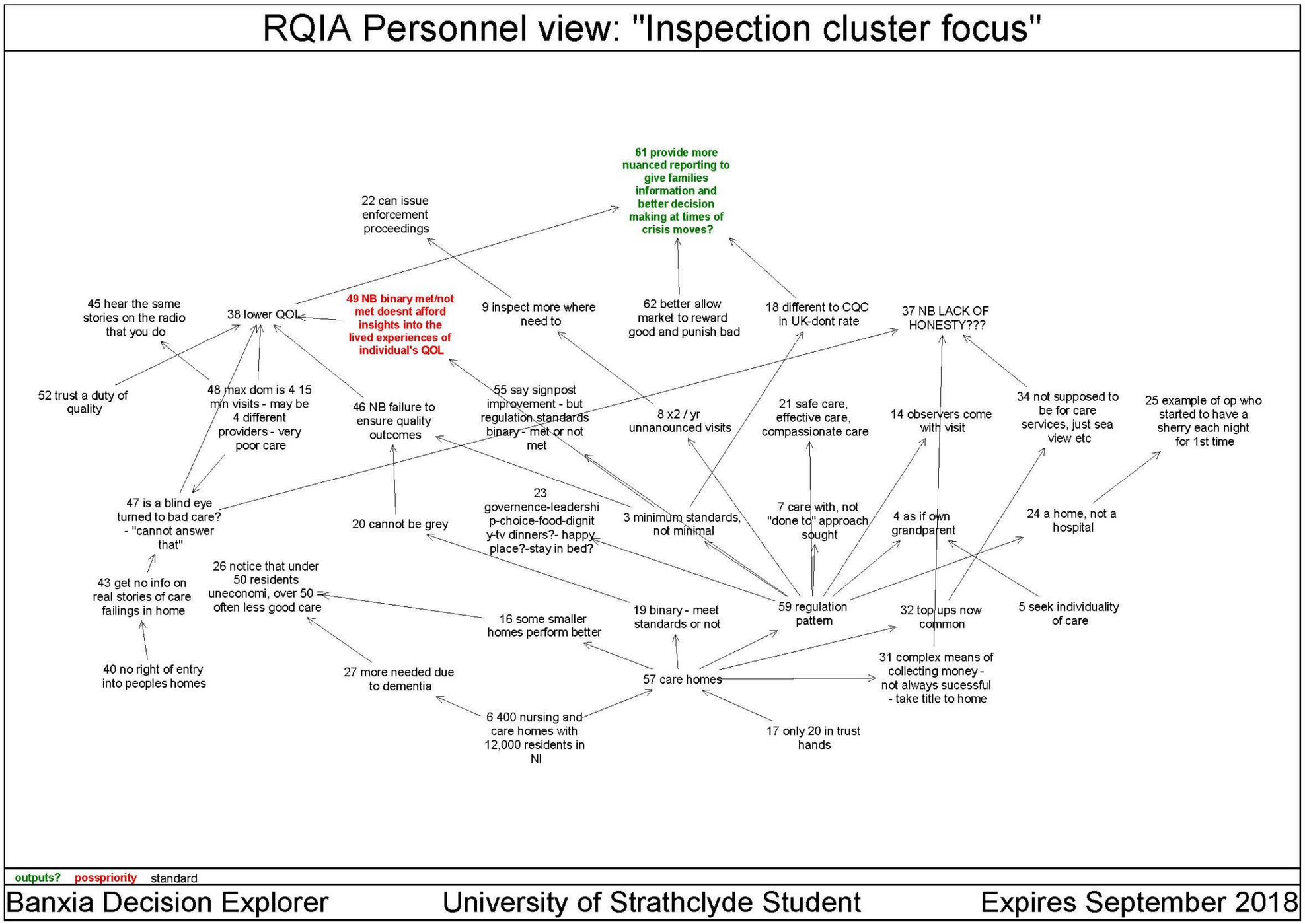


Figure 21: P7 cognitive map 'Inspection Cluster Focus'

Figure 22 displays the cognitive map for domiciliary care. The passivity of the RQIA is noted and the priority question asked that if the RQIA is not driving quality improvements, then who is? In short, the map asks

- **who drives improvement policy?**

If as I have outlined, the P7 definition of quality seems narrow, the map then asks if we accept that the RQIA is confined to following a narrow policy, then who is it that drives the improvement of policies?

In the context of providing the public with better information in order to choose between good and less good care homes, the map notes that with the right information and a functioning market, good behaviours get rewarded, thus the map concludes with the strategic output of:

- **a need for a market with better information and choice rewarding.**

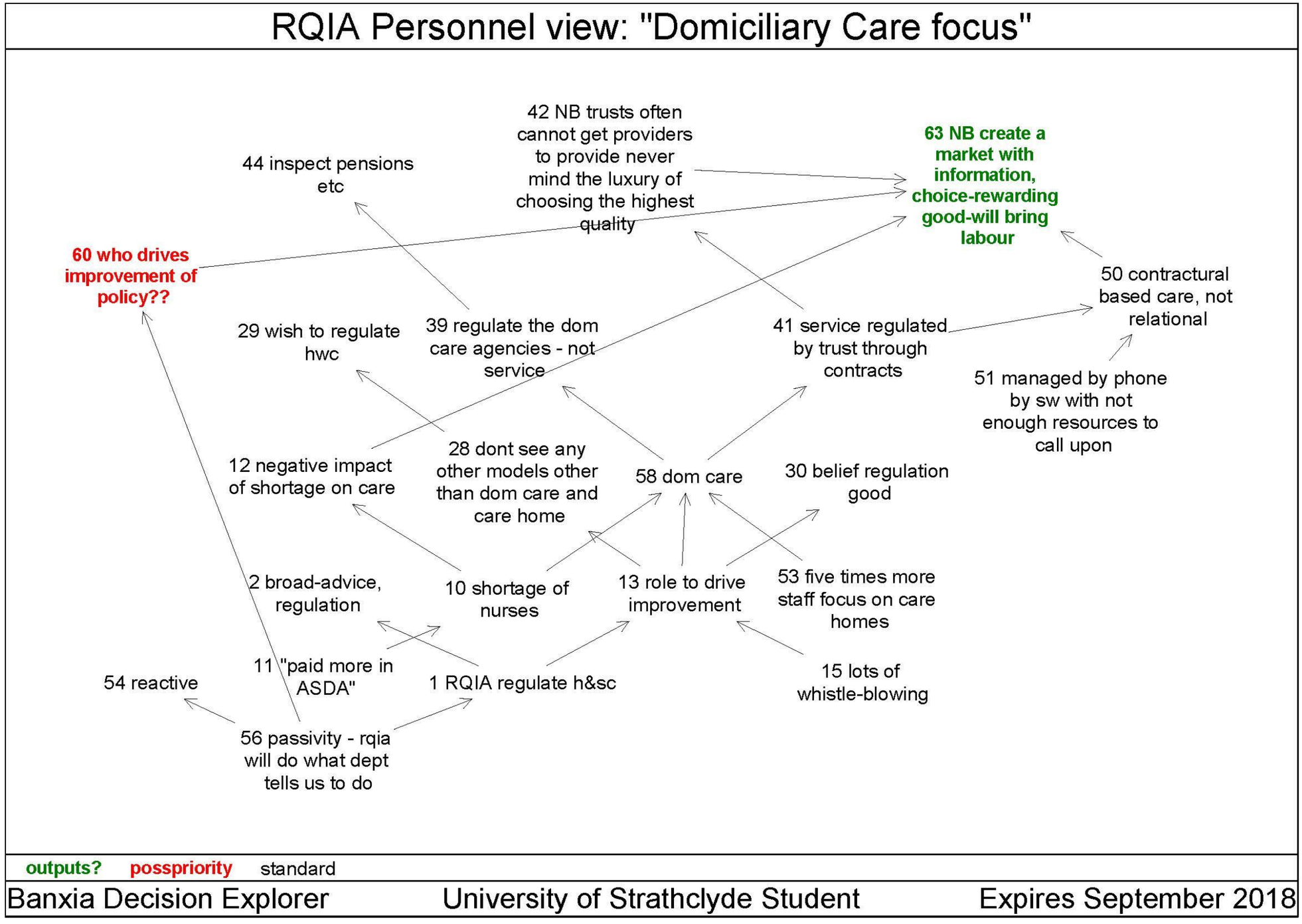


Figure 22: P7 Cognitive map for domiciliary care

2.2.8 Participant 8 (P8)

Interview date: 21.03.2018

Profile: At the time, P8 held the post within the Department for Social Development tasked with developing relations with the third sector and private sector. In addition, they led the housing strand of the *Power to People* review (Kelly and Kennedy, 2017). Their role was to develop new approaches, new models and new funding strategies, including the use of financial transaction capital (FTC) to try to increase supply.

2.2.2.1 Participant (P8) sensemaking

I met participant eight (P8) on three occasions, with the first being the introductory meeting, the second being the transcribed interview, and the third where I presented P8 with the draft cognitive and causal maps for confirmation.

P8 noted the 'overwhelming' focus of the Department on social housing. P8's role had come from ministerial initiatives anxious that the Department has a broader focus on its full remit as the Department for Communities, rather than merely the department for welfare distribution and social housing. As P8 said 'I'm building a business from scratch'; however, they relayed the breakdown of the Department budget, highlighting that their budget was very much 'small beer'.

Comment: The Department is allocated a small budget thanks to ministers pushing for the Department to be less of a narrow conduit for the distribution of welfare payments and social housing provision. When P8 subsequently moved to a different department, and in the present absence of ministers, the post has no permanent replacement.

2.2.2.2 Financial Transactions Capital (FTC)

P8 went into how private / public / third sector funding arrangements can be made to work using FTC. Recently, the Department has been able to support housing associations by way of loans that are subordinate to the senior debt and have been treated by loan providers as being akin to equity. FTC has thus enabled the housing associations to achieve excellent rates of secured lending. P8 explained that whereas 15 years ago the associations would have received £15m of a grant, now they are receiving £25m of a loan. Moreover, the monies come from the UK Treasury rather than from the departmental budget, as was the case with the grant.

P8 explained that the means of financing 'would be loan capital, either at a commercial or zero interest rate for a wide range of purposes. That's what we are trying to get to.'

P8 explained that FTC is available from the UK Treasury on the basis where departments partner with private initiatives that seek to contribute to public problems. Moreover, for every £10 drawn the sponsoring department need only return £9 to the Department of Finance, who in turn need only return £9 to the UK Treasury. It follows that of the loan from the UK Treasury, only approximately 82% needs to be repaid. This policy reflects the UK government seeking to incentivise Departments working with private capital in order to assist give such capital the possibility of debt leverage.

Comment: FTC is an innovative means of stimulating public partnerships with private and third sector organisations. Being off-balance sheet, it is designed to be a highly cost-effective means of delivering stated outcomes.

2.2.2.3 Reasons for lack of take-up

P8 volunteered that 'a lot of the challenge … is around the conservatism in the system', and recounted the effort they have had to put in to get some quite limited progress:

'So, for example, I mean, I have been working for a year now on a business case for people with learning disabilities. Three months were wasted on state aid issues. The Department for Finance is very conservative. So, there is a real fear of funding the private sector… a real risk aversion. So, we're really trying to push water uphill here with very limited staff and resources. We are having to pick our battles. So, we will get there, but I think it's going to take a number of years.'

Comment: P8 was expressing frustration at their and other departments. P8 was finding that the Department had a cultural difficulty with engaging with doing things different to the norm. The budget allocated to the P8 role is 'small beer' and they were finding considerable institutional sedimentation, if not actual resistance, making change very difficult. Indeed, P8 shortly after my third interview, took a post in another department, and their post has been covered by another staff member since then. It is possible that in the absence of ministers maintaining the pressure on the Department to change, they are not giving the role that P8 had much attention. As an institution, the 'conservatism in the system' seems to make strategising and effecting change difficult.

2.2.2.4 Adults with learning difficulties case study

P8 explained at length the case study using FTC capital for 30 homes for people with learning difficulties, including the philosophy and finance proposals. The homes are designed to keep people with complex needs in an environment that is supportive, and

prevent the situation where funding stops for people that turn 12. Such a change in funding often leads to young adults being required to move into an institution, since funding for care in that way exists.

The parallels with Extra Care were evident to us both. The P8 proposal thus allows families to remain together or set up their own home independently in order to 'leave the family home with [its] older carers'. The funding structure means that the rent levels in the 30 homes are 'something that's affordable'. This allows individuals who self-pay to benefit from such homes as well as those in receipt of housing benefit. The cost comes out at £1,300 per week, instead of up to £5,000 a week in Muckamore (an institution for adults with learning difficulties that has been extensively exposed for its poor levels of care). P8 thus noted the 'betterment issue' of higher quality of life through being in control in one's own home, rather than in a care home, as well as the very significant cost savings.

At the time of the interview the business case was '70% done'; however, I am not aware of the initiative being launched at the date of writing.

Comment: We agreed that the parallels between this case study and housing with care for older people were visible. Accordingly, a strategic output is to compose a Strategic Outline Case jointly for the Department for Communities and Department of Health making the strategic case for Extra Care Plus.

2.2.2.5 Towards a consistent strategic contribution

P8 noted that 'I think direct payments are a brilliant idea, but you need some kind of community navigator' thanks to the structure of the payments that require the older

person to be the employer. P8 also believed that there was a need for the Department to be strategic and pro-active. However, in the departments there is:

'some sort of belief that self-directed support will just happen organically. People will come to it and services will develop. Well, that's not going to happen. We need to actually encourage services… people are not going to take self-support unless there is someone to support them doing that. There needs to be a wider range of provision, so let's seed something.'

In this context, P8 therefore considered a strategic element would be the community navigator. P8 welcomed hearing of the Older Person's Commissioner participant's proposals for everyone aged 75 to have a visit when saying, 'How do you know what your options are? You're informing people, helping them to make informed choices.'

P8 considered another strategic element would be to have appropriate housing within older people's own community. They stated: 'so any research that I've seen for older people says that they would be willing to move within their community that they have lived in for many years… (if such homes existed) but good quality, right-sizing options don't exist… so actually what choice do they have?'

A third strategic proposal that they were seeking to implement was for a private entity to partner with a housing association to create a mixed tenure scheme for general housing. P8 was open to the concept of such a partnership being for older people also. Together, we recognised some potential issues that might need to be considered under such a proposal, such as whereas it is reasonable to expect private providers to create housing for the purposes of sale, it is quite another to create housing to rent.

Comment: P8 volunteered keen and positive strategic contributions, which included:

- They considered the attributes and issues that needed to be deliberated when designing a model for older persons' housing with care, including political implications.
- They outlined the financial model that can be a highly cost-effective way of the departments achieving their strategic aims, using FTC.
- They outlined a parallel case study in the process of being approved, including the steps to take and the pitfalls to try to avoid.
- They highlighted the partnership with housing associations channel that they were exploring and assisted with referring me to the contacts in each case.

P8 therefore added a significant strategic contribution but was evidently frustrated at the difficulties that they were facing with getting progress at any scale in their own Department. They noted that it was the ministers who provided considerable drive to the Department having a wider community and social scope. Regrettably, with the collapse of the political institutions, such initiative is absent, and P8 has also accepted another post in a different department, with the post they have left being unfilled. Perhaps P8's strategic thinking is not always the norm.

2.2.2.5 P8 cognitive map analysis

The issues that P8 considers essential are presented in Figures 23-24.

Figure 23 backgrounds the alternative approaches to achieving the departmental goals.

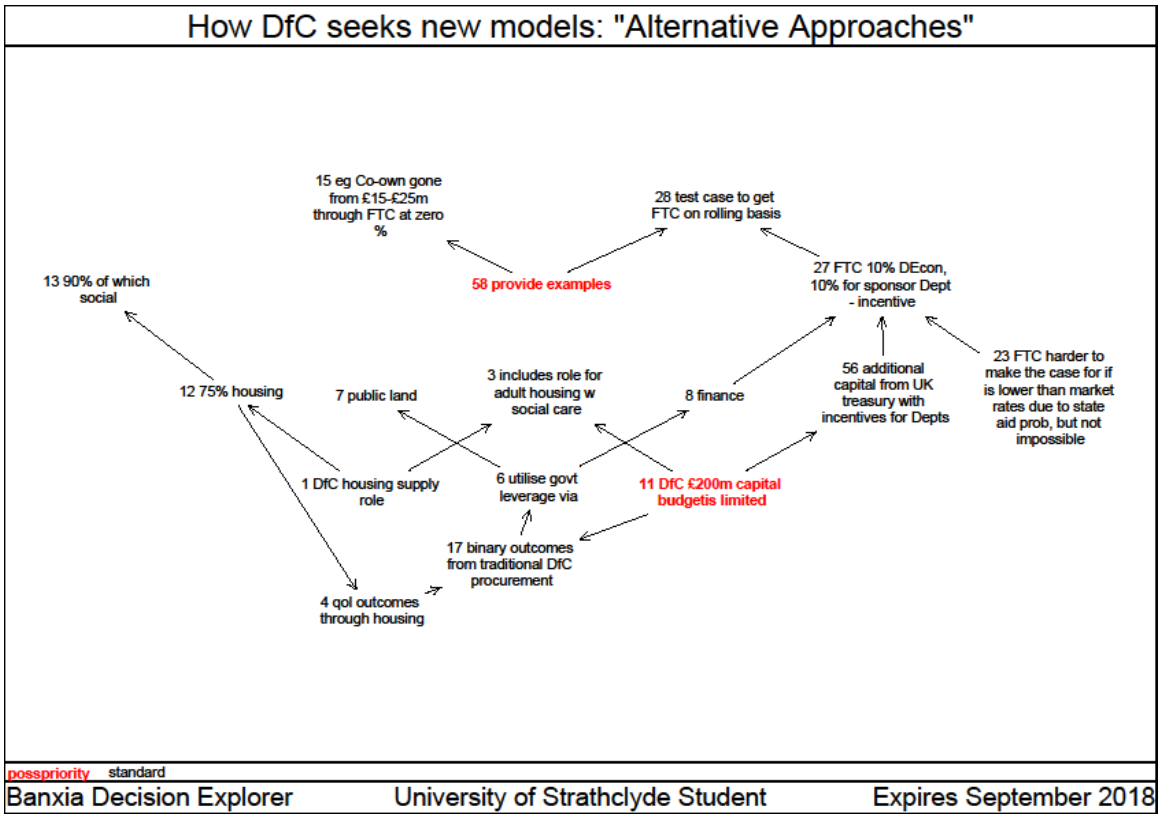


Figure 23: P8 Department for Communities seeks new approaches cluster

Figure 24 presents their cognitive map concerning 'private routes' to achieve departmental goals. A priority shown is to **put a framework in place that encourages innovation and risk-taking**. It maps as a strategic output the node of **needing a community navigator.**

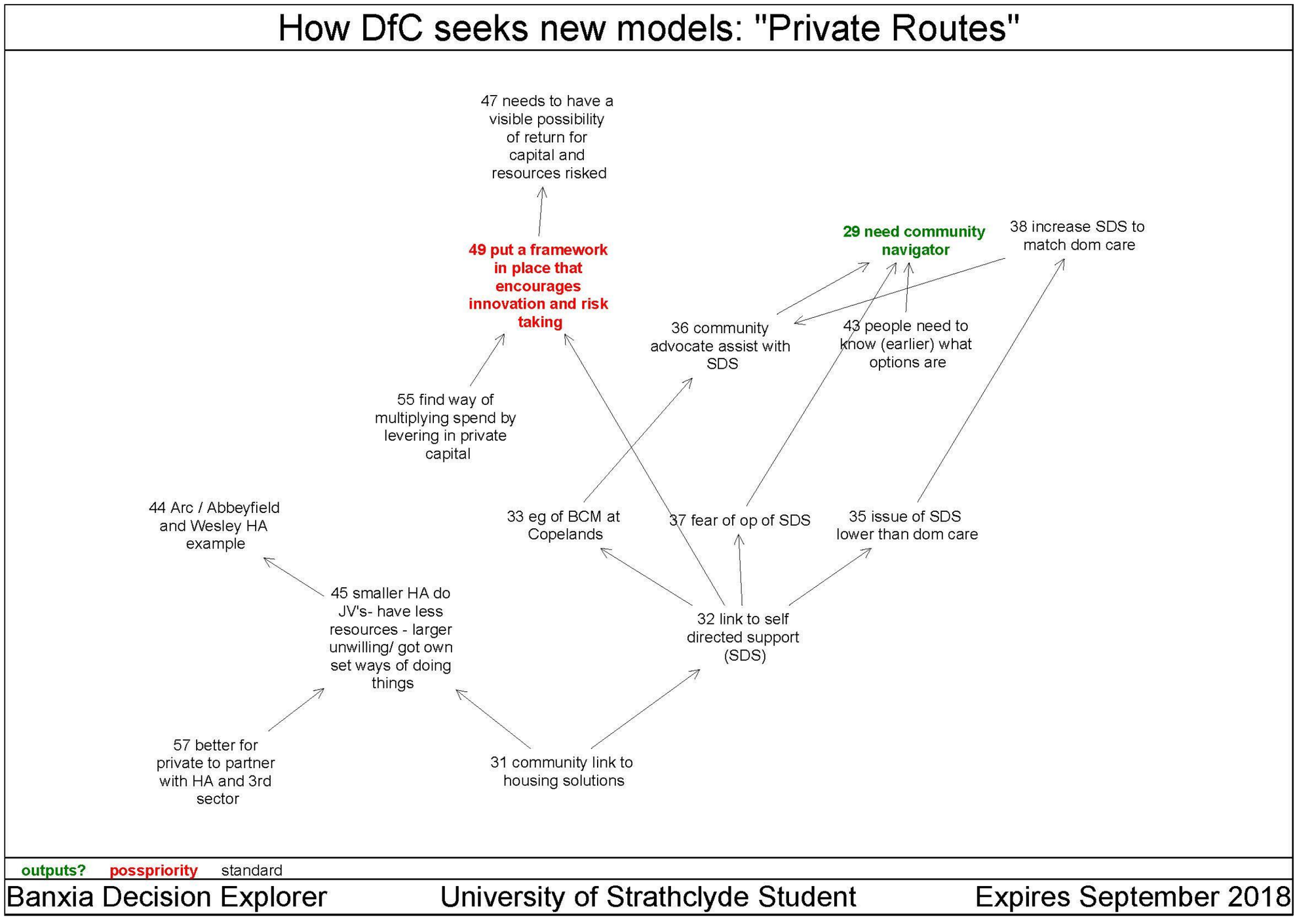


Figure 24: P8 Department for Communities new models: 'private routes'

Figure 25 presents how P8 makes sense of the ‘conservatism in the system’.

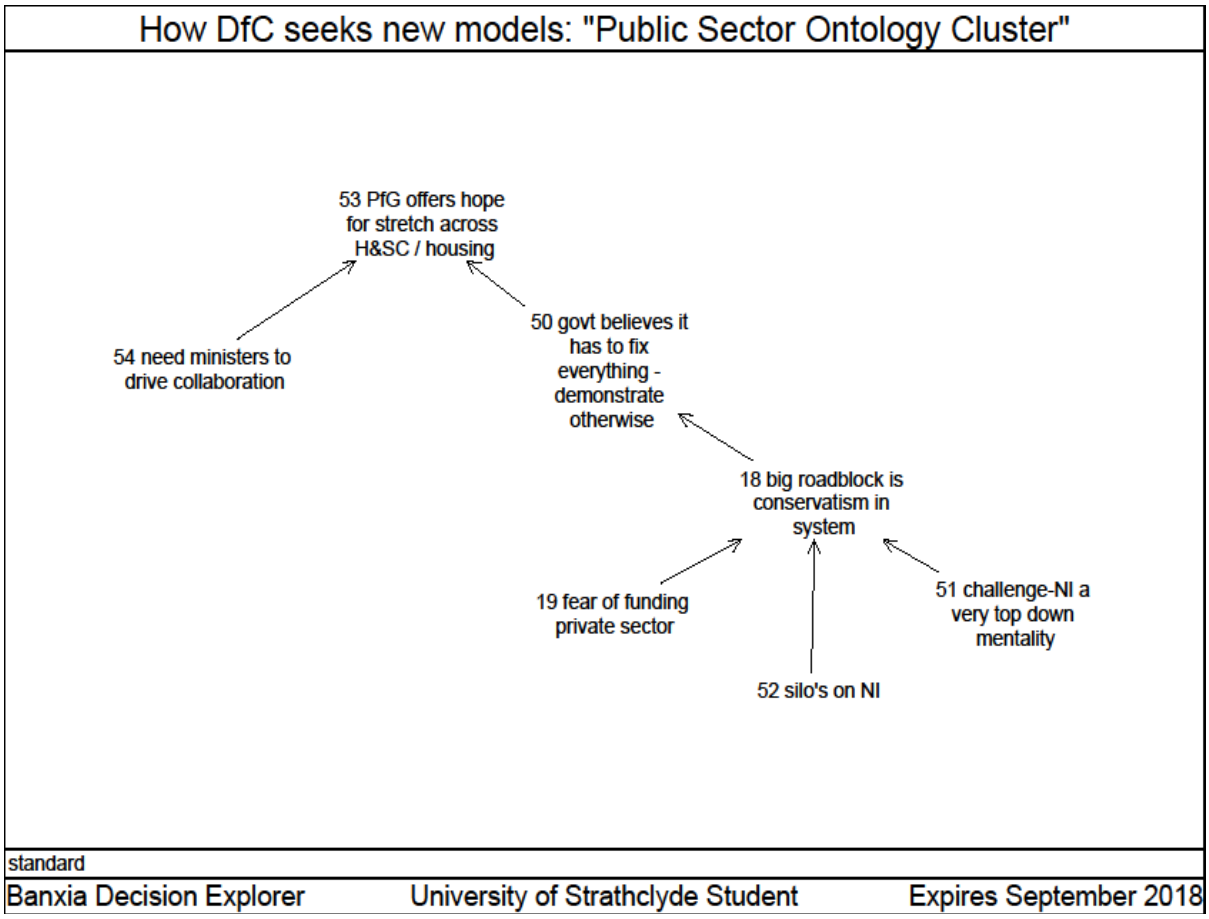


Figure 25: P8 Public sector ontology cluster

Figure 26 below picks up how the participant makes sense of the balance that may be struck between the public and private sector when considering housing with care. The cluster highlights priorities and strategic outputs as:

- **To lever in private initiative, investment and capital (a challenge).**
- **To provide environments within which personal choices can be made that are vital for well-being and life satisfaction**.
- **To involve the private sector and third sector to improve and increase supply**.

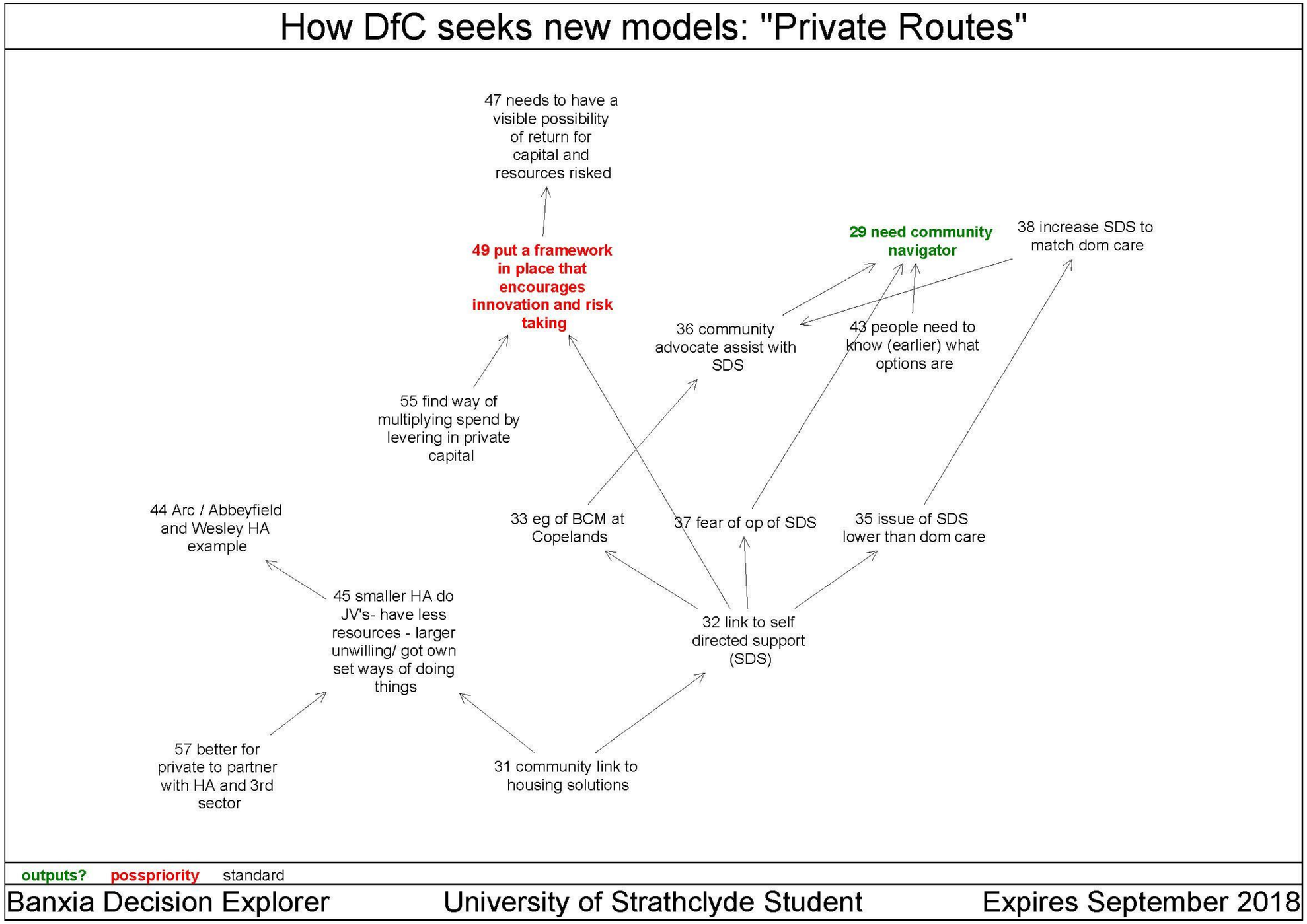


Figure 26: P8 Striking a balance between the public and private sector with more 'Private Routes'

2.2.9 Participant 9 (P9)

Interview date: 23.03.2018

Profile: Participant nine (P9) is the CEO of Age NI, which is, according to their website, the leading charity for older people in Northern Ireland.

2.2.9.1 Participant (P9) sensemaking

P9 introduced themselves and their role as follows:

> *'I've been in the sector of ageing for 30 years. What drives me is a passion for working with older people to ensure that we have a good quality of care so that people live well and die well at the end of a long life.'*

They quickly highlighted the growth of the demographic of those over 85 years old being a central issue, where Age NI has 2000 people per week through some type of Age NI service. In the past, the profile for those helped was 75 and over, but now Age NI deals with more people over 90 than in their mid-70s, and the norm is that this older old have a number of chronic conditions, especially dementia and diabetes. In this context, P9's focus was an approach for living well in old age that consists of

- health promotion,
- independence,
- prevention'.

2.2.9.2 Services

P9 explained the different Age NI offerings. These include regulated services of a residential care home and the domiciliary care services, and unregulated services such as their 13 daycare centres, advice services, and recent community navigator services.

P9 highlighted the high level of loneliness that older people experience; for example, in daycare, 'the vast majority of them are coming in because there is no-one to look after them'. They described their own experiences:

'When I used to do daycare, I remember very well my first week or two in the job. I was taking 'Joan' to the day centre in Lurgan, and no one came in [to her home] other than us. So, I knew that when I left her home on a Thursday, she would have no one to come until the next Thursday, to speak to, to communicate with.'

P9 detailed the Age NI care home as a home for older people with dementia, with 24 bedrooms, saying 'you don't need an 80-bed care home. You need small, domestic.'

2.2.9.3 Conor and Joan

P9 volunteered their thinking of the case of Conor and Joan as an archetypal case of older people in Northern Ireland:

'what typically happens to confirm the story (of Conor and Joan)… is that the wife will become so stressed through the burden of care, because you see the burden of care increasing… you see medical problems for Joan where she becomes hospitalised, then the husband would go into care, and not come out again. Or Conor would have constant infections going to hospital and nursing care… the wife would be on her knees… feeling the pressure that she's not done the right thing. She's let him down

because he's gone into care. So she's feeling the guilt of that, the burden of caring and she's become very unwell herself.'

2.2.9.4 Domiciliary care issues

P9 explained that the charity was withdrawing from providing domiciliary care services as it was losing too much money, and this was putting pressure on charity resources. The reason is that the charity is an employer that pays the living wage and pays travel time between care calls. However, the payments from the Trusts do not cover these costs and the board has directed that the charity deploy its scarce donations more effectively than competing, and making a loss, within the domiciliary care system. P9 stated

'if you're doing personal care, if you're doing meals, there is no way that you can do that in a 15-minute call… For a start, if I'm the client, I might be ill. There's no way that I'm going to be able to race to the toilet and race back again.'

Where the HSC Trust is offering only £12 per hour, P9 have costed such services at typically £18 to £21 per hour. Some providers are 'prepared to take a loss for the first couple of years because they reckon that will change in the longer term', but not Age NI. P9 commented that 'the two biggest things within domiciliary expenditure are mileage and salaries. So, there's nothing left.' Since Age NI pay for mileage and time spent between calls, it has been unable to compete. The system, according to P9, is thus complicit in exploiting labour and driving out 'mom and pop' providers, leaving care to large-scale, geographically remote and less personal organisations, damaging the community fabric:

'I do firmly believe that the small providers lose out. You lose small community support through the large provider coming in, mopping up all the hours. You then lose the connectedness of a local provider in a local area, a local community. That's what domiciliary care was built on – the success of domiciliary care. In the old home help [era], you were just a street away… We have lost all that because of all the travelling between calls.'

P9 bemoaned the residualisation of domiciliary care. They recalled the days of the home help that had a much greater social element:

'Somebody coming in, telling [them] who's doing what, what's happening in the street. These important mental and social stimulus things have gone. I know the advantage of someone coming in at lunchtime and to put a potato on, and a wee bit of meat, a few vegetables. You had local smells in the house, and you had a chat while you were making the meal, and you knew the person… all gone.'

A further factor is the guilt of an older person less able to look after their home, roof and garden: 'I never met an older person who hasn't said to me that they would like their home to be nice and tidy.'

As an alternative, Age NI has been negotiating a bespoke 'full cost recovery' dementia service. Initially with the Belfast Trust, P9 expects to roll it out for the other Trusts. The service is for a quality visit into homes of older people living with dementia, and during every other visit to take the client out and about for a couple of hours.

2.2.9.5 Losing control

P9 explained how an older person quickly loses control through encounters with acute care, where the first unplanned hospital visit is very often a huge knock to people's confidence. After which:

'All of a sudden people start to make decisions… taken out of your hands. So, the classic one… someone's being discharged from hospital. The ward nurse or doctor has found the daughter, but not necessarily told the person. So, it's like "you're going home"… and they say "it's the first I've heard about it" and "don't worry because I've phoned your daughter".'

After that, according to P9, 'people tend to make decisions for you: "I think you need residential care because I'm afraid of you falling on your own".' They explained how adult children are content for their parents to fall in a care home, but not in their own home. Thus, issues of risk avoidance and guilt on the part of adult children, perhaps living in England, conflate into a decision being made for an older person entering into care, given the absence of alternatives.

2.2.9.6 Alternatives

I interviewed P9 on two occasions: the transcribed interview and a follow-up. We met for the transcribed interview after both attending the opening of Rivara House, a Trust-run Extra Care facility. P9 noted that Conor and Joan 'would be ideal candidates for something like Rivara where one part of the team has a level of dependency that could be supported in a supportive environment… for husband and wife, keeping them together, supporting them in their care needs and recognising that things are getting a bit tough'.

P9 explained that Rivara ‘didn’t feel like an institution’, that people have their ‘own front door, their own living space. Even if it’s another six to nine months, another year of being together, that’s a year of quality… everybody feels safe in their home that belongs to them, their independence is maintained, and that’s paramount.’

P9 noted that the RQIA regulations surrounding regulated services seemed to ‘strangle’ quality in many cases, and that was not in evidence with the Extra Care example. ‘There is no feeling of red tape around there, there is no failing and the regulations around that. And that’s what hampers residential and nursing care, because it is all registered.’ They continued by saying ‘I see the benefits of registration for comfort’ for the family, but ‘you’ve always got to be ready for an inspector’. P9 believed that the well-being produced from this example of Extra Care was better than institutional care: ‘I think the outcomes are better.’ However, they expressed doubts about the level of cost that was implied by the sheer number of Trust staff in evidence. We also discussed that the residents in Rivara were almost exclusively drawn from those in receipt of housing benefit and we expressed doubts as to whether this was scalable; accordingly, I resolved to seek an interview with the housing association provider concerned and the relevant Trust CEO for their perspectives.

Comment: As CEO of Age NI, P9 has had a long career in care. They spoke at length of the failings of domiciliary care, and the issues surrounding life in a care home. They were clear in their praise for the Extra Care environment that we visited together but expressed reservations regarding scalability when the example was exclusively public sector managed care, housing and (for the most part) residents. Achieving a scalable Extra Care solution must therefore be done through a partnership with Trusts, 3rd

sector which in turn may provide the private sector with the requisite covenant strength in order to draw in the quantum of capital that only the private sector can introduce.

2.2.9.7 Community navigator

P9 was emphatic that the role of the community is fundamental for well-being and a community navigator is a good way to aid people from becoming isolated and help with providing people with help and information when encountering the complicated care services. Age NI has a pilot scheme that does this role named ‘Living Well in Moyle’, and there are important lessons that may be drawn from this experience as a ‘sign-poster’ and for ‘Joan’, for example, for whom ‘it must be so frightening’.

Comment: Throughout the interview, P9 returned to the contribution that someone local has for helping an older person with small things, reassurance and company and have been removed by the medicalisation of domiciliary care. The ‘Living Well in Moyle’ project has confirmed the benefits for older people’s well-being that can be had from a community navigator who should be an integral element of any strategy to cost-effectively improve the quality of life of older people.

2.2.9.8 P9 cognitive map analysis

Figure 27 highlights the structural factors that are driving change, such as

- **older people living longer with chronic conditions such as heart disease, cancer, diabetes and dementia**
- **importance of independence for quality of life.**

In the cluster, these priorities interface with other issues and lead to a strategic outcome of: **Housing with care to keep people together in their own space.**

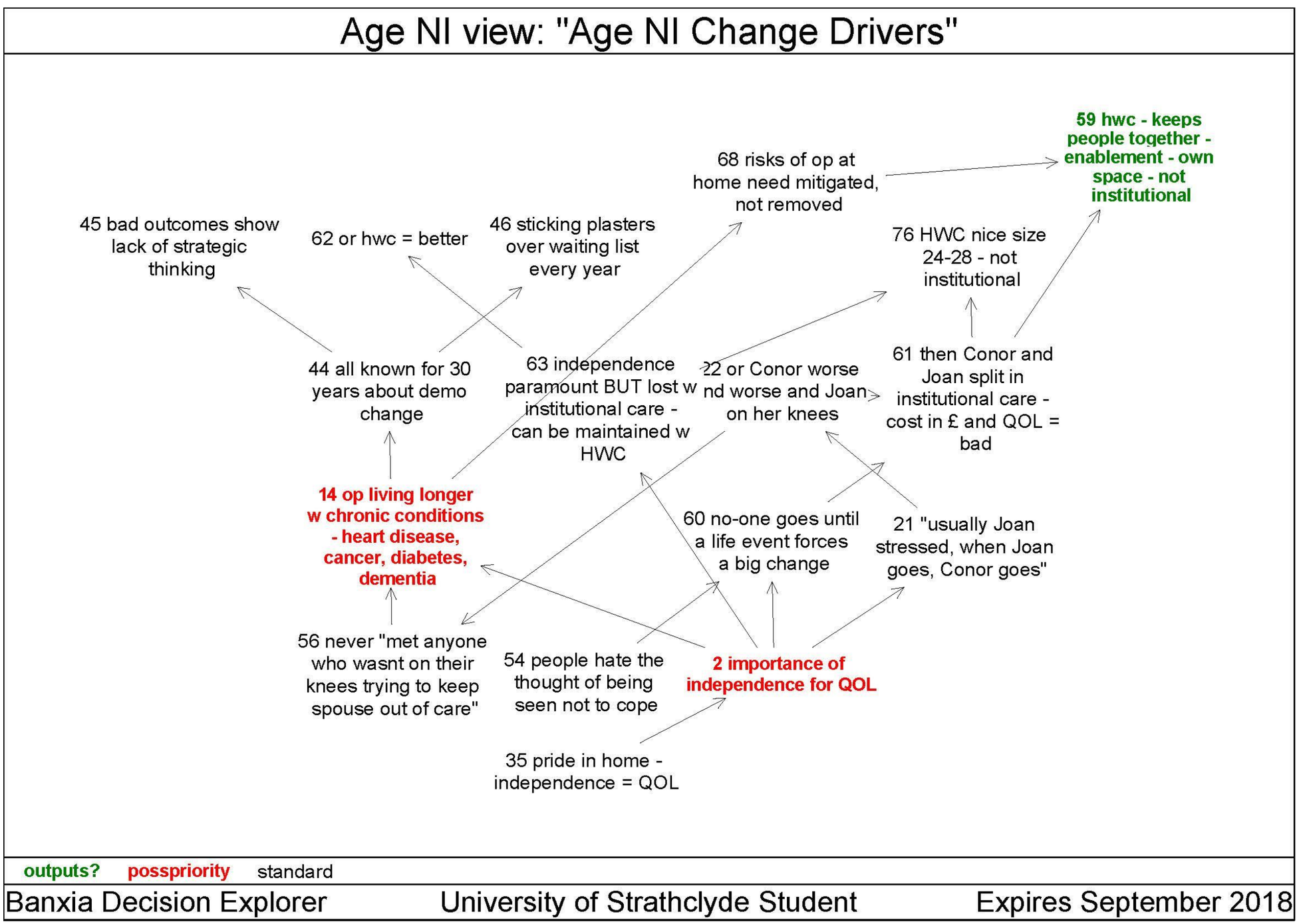


Figure 27: P9 Age NI change drivers

The state of domiciliary care is the focus of the cluster in Figure 28 below. The map highlights the interplay between the issues that together coalesce towards the services not being an effective means of producing welfare. In the map, the under-priced procurement contributes to a lack of local provision and a residualised service where staff have no time to spend with older people.

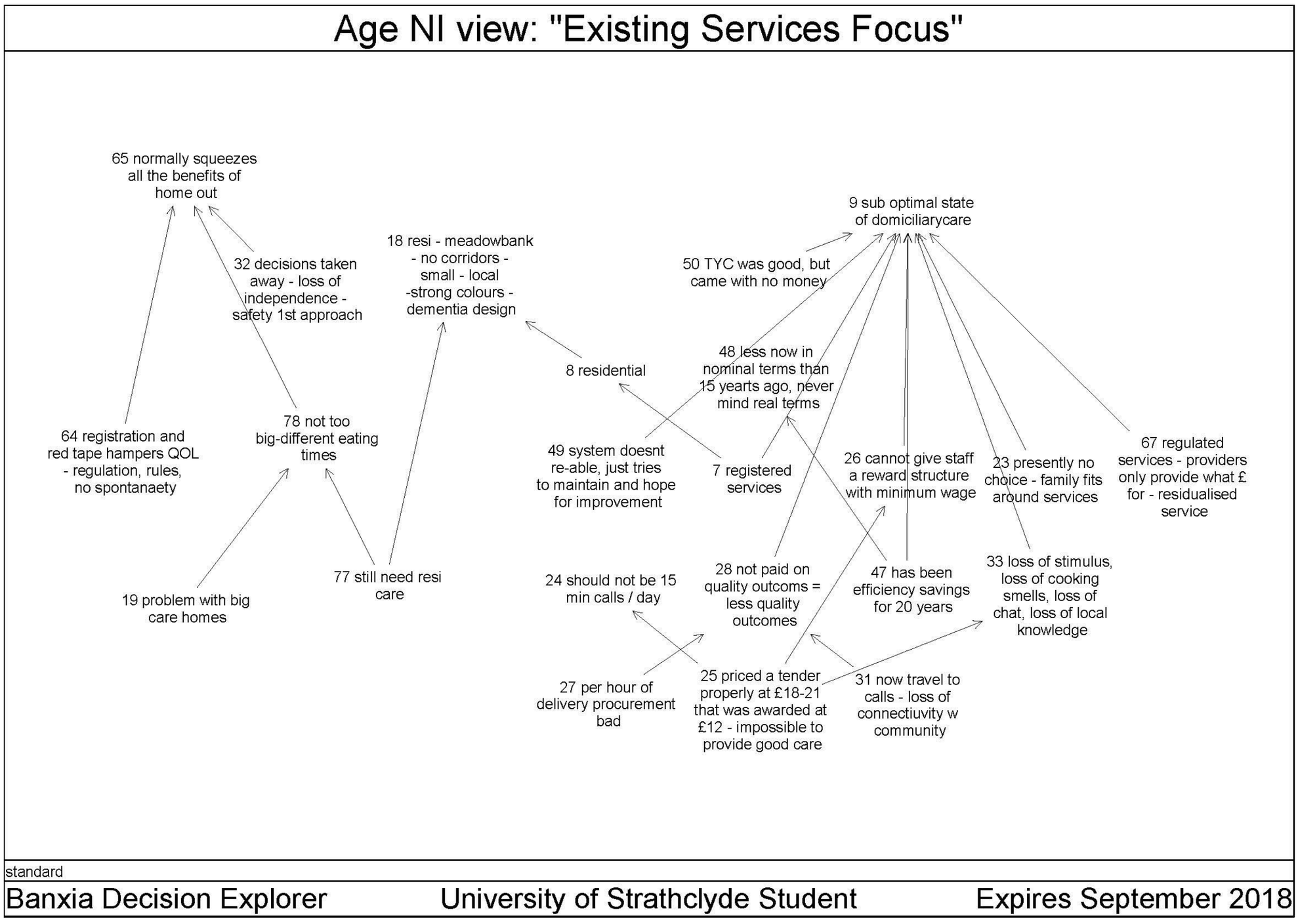


Figure 28: P9 Existing services cluster

In Figure 29 below, the way P9 considers the role of Age NI and is mapped to include their service offers. A strong theme is the importance of social factors that the Trusts can no longer afford to provide thanks to demographic changes. The cluster highlights how the charity promotes integration as a means of adding to the social life of older people, including, for example, the matching of local volunteers with older people.

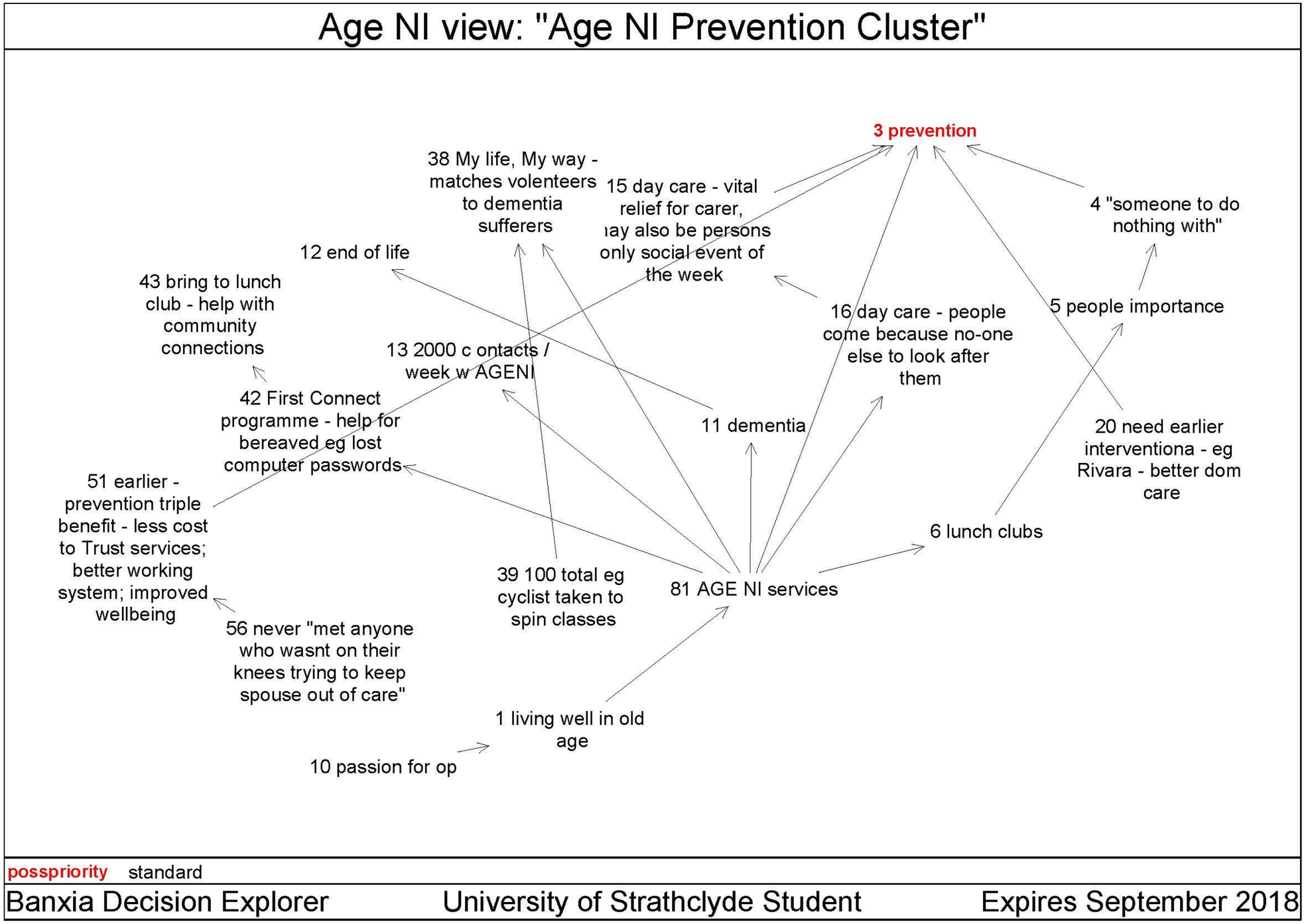


Figure 29: Age NI prevention cluster

Figure 30 below represents the ‘Outputs Cluster’ of P9. Herein, the priorities shown are

- **for more effective interventions**

to achieve welfare such as the role

- **for community navigators**

as a cost-effective means of achieving these goals. The interplay of the community navigator and the importance of one’s home and community for quality of life are shown, as a means of maintaining independence and self-mastery. Self-directed payments are a key way for older people to remain in control, especially in a housing environment where an older person remains in control, the community navigator may assist with demystifying the present system. This interplay is shown as that

- **housing with care may be a way to assist with self-directed payments**.

The strategic outputs recognise ‘Rivara’ the Trust-run Extra Care scheme works in line with community navigators, namely:

- **to link community navigators with housing with Rivara care success**.

However, to provide effective scale, additional elements are needed such as private capital along with the opening of Extra Care to more than those receiving housing benefit. This node is thus shown as

- **find a model of private, Trust, housing association, community and charity**

to better create Extra Care and more effective welfare production.

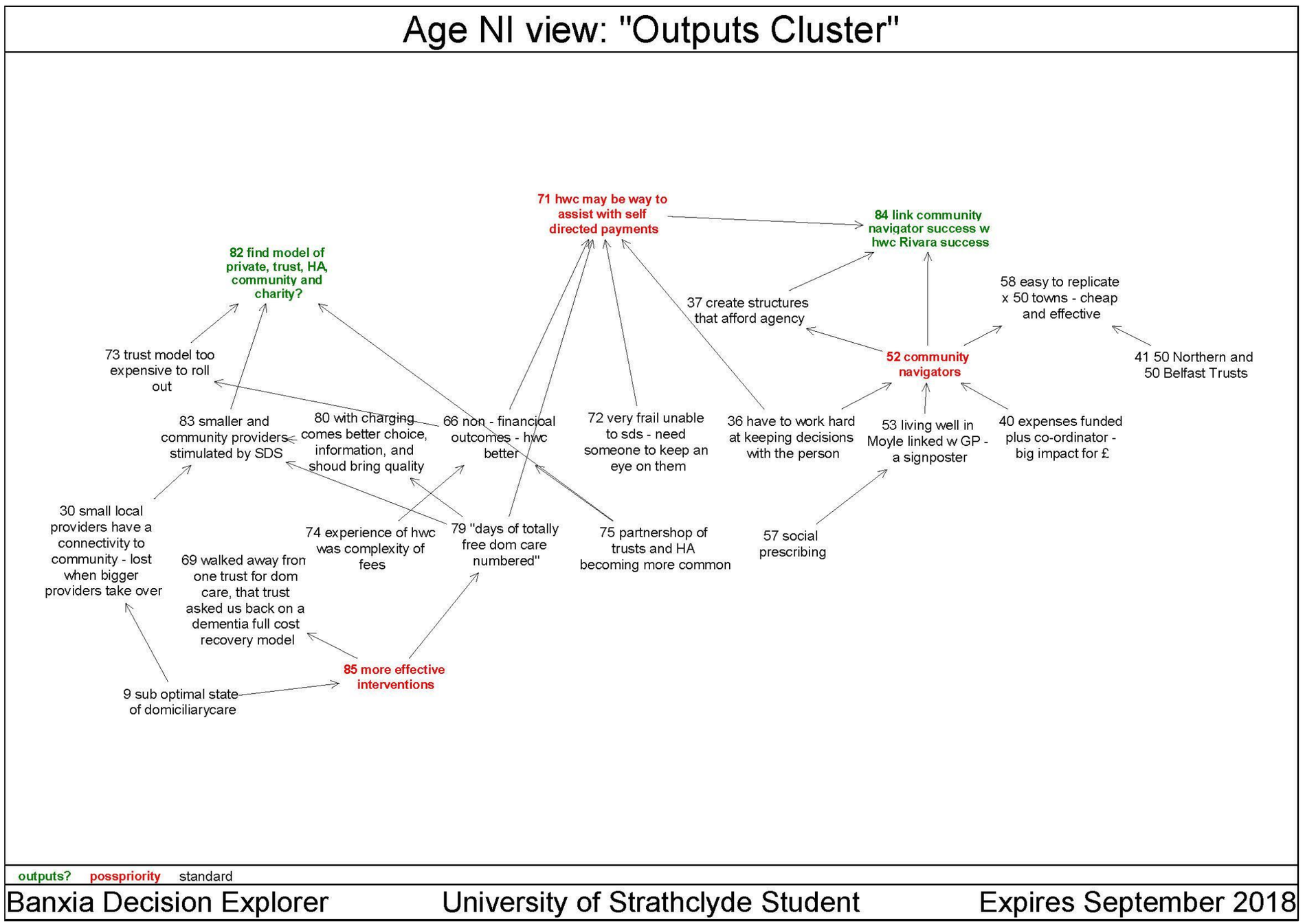


Figure 30: P9 Age NI 'outputs cluster'

2.2.10 Participant 10 (P10)

Interview date: 04.04.2018

Profile: Participant 10 (P10) is a Member of the Legislative Assembly (MLA) and party spokesperson for both housing and older people within the SDLP.

2.2.10.1 Participant (P10) sensemaking

P10 immediately stressed how difficult it was to achieve any strategic goals, whatever the issue, due to the siloed nature of government in Northern Ireland, and this phenomenon was all too apparent in relation to older persons' care: 'so, for example, housing and health care are very interrelated' but things only get done where 'there are very strong relationships' on a personal level between areas of government.

2.2.10.2 Domiciliary care

According to P10, the system of domiciliary care is 'not working', and they repeated, 'It's not working'. The carers 'don't get to spend the time that they need to'. They went on to say that 'we're looking at issues around mental health and isolation and all of that', and a rushed 15-minute call does little to help that common situation. Related issues that P10 noted were that carers (such as Joan) are not recognised and that the level of pay and career structure for professional carers was such that it is becoming increasingly challenging to recruit and, even more so, retain professional staff. The work is hard, not well paid, and now has few of the social rewards of being able to spend time with people.

As a constituency MLA, P10 has regularly had to intervene in order to get the services that older people are entitled to into gear. However, they were worried for those who did not have a family member able to alert the likes of their MLA: ‘what concerns me is the number of people who don’t have family members to speak up for them. There can be situations where someone calls in sick on a Friday… and the older person is just left.’ Often, the carer is ‘the one person that they see coming through the door’.

2.2.10.3 Housing and care

P10 was aware of several housing with care establishments and spoke highly of the positive effect that the home had for the older resident’s quality of life:

‘There is Hemsworth Court, not far from here – a wonderful place. They have dementia-friendly and they have independent flats and the people there have that independence. But they still have the friendship and camaraderie and lots of activities.’

P10 compared such environments with some institutional care homes at which they have visited constituents, outdated places where residents ‘are drugged just to sit there, they are horrible places’. When I inquired as to what the strategy was to build more housing with care environments that promote independent living, their response was that ‘we are not in any way doing enough… There is no long-term plan.’

2.2.10.4 A wider picture

P10 framed the widespread examples of care failings as part of a broader picture where there is an underlying failure of political leadership. In Northern Ireland, the two largest parties have been successful in a narrow sense of extracting money from HM Treasury, but having this ready access to money has stunted politicians leading,

governing and having to choose. They have not presented real choices to the electorate since it is much easier to blame the other side, be that green or orange. As such, when acute care hospitals have had to close, there has been no strategy presented: ‘better specialist care is never articulated.’ P10 then stated that this lack of strategic leadership had resulted in ‘presiding over a society where more people are killing themselves than died during the Troubles.’

Comment: P10 reinforced the picture of a social care system that is not currently effective at delivering welfare but noted examples of good care arrangements in housing with care. Their lens is political, and they were able to provide an insight into the lack of strategic thinking in health care and social care overall. In this context, the political strategy devoted to housing with care can be said to be almost nil.

2.2.10.5 P10 cognitive map analysis

Figures 31–32 each focus on a cluster of issues within P10’s total cognitive map.

Figure 31 presents how P10 explained what very often happens to those older people who are less resilient. Their strength of feelings at how the system can let some people down is apparent:

- **‘then you are just keeping them in a warehouse.’**

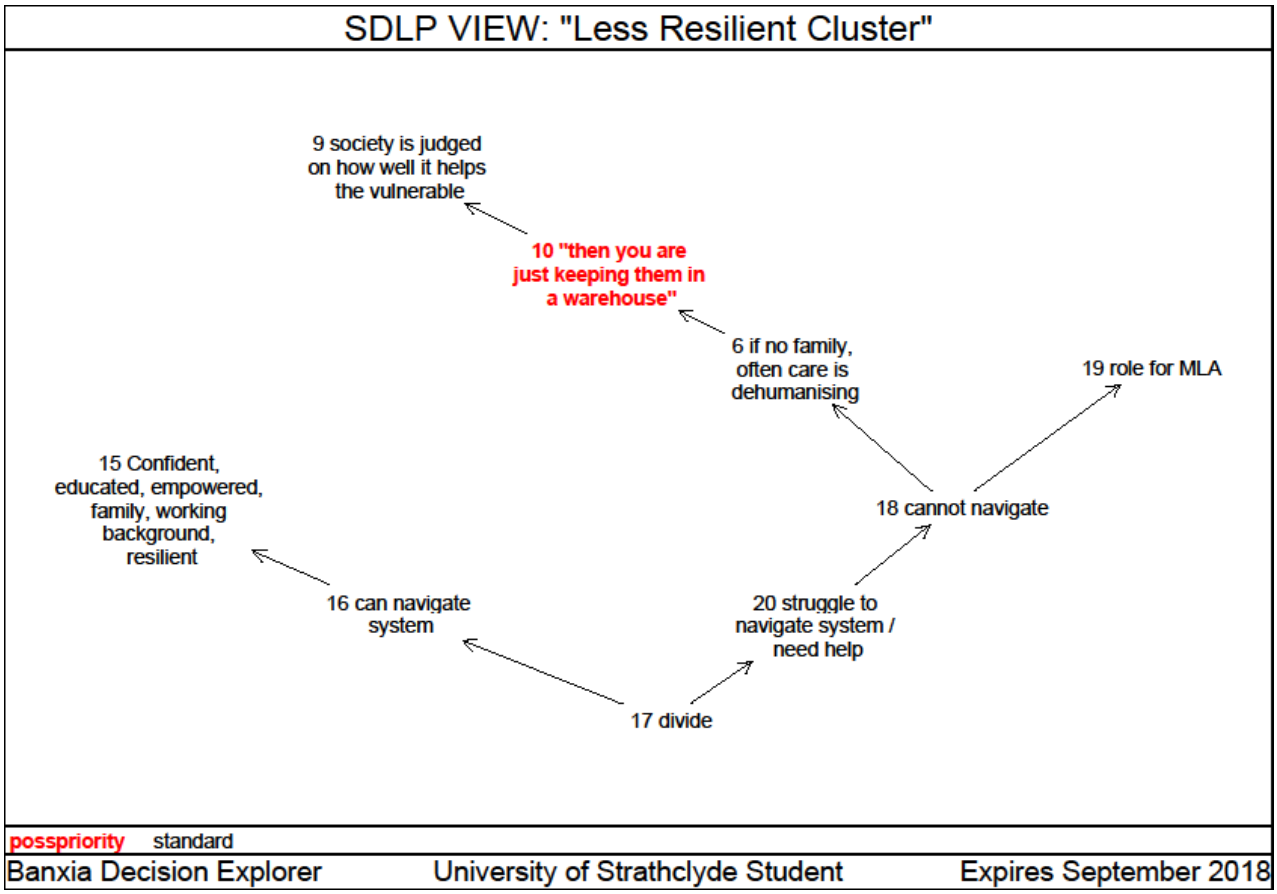


Figure 31: P10 Less resilient cluster

In Figure 32, the cluster examines how P10 considered how housing and care interrelate. The cluster summarises the lack of political leadership in hampering housing and care to achieve stated welfare goals stating that:

- **quality of life is hard to measure**

and the difficulty with this subtlety is that it puts social care at risk of being cut in Northern Ireland. Where there has historically been little scope for subtlety and arguments have been often binary. A priority area that they highlighted in order to maximise the welfare of older people is the

- **housing is an enabler of well-being**

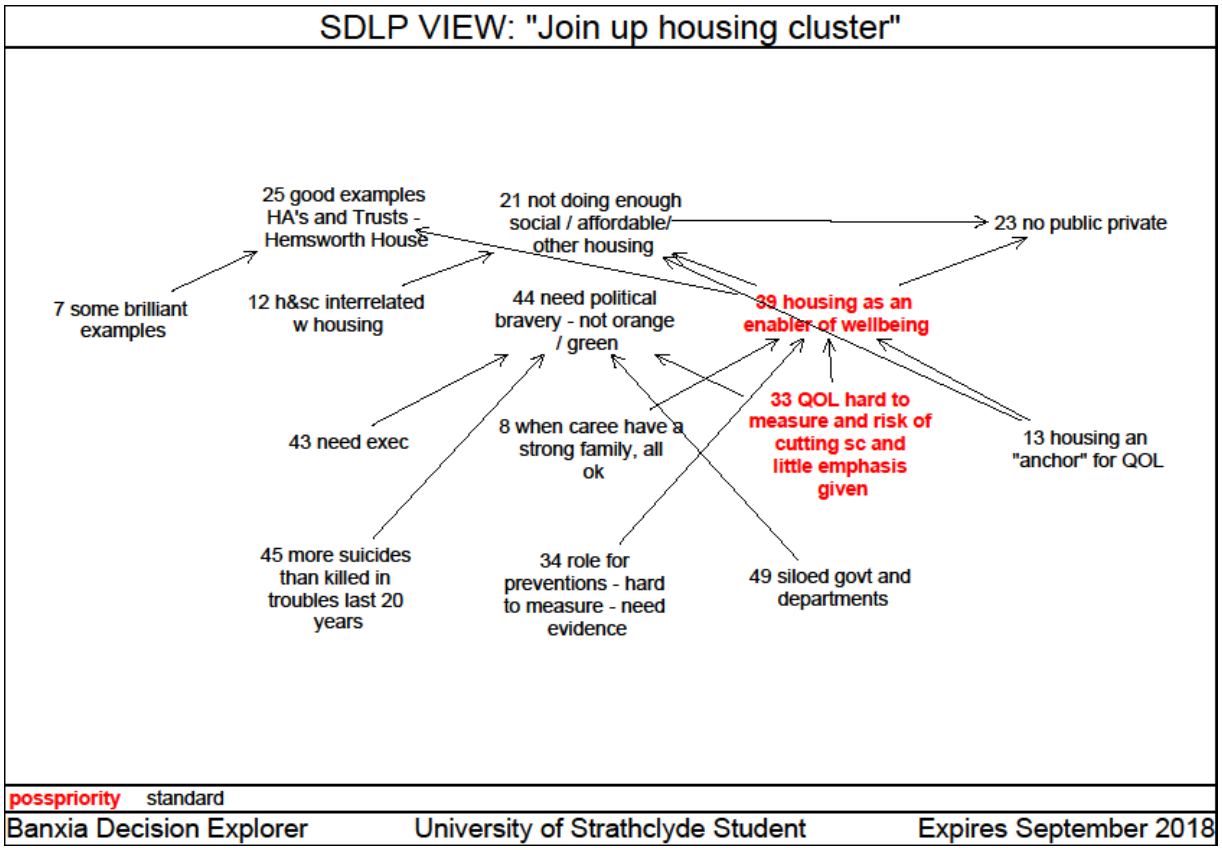


Figure 32: P10 Join up housing cluster

Figure 33 is an interpretation of the P10 focus on

- **the need to join up care**.
- **there should be private as well as public housing**

In looking at how to do so, it highlights the role of the Supporting People Programme and its powerful message that £1 invested saves the Department of Health £1.84. The strategic output shown in the map as that

- **there should be more private capital for mixed housing**.

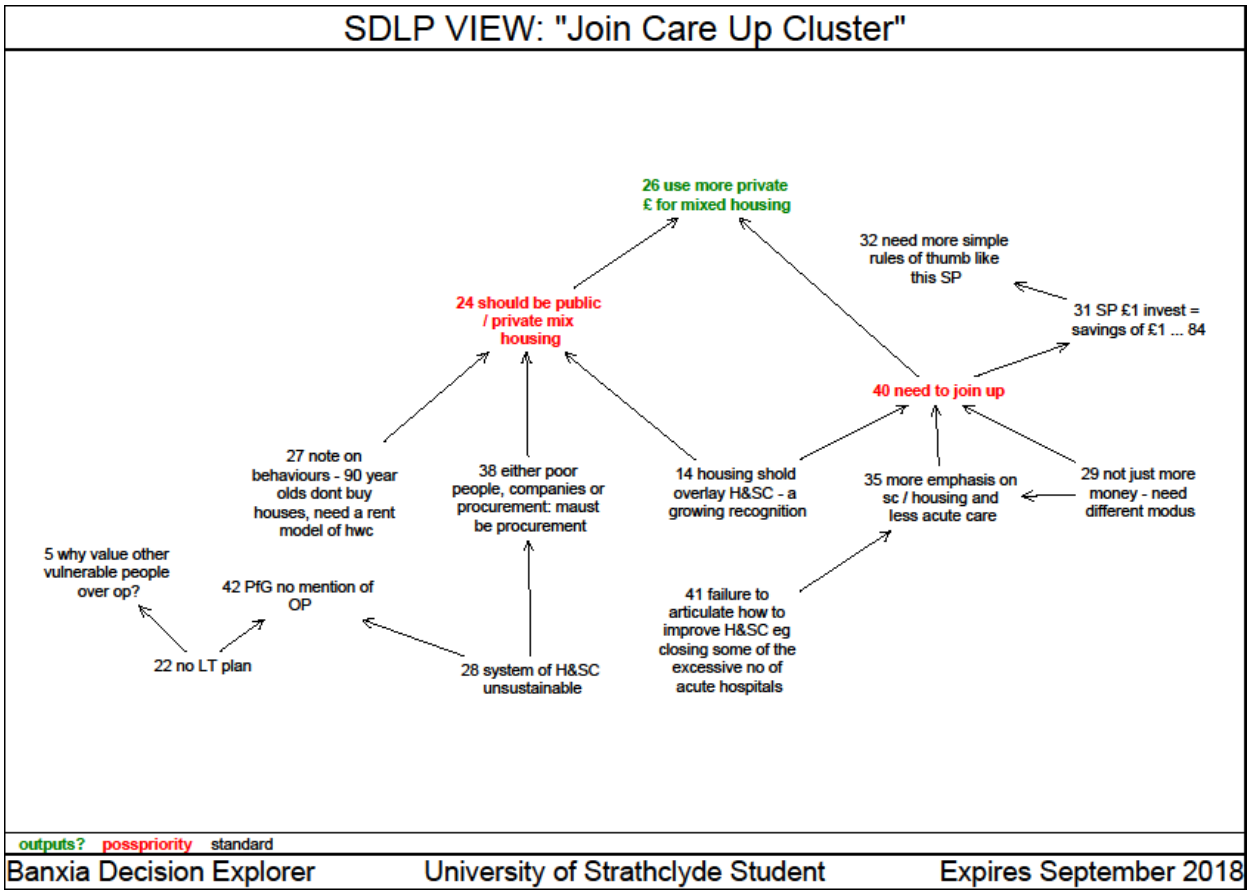


Figure 33: P10 Join care up cluster

2.2.11 Participant 11 (P11)

Interview date: 12.04.2018

Profile: Participant 11 (P11) is the CEO of a housing association that owns and manages sheltered housing for older people – supported, sheltered housing and their own 39-bedroom nursing care home for those living with dementia.

2.2.11.1 Participant (P11) sensemaking

P11 provided an insight into their thinking when explaining what happened when they acquired a dementia care home that was failing. They continued:

'When we merged in 2013 it was like a very nice hotel… and we said "Well, where is all their stuff?" … now, we have people coming from various Trusts to see what are the things that we do, and I keep telling them that a lot of what we have does not cost very much money… One of the things that frustrates me about the health service is that they can't seem to do anything without it turning into a great big project that's going to cost them lots of money. Some of the stuff in the home costs virtually nothing… I ask relatives "Have you any old scarves, handbags, books…" – the whole place is completely covered with things that people with dementia can pick up and fiddle with… There will always be something that attracts them. No one goes out of their room and goes "What am I supposed to be doing?" So, they are much less agitated… So, the really wonderful thing is that we have people with quite advanced dementia… (but) you can go into that care home and its quiet and think "Where is everybody?"'

P11 spoke at length and with many examples, giving an insight into the matters that constitute quality of life for older people with dementia and their difficulties in negotiating ways of delivering quality of life within a system that is designed around a medical model. For example, the finances for dementia are no different from the funding for a residential care home, and yet require much more staffing and social stimulation. This example seemed to typify how P11 is sure that the quality of care exists in spite of the system and not as part of it. Similarly, to be sustainable, new care homes have evolved to be 60- to 70-bedroom nursing care homes, but according to P11:

'60/70 bed just becomes institutionalised. It does become institutionalised no matter how much you're trying to do the thing with wings and all that. It does become institutionalised.'

Another frustrating factor for P11 concerns the sensitive issue of top-ups. P11 explained that the Department of Health has accepted over the last number of years the financial imperative of care home providers needing to charge a top-up for residential and nursing care. It is widely recognised, according to P11 (and other participants), that the statutory amount paid by the Trusts to care homes is insufficient to allow the homes to remain solvent. As such, the Trusts have recently accepted that the homes be allowed to charge an additional fee from residents for, what are supposed to be, additional items such as trips, a better view and so on. Seemingly, however, there are fewer and fewer rooms available where a top-up is not required, rendering the practice somewhat dishonest in the opinion of participants. Furthermore, the top-up

'Quite clearly must be paid by a third party… Why would a family have to pay a top-up? It is bizarre, but in the regulations. This sort of stuff is absolutely illogical. It does not make sense. That would mean if you had someone who didn't have family… [they could not get a top up] The thing is a complete mess. Everybody knows it is a mess. (But) none of this… permeates out to the minister.'

P11 expressed deep frustration with the system of regulation from the RQIA and explained at length the difficulty in balancing a home-like and social experience with compliance, saying 'everything becomes very mechanised, regimented, because that's the regime you have to follow. A lot of it is very procedural… it has become a tick-box exercise.' P11 was most irritated why they had failed an inspection on one occasion due to an updated safeguarding policy that was solely awaiting board approval at the upcoming quarterly board meeting. The policy was thus in place, but awaited ratification by the Trustees. By contrast they discussed the widespread stories

in the media of care homes continually failing including verified examples of older people being abused. Such homes seemed to operate seemingly without censure. P11 was convinced that well run homes were a ‘soft touch’. Claiming it was easier for inspectors to upbraid well-run homes for irrelevancies rather than tackle genuine cases of human rights abuse in the poorly run homes that it took whistle-blowers to the media to expose.

Comment: P11 added valuable insights into dementia care, the deficiencies of the present system, and the difficulties of providing dementia care within a regulated environment. Given these issues, an important consideration when designing Extra Care Plus is to balance the benefits of regulation as far as public confidence is concerned, against the damage to achieving quality of life that it evidently entails.

2.2.11.2 Supported, sheltered housing

The housing association owns and runs a number of establishments where older people may live together. According to its website, ‘living in a supported, sheltered house can help prevent people becoming isolated and lonely. The supported, sheltered houses are family-style in design and provide accommodation for seven to ten older people. The residents can be independent, come and go as they please, be private in their own rooms, whilst at the same time have the knowledge that others are nearby, so they are not alone, and staff are there to provide support. A key feature in alleviating isolation is that home-cooked meals, prepared by staff, are eaten together in the communal dining room’ (Abbeyfield and Wesley, 2019).

P11 gave an example of a gentleman who had been living alone with domiciliary carers coming in to heat his meals in a microwave, as they are forbidden from using the cookers:

'All of a sudden, he has come to somewhere where you can smell the food cooking because the food is very much a family-type environment. So, you smell the food cooking, come down, and what's better than that? You are having a meal with a maximum number of ten people, there is a sense of community… Who wants to sit eating on their own? That makes a huge difference to people's lives.'

Comment: In common with secondary research, P11 emphasises the importance of cooking and communal eating for quality of life. An important consideration, therefore, when designing the elements of Extra Care Plus is to include ways that people can socialise together while eating lunch and dinner.

2.2.11.3 Financial focus

P11 explained the costs for a resident living in supported, sheltered accommodation is no higher than an older person could afford through benefits. The cost at the time was £355.85 per week.

Likely minimum benefits were as follows:

Pension Credit	£163.00
Housing Benefit	£113.92
Supporting People	£71.25
Fuel Allowance	£3.85

Attendance Allowance	£57.30 (many eligible for £85.20)
Total	£402.47
Less cost	£355.85
Balance:	£52.62

P11 explained that these figures left a minimum of £52.62 for personal expenses such as a mobile phone. P11 considered this not unreasonable given that all costs of home, food, heat and light were covered. P11 noted that some 60% of residents were funded by housing benefit at the time. This made this form of older person living under P11 the most evenly balanced between self-payers and state-supported clients. For example, P11 noted that only 17% in Northern Ireland self-pay in care homes, and a similarly low percentage self-pay in sheltered housing schemes.

P11 highlighted how vital the 'Supporting People' funding was. Such funding is distributed by the Department for Communities as a contributor to quality of life and to enable vulnerable people to continue to live independently. P11 noted that in the rest of the UK this funding was 'basically gone'.

P11 noted that they believed that if Conor went into care then Joan would be eligible for housing benefit until their house is sold, but 'these things are a minefield, and it should be done by a social worker or a care manager in the local community'. Most often this does not happen, leading to an extremely stressful situation of a spouse either losing their home in order to pay for care costs, or being petrified of such a prospect, perhaps for years.

Comment: The insights into how P11 pitches the costs were invaluable when I moved on to compiling the financials for the Strategic Outline Case.

2.2.11.4 P11 cognitive map analysis

Figures 34–35 each focus on a cluster of issues within P11's total cognitive map. Below Figure 34 gives an insight into the strategic drivers for older persons' care. Thanks to factors that include the poor outcomes that are often apparent with underfunded domiciliary care, and characterised by 15-minute calls The map displays this point as: very often older people's

- **well-being is improved when coming to a sheltered environment**

such as P11's supported sheltered housing. This is thanks to factors such as increased well-being through camaraderie and communal cooked meals.

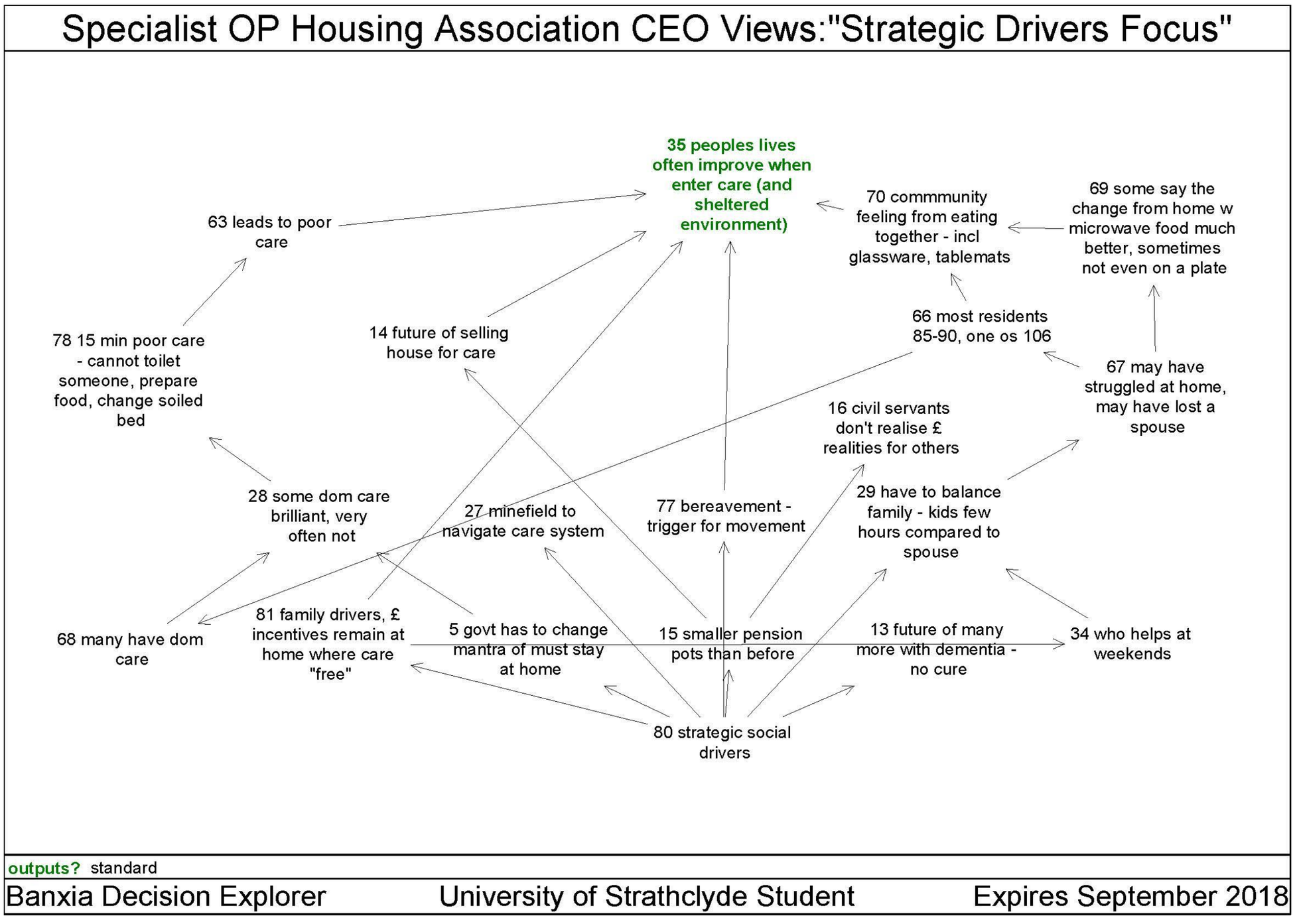


Figure 34: P11 Strategic drivers focus

In Figure 35 below, the cluster is a focus on the issues surrounding well-being within a residential care home setting. P11 explained that in their garden there is a car and a caravan. Visitors can take residents for a

- **'wee trip to the caravan' with a flask**

and enjoy quality time without leaving the premises. This is an excellent example of staff being creative for good social prescriptions rather than a blanket medical prescription. Also, the implication is that empowering and rewarding staff is critical, but according to P11 is not the norm.

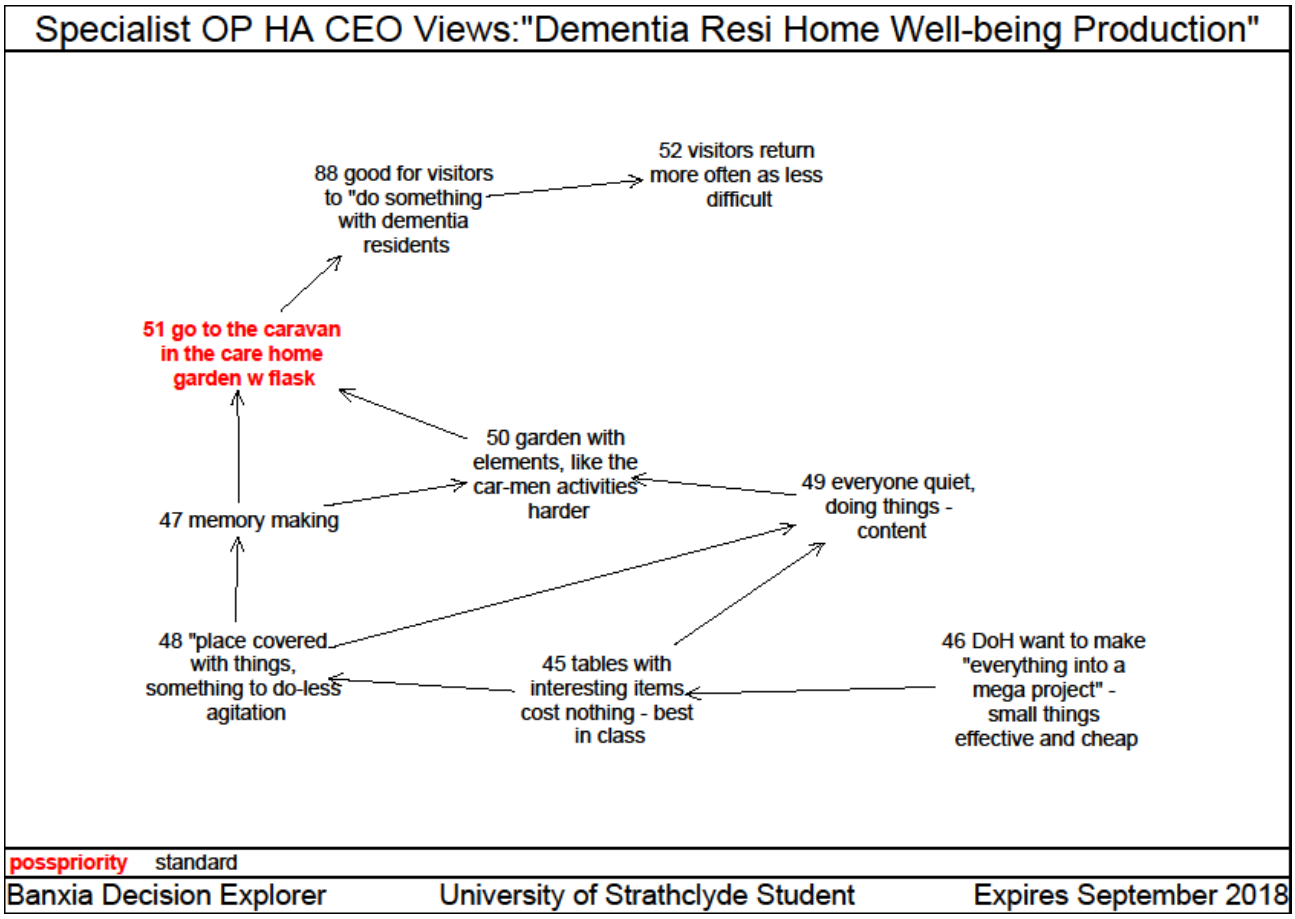


Figure 35: P11 Dementia residential home well-being production

Figure 36 below gives an insight into the **perverse incentives** at play that P11 must deal with in relation to residential care.

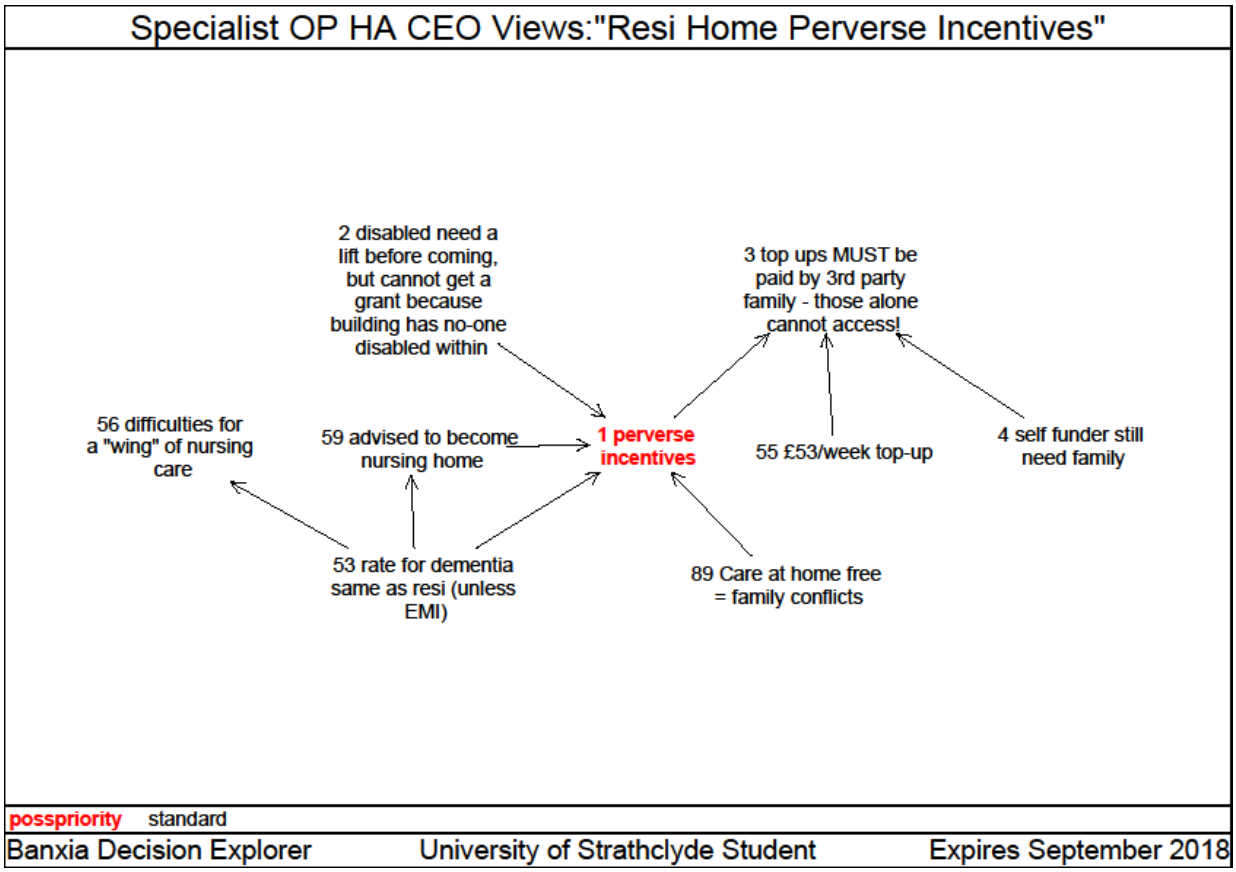


Figure 36: P11 Residential home perverse incentives

Figure 37 explores the interplay of the issues as overlapped with financial considerations and quality issues. P11 recognises the important role that couples have to co-create each other's quality of life. This ranges from simple company right through to compensating for each other's physical and cognitive deficiencies: Conor could conceivably be blind and Joan could conceivably be challenged with speech or hearing deficiencies, but as a unit they may very well create a quality of life together that is unlikely to be matched by external interventions. As such, a model of care that keeps

them together whenever managing a home becomes difficult is likely to be a vital way of maintaining quality of life.

When providing care within the existing formats, P11 highlighted a

- **stark choice – a trade-off between losing money or providing worse care**,

and this led to a strategic output of

- **providing care outside of residential homes using housing with care**.

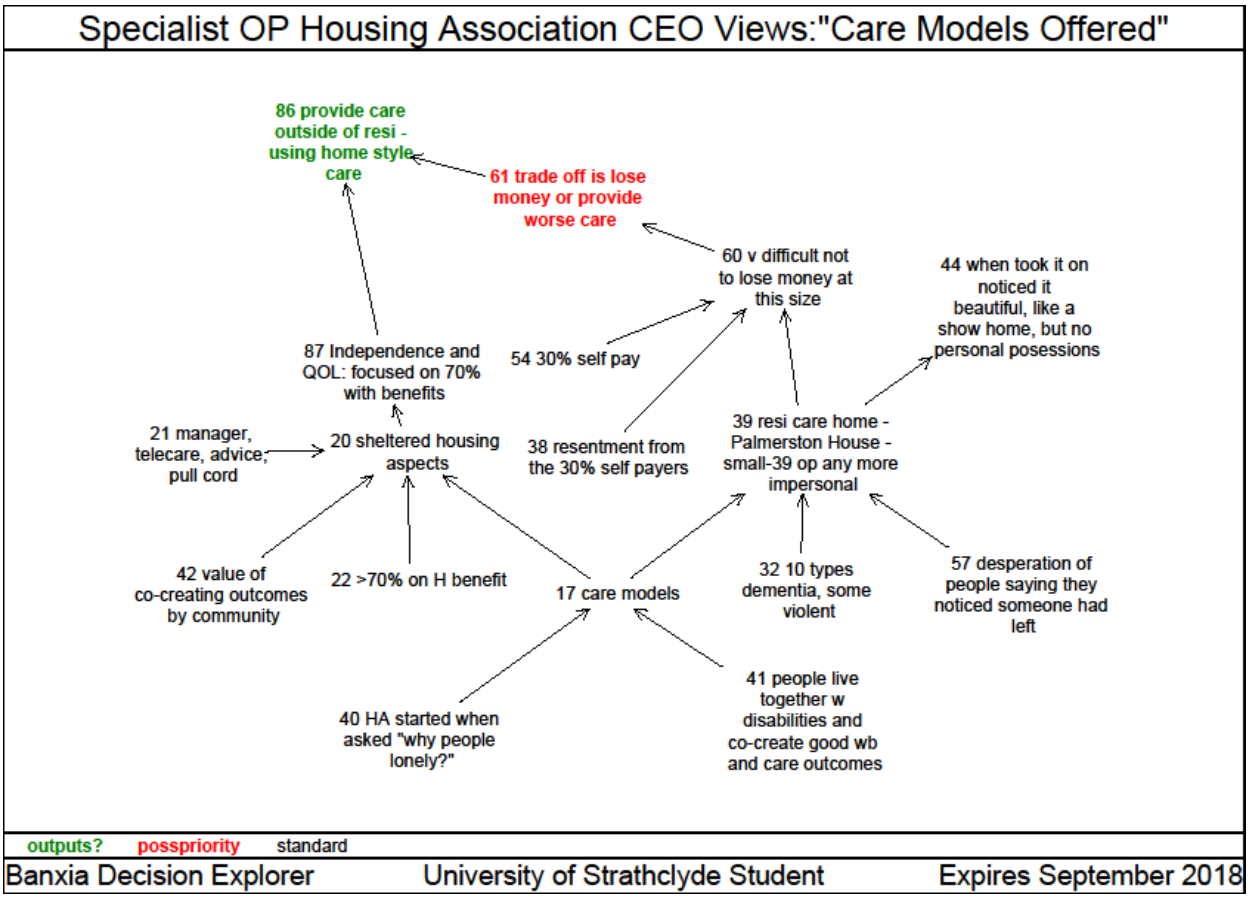


Figure 37: P11 Care models offered cluster

Figure 38 below captures how some general issues interrelate and draws upon some of the issues at play during the 1,000 days before an older person with cognitive decline enters an institutional environment. The system is described as a minefield by P11, where moves are made at a time of crisis;

- **when there is a crisis, there is no preparation**.

P11 stresses that since institutional care has become residualised, it has become like something of a ‘bogeyman’ that is feared, both in terms of crippling cost and the reported abuse of older people in certain institutions further scaring older people and ensuring that even less forward planning is done. P11 highlights that there is a need, therefore, to get information to people and to

- **repeat the successes of small-scale support, have a shoulder available to lean on to help give that ‘little bit of help, a lot’.**

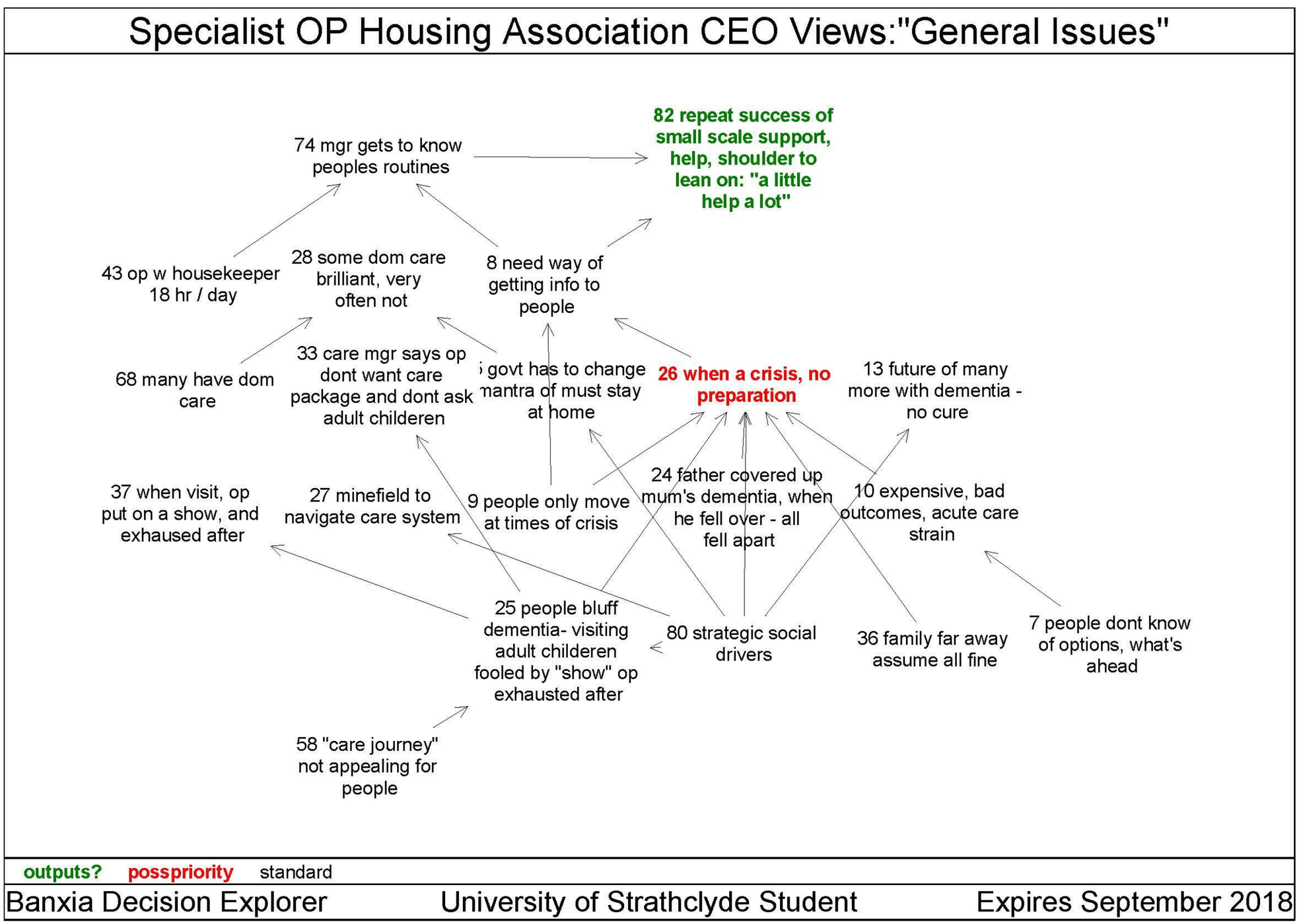


Figure 38: P11 General issues cluster

2.2.12 Participant 12 (P12)

Interview date: 24.04.2018

Profile: Participant 12 is the CEO of one of the five health and social care trusts (HSE Trusts) in Northern Ireland. P12 is responsible for the management and administration of the hospitals, health centres, residential homes, day centres and other health and social care facilities in their area as well as overseeing the provision of a wide range of community health and social care services.

2.2.12.1 Participant (P12) sensemaking

P12 commenced the interview with their strategic overview of how to achieve a sustainable health and social care system. In their opinion, as a country, what the UK spends on health is 'much lower in terms of GDP' than other advanced economies. When compared to the rest of the UK, Northern Ireland has a slightly lower spend level per head when compared with Scotland, though it is slightly above England and Wales. 'Which is not surprising given the economies of scale concerned and that we have chosen to perpetuate the hospital model.' P12 considered the UK system 'an incredibly cheap model globally. We have, over the last 15 to 20 years, been obsessed with the tax level, whereas Scandinavian countries and others would pay significantly more.' They noted that this was a 'contextual debate which won't solve the issue which is around the ageing population'.

Comment: There is a need for honesty from the very top of government in the UK.

2.2.12.2 Demographics

P12 considered that most people did not understand the full implications of an ageing population. Citing Bengoa (DHSSPS, 2016), he states that during the current eight-year period to 2023, the proportion of those over 65 is set to grow more than it did in the previous 40 years. 'It's not a straight line, it's accelerating, and from 2023 it will grow faster still… So, we have a rump who will have increased dependency and a smaller economically active population to pay for it.' It is for this reason, 'we have got to change the model'.

Linking demographics to the need to change the care model, P12 said 'if we don't encourage and incentivise and find a way to keep people independent, then the dependency wave and tsunami that's coming will overwhelm us'.

Comment: The importance of the demographic changes as a driver of the need for strategic change is underestimated. A change to the model that better accounts for incentives is needed, and one that is based on older people being aided to remain independent. If compensations are needed to allow people to look after themselves, then the system should provide such compensations.

2.2.12.3 Incentives and the entitlement culture

P12 consciously or subconsciously quoted Landsburg (2007) when stating that 'people respond to incentives' and having to 'put your hand in your pocket brings home the value of it' – with the implication being that it is inevitable that care in Northern Ireland will need to change from domiciliary care being free, thanks to the quickly ageing population. P12 asked, 'Why do I get free prescriptions? Why [in Northern Ireland] do we expect everything for free?' and they continued to highlight the absence of water

charges in Northern Ireland as well as noting as an example that transport is free in Northern Ireland for those over 65. They considered this wider sense of entitlement unhelpful when the system is facing its hard choices. It needs a huge amount of additional capital and that is not easy to get from a population expecting and conditioned to pay nothing in the case of health, care and the other examples.

Comment: There is a need for financial honesty about how much care will cost and a need for incentives to be better aligned.

2.2.12.4 Local care system overview

P12 stated that 'we have too many hospitals… so we need to change and concentrate care around the big five sites… and not closing the rest, but making them centres of excellence for frail older people, for diagnostics, for chronic disease, and much more part of a proactive system: keeping people independent, and we haven't been very good at that.'

P12 stated that for older people the NHS principles need interpreted from trying to cure those who are sick towards prevention and enablement. To date the role is:

'To respond to deficiency, to react when people are vulnerable… But we have an increasing number of people that we are trying to fish out of the river as they flow past us and we are struggling to do that. So, in some ways, we need to get upstream and stop them falling in the first place.'

P12 also spoke at length of how hospitals make people unwell, and the more that care can be provided in the community and in people's homes the better. They spoke of acute care at home and community care, in contrast to the 'PJ paralysis' that occurs

with older people in hospitals: ‘their muscle deterioration, physical deterioration and even sometimes their mental deterioration will be quite rapid, so it is important to get people up and active again.’ They said that nowadays 90% of people are out within 48 hours and that had changed from only 50% in just a few years. This was a response to the twin drivers of improved well-being outside of acute care and the pressures of numbers in the system. Such pressures will increase on account of the demographic changes ongoing, and P12 noted that on the ‘Transformation Implementation Group’, where the CEOs and other strategic leaders within the system regularly met, ‘effectively we’re going to see a doubling of demand in the next ten years.’

Comment: P12 believes that many of the changes needed are philosophical. People need empowered rather than fixed and this is the only way to cope with the demands on the system that are set to double.

2.2.12.5 Change to domiciliary care model

P12, in common with other contributors, recognised that some Trusts were struggling to provide domiciliary care: ‘Belfast is struggling… we have pockets where we are struggling as well. We are struggling to provide providers… we have got to create a different workforce… put a higher value on them… a career structure… give it a sense of a valued job’ since it is currently not. P12 used the phrase ‘you can swipe or you can wipe’, meaning that the pay and conditions are very often superior on the high street, where employees may earn a living wage in retail, ‘swiping’ credit cards. So why would young people choose to enter a profession where they can see that the staff are not valued?

Comment: Staff need to be empowered within a system where demand and supply are given licence to interact. Meaning that demand increases raise the equilibrium price and signal that more supply is needed. P12 is clear that care cannot be equitably, sustainably or efficiently provided through a Universalist state-run system as it presently, and somewhat dishonestly, claims it does.

2.2.12.6 Last 1,000 days and a need for quality via housing with care

P12 continued to examine how quality may be conceived in this context:

'It is that Atul Gawande stuff: what should end of life look like? What should the last 1,000 days look like? And what would quality look like? In Northern Ireland, every fourth person in hospital right now will not be alive in 12 months… It would be about the higher purpose of things… about as much independence, as much contact with our loved ones and family, being able to pursue our interests and continue to have as much fulfilment… Coming in and out of hospital isn't part of that… ***we have to redesign the model around your piece, that is housing and the maintenance of independence.'***

2.2.12.7 Housing with care

P12 described the number of housing-with-care facilities that they are responsible for, and recounted what was previously happening in residential care where

'we were killing them with kindness and fitting 20–30 people into the regime of the home… you got up at a particular time, you got your meds at a particular time and you ate at a particular time. So, we were taking the independence – Gawande's thing again

– away from people… supported housing (by contrast)… actually maintains that independence in a supported way… to me, it's such a no-brainer.'

P12 recounted the story of 'Bill'. A resident who had come from residential care whose quality of life increased. 'He increased his functional ability to the extent that Friday was…[spent going] into town on his mobility scooter to get fish and chips.'

Comment: Overall, P12 linked the drivers change to the need to change to a system that is empowering as the empirical successes of Bill and others in Extra Care.

2.2.12.8 P12 cognitive map analysis

P12 provided a wealth of strategic thinking material, and the cognitive maps presented each contain strategic considerations and an illustration of how they are intertwined.

Figure 39 is a presentation of the quality of life issues that underlie the considerations of the social care of older people. Amongst the issues that are individually pertinent, I have chosen to highlight that P12 considered that:

- **hospitals make people sick**,

and the

- **Trust housing-with-care example**

was a much better way of affording quality of life for older people's last 1,000 days. They also noted that the Trust examples were each located in areas of social housing and removed from shops and activity; hence, the graphic notes that in the future, housing with care could be

- **better located near cafes and the community.**

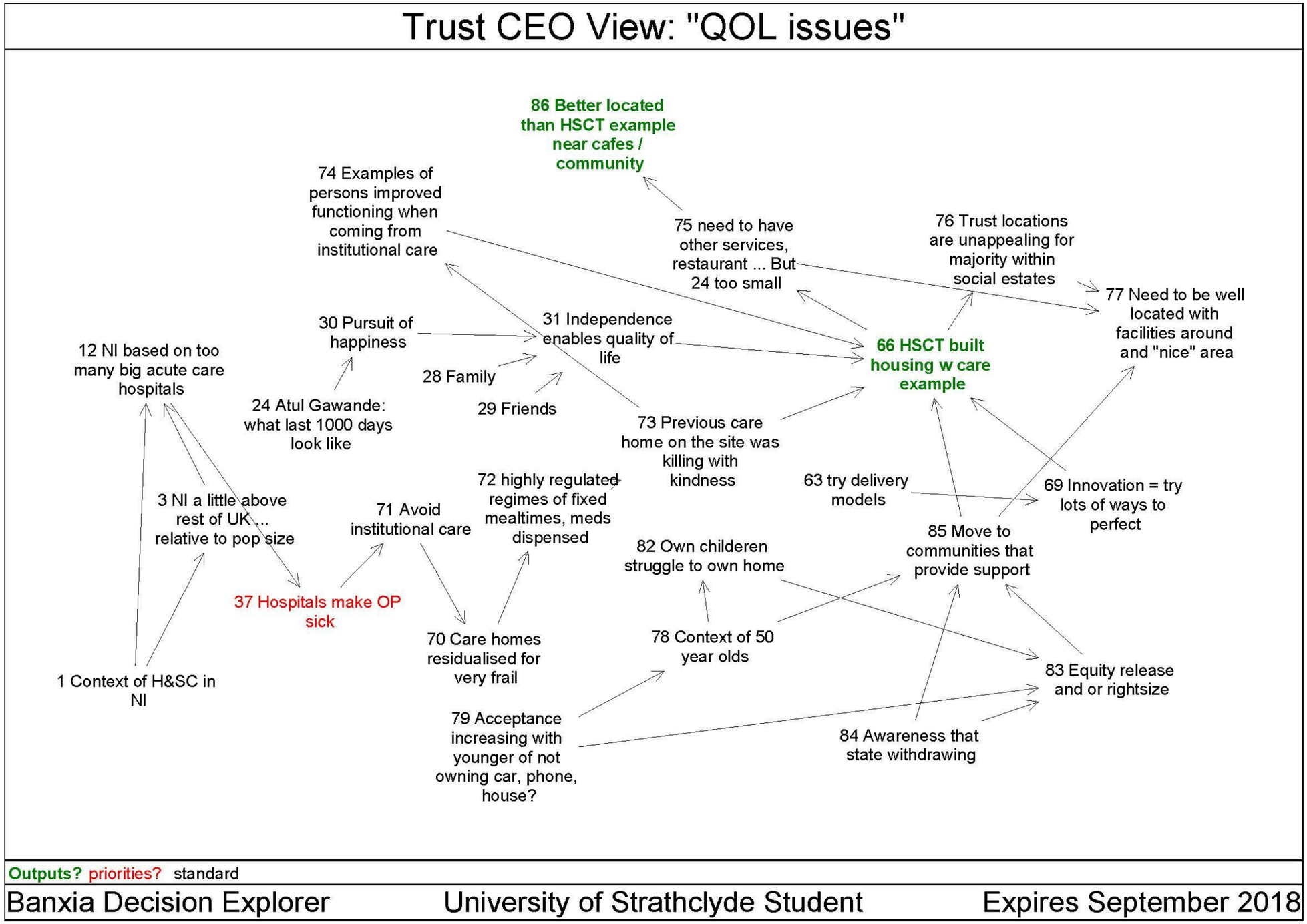


Figure 39: P12 Quality of life issues

P12 stressed the contexts within which the HSC Trusts work, which is presented in Figures 40 and 41. In Figure 40, entitled HSC Context 1 explores how the misaligned incentives interplay with the strategic context. Figure 41 goes on to focus on how these factors presently play out negatively but could be much better with a philosophical change to care that is based on empowering the individual and focusing on their life fulfilment in their last 1,000 days.

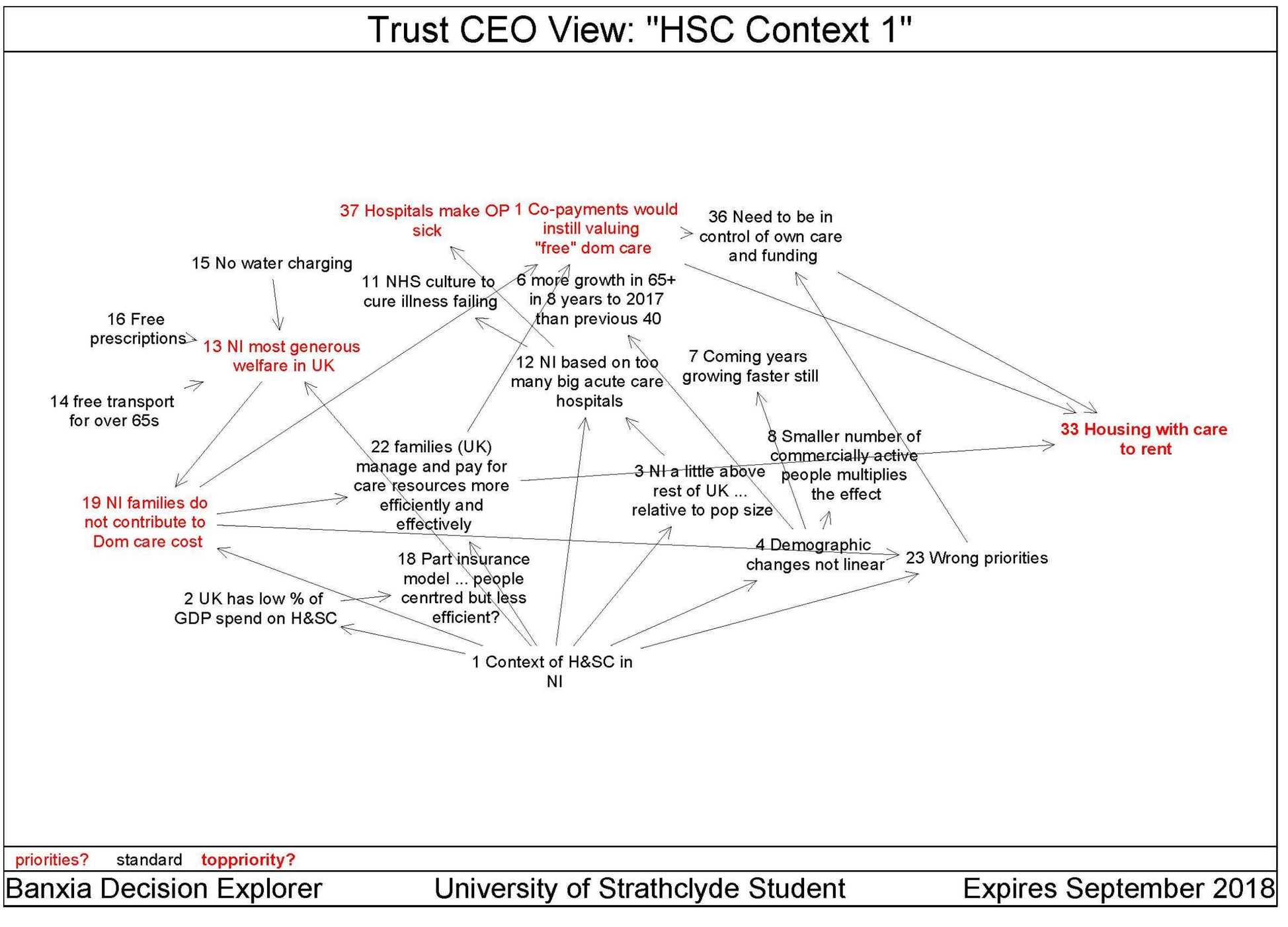


Figure 40: P12 HSC context 1

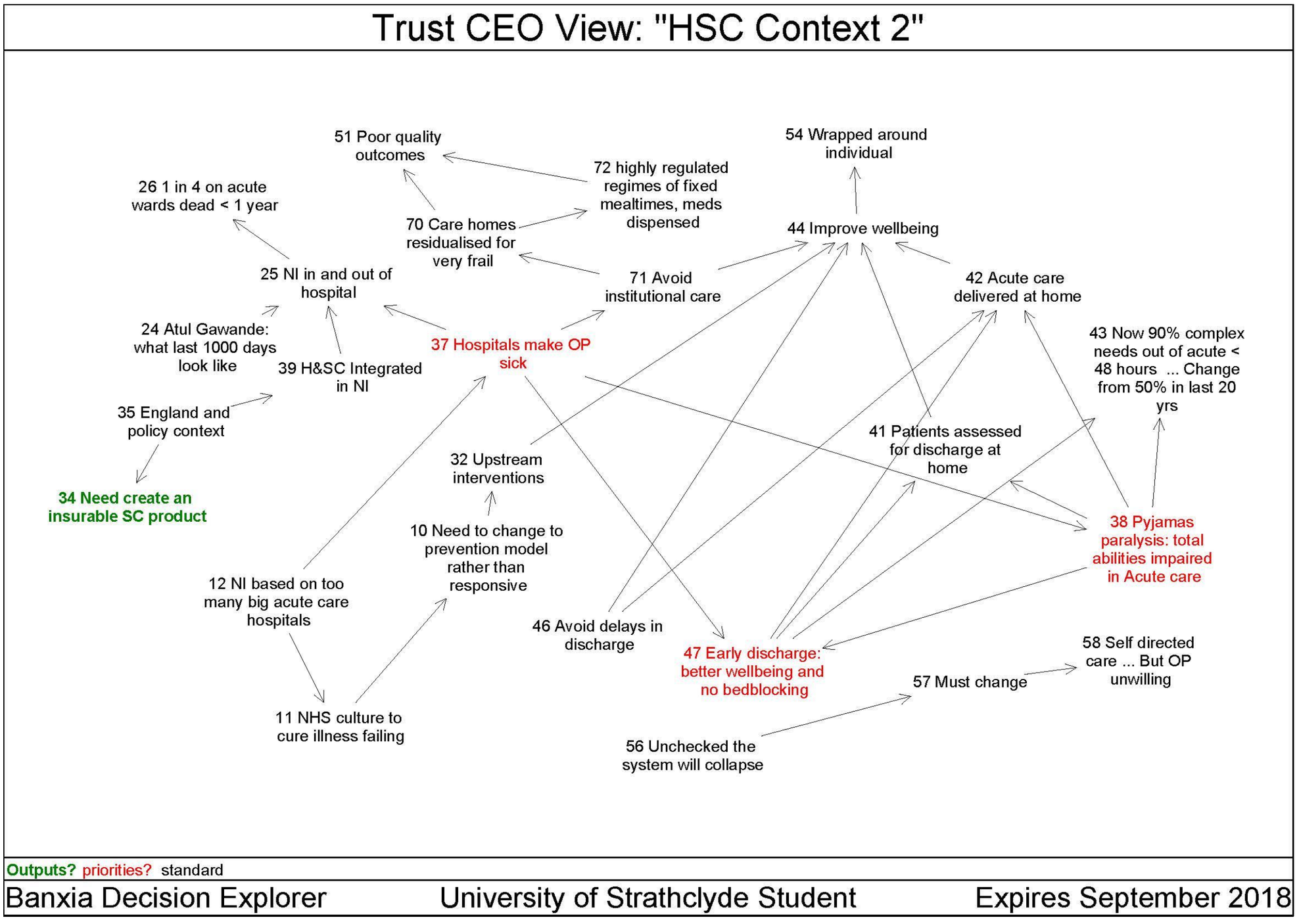


Figure 41: P12 HSC context 2

Figure 42 below is a presentation of the cluster concerning housing with care. P12 is responsible for several housing-with-care / Extra Care settings and knowing them allows P12 to consider some wider issues of social care to be framed within this cognitive cluster. Thus Figure 42 considers social care through the Extra Care lens. In the graphic P12 states that there is a strategic

- **need for co-payments**

to bleed off demand for health goods that are otherwise considered to be free, presently this results in

- **a false entitlement culture**

In this context,

- **housing with care to rent**

offers a way for accommodation costs to be covered by those who can afford to rent, such as is likely with the almost 70% of older people in Northern Ireland who are homeowners. This would both ensure Conor and Joan remain together for their well-being, but allow 70% of accommodation costs of care, where appropriate, to be covered. P12 explored the pros and cons of the **HSC Trust example**, including the lack of a cooked meal option and **the sub-optimal locations**. Notwithstanding that, these models would be a ‘no brainer’ for Conor.

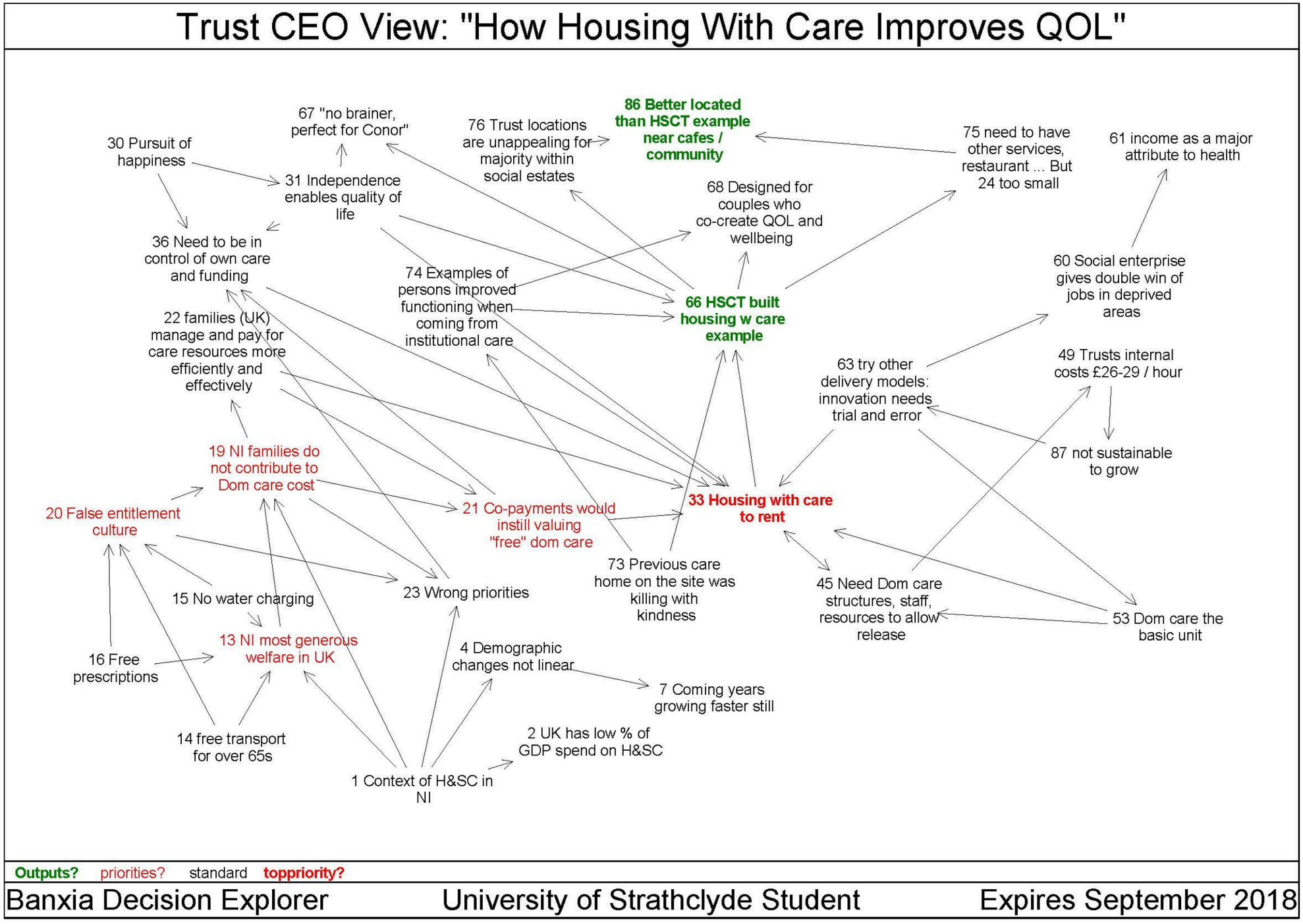


Figure 42: P12 Housing with care improves quality of life

2.2.13 Participant 13 (P13)

Interview date: 01.05.2018

Profile: Participant 13 (P13) is the CEO of one of the housing associations that partners the HSC Trusts with their Extra Care facilities. The housing association owns and manages 425 homes in Northern Ireland, including some sheltered homes separate to the Extra Care facility. In addition, the association owns and manages a small 11-bedroom care home.

2.2.13.1 Participant (P13) Sensemaking

Thinking about Conor and Joan and the Extra Care facility of 24 homes, P13 relayed an example of two tenants who have recently moved in and who had much in common with our archetype, Conor and Joan. With their example,

'The gentleman is 92 or 93 years of age, still driving and taking care of his wife... who is 11 years younger and living with dementia. He was finding it quite difficult to cope as he was [frail and was] the person looking after his wife… The scheme and the support that is there had a huge impact on him and his life. It gave him independence as much as his wife, and [took away] quite a lot of the burden of care.'

P13 recalled that of the 24 homes at the Extra Care facility around a third were lived in by couples; and most often one partner was living with dementia. 'It seems to really fit Conor and Joan's needs.' Adding that there is 'something like 20,000 people in Northern Ireland with dementia at the minute, and that number is set to triple in the next 20, 30 years, so there is a dire need for some sort of overarching strategy'.

Comment: The example highlights the benefits that Extra Care has for the carer; in this example, a 92- or 93-year-old gentleman benefits enormously from the respite and freedom of providing 24-hour care. In their opinion Extra Care could be a strategic mainstay in new policies directed at addressing such a 'dire need for some sort of overarching strategy'.

2.2.13.2 Procurement

P13 explained the means of the building procurement and the fee structure that is paid including service charges, as well as the care element that is provided by the HSC Trust, which has a significant presence on-site.

2.2.13.3 Sheltered housing scheme supervisor and care staff

Like many others, P13 recognised that the system of domiciliary care was working sub-optimally.

'You do see the degradation, if you like, of the care offered. They are rushing in, there are 15 minutes and they are out again, and sometimes they are not staying for 15 minutes… You know, traditionally, the support was aimed, not only delivering those specific services, but to be there as a friend, a neighbour, and there is no time for that anymore.'

In contrast, the scheme supervisor in P13's sheltered housing schemes does provide this social support: 'there is a contribution that isn't measured financially… they go above and beyond, they stay behind after hours, they get involved with evening and weekend activities … You know, it's like they are family.'

Within the HSC Trust-run Extra Care facility, P13 agreed with my suggestion that such a model could not be multiplied across the country thanks to the high numbers of Trust staff on hand 24-hours per day. Thus, while the scheme supervisor role is very much under pressure financially, the Trust-run Extra Care versions are seemingly too overstaffed to be sustainable: 'it's a difficult one. There is a need to find a cheaper way without losing the quality and support… maybe a role for technology, such as the room sensors we have for older people with dementia.'

Comment: The implication from this point is to stress the importance of the community navigator, who can go a long way towards the full HSC Trust care on offer at the Trust Extra Care facility. Also, the need to incorporate technology and afford future-proofing for technology is noted for design purposes.

2.2.13.4 Supporting People funding

P13 explained how the funding for such supervisors was slowly being withdrawn as it came from the Supporting People programme 'pot'. This pot was not growing in line with wage growth, plus the pot was being always divided further among additional projects. Indeed, P13 expressed considerable uncertainty whether the HSC Trust Extra Care facilities could be now built thanks to the funding squeeze and lack of such a stream being underwritten.

Comment: The implication is that there is a need for an additional source of capital, such as the FTC described by P8, to provide capital for Extra Care housing facilities.

2.2.13.5 Community contribution to quality of life

P13 explained the successful partnership that the care home and sheltered housing has with neighbouring schools, where young children come and have stories read to them by older people, and older children come and play lawn games, etc. 'Toddlers and babies would be coming through the facility on a daily basis… it has brought a whole new lease of life into the scheme.'

Comment: In line with the need for Extra Care to be in areas close to commercial centres, and village centres, there is scope to partner with local schools thanks to its evident contribution to quality of life.

2.2.13.6 P13 cognitive map analysis

P13 offered an invaluable perspective of managing an Extra Care facility in conjunction with the HSC Trust who provide the care, as well as sheltered housing and a residential care home. Overwhelmingly, in each case the clientele are older people in receipt of housing benefit. As such, the insight into what works and how to scale up what works beyond social housing into mixed tenure is important and thus generate a sustainable model of care.

Figure 43 highlights the improvement of quality of life thanks to housing with care.

- **provides friendship and support that not measured**
- **the wrap around enables independence and thus quality of life**
- overall −how to build more housing with care facilities (with limited government capital?)

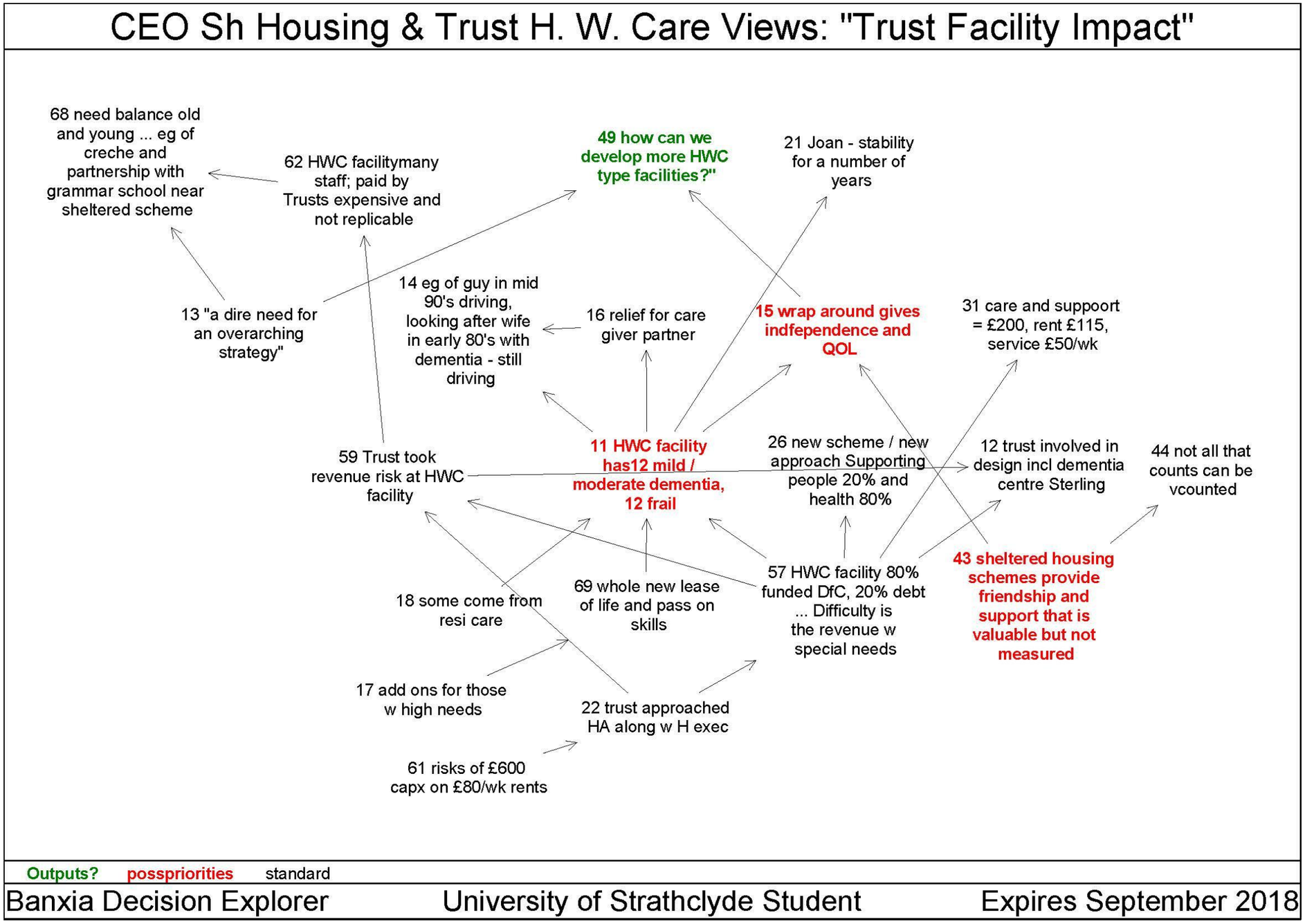


Figure 43: P13 the positive impacts of Trust run housing with care

Figure 44 below concerns the positive impact of the scheme manager / community navigator.

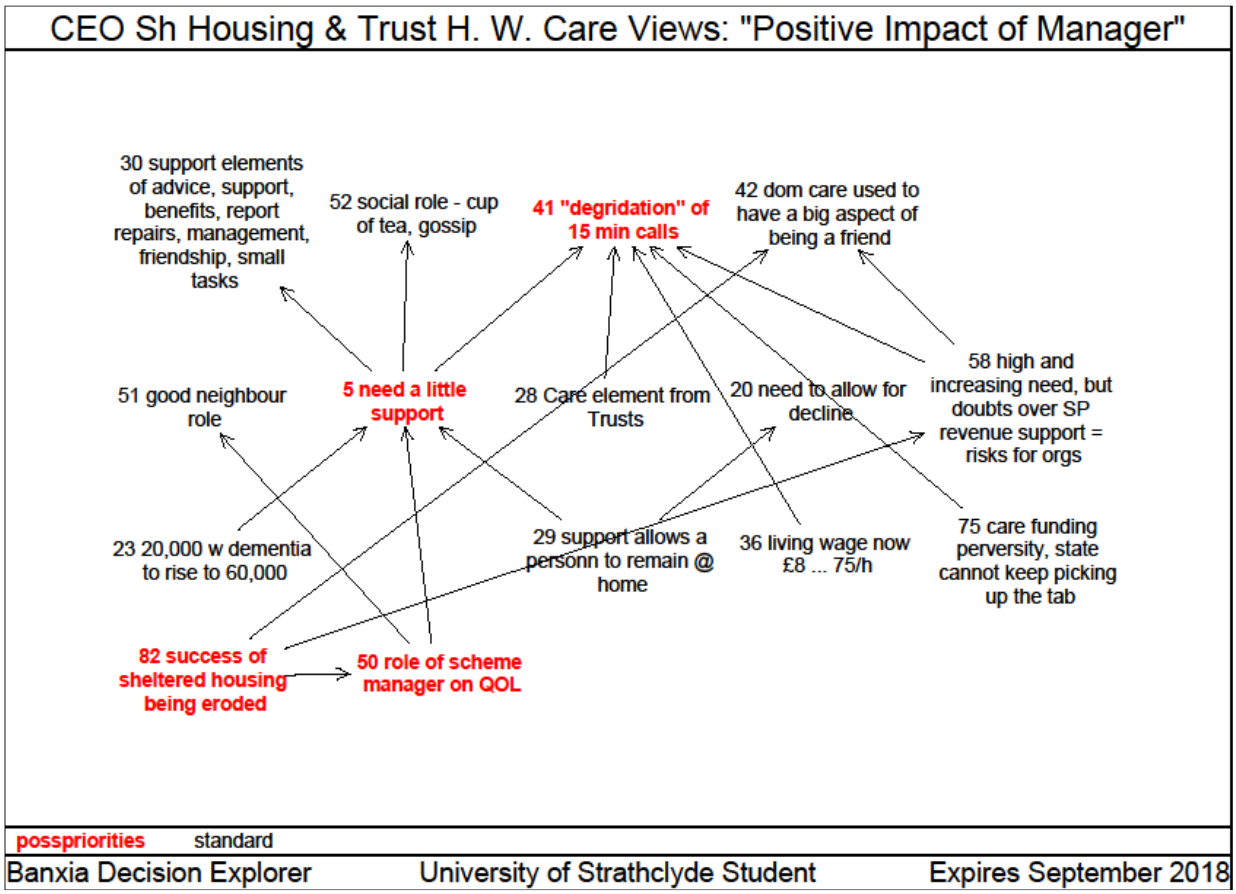


Figure 44: P13 Positive impact of manager in sheltered housing

Figure 45 below presents P13's cognitive cluster concerning the interplay of issues surrounding the HSC Trust Extra Care facility. The map emphasises reinforcing the relationship with the community thanks to the social benefits for well-being that it has. The map shows:

- **sheltered housing schemes provide friendship and support that is valuable but not measured.**

In tandem, the Extra Care facility has given people a new lease of life and allowed couples to remain together, benefiting from the community and friendship, far better than any medical intervention. Similarly, within the facility P13 had managed to achieve a balance of older people and their care needs, half with mild / moderate dementia and half frail. This is presented as

- **Housing with care facility has 12 mild / moderate dementia and 12 frail**.

The relationship with good outcomes stemming from this are shown,

- **including giving independence and quality of life**

and ultimately asking

- **how can we develop more housing with care type facilities?**

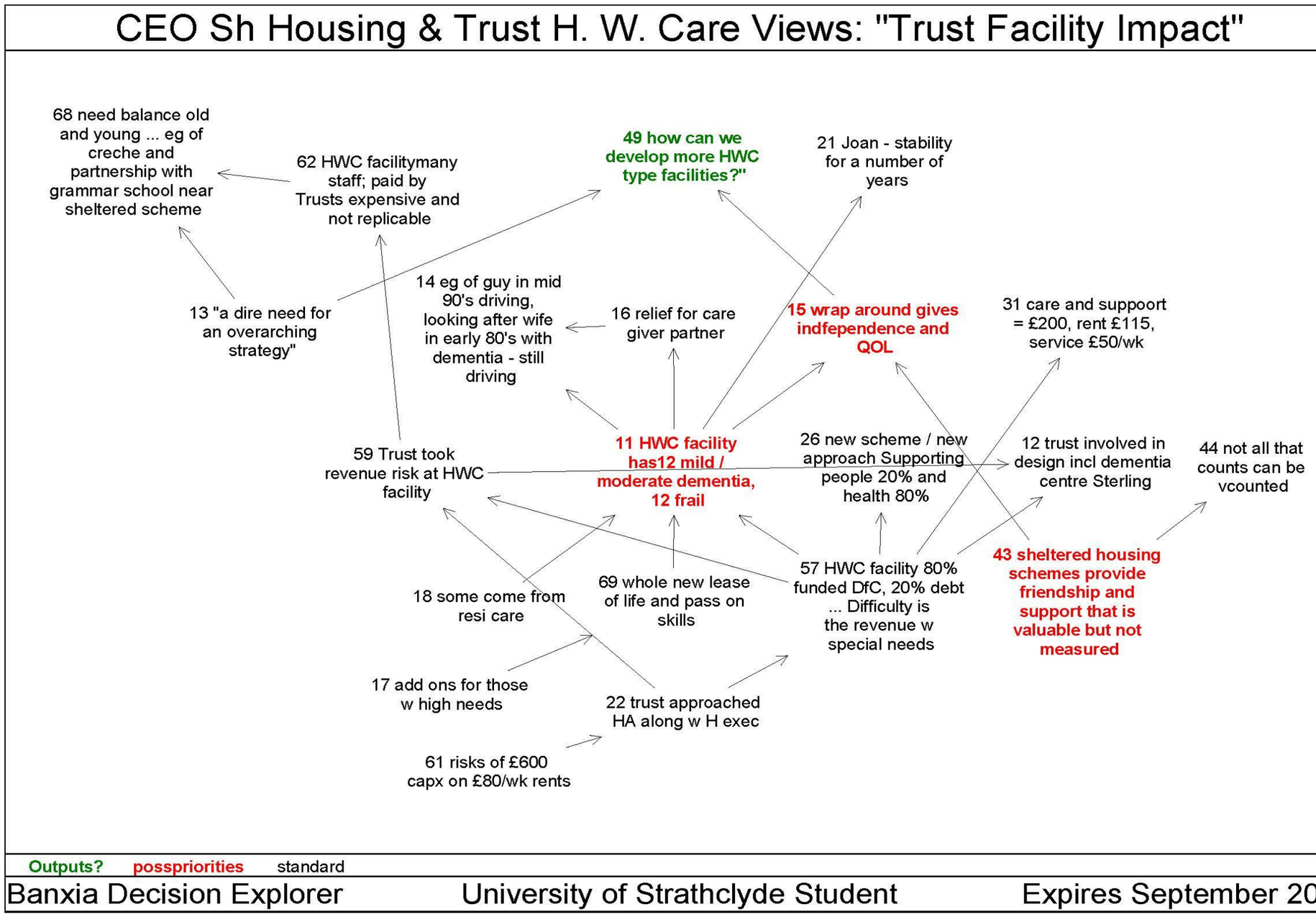


Figure 45: P13 CEO Trust view of Extra Care impact

Figure 46 presents the Decision Explorer software cluster concerning the conclusions that I induced with P13 during the interview. The priority of

- **‘how do you put a metric on companionship?’**

is shown, underpinning the importance of friendship and social interactions for quality of life. Ultimately, the strategic priorities are shown as a

- **need to find other ways of procuring housing with care and companionship by building on what works**,

rather than how domiciliary care and nursing care is most easily procured, as is presently the case. A strategic output is shown as a need for

- **mixed tenure Extra Care and sheltered housing.**

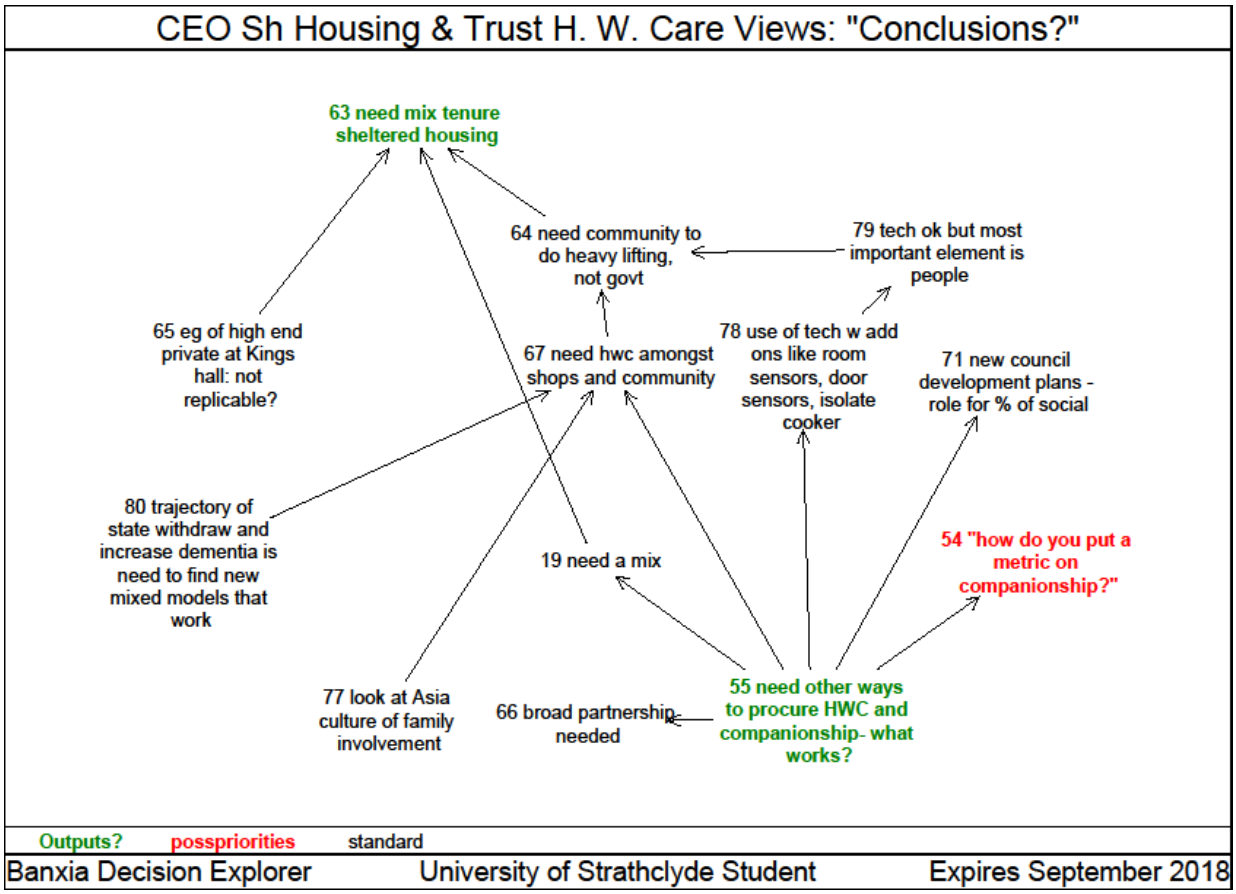


Figure 46: P13 CEO of housing association who manages Extra Care – conclusions

2.2.14 Participant 14 (P14)

Interview date: 09.02.2018

Profile: Participant 14 is a recent past director of older people's services within the largest HSC Trusts in Northern Ireland. This role encompassed care in the community, care within care homes and older people's services within hospitals. In all, P14 managed over 2,500 staff.

2.2.14.1 Participant (P14) sensemaking

P14 stated

'the key, I feel, has got to be around the whole issue of independence… anytime I have ever spoken to a group of older people in terms of a consultation process, they are always very keen to say that "I want to stay where I am".'

Similarly, each government report *'that's ever been done highlights keeping people at home for as long as possible, but with that goes a lot of support services and a lot of funding, and that's where the whole thing breaks down'.*

There is not enough money available to provide good social care at home. P14 noted: 'the care services are really, really back to the bone at this stage. There is a very limited amount of time going into people who really do want to stay at home.' Previously, Social Services were able to put fairly good packages into people's homes, but:

'That all changed in the last ten, 15 years; and every year when I was working the budgets were chipped away, you had to find 3%, 5% and the soft targets were older people's services, ten hours per week became seven… and the amount of time going into people's houses, like the 15-minute calls, is always a big problem, but it is often necessary because of the pressure on that Trust.'

Comment: The financial reality is leading to 'the whole thing breaking down', given the number of people over 65 presently doubling in only eight years, it follows that there is an urgent need to find other ways of providing social care. P14 considered that this should be done through the medium of keeping people independent, and that such a strategy should be based around home, and home-like care environments.

2.2.14.2 Provision of care

With care at home, P14 stated that

'Most people don't have a choice. You get a bit of service in bits and pieces and maybe a family member cares, you know, doing their best. But that will break down eventually and people are forced to move into an institution, where people there are very sick, and you know, disabled people who (actually) don't need to be there… but I still think there is a continuum here and there's a bunch of people who could actually still be at home if we had decent comprehensive care packages and decent accommodation. (For many) a care home would not be necessary.'

Older people are assessed as to their 'needs' 'but there isn't an automatic follow through that you will get what you require. You get the minimum to get by.' As with the MLA participant (P10) who is often required to step in so that some older people receive sufficient services, P14 said, 'I think we have been lucky up to now that older people have not complained' since what many often get is very unsatisfactory.

P14 confirmed that when people remain at home their quality of life is sometimes very poor. They explained how some older people are bed-bound: 'as undignified as it sounds… often the only living person that they see is the carers.'

Comment: P14 managed domiciliary services for the largest HSC Trust. They confirmed that the level of service was unsatisfactory and that the way it is distributed is often capricious. Also, the desire to remain at home can mean that people become isolated.

2.2.14.3 Sustainability, money and incentives

P14 believed that there is an increasing recognition amongst the public that something had to change, and this could aid ministers to press on with some of the difficult decisions that are sorely needed (subject to devolved government returning to

Northern Ireland). For example, P14 said, ‘I think that might be changing… a recognition that there’s this ridiculous situation where if you’re sitting at home and you do happen to have a decent care package, you are not charged. Whereas, if you go to a care home you would have to be.’ Asked about whether the differential drives perverse behaviour, P14 stated: ‘every now and then, where families insist on the older person remains at home, when they should be in care. They won’t let them go because they know that they are going to be charged. That’s an awkward situation I have dealt with many’s a time.’

They highlighted the present generation of those having retired in the last number of years with a rather good pension: ‘I think of my father who would be prepared to pay for a decent service. I think there’s a recognition that we can no longer get everything for free.’ They added: ‘I do think that there is a market there for people who would… prefer to pay for their own services, not rely on the trust, and get it when they wanted.’

P14 also discussed the ambiguity over who is charged for care and how the social workers have little incentive to investigate the finances of older people forensically, and for this reason many families who have the means to pay manage to avoid doing so. Similarly, the matter of top-up payments in care homes is ambiguous: ‘there is a top-up in every home… they are supposed to be for enhanced services but (they) are needed, and it’s something that our department hasn’t really grasped.’

Comment: According to P14 it may be increasingly the case that there is a more widespread public acceptance that quality social care comes at a cost, and that it is equitable that people contribute towards it.

2.2.14.4 Extra Care

Thinking of the Extra Care facilities within which P14 previously managed the older people's services, they noted

> *'I mean, they work very well for people from the local area and they are very successful…but you're right, there is a gap for people who are not entitled to be a tenant in one of those facilities, and a gap for something similar around housing specialising in dementia… allowing your carer to come and live with you, have all the support in pleasant surroundings, and be able to purchase additional care if you need to.'*

P14 provided an insight into Krugman's (1988) 'English food phenomenon or the demand chicken and egg problem', whereby until it exists no one will demand it. P14 said

> *'we aren't three yet… they are not known well enough here, there aren't that many of them right here. I think they need to be physically there for people to see and find out if it would be suitable for them. How much is it going to cost… "What will I lose by moving out of my current home and what would I gain?" And I do believe there would be an appetite for them.'*

Commenting on the model that I have previously built, P14 stated:

> *'I think it's an attractive option … I think that the problem for us here is that it is the newness of it; it is the selling of it; it is making people understand that it is a good option; it is not going to cost them a fortune, but there are excellent support services and that they could end their days very nicely there.'*

Comment: P14 captures a significant issue – that Extra Care is predominantly for individuals, or individuals with a partner, at the end of their lives. As such, there is a delicate balance as to when a tipping point is reached whenever well-being at home becomes inferior to that available within such a facility. This insight takes the emphasis of Extra Care to people's last 1,000 days, rather than being in any way a retirement village for 55-year-olds. P14, along with a very large majority of participants, grasped this point, a point not widely appreciated. At the time when an older person's quality of life is diminished, perhaps due to living with dementia or successive falls, then older people will need to be aware of such facilities. P14 believes that people will need to see what Extra Care looks like — further implying that there is a good case to be made for a small number of pilot facilities to be built.

2.2.14.5 Private vs public and silos in government

P14 explained how the public sector is suspicious of the private sector:

'we are still hung up about the private sector. I would have had colleagues of mine who really find it very difficult to accept that the private sector could do as good a job as the health service. In fact … sometimes they fail, sometimes the Trusts fail, but you can't have this problem.'

I scanned down along with P14 the working list of important issues, and I asked them to 'jump in' whenever there was an issue that they felt strongly about, given that we were already 53 minutes into our interview. P14 quickly interjected when I mentioned the risk of siloed government:

'Yeah, that was one thing, I think, well haven't really talked about; the fact that we have different ministers for different sections here and I'm not sure that there has been an

awful lot of joining together. You know, sometimes they say in the strategies that there is, but I'm certainly not aware in my career of, you know, uh, uh, a joined together (situation) at a very senior level around this issue: except if it's about a specific project like Hemsworth or Sydenham Court… I'm not aware that the movers and shakers in each of those departments actually work closely enough together.

Comment: Both these issues imply that creating an Extra Care environment in the Northern Ireland jurisdiction is problematic. The public sector seems to be unwilling to conceive how private resources could be harnessed to assist with an existential public problem. Moreover, the two departments concerned with health and housing seem to have a limited track record of working together to enable independence to leverage quality of life. Furthermore, in the absence of ministers, there is a culturally more limited appetite in the public sector for innovation and change. There are added legal limitations, since legislation across strategic change requires ministerial sign-off. In the absence of ministers, many such decisions in 2018/2019 have been put off, as seen in the recent *Belfast Telegraph* special report: 'Revealed: Urgent health decisions held up due to lack of Northern Ireland government' (Bell, 2018).

2.2.14.6 P14 cognitive map analysis

P14 provided a critical insight from a past Director of Older People's Services within the largest HS Trust in Northern Ireland, a Trust that has 2,500 staff working within older people's services.

Their sensemaking of the problem of older people's care and well-being is presented in Figure 47, a summary cognitive cluster. Important issues within this map include P14's belief that for quality of life, 'independence is key', but highlights the hurdles

placed in front of older people and their carers when seeking to achieve social care support at home. Indeed, principally due to demographic pressures, there is ‘now a greatly diminished service:

- **you get the minimum to get by,**

and sooner or later

- **charging is inevitable.’**

In this context, housing with care / Extra Care is a good option that bridges domiciliary care and nursing home care, especially for those living with dementia. However, the case has to be made by way of actual open facilities, and by running a pilot. This will allow the model to improve by using empirical evidence of what works in practice, the size of the facility, the mix of owner occupied / private / social rent, the financing model, the locations, the facilities within, the size of the dwelling and so on. As a strategic thinker, P14 recognises that people will both need to see the Extra Care facilities working, and that the initial models that mix the attributes noted above is unlikely to be optimal first time. The map frames this issue as a strategic

- **need to demonstrate care and housing with mixed payments.**

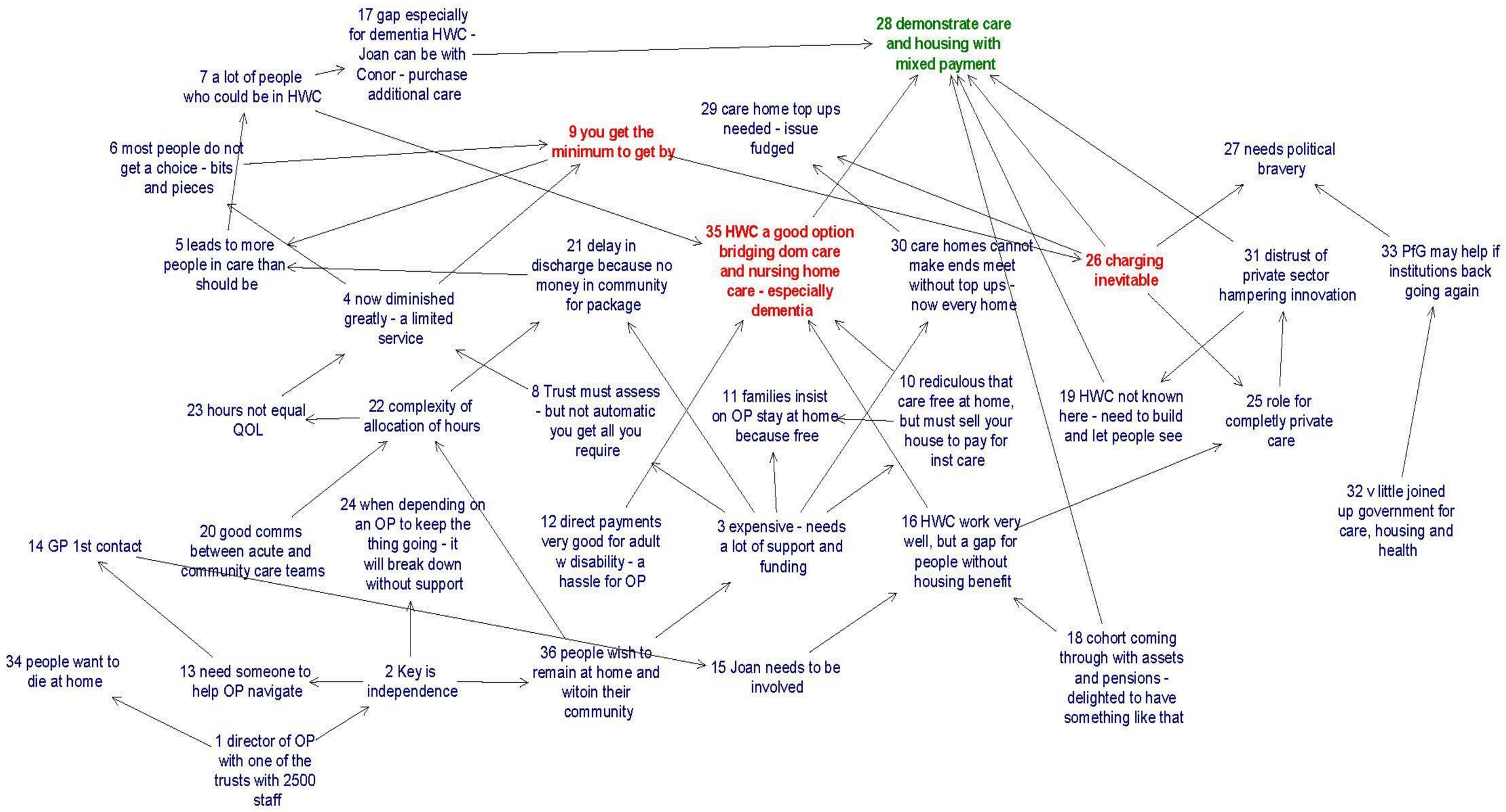

17 gap especially for dementia HWC - Joan can be with Conor - purchase additional care
28 demonstrate care and housing with mixed payment
7 a lot of people who could be in HWC
29 care home top ups needed - issue fudged
6 most people do not get a choice - bits and pieces
9 you get the minimum to get by
27 needs political bravery
5 leads to more people in care than should be
35 HWC a good option bridging dom care and nursing home care - especially dementia
21 delay in discharge because no money in community for package
30 care homes cannot make ends meet without top ups - now every home
26 charging inevitable
31 distrust of private sector hampering innovation
33 PfG may help if institutions back going again
4 now diminished greatly - a limited service
23 hours not equal QOL
22 complexity of allocation of hours
8 Trust must assess - but not automatic you get all you require
11 families insist on OP stay at home because free
10 rediculous that care free at home, but must sell your house to pay for inst care
19 HWC not known here - need to build and let people see
25 role for completly private care
32 v little joined up government for care, housing and health
20 good comms between acute and community care teams
24 when depending on an OP to keep the thing going - it will break down without support
12 direct payments very good for adult w disability - a hassle for OP
3 expensive - needs a lot of support and funding
16 HWC work very well, but a gap for people without housing benefit
14 GP 1st contact
34 people want to die at home
13 need someone to help OP navigate
2 Key is independence
36 people wish to remain at home and witoin their community
15 Joan needs to be involved
18 cohort coming through with assets and pensions - delighted to have something like that
1 director of OP with one of the trusts with 2500 staff

Figure 47: (on previous *page.) P14 considers quality of life arrangements and relationship with housing*

2.2.15 Interviews numbered 15-25: sense checking and additional views

After 14 interviews, I had achieved saturation of arising issues. My spread of participants across the domains of health, social care and housing had resulted in a broad range of complex and interrelated issues, their relative emphasis and the way in which different participants had the issues interlinked as they made sense of them. At this point, I compiled the causal maps and took these to re-interview several participants and additional participants as opportunities arose. I emailed each participant with their cognitive map clusters and invited them to discuss these early findings, and several them took up such an offer. I also interviewed a number of additional participants, of which participant number 17 provided some insights worthy of note.

P17 is the Chief Nursing Officer in Northern Ireland, leading the nursing contribution to the development and implementation of health and social care policy in Northern Ireland. They provided several additional nuanced contributions. One such insight fed into the divergence between expectations of care and reality, a context where the absolute maximum number of domiciliary care hours is two per day, with 22 either provided by family or not at all. In common with many power brokers, P17 provided some of the most interesting insights when considering their own circumstances. P17 highlighted the social changes that mean that very often both a typical husband and wife are working and dealing with teenage children at a point when one or more of their parents, perhaps living far away, begin to need care. P17’s mother lives in Dublin and

they highlighted that the only way to provide her mother with care would be to stop working, but due to her career and family of younger children this was unaffordable: ‘it’s not practical for any family at the moment to live mostly on one income... you are not sticking a couple of grand in the bank every month, saving for a rainy day.’

P17 also sits on the ‘Delivering Together’ reform panel, charged by the last Minister of Health with implementing the Bengoa report. Their strategic drive is to ‘have more community care and to have care closer to home’. However, as part of this strategy group, their hands are tied by the effective cuts in resources. P17 explained that over the last number of years the budget has remained static; however, they noted that to stand still, a significant increase every year is needed: ‘so for us, that’s a cut because of inflation and the cost of care, and what we need to keep up with demographics, we reckon is about 6% per year.’

As a member of the Delivering Together strategic team, P17 was able to provide an insight into the political implications of the financial commitments that were made by the Conservative government, thanks to the DUP ‘confidence and supply’ arrangements following the 2017 general election. As part of this arrangement, substantial monies were allocated for the transformation of health, plus additional monies were offered but were contingent upon the parties within the Northern Ireland Assembly agreeing to re-enter government and disappointingly such political compromise has not happened to the detriment of reform. P17 discussed some of the initiatives that this transformation budget so far was enabling despite being handicapped by there being no minister in post— since the legalities of policy change require ministerial sign-off. Much of the reform is in stasis.

2.3 The Data Structure

Following my methods at this point in my research, I overlaid the data structure over the cognitive analysis and to serve two related purposes: to add a deeper level of analysis for me and to add additional academic validity.

2.3.1 Ordering the data

There were 50 themes that emerged, as presented in Figure 48 below.

1. Is the system sustainable?
2. How to procure liberty, choice and personal options? Synonymous with quality of life.
3. Demographic change.
4. Empowerment, importance of independence and personalisation.
5. Carers role: prevention of acute care interventions.
6. Where formal care and informal care start and finish.
7. Focus on communities. Role for quality of life.
8. Appreciation of professional social care workforce.
9. Honesty needed in the market for care.
10. Silos in government / care / health / social care / housing associations.
11. Greater role for housing with care (HWC).
12. Option recognition. When an older person and family truly consider institutional care as an option.
13. Compare younger disabled with older disabled.
14. A future focus for those > 75
15. Vulnerable, alone older people. Social isolation issues.
16. Pressure on acute care and step-down care.
17. Conservation in the system.
18. A lack of functioning NI Executive.

19. Can domiciliary care manage complex morbidities?
20. Issue of poor-quality care delivered via 15-minute calls.
21. Negative comments re. large care homes. Issue of conformity – registered care.
22. “Conor’s” future.
23. Couples together.
24. Dementia issues.
25. Difficulty negotiating care system.
26. Importance of home for well-being and quality of life.
27. Family tensions over money and / or care arrangements.
28. Need for people to pay for care?
29. Conformance impacting on performance & quality of life.
30. Trigger for movement.
31. NI handout culture.
32. Need more proactive health service?
33. Last 1,000 days of a person; quality of life.
34. Quality end of life aspects.
35. Crisis moves are bad.
36. Spouses / partners do many more times caring than adult children.
37. People don’t think about their end of life / needing care / someone assisting with their toileting.
38. Proposing changes to NHS / Health and Social care is political suicide.
39. Problems finding a (good) care home.
40. Complexity of domiciliary care package issues.
41. Older people worrying about money.
42. Prophylactic care in care homes needed.
43. Older people need a little care – a lot.
44. Advocacy / community navigator/ help with thinking ahead.

45.	Demands upon females; working lives nowadays; often caring for two sets of parents, teenage children?
46.	Older people have a weak voice.
47.	Steady reduction in care offered – meals on wheels long gone.
48.	Safety issues regarding older people.
49.	Older people have no wish to move into institutional care.
50.	Direct payments issues.

Figure 47: The 50 themes that emerged during the research

Using the technique described in my methods section, I calculated the mean relevance / amplification score for each issue against each participant to seek the 30 most important issues to ensure that they were given due weight within the causal maps that follow. This relevance / amplification score is an ethnographic technique that gives a lesser score to an issue that may be mentioned by participants in passing and a higher score to such issues that are emphasised as critical by participants. I ordered the issues across the top against the participants shown in the vertical axis, and a simple mean calculated in the bottom row.

The top 30 issues are presented in Figure 49 below.

Rank	Issue No.	Mean Score	Issue
1	2	8.79	How to procure liberty, choice and personal options? Synonymous with quality of life.
2	9	8.43	Honesty needed in the market for care.
3	4	7.36	Empowerment, importance of independence and personalisation.
4	20	6.57	Issue of poor quality care delivered via 15 minute calls
5	11	6.64	Greater role for housing with care (HWC).
6	7	6.14	Focus on communities. Role for quality of life.
7	44	5.79	Advocacy / community navigator/ help with thinking ahead.
8	6	5.64	Where formal care and informal care start and finish.
9	26	5.50	Importance of home for well-being and quality of life
10	21	5.29	Negative comments re. large care homes. Issue of conformity – registered care
11	24	5.21	Dementia issues
12	36	5.07	Spouse / partners do many more times caring than adult children
13	29	4.93	Conformance impacting on performance & quality of life.
14	8	4.86	Appreciation of professional social care workforce.
15	43	4.93	Older people need a little care – a lot
16	1	4.86	Is the system sustainable?
17	50	4.64	Direct payments issues
18	25	4.64	Difficulty negotiating care system
19	48	4.50	Safety issues regarding older people
20	37	4.50	People don't think about their end of life/ needing care / someone assisting with their toileting
21	49	4.29	Rather die than go into institutional care
22	19	4.29	Can domiciliary care manage complex morbidities
23	34	4.21	Quality end of life aspects
24	5	4.21	Carers role: prevention of acute care interventions
25	46	4.14	Older people have a weak voice
26	10	4.14	Silos in government / care / health / social care / housing associations
27	47	4.07	Steady reduction in care offered – meals on wheels long gone
28	45	3.86	Demands upon females; working lives nowadays; often caring for 2 sets of parents, teenage children
29	42	3.86	Prophylactic care (in care homes) (and HWC) needed
30	18	3.71	A lack of functioning NI Executive

Figure 48: The top 30 issues as calculated by mean relevance / amplification score

2.3.2 Data analysis through quotations and induction

I was then able to order the key quotations by issue. I did this by selecting the most important issues as determined by the relevance / amplification score and set against them the relevant quotations that emerged from the power-broker participants.

Grouping the quotations by issue in this way gives a powerful expression of how participants make sense of the topic and what can be done. In so doing, the quotations underpin the importance of the issue and carry with them a powerful authenticity. Indeed, they carry more emphasis, and a more nuanced understanding than the aggregated summary used in the cognitive maps, and thus triangulate and enhance my research.

I carried out this exercise after mapping each of the 14 participants and their cognitive clusters. This technique, done at such a time, allowed me to ensure that in the subsequent causal maps that synthesise the cognitive maps, no important issue is lost, and also that the correct emphasis and conclusions are presented.

Using Excel software, I have been able to analyse the data across the 50 themes easily. For example, the tabs within Excel allow the entire 185 pages of quotations across 50 themes to be accessed from one summary sheet and this therefore affords easy analysis. Regrettably, such analytical depth confounds easy reproduction in Microsoft Word. Accordingly, I present theme number two in figure 50 below as the most important meta-theme (according to the relevance / amplification score) and place the analysis of the next two most important themes within Appendix four.

2.3.3 Quotation analysis across the themes

Figure 50 drills down into issue numbered two, found to be the most important issue according to the participants, being:

'How to procure liberty, choice, and personal options? Matters that are synonymous for quality of life.'

In Figure 50 below, I present the quotations relevant for this theme and in the outside column, my interpretations may be seen. These are how I, as an insider, have interpreted the comments made by the participant. The comments aid my understanding of the implications of the participant's comment since by continually asking myself the 'So what?' question I can probe and present their underpinning assumptions. Thus, by seeking to answer the 'so what' question the exercise tries to build a theoretical construct and contribute to building a cogent theoretical strategy.

Since the subsequent stage is my compilation of the 14 cognitive maps into two synthesised causal maps as the culmination of my strategy theory, the technique ensures that the interpretations in the causal maps best reflect the actual views of the participants as presented by their spoken word and that the content of the causal maps has maximum reliability and validity. As such, the entire chain of interpretation may be followed from the direct power brokers' quotations all the way through to the strategic conclusions presented.

2. How to procure liberty, choice and personal options? Synonymous with quality of life.				
Part'pant	Quote	Quotations	So	- What? What interpretation / What can be done?
1	3	Conor and Joan's story resonates, and it's the decision making that happens around that.		
2	1	Report on the lived experience of the older person living with dementia in a home with other people with challenging behaviours in the same home.		
2	3	**We keep reminding people that they're not making widgets. We're dealing with the lived experience every day for an older person in the last years of their life.**		
2	4	**There is no governing structure that can cope with that sophistication of understanding lives.**		
3	3	You're asking a minister essentially to trade their personal reputation for the good of the system, and that's pretty tricky stuff.		
3	5	**Who is going to pay for all this?...At some point charging becomes inevitable.**	x	"charging inevitable" so need a structure that affords charging
3	6	The issue is that your life is **not just about your health**. The object should be **more about having a good life**		
3	7	There are social enterprises doing really interesting things, but they're really small.	x	social enterprises are good but unrealistic to expect solutions to magically appear
3	8	If Health Service gets involved it becomes about managing risk. How does the state get out of the way?	x	answer - the state must not be involved. But needs to create the *structures* for *agency*
4	4	**We are creating a culture of dependants rather than a culture of independence**		
4	7	There are very, very limited choices and options; very, very limited.	x	need personal choice, but that not possible under the state provided version, so need private
4	8	But it is the social engagement parts (that get lost with current domiciliary care arrangements), the chat. That's what they valued, that's what they wanted, they wanted someone to talk with them, to engage with them	x	Importance of social interactions in any solutions that have been stripped out
4	9	One gentleman we interviewed, his wife had Alzheimer's, all he wanted was a couple of hours, maybe 2-6 on a Sunday, to go and play his golf. But that couldn't be accommodated.		
4	11	There are examples of very, very poor care. There are very good homes. We tend not to hear about those and that worries me.	x	Need to aid decision making when a move to institutional care becomes the only option, currently stressed octogenarian decision makers have little to go on. Rating like CQC?
4	12	There is a disincentive to move to institutional care because at the moment domiciliary care is not means tested. To stay at home is far better from a business perspective.		
4	15	The reality is that these older people do not exist in isolation from their families. So somebody wants to live at home with risk…**that's tricky…treating people like adults…**but at the same time realising very often they can't execute those decisions.	x	The present arrangements make little allowance for this reality, nor utilise the fact for personalisation and QOL
4	16	(re. HWC) you can literally see the merits for a lot of people who have dementia to be around other people and more intergenerational contact.	x	Extra Care / housing with care would be especially good for those with dementia
4	17	My understanding of supported housing is (that) if you get it right for older people, you will get it right for people with dementia, because it is about the family unit rather than the individual. I call it the caring diet.	x	Extra Care / housing with care would be especially good for partners of those with dementia
5	2	I'd be looking for the maximum bang for your buck (rather than the Dept. being a conduit for UK treasury welfare payments)	x	leverage government interventions to achieve more than 1:1 multipliers
5	4	There was a recognition that the Department needed to change…recognising that it had become too focused on purely meeting social housing needs.		
5	6	A greater focus on the private sector so they can be doing what needs to be done…this needed to happen.	x	Need a private sector solution to have impact - and that needs a structure of incentives - and that means not being scared of organisations making money
5	7	In terms of trying to advance anything in government…you really need to have champions from within the system that can be strong advocates. Otherwise you can have the idea and the vision, but if you don't have civil servants that are bought into that concept, then its going to be difficult, even with a political will.	x	change needs champions - change is very difficult otherwise
6	5	There is no QOL aspect to that (re 15 minute calls) no, not at all; and in many respects that's what we have heard continuously; not just from front line social care staff, but from employers themselves. There is real ethics within dom care providers, they know they are not doing what they could be doing...the added value of a cup of tea with someone who hasn't seen anyone else for a week.		

7	4	(so you cannot comment as to whether if someone is double incontinent, bedridden, alone, (whether) four 15 minute calls is sufficient for quality of life?) **No (there could be) four different providers each day, four different sets of people going in, so we can say that's a very poor care experience for someone.**		
8	3	We have a budget of £10m for rented housing for people with learning disabilities. So lending at zero interest rates to allow thirty new homes for people with quite complex learning difficulties to leave family homes of older carers and keep rent levels affordable.	x	a potential model already exists for adults with learning disabilities, a model that uses UK treasury FTC money and leverages in private and 3rd sector capital for a multiplier effect - following this precedent would be good
8	8	If it works, we would get FTC on a rolling basis. It won't all be at zero percent, and use it for a range of purposes, it could be vulnerable older people.	x	DfC could get FTC on a rolling basis for (e.g.) older people
8	10	But I think there is a sense in Health and social care that self-directed support will just happen organically… that's not going to happen. We need to encourage services, or support community based organisations. Services are not going to develop on their own, and people are not going to take self-directed support unless there is someone to support them doing that.	x	Self directed support (that gives choice and agency) will not happen unless stimulated
8	11	So let's purposefully seed something	x	so lets stimulate it!
8	15	**There is a sense that government has to fix everything. Government doesn't.** What we are trying to put in place is a **framework** that allows people to develop within and be innovative. That's challenging because we have actually got quite a top down kind of approach in Northern Ireland, a top-down mentality.	x	need a framework that allows private sector to do the heavy lifting
9	6	You don't need an 80 bed-home. You need small, domestic.	x	framework should be such that big 80 bed homes are not the only way to be viable (as at present): housing based care
9	7	Conor and Joan would be ideal candidates for Housing with care. One part has a high level of dependency that could be supported in a supported environment. Keeping them together: the alternative is the classic model of the husband ending up in nursing care, the wife will be so on her knees, she feels the pressure. That she's not, not done the right thing.	x	Extra Care / Housing with care ideal for Conor and Joan - "the alternative is the classic model of the husband ending up in nursing care, the wife… on her knees"
9	8	She's let him down because he's going into care. So she's feeling the guilt of that, the burden of caring and she's become very unwell herself.		
9	9	Families fit into services, as opposed to services fitting into individual's needs.		
9	11	Purely hourly, no career structure, no enhancement for 5 years, 10 years [service] because it doesn't allow the provider to do that.		
9	13	If people give you £12 per hour, you can't do everything. The two biggest things in domiciliary care expenditure are the salaries and the mileage, so there's nothing left to give anybody anything else.		
9	14	You lose community support through a large provider coming over from England., mopping up all the hours, you then lose all the connectedness of a local provider, in a local area, in the local community. That was the success of domiciliary care.	x	dom care success when small, local: it has moved away from that. Need to get back to a model that has domestic scale i.e. housing care: such as HWC / extra care.
9	15	The connections aren't there…somebody coming in, telling whose doing what, what's happening in the street – were so important.		
9	16	The advantage of someone coming in at lunchtime and to put a potato on and a wee bit of meat, a few vegetables. You had local smells I the house, you had a chat while you're making a meal and you knew the person. All gone.		
9	17	I haven't met an older person yet who hasn't said to me that I like my house clean and tidy, and my garden, because if all that is all right, then I'm happy. And you are not allowed to do that anymore…All the things that give people pride start to dwindle away, and that's what erodes your independence.	x	keeping pride in home and independence critical for sense of worth, well-being and quality of life. Need housing with care models that afford this.
9	23	The biggest thing is [about HWC] is keeping people together. In my lifetime it's always been that one of the couple has had to go into care, causing distress to both. Whereas that one enabled people to live together and that's so important	x	So models of care that keep couples together and keep each other well are vital - such as HWC / EC
9	24	It was relaxed and homely, giving the things that people want. It didn't feel like an institution, as if it was their house, you have your own front door, living space.	x	Positive experience of Trust run HWC, more needed. Only available through stimulating private / mixed tenure provision.
9	25	The carer won't have the stress and so much ill health. Even if it is another 6 months, another year of being together, that's another year of quality time, that's precious.	x	Even another 6 months / year together is precious that HWC can give
9	26	Everyone feels safe in a home that belongs to them, and their independence is maintained and that's paramount	x	feeling of being in control is paramount for QoL, maintain this via HWC
10	1	Your home where you live is… the anchor stone upon which other aspects of your life are held together	x	feeling of being in control is paramount for QoL, maintain this via HWC
10	2	What concerns me is the number of people who don't have family members to speak up for them	x	need an advocate on HWC site to co-ordinate individual needs
10	3	I always worry about those who continue on their own. Who speaks up for them? Challenge the level of service that they receive? Because that's the one person that they see who is coming in through the door.		
10	5	Isolation is a form of torture. We have some very frail and vulnerable people who are basically in isolation		

11	1	60, 70 bed homes just become institutionalised, no matter how much you're trying to do the thing with wings and all that. It does become institutionalised.	x	need smaller care environments - but are not currently viable, so introduce HWC as a viable option between home and institutional care, even if only for a year.
11	3	You smell the cooking…and what's better than that? You're having a meal with 8, maximum 10 other people. There's a sense of community. Who wants to sit on their own?		
11	4	[Re. Supporting People] We're really glad to still have it in Northern Ireland. It makes a huge difference, a huge difference		
11	6	So the two beds were pushed together…literally until the day my mother died and the staff went in and they were holding hands…they had been married for over 60 years and I think that is wonderful that they managed to share that		
11	7	Couples co-create their well-being	x	So keep couples together using HWC (when the only other option is institutional care).
12	4	When people make a contribution to domiciliary care, that makes a massive effect on demand; it brings home the value of it.	x	Eventually use pricing / co-payments to regulate demand. This politically difficult now, so create structures for individual budgets / self directed support (SDS) that may be "topped up". Need SDS to work 1st, and for that to work need a navigator to assist older people first, and second need to change from the current system of cutting the £ when SDS option taken up.
12	6	Much more part of a proactive system…**we have we have to get much better and proactive at keeping people well, and keeping people independent**. And we haven't been very good at that, whereby the principals of the NHS are to rescue and recover people…to react when people are vulnerable, but actually all that is doing is that we have increasing number of people that we are trying to fish out of the river as they flow past us and we are struggling to do that…we need to get upstream and stop them falling in.	x	HSC poor at being proactive. Rather than attempt to change this culture, better have structures in place for private / 3rd sector that assist individuals stop "falling in" in the 1st place.
12	8	We need to define what quality looks like, **If we had 12 months to live what would the things be that we would want? Independence**, as much contact with our f**riends and family, being able to pursue our interest…a sense of fulfilment**…I think we have to redesign the model…part of that is **housing and maintenance of independence.**	x	Be clear what outputs are sought: will be well-being and fulfilment in nature and unlikely to be achieved with 4 x 15 minute domiciliary calls or in an 80 bed home. Can however be achieved using the power of "home"
12	11	When you do traditional tendering procurement you are trying to get economic scale by bringing in a huge provider that people in the area don't know. The wealth goes to the main company based outside the area. With a social enterprise model we can actually get them a double whammy, because you get the care for people who need it, but you also provide some income for the area which is one of the main determinants of health…then it will also build social engagement.		
12	12	The residential home…what the staff would actually say was that they were increasing dependency and killing people with kindness. Actually what we were doing was fitting 20 or 30 people into the regime of the home, moving round the procedures and arrangements around the needs of the care home. So you ate at a certain time, you got up at a particular time and you got your meds at a particular time. So we were taking the independence away from people.		
12	13	People have transformed so much since moving into housing with care…I have witnessed people completely blossoming [from SEHSCT website video on Cedar Court]		
12	15	With more independence they take care of themselves because they are given the opportunity. In the care home we bathed them; their meals were made for them. I think it helps them greatly being here (HWC) compared to residential care.	x	Evidence of good outcomes in HWC so more needed, and to make an impact the need to be private rented / mixed tenure. To do this needs private capital unlocked and to do that requires government covenant underpinning rent to make an investible proposition.
12	16	She just loved the model because she can maintain her independence with just a little bit of support and a sense of being a home within a little community		
12	17	We can actually keep people with quite significant dementia independent because of the design of the building		
13	1	One gentleman in his mid 90's who is still driving, but his wife was 11 years younger than him and is suffering from dementia. .. He was the one looking after his wife; there he was at 92 or 93, still up and down to the town in the car, and taking care of his wife. The [EC] scheme, support and independence obviously had a wrap around and huge impact on him, his life and freed him up of quite a lot of the burden of taking care of his wife		
13	2	We have £72.8 million [of Supporting People money] across so many hundred services, and new services come on they have to be funded from the same pot. And for me in my mind, that's where the problem lies. How we can develop future Rivara houses within a restricted pot of money. SP pays for the scheme administrator, exactly the bit that makes life good. Prior to 2003 it was all about the social interaction with the resident, sitting with them, having a cup of tea and so on. With SP now there is a need to demonstrate how that money is spent and outcomes for the older person. All of a sudden you're into IT and administration so the scheme administrators are drawn into their offices to get their paperwork sorted.	x	need to keep the navigator with the older people not behind computer screen doing compliance
13	3	It's very hard to put a metric on companionship.		

13	3	It's very hard to put a metric on companionship.		
13	5	You're looking at private leasehold for older people, you are looking at affordable home ownership, and you are looking at dementia care units. A sort of mixed use, mixed tenure development where you have clinics…social and community facilities all on one site. A sort of broader partnership arrangement with a number of key players. That for me needs to be built into a broader strategy. That's the kind of model that gives you that level of sustainability	x	"You're looking at private leasehold for older people, you are looking at affordable home ownership, and you are looking at dementia care units. A sort of mixed use, mixed tenure development where you have clinics…social and community facilities all on one site. A sort of broader partnership arrangement with a number of key players. That for me needs to be built into a broader strategy. That's the kind of model that gives you that level of sustainability"
13	6	Best when there is a greater interaction with younger people. For example I know of a care home that partnered up with a crèche, with toddlers coming through on a daily basis. That brought a whole new lease of life for the older person.	x	need HWC / EC to be amongst community, post office, crèche, nursery, coffee shop
14	1	The key I feel has got to be around the whole issue of independence.	x	Independence key to better social care for older people - keeping independence after when "forced" to move from existing home. This cannot be done in a care home, so need HWC / EC
14	3	Highlighted in every government report that's ever been done around older peoples services is keeping people at home for as long as possible. Having said that, that goes along with a lot of support services and a lot of funding, and I think that is where the whole thing breaks down.	x	At some point, the effort required to keep people at home becomes worse for their and their families QOL. Presently this is happening earlier than it needs to thanks to the limited nature of domiciliary care and the lack of scope for spouses, partners, volunteers and family to contribute, and often the inappropriate nature and location of the existing home. Presently people therefore either stay at home for periods of time with sub-optimal well-being, or move to a care home "early" with sub-optimal well-being and cost outcomes. HWC offers an option for this point on the continuum where independence may be maintained and important aspects of quality of life may be manifested.
14	4	You have this ridiculous situation where people paying for their care in a nursing home have to give up their homes [to pay for care] whereas if they are serviced at home their care [is free] and really is back to the bone at this stage. The domiciliary care services are depleted, they really really are back to the bone at this stage, there is really a very limited amount of time given to people who want to stay at home.		
14	5	**Most people don't get a choice**. You get a bit of service in bits and pieces and maybe a family member cares, you know, doing their best; but that will break down eventually.		
14	6	People are forced to move into institutions where people are really very very sick		
14	7	**I think there is a continuum here**, and there is a bunch of people who could actually still be at home…if we had decent comprehensive care packages and support in decent accommodation **it wouldn't be necessary for them to move [into a care home]**	x	Need HWC to fill the gap between poor care provided with domiciliary care on the one hand and institutional care on the other
14	9	They should be complaining, saying "look, I am at home here, you are giving me two 15 minute calls per day; my wife is breaking down here!" But they don't, they put up with it	x	need community navigator / advocate
14	12	Direct payments are good in theory and in practice are for a younger generation	x	need to change them to be a good option for older people, specifically stop cutting the amount if SDS option taken, this allows the community navigator to run it.
14	13	Somebody needs to be in that [community navigator] role for that couple [Conor and Joan] to navigate through the situation…get help.; know what's available, what can we get them.	x	its obvious that Conor and Joan need the community navigator
14	14	[HWC] they work very well for people from the local area and they are very successful. But there is a gap for people who are not entitled to housing benefit…a gap for something similar, specialising around dementia; allowing your carer to come and live with you, have all the support, be in pleasant surroundings, and be able to maybe purchase additional care if you want to.	x	need HWC for the 70 % of older people who are homeowners
14	15	A growing number of people who have private pensions… who would be delighted to have something like that, prepared to sell assets… without disinheriting their children…		
14	16	**[EC / HWC] They are not known well enough here, they need to be physically there [built] for people to see, find out if it would be suitable… how much is it going to cost…I do believe there would be an appetite for that**		
14	21	There is a cultural thing here in Northern Ireland about the private sector and we are still hung up a bit about that. I would have had colleagues of mine who would have found it very difficult to accept that private sector could do as good a job as the health service, and in fact they can	x	public sector needs to appreciate private sector needs to have a margin in order to put capital at risk
15	1	90 year olds don't buy houses so we need to find a way of having that conversation with people	x	HWC needs to be rented. Either social housing rent, or private rent. When more commonplace, older people may see the benefit and move prior to the very last minute / crisis moves.
15	4	Fundamentally about her having control of her life, having her dinner when she wants to	x	control = well-being
15	7	**People don't want to go into nursing home care, that's kind of like a last [chance] saloon**. They don't want to pay, they want care in their home, domiciliary care, but they don't want to pay for that either	x	this relationship must underpin improved care outcomes. Control most easily afforded through a housing / care model.

15	10	That's just an existence to me; there is no quality of life for someone who is bedridden and requiring care workers [isolated, at home]		
15	17	Communal areas are important because of the social engagement function; they just want people to talk to and share stories	x	Design needs to have coffee shop feeling
15	18	The only people coming in are the people coming in to dress her leg ulcer or do their bloods or whatever; how do you prevent that social isolation from happening? **Where's the story telling factory?**		
15	19	Don't think domiciliary care is sustainable, what we need is a mixed model of nursing care		
15	24	My drive is to have more community care closer to home		
15	27	Early intervention prevents crisis, but if you don't have the right people in place to do that… multi-discipline team wrapped around a GP practice, including social worker community navigator for social prescribing. This social worker then becomes key, and more appropriate to see Conor and Joan than the GP		

Figure 49: Issue 2: how to procure liberty, choice and personal options?

It will be recalled that the causal maps are the primary graphic illustration of the strategy forming approach. However, as I discuss, the maps carry with them a risk of loss of vigour due to aggregation. To counter this risk the data structure analyses each of the most pertinent 30 themes, by referencing specific participant quotations across the issues and themes that they determined as the most important and are fed directly into the causal maps. The strategy conclusions presented within the causal maps below may therefore be traced directly back to the specific quotations of the power brokers within health, social care and housing.

2.4 Section Conclusion

This section has presented and analysed the findings of the research. Each of the transcribed interviews has been dissected to uncover how each power broker makes sense of the system of social care for older people, and how they strategise to improve their welfare. In each case, I have highlighted and analysed some of the most important issues the participant discussed. I have provided a summary of comments in the text where I note how I have induced the relevant essence from such comments, and I have incorporated these into the cognitive maps.

The maps display how the Decision Explorer software clusters the issues, and this provides a cognitive insight into how such issues interrelate across the broader themes. I have commented on each cluster to draw out the possible priorities that the participant, in conversation with me, considers essential, as well as the strategic outputs that I have induced from the data.

The latter sections presented the analysis of the ethnographic data that I overlaid over the cognitive maps for better reliability and better validity. I have covered the 50 most important issues and my means of ordering them into the top 30 themes. This serves to determine the emphasis needed when creating the strategic causal maps that are the subject of the subsequent conclusion section. Secondly, I have presented the quotations that are applicable to each of the most important themes and applied the ‘So what?’ question. Continually applying this question adds leverage to the theory that I induce and present below.

3.0 Conceptualising Extra Care – My Approach

3.1 Economic Backdrop

I became Executive Chairman of WJ Law, one of Northern Ireland's foremost private housebuilding firms, as the catastrophic fall in the construction sector took hold. From 2007 to 2012, there was a 50% fall in house prices and a 50% fall in the numbers of buyers. At that time, when revenues were thus falling by 75%, costs were rising thanks to higher design standards and inflation being over 5%. Cumulatively, the business environment for private housebuilding in Northern Ireland was catastrophic.

3.2 Designing and Building Homes for Older People

Prior to the great recession taking hold, my strategy for WJ Law as Development Director and latterly Executive Chairman had been to specialise in homes for the discerning second- and third-time buyers on greenfield land in 'good' locations. This strategy broadly followed that of 'Differentiation with Broad Scope' from the 'generic strategies' of Porter (1980), as may be seen in the top right of Figure 51 below.

Figure 50: Generic strategies: sources of competitive advantage

Adapted from Porter (1980)

The demand side was strong during the 1990s and 2000s and the strategy afforded healthy margins thanks to a configuration of specific supply side resources and competencies:

- Scope for margin through site acquisitions: planning delays and site scale were effective barriers to entry, tying up significant capital.
- Scope for margin through gains from planning approval.
- Scope for margin through attached homes and higher density.
- Scope for higher prices thanks to compelling quality in architectural dwelling design and landscaping design.
- Scope for margin through quality management and management systems spread over multiple sites and high volumes.

When the tsunami of the great recession hit, it caused the demand side to collapse, and the supply side factors became a poor fit for the business environment:

- With house prices lower than the cost to build the dwelling, the land bank changed from being a significant balance sheet asset to a significant balance sheet liability.
- The delays of planning resulted in an inability to conduct business, plus high professional fees necessary to achieve approval became inappropriate when assets had become worth so little.
- The level of density became inappropriate, given the weak market demand. Being given such a wide choice, such buyers that were in the market preferred lower density homes.
- The weak demand meant that there was no value to be added through design in a volume-based market sector; the product had become commodified – the price was king.

6. The weak volumes and inability to commit the necessary capital to commence new sites meant that the company overheads became excessive.

Faced with such challenges, I instigated a comprehensive review with employees, many of whom were facing redundancy and other key stakeholders. I engaged with the board and others to convey the sense of urgency at hand, and I established myself as a conduit to underpin the credibility of my future vision allied to my candour as to the company's financial position. I proposed a four-point strategic plan:

1. Risk management: I proposed a change in the company structure to being a totally outsourced model. This would ring-fence the interests of investors, remove health and safety risks and provide continuity of employment for staff.

2. A customer orientation: I had attended the show homes each Saturday for five years and instilled a relaxed atmosphere to hear first-hand the views of customers and key personnel that proved invaluable. My customer insights allowed me to forge a leaner organisation to focus on those customer needs and maximise revenue within the flatter structure that I proposed.

3. The products on offer: I proposed changing to a higher-value and detached product range rather than compete with distressed sales and social housing competition. I also proposed a range of properties for older buyers aimed at those who were least likely to be in negative equity.

4. The method of construction: I proposed moving entirely to a timber frame form of construction. In line with the move to higher-value detached dwellings, this aimed to maximise the use of working capital towards high-value dwellings for individual customer wishes, and “pull-through” a lean production system based on contracted sales.

The traditional core buying cohort of discerning second-time purchasers buying attached housing in ‘good’ areas were precisely the ones who were disenfranchised thanks to them being in negative equity and unable to move. I had the choice of competing below or above that traditional market segment. Below, in the cheaper product end of the market, the company would have been competing against distressed sales that receivers were selling for less cash than it was possible to build them for and competing against government-supported housing associations. Above the company traditional market segment was a higher-priced housing market where buyers had equity or were financed by the ‘bank of mum and dad’. Despite requiring

considerably more customer relations management, the buyers in this segment were likely to be discerning, appreciate design, quality and locations and thus afford margin. For these reasons, I proposed to shift the value proposition to the bottom right quadrant of Porter's (1980) generic strategy matrix: to the differentiation, narrow scope sector of Figure 51.

I secured board approval and communicated and executed the plan that ensured WJ Law had a strategic fit for the business environment. I combined the four elements to ensure the company was lean and responsive to customer needs. This meant that the senior team and I worked at length with each buyer and adapted their home for their individual wishes. Typical changes were to add attic bedrooms, vaulted ceiling sunroom, or indeed provide 'his and hers' dressing rooms and en-suites. Upon the legal agreements being signed, the timber frame technology allowed the dwelling to be quickly built. As such, the change to detached dwellings and timber frame ensured very effective and contractually secure working capital management. Rather like the 'Toyota production system', it became customer needs that initiated processes, waste minimised and margin were afforded.

The strategic change was a success and instrumental in the company surviving through the recession of 2008 until a pre-packaged sale in 2015. Its success was based on a single-minded focus on seeking to 'delight' customers, thanks to the relative changes in the strength of resources and capabilities to hand. Whereas previously the strengths were based on tangible resources, such as the land, latterly the key resources were relatively more towards the 'dynamic capabilities' of Ambrosini and Bowman (2009), meaning that the capabilities of management skills of design, procurement, sales, marketing and customer relations were dynamically developed to

be resources in themselves: particular to the industry, particular to the company and particular to its activities. These capabilities thus became valuable (V), rare (R), inimitable (I), and non-substitutable (N) and thus matched the VRIN model of Barney (1991) by being matched to the challenging business environment.

As explained above, the strategy was based on providing a compelling offer for those buyers who *were* in a position to buy – buyers other than those who had acquired their first home in the period from 2004 onwards, since it was these buyers who were especially likely to be in negative equity and unable to buy. Buyers in the market who had acquired their first home prior to such a date often tended to seek larger and detached family homes. Moreover, I also discerned a set within this group of older buyers. It was thinking of an offer for this cohort that led me to thinking of older people's housing.

3.2.1 Models of homes for older people

3.2.1.1 Single-storey retirement cottages

During the period 2009–2012, I designed a range of homes for older people, initially as compact detached homes. Some were purpose designed for specific areas on a development that was suitable for single-storey dwellings, since single-storey homes are not required to have the same sizes of gardens as two-storey homes, and for this reason they may be utilised on smaller plots. An excellent example of this approach may be seen in Figure 52.

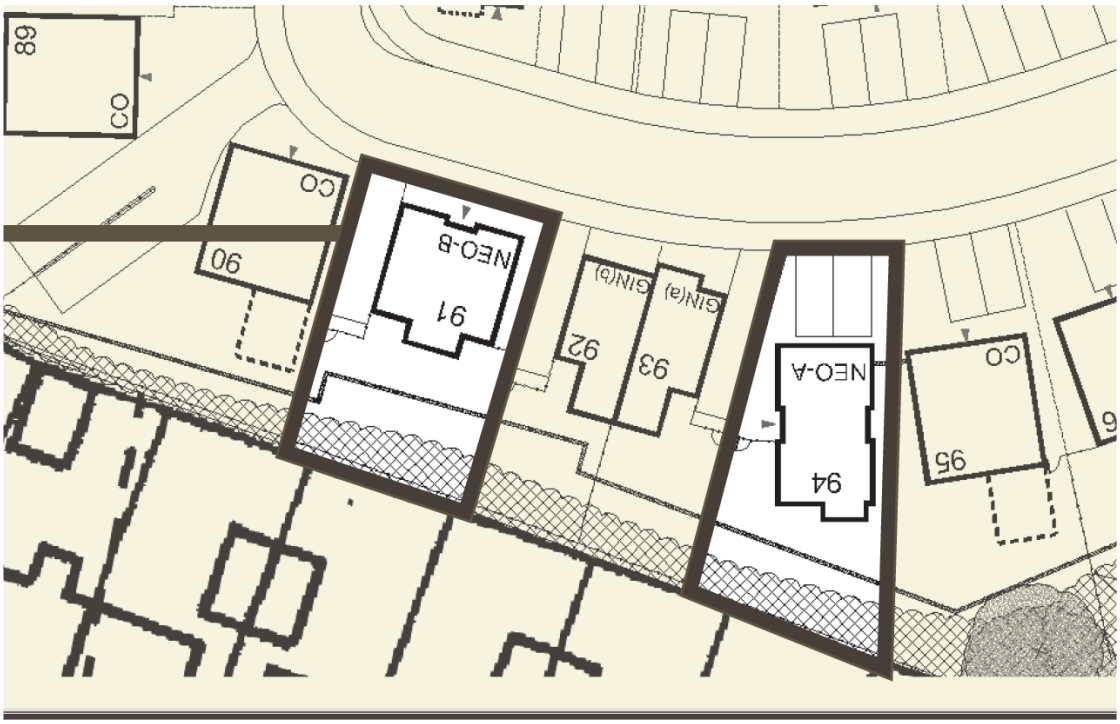


Figure 51: Site plan detail showing single storey detached retirement cottages

In the site plan detail of Figure 52, the two dwellings numbered 91 and 94 have comparatively small gardens relative to the dwelling footprint. The garden size may be compared with the adjoining site numbers 90 and 95, which have a similar footprint, but due to being five-bedroom detached family homes are required to have large gardens. Clearly, using such a house type on site numbers 91 and 94 would have been inappropriate, but the single-storey cottage was an ideal solution. The floorplans and elevations of these single-storey retirement cottages are shown in Figure 53 below. I also present a photograph of site 91 in Figure 54, where the reader may also note the black ‘occupational therapy’ handrail to both as a means of front door access.

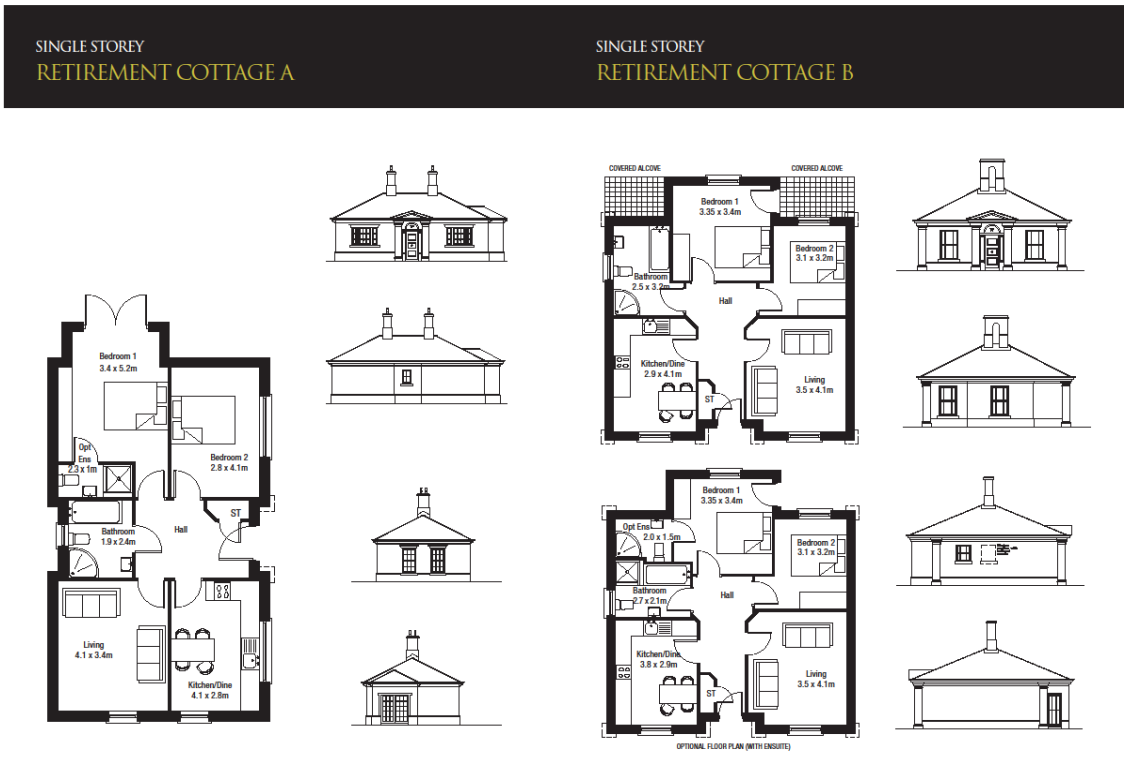


Figure 52: Plans and elevations of single-storey homes

Figure 53: Photograph of site 91 Ballantine Garden Village, Lisburn

On the face of things, the single-storey retirement cottages were a profitable proposition: selling at approximately £200,000, and being approximately 1,000 sq. ft., the estate agents were highly excited about them. My quantity surveyor was less excited, since, having one floor over which to spread fixed costs such as the foundations and roof structures, the homes were extraordinarily expensive on a £ per sq. ft. basis. Overall, they were a useful addition to an eclectic house type mix, and useful for certain constrained plots, but not a widespread answer on the supply side, demand was limited and not many were sold.

3.2.2 Bespoke cottages for older people

I considered one way that would combine the build-ability efficiency of a two-storey home with an ‘offer’ for older buyers would be a two-storey home that might be adapted for ground floor living. Such a home would have the potential for a large shower room

on the ground floor suitable for disabled bathing, with a drain built into the centre of the floor. However, until such times as this might be needed, the room might be used as a utility room/cloakroom. The design ensured that the hallway was wide and there was a straight flight of stairs, such that a stairlift might be more readily installed later. The primary design feature, however, was that the upstairs was designed to be readily adaptable into a carer's apartment, with the dining room changed into a bedroom. The power points, waste and water supply on the upper floors would be positioned in locations to suit a future carer's kitchen. Likewise, the principal bedroom would have its electric points suitably positioned around a future hearth and television points for use in its future life as a carer's living room. The 'before' and 'after' plans are reproduced in Figure 55 below, and photographs in Figure 56.

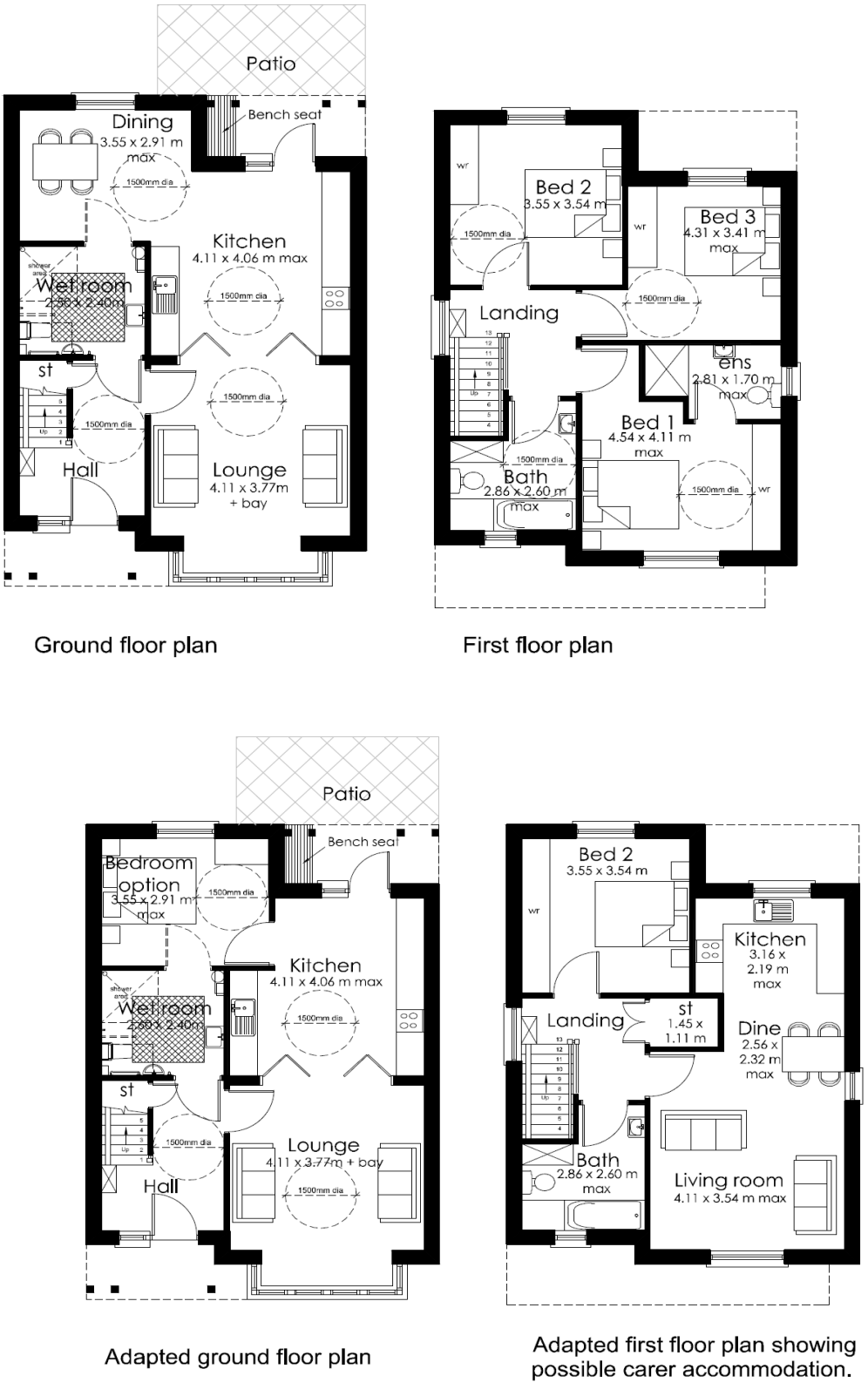


Figure 54: Bespoke cottage for older people – 'before' and 'after' floor plans

Figure 55: The bespoke cottages, exterior and interior

I constructed an example of a bespoke home as one of the show houses, and built it in its 'adapted' state, meaning that viewers were invited to imagine the home having been adapted for older people's living, with the ground floor bedroom and upper floor carer's apartment in place. I hosted delegations of ministers and representatives from the relevant charities and departments, who acclaimed the forward-thinking approach. The difficulty was that very few of these homes sold either.

3.2.2.1 '90-year-olds don't buy houses!'

To the extent that it was buyers with equity who could buy, only a small number of 'older' buyers did so. As my section on moving decisions has highlighted, the

percentage of people who move diminishes quickly with age. There was, however, a small customer cohort of widowed women recognising that they would prefer to live closer to family and others. Such a cohort was also able to afford a new home that is relatively expensive, as Figure 57 shows.

Margin and cost analysis

	Small detached home	Larger detached home	Smaller semi-detached
Sale price	**£215,000**	**£275,000**	**£170,000**
Less			
Build cost:	£100,000	135,000	£90,000
Fees:	£5,000	£5,000	£5,000
Site development works spread:	£28,000	£32,000	£20,000
Finance:	£15,000	£18,000	£10,000
Land:	£37,000	£40,000	£25,000
Residual margin for risk and profit:	**£30,000**	**£45,000**	**£20,000**

Figure 56: Margin and cost analysis (figures)

The table is a stylised example of the Northern Ireland market in 2019 and it affords some insights. Firstly, that housebuilding is expensive: in a typical provincial location, costs are a high proportion of selling prices. In many areas of Northern Ireland, the

sales prices are actually below the cost of build, even when the land cost is zeroed. Secondly, it highlights the related insight into the development process where years of planning and costs are undertaken for an uncertain and limited return. Thirdly, the example illustrates a trade-off between larger detached homes and smaller semi-detached homes. The developer may avail of the semi-detached market, which is a lower risk due to buyers being supported by 'Help to Buy' mortgage availability. In the example, a pair of such homes generates £40,000. In contrast, the larger homes come with considerably more risk due to there being so many fewer buyers, but may generate higher returns, such as the £45,000 in the example. Fourthly, the table highlights a certain premium for detached four-bedroom homes that is absent, for example, with detached three-bedroom homes. Due to lower margins, there would need to be site-specific reasons to pursue a strategy of building smaller detached homes.

Figure 57: Margin and cost analysis (discussion)

Figure 58 underlines some of the problems that I faced in 2011–2014. While there was a market for buyers with equity, including an 'older' buyer, both margins and buyer numbers were low. It struck me that until there was a compelling reason to move, very few older buyers would. It seemed to me that few could afford to move; those who could saw little reason to do so. Why would they entertain the upheaval of a move to a home that was likely smaller? Still fewer wished to entertain the concept of their own decline, to somehow 'futureproof' their lives; then those who were faced with their decline were in no place to purchase. Hence, when there was a compelling reason to move, such as when an older person is being forced to consider moving to institutional

care, such older people were not going to buy. Since no such homes are demanded, none have been built. Thus, whenever an older person seeks such a home at a time of crisis, none are available.

I was aware of the notion that '90-year-olds don't buy houses'. Neither would they want to move into a care home, often necessitating splitting up a couple. All in all, this struck me as a supply and demand problem: since no such homes were demanded, no such homes were built. Latterly, I discovered this charming short piece by Paul Krugman (1988) where he wittily illustrates how, in such circumstances, markets can fail to form. His example was that of English food in the 1970's — that was stuck in a bad equilibrium.

'The appreciation of good food is, quite literally, an acquired taste – but because your typical Englishman, circa, say, 1975, had never had a really good meal, he didn't demand one. And because consumers didn't demand good food, they didn't get it.'

Good food was not supplied because it wasn't demanded and not demanded because it wasn't supplied. It took the exogenous shocks of external factors such as an influx of foreign nationals and their cuisine to stimulate the market. It occurred to me that the market for housing is also stuck in a bad equilibrium – supply and demand are mismatched – it also needs to be stimulated. Firstly, however, I needed to decide what it was that needed stimulating, and that necessitated designing and building a form of home that could be profit-making, could be suitable for renting, and could provide the attributes suitable for those at the interface between home care and institutional care. I needed a financial model and I needed a prototype.

3.2.2.2 The financial backdrop of renting

It is perhaps not immediately apparent to all why building to rent is rarely a profitable exercise and so at this point I devote the following short section to explaining this.

The value of an investment property depends both on the quantum of rent flowing and how risky this income stream is. There are three broad sources of risk to the income stream: the location, the characteristics of the tenant, and the lease terms.

With regard to location, the theory is that if the subject property is in a desirable location, then in the event of a tenant leaving, a new tenant may be found quickly, thus ensuring that breaks in the flow of rent are minimised. Also, in prime locations, there is an expectation that rental levels will rise over time. Some years ago, when interest rates were 7% and bank deposit rates not much less, rents in Oxford Street in London were generating a return (called yield) of typically 3–4%. As such, the investors were, on the face of it, losing money. They would have been better keeping their money in the bank earning 6% or 7%, but they did not. The reason they did not was due to the expected rental growth available in such locations. Since property value = rental income / yield, an increase in the rent passing will positively affect the property value. Such capital growth more than compensated the investor for the rate of return from rents being lower than the risk-free bank rate.

Thinking about the characteristics of the tenant, referred to as the tenant ‘covenant strength’, it may be seen that having a tenant from the FTSE 100 Index or the government will give a property owner considerable comfort that the tenant will be around in the years to come, and that they will pay the rent. Conversely, a lease to an individual who has few or no assets is a much riskier affair.

Thirdly, risk comes from the lease agreement, where it may be seen that an ‘institutional’ type lease for 21 years with rents that are reviewed on an ‘upwards only’ basis every five years is a robust contractual arrangement that may be relied upon by the landlord to ensure that the rents are paid. Conversely, if there is no lease in place, or where the term is very short, or where there is a longer term but no chance of a review, then there is considerable risk that the rent will not flow or not be paid at all, and the value will be lower.

When all three factors are combined positively, the value of the asset with such an underlying flow of rents can be very high. For example, a property will have a high value when it is in a prime location, rented to the government, on institutional terms, with an institutional lease consisting of a 21-year lease, and with regular upwards only rent reviews.

Unfortunately, the proposition of renting to older people just about has each of these positive aspects turned on its head. Instead of a prime location where alternative uses and users may be had, we see purpose designed homes for older people in residential settings. Instead of the covenant strength derived from a FTSE 100 company, we have a lease to an individual aged 90 who may not be alive in 18 months. Instead of an institutional lease, we see some form of tenancy agreement where typically, in residential lettings, the landlord is liable for rates and may be continually attending to repairs.

Using their market knowledge and experience, professional valuers such as I apply a single ‘all-risks yield’ against a particular leased asset. To illustrate, a property located in a prime location, rented to the government on institutional terms, may attract a yield

of 3.5%. Say the passing rent was £7,000, then the valuation (ignoring for a moment costs of acquisition) may be calculated as property value = rental income / yield, giving £7,000 / 0.035 = £200,000.

In the case of a rental to an individual older person aged 90 in a less prime location on month-to-month terms and imagining the net rent (after repairs and rates) was again £7,000, the valuer might well apply a yield of 17.5%. Plugging these figures into the equation of property value = rental income / yield gives the following answer: £7,000 / 0.175 = £40,000

I have not chosen these figures arbitrarily, since £7,000 may be the around the amount of annual rent that might be expected for such a property. Since such a property may cost, including land, £175,000 to build, and valuation for such a property let to older people implies a value of only £40,000; clearly there is no economic case to build in order to rent to individuals. However, if the lease was to the government, the situation would become viable, where the costs of £175,000 are covered by the value of the institutional lease of £200,000.

This explanation of how value is determined underpins the approach that I have adopted, underlying the insight that some form of government covenant is required to make rented homes for older people viable. An insight that I return to in the discussion.

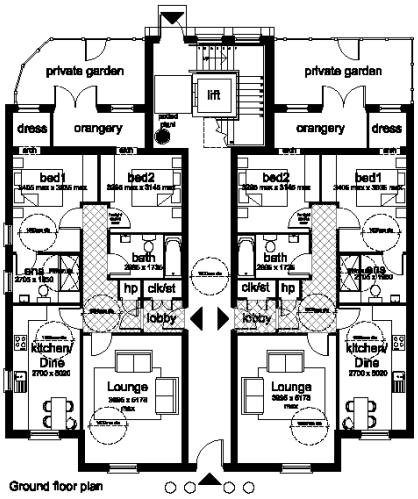
3.2.3 Hawksmore House

If an institutional lease might be possible, what would the design of the built environment look like? Having built over 1,000 homes, I know well that the second and third examples of a new house type that are built are inevitably an improvement on the first. As Mathew Syed (2016) explained, James Dyson went through 5,126 failed

prototypes, learning with every mistake, before coming up with the vacuum cleaner design that changed the world of domestic cleaning. I did not have the luxury of 5,126 prototypes, but I knew that the Extra Care environment would be better for having a prototype built, and it would provide a compelling statement for government decision-makers as a tangible showcase for the model. Accordingly, I designed Hawksmore House as homes for older people to purchase. Whilst these residents would likely be younger than for whom Extra Care is ultimately designed, the building allowed me to physically embody one of the constituent buildings within what I named ‘The Pavilions,’ the physically adjacent initial Extra Care proposal. In Figures 59–61 below, I detail Hawksmore House.

Figure 58: Proposed Hawksmore House elevations

Drwg No: 1847-010-00-01-01 | Pied A Terre | 01



Ground floor plan

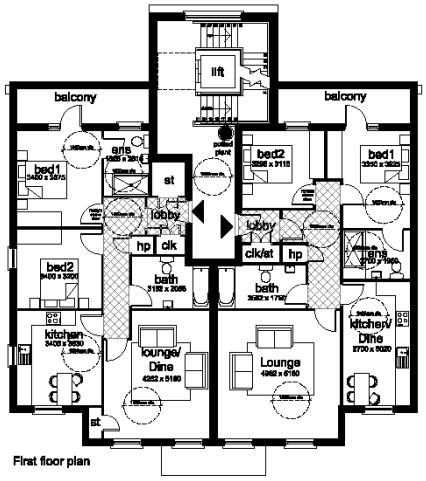
WJ LAW
Building quality since 1903

Pied A Terre - Site's 121-125
BALLANTINE GARDEN VILLAGE
HILLHALL ROAD, LISBURN
Date: January 2012 | Scale 1:100 | Drawn by: LS

Total Area: Site 121 864 ft² approx
Site 122 866 ft² approx
Site 123 937 ft² approx
Site 124 918 ft² approx
Site 125 1794 ft² approx
(Gross Internal Area)

Alan Patterson Design

Drwg No: 1847-010-00-01-02 | Pied A Terre | 02



First floor plan

WJ LAW
Building quality since 1903

Pied A Terre - Site's 121-125
BALLANTINE GARDEN VILLAGE
HILLHALL ROAD, LISBURN
Date: January 2012 | Scale 1:100 | Drawn by: LS

Total Area: Site 121 864 ft² approx
Site 122 866 ft² approx
Site 123 937 ft² approx
Site 124 918 ft² approx
Site 125 1794 ft² approx
(Gross Internal Area)

Alan Patterson Design

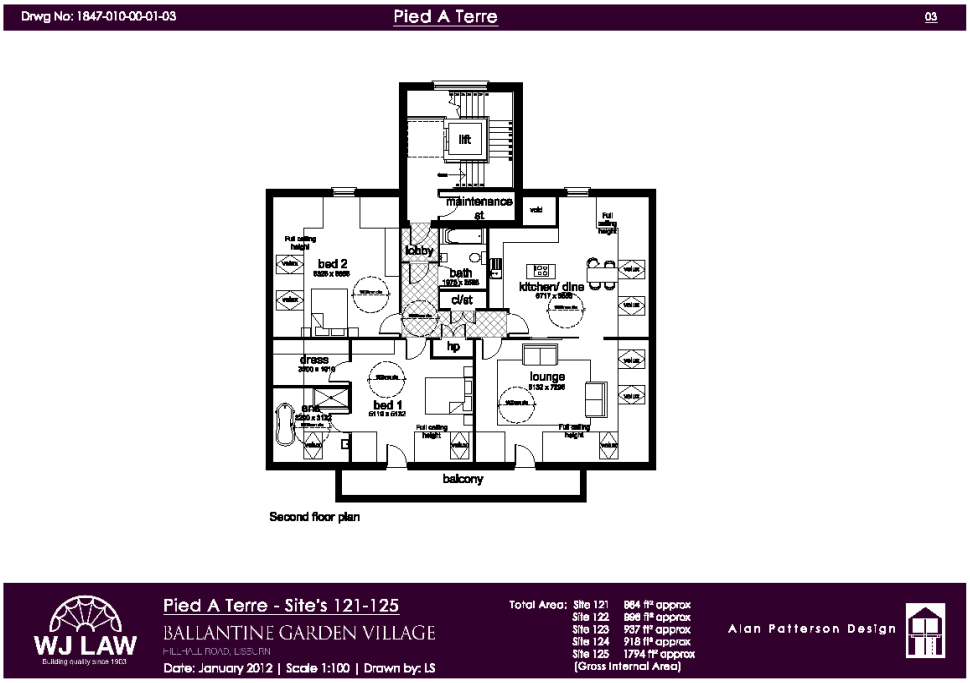


Figure 59: Proposed Hawksmore House floorplans

Figure 60: The completed Hawksmore House in 2018: it may be compared with the proposed building and setting from Figure 59

Hawksmore House is located on the edge of Lisburn, Co. Antrim and it forms a centrepiece to Ballantine Garden Village. The building commands one of the major green areas within the development, an open space that consists of two open circles encased within a substantial beech hedge, and the space affords recreation for all: older people and the young. I specified the turf to be as per the United States Professional Golf standards for golf greens, which essentially means the grass is a seaside links type fescue growing on a sand/soil mix laid on free-draining clean aggregate. With this specification there is less chance of children bringing mud on their shoes into the nice homes of their parents! Hence, the external environment is one in

which young children are safe to play, and there are tarmac paths that allow more frail users to enjoy the bustle of children's activities that spontaneously happen each evening. In short, I sought a balance of 'Structuration' in seeking to ensure that the structures were in place to allow personal agency to flourish.

The building is divided into three floors, with two homes on the ground floor, two homes on the mid floor and a 'penthouse' on the top floor. The ground floor apartments are some 900 sq. ft., the mid apartments gain some space through sharing the space gained from the hallway below and are some 920 sq. ft., and the top floor is some 1,700 sq. ft. Each home benefits from an external heated garage/store where some of a life's collected possessions may be safely stored.

At the time, the average price for an apartment in Lisburn was around £75,000 – far below the £135,000 build cost for each of the homes within Hawksmore House. However, I succeeded in selling the ground- and first-floor homes for £175,000 and the penthouse for £225,000 (latterly resold for £285,000).

For me, this underlines the point that Krugman (1988) was making, where until there is a supply of a product there can be no demand, since consumers do not know of it in order to demand it. Similarly, with Hawksmore House, prior to there being a supply of homes for older people, there was also weak demand, as witnessed by the low average apartment selling price. Economists refer to this phenomenon as 'Say's Law' where, under certain circumstances, an increase in supply may create an increase in demand, opposite to the norm of Samuelson's classic economic text. A similar phenomenon will likely occur with Extra Care, where there is presently an absence of homes in a caring environment. At present, older people and their families' face the 'Hobson's choice' of

care at home – which must be unsatisfactory or else moving would not be considered – or a move to a care home.

The design of Extra Care homes is an important factor in maintaining quality of life, and Hawksmore House serves as a showcase for physical design. A significant factor in their success in achieving well-being goals is that they be large enough and have specific attributes to compensate for lower cognitive and physical functioning. The homes in Hawksmore House are large and designed for disabled living, including bathing. To assist, I engaged the help of the Dementia Centre of Scotland, and this help ensured that the internal design was appropriate and included other features such as:

- The oven at chest height rather than having to bend down to lift out a heavy roast dinner;
- Potential removal of the ability of residents to access potentially dangerous appliances;
- Technological enablement: a ‘telecare’ service, in case of falls or assistance being needed, and other services such as older person movement monitoring;
- The kitchen units being glass-fronted to allow residents to see inside;
- The kitchen being separate, rather than the norm nowadays of kitchen/living rooms;
- The WC being a wet room with a waste trap in the centre of the floor;
- The doors all being wide enough for wheelchairs;
- The rooms being bright, with large Georgian-style windows;

- The windows being ‘easy open’ without having to stretch over kitchen units;
- The décor being different on each floor and free of busy patterns;
- That each benefits from a heated external storage unit.

Each of the homes enjoys outside space, the ground floor a small private garden, the first floor a large balcony, and the second floor a balcony the full width of the building, linking the master bedroom with the living room. On the ground floor, the design for the ‘Orangery’ allows an older person to benefit from a glazed room to appreciate the outside while remaining warm. The Orangery extension on the ground floor provides the space for the first-floor balcony above and serves to add privacy for the ground-floor bedrooms when visitors and other residents are entering from the rear.

3.3 The Pavilions

‘The Pavilions’ at Ballantine Garden Village are designed as five buildings that are like Hawksmore House and form the first Extra Care community. They are located close to Hawksmore House, as may be seen in Figure 62 below.

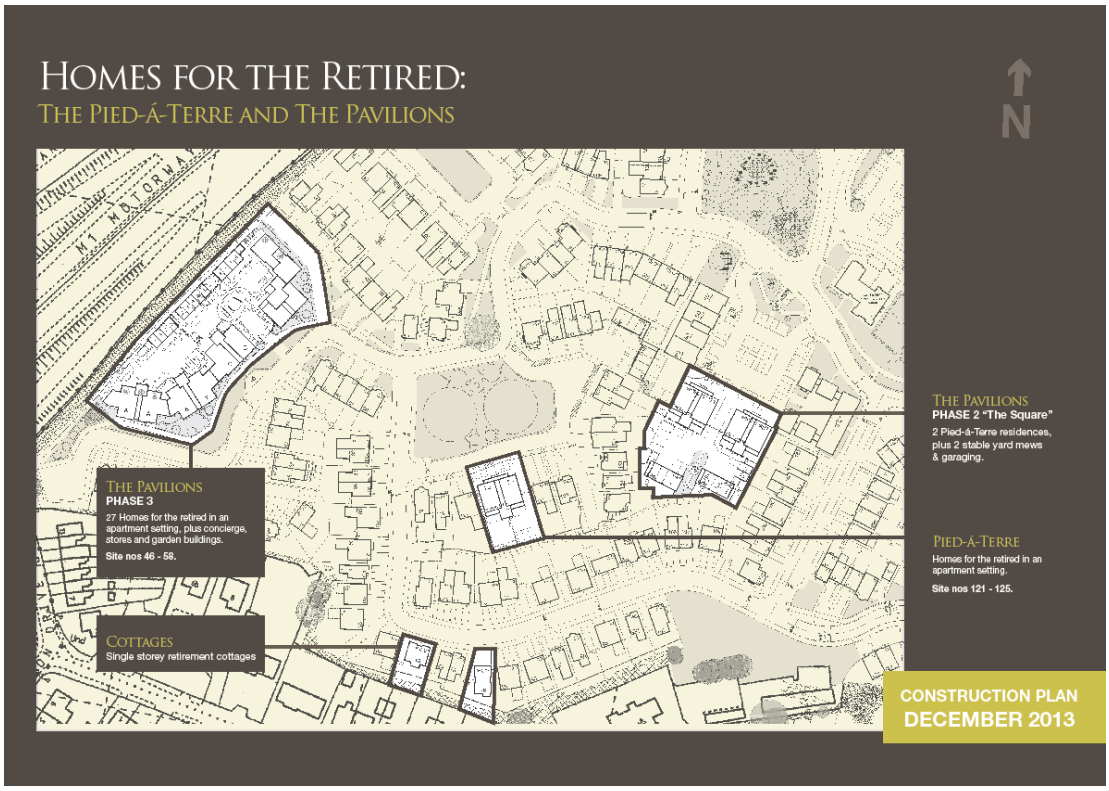


Figure 61: The Pavilions

Within 'The Pavilions' there are attributes in addition to those offered by Hawksmore House. These are highlighted below and are featured in the images within Figures 63 and 64:

- Managers office
- Restaurant and reception area
- Separate gentlemen's and ladies' 'Wi-Fi retreat'
- Apartment for relatives to stay
- Full-sized garages
- Additional stores, including a potting shed
- Separate allotments and greenhouses
- Internal courtyard for safe outside recreation

Figure 62: The Pavilions images. The top view shows the storage / garage with guest apartment over and resident's library room. The bottom view shows the inner courtyard.

Figure 63: The Pavilions: A proposal for 27 Extra Care dwellings with supporting facilities and community navigator.

3.4 My Approach to Extra Care: Conclusion and Next Steps

This section has chronicled how, thanks to the great recession, I sought customers who were not in negative equity, and this took me to older buyers and consideration of the very old. I noted that older buyers did not buy, and I recognised that when many become aware that their present home is inappropriate, it is often too late to move. Consequently, very few do. In short, '90-year-olds don't buy houses'. I recognised the reluctance to move into care, and the government policy of keeping people at home that likely meant that there would be many at the 'interface' between care at home and a care home, whose quality of life was impaired by both options. For them, an additional option of care in a housing environment would maximise their well-being. I

composed a coherent design for ‘The Pavilions’ and built the prototype of Hawksmore House.

I unpicked how an institutional lease is valued and I demonstrated how it is that a lease to an individual could be worth as little as £40,000, whereas a lease to an entity with potentially costless government backing could be worth £200,000. I noted that with build costs being some £135,000, a proposal to lease to older individuals is uneconomic, whereas a lease to a government-supported entity could be a valid proposal, depending on the cost of the land, acquisition costs and finance costs, etc. Remarkably the rent quantum does not change in the two examples, yet the value of the proposal changed by a factor of five. Moreover, the way in which the government lends support is not specified. So, there is not a need for government to acquire land and procure Extra Care on its own; indeed, it may not have the requisite capital nor be good at it. Whereas underwriting cash flow has a dramatic effect on viability and such a commitment need not require any capital at all. In the Strategic Outline case presented to the Department for Communities, I have detailed a proposal that fulfils the twin aims of underpinning the Extra Care asset value to make the proposal viable, as a highly cost-effective social care policy for government.

In this section of my thesis, I have built on the matters that are important for the quality of life of older people, built a prototype and achieved all approvals for ‘The Pavilions’ Extra Care community and conceived the model’s viability. My thesis fuses this empirical evidence along with the investigation with the field strategists.

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Appendix 1: Participant Information Sheet and Approval Forms

Participant information sheet and approval forms follow.

Participant Information Sheet for Informants

Name of department: Management Science
Title of the study: The Strategy of Housing with Care in Northern Ireland: Interviews with Health, Social Care and Housing Powerbrokers in Northern Ireland

Introduction
My name is David Law. I am postgraduate research student at the University of Strathclyde, Glasgow, United Kingdom. If you have any queries about my investigation, please contact me at davidlaw@wjlaw.co.uk

What is the purpose of this investigation?
The ultimate purpose is to improve the quality of life of older people who face institutional care entry. Instead of institutional care, housing with care can produce well-bring more effectively and efficiently and is increasingly available in England, Wales and Scotland.

The research considers the situation of "Conor and Joan," a fictitious archetype, where Conor is in just such a position of being at the interface between care at home and institutional care thanks to his dementia condition. Caring for Conor is damaging Joan's quality of life, and their options are expensive for personal and public budgets with poor well-being outcomes for them.

The research investigates the strategy for improving the quality of life for older people like Conor and Joan, at the interface between care at home and institutional care, and the role of housing with care.

The research question is:

> *"With reference to housing with care as one means of improving well-being, and with "Conor and Joan" in mind, how do power brokers make sense of social care for older people and strategize to improve their well-being, independence, and control."*

The investigation asks 20 power-brokers this question to make sense of how the strategy of Health, Care and Housing in Northern Ireland overlaps and is progressing, and asks the views of the power brokers as to how it should. Since one definition of strategy is matching internal capabilities to the external environment, the power-brokers are asked as to their organisation's strategic fit and addressing the societal challenge of aging.

The investigation will assimilate the data collected, collate the issues and induce strategy theory.

Do you have to take part?
No, participation is entirely voluntary

What will you do in the project?
The informants are to be interviewed for about an hour in their office where the investigator will enquire of the informants how they strategize to improve the quality of life for older people such as "Conor and Joan."

Why have you been invited to take part?
You have been asked to take part as you have valid opinions on the strategy of improving quality of life outcomes for older people such as Conor and Joan. As a power-broker within one of the fields of Health, Social Care or

Housing, you have influence on your organisation and ultimately the well-being outcomes for such older people. Your views on the direction and scope of social care for older people are important.

What are the potential risks to you in taking part?
The investigation has no special risks.

What happens to the information in the project?
The information about participant's identity will be confidential in the written report. The data provided by participant's interview will be saved in the Research Data and Management Sharing system of University of Strathclyde and destroyed on completion of the research.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 1998. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?
The researcher will make a report of the interview which you will be able to change and/or validate. The outcome of this investigation will contribute to the doctoral thesis which will be communicated to the participants through the participant's email if it is required.

If you are happy to be involved in the project, please sign a consent form to confirm this, if you do not want to be involved in the project, thank you for your attention.

Researcher contact details:
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Telephone : +44(0)2892 677317
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Chief Investigator details:
Name : Professor Alec Morton
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Telephone : +44 (0)141 548 3610
E-mail : alec.morton@strath.ac.uk

This investigation was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee, Research & Knowledge Exchange Services
University of Strathclyde, Graham Hills Building, 50 George Street, Glasgow G1 1QE

Telephone: 0141 548 3707 Email: ethics@strath.ac.uk

Consent Form for informants

Name of department: Management Science
Title of the study: The Strategy of Housing with Care: Interviews with Health, Social Care and Housing Powerbrokers in Northern Ireland

- I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences. If I exercise my right to withdraw and I don't want my data to be used, any data which have been collected from me will be destroyed.
- I understand that I can withdraw from the study any personal data (i.e. data which identify me personally) at any time.
- I understand that anonymised data (i.e. .data which do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project
- I consent to being audio and/or video recorded as part of the project

(PRINT NAME)	
Signature of Participant:	Date:

Appendix 2: Samples of Issues 4 and 9

Samples of the second and third most pressing issues, showing the application of the ‘so what’ question.

Issue 4 ‘Empowerment and choice issues.’

Issue 9 ‘Honesty needed about money.’

4. Empowerment, importance of independence and personalisation.

Part'pant	Quote	Quotations	So -	- What? What interpretation / What can be done?
2	3	We keep reminding people that they're not making widgets. We're dealing with the lived experience every day for an older		
2	4	There is no governing structure that can cope with that sophistication of understanding lives.	x	"top down" solutions don't work. Need a ***structure*** that affords ***agency***
3	6	The issue is that your life is not just about your health. The object should be more about having a good life as opposed to the state trying to keep you out of harm's way.	x	state too clumsy for individual well-being, need a structure that affords agency
3	8	If Health Service gets involved it becomes about managing risk.		
4	4	We are creating a culture of dependants rather than a culture of independence	x	need a solution that does the opposite i.e. fosters independence via the home and supported with a
4	6	It is not possible to meet your needs well (at home)	x	many "forced" into care before they need to. Another year or more of independent living is possible for very
4	7	There are very, very limited choices and options; very, very		
4	8	But it is the social engagement parts (that get lost with current domiciliary care arrangements), the chat. That's what they valued, that's what they wanted, they wanted someone to talk with them,	x	need community navigator
4	9	One gentleman we interviewed, his wife had Alzheimer's, all he wanted was a couple of hours, maybe 2-6 on a Sunday, to go and play his golf. But that couldn't be accommodated.		
4	12	There is a disincentive to move to institutional care because at the moment domiciliary care is not means tested. To stay at home is far better from a business perspective.	x	many at home inappropriately due to family money concerns, HWC maintains housing equity
4	15	The reality is that these older people do not exist in isolation from their families. So somebody wants to live at home with risk...that's tricky...treating people like adults...but at the same time realising very often they can't execute those decisions.		
4	16	(re. HWC) you can literally see the merits for a lot of people who have dementia to be around other people and more		

9. Honesty needed in the market for care.

Participant No.	Quote No.	Quotations	So	What? What interpretation / What can be done?
3	5	Who is going to pay for all this? And suddenly it's that dirty word isn't it? At some point charging becomes inevitable.	x	
4	11	There are examples of very, very poor care. There are very good homes. We tend not to hear about those and that worries me.	x	many recommend rating homes so that loved ones have less fear of an older person suffering abuse
4	12	There is a disincentive to move to institutional care because at the moment domiciliary care is not means tested. To stay at home is far better from a business perspective.	x	HWC still allows for this, but also affords top ups and means testing if/when inevitable
4	19	The private sector can be demonised. Why is it they are lambasted (for trying to make a profit).You go into a nice restaurant and pay for your meal. You will not say god they are only in it for the money! Actually private hospitals are not demonised. Our idea of anybody providing care should be altruistic, and not worry about the money aspect (is wrong) ...and		
5	1	The private sector organisations were providing a clear message that they weren't able to provide the services at the level of support that was being provided.		
6	1	Employers are telling us we can't go on like this! We know there are one or two big employers who are talking about pulling out of the sector entirely, they still want to deliver good care, but they are businesses, they have to make a profit at the end of the day.		
6	3	The professional aspect is: what is the care that this person is required to get and where can they get it? Not actually can you afford to do this? That's been a change to their role.		
6	6	They don't cry wolf because they don't want to lose any contracts. It's a catch 22 for the employers.		
8	9	I think direct payments are a brilliant idea, but you need some kind of community navigator	x	
8	10	But I think there is a sense in Health and social care that self-directed support will just happen organically... that's not going to happen. We need to encourage services, or support community based organisations. Services are not going to develop on their own, and people are not going to take self-directed support unless there is someone to support them doing that.		