

**Mindfully Coproduced Care at Home;
older people and district nurses
working together**

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Abstract

Older people are at the centre of much contemporary UK healthcare policy with its focus on ageing well in place and care delivered closer to home when required. District nurses provide home-based care for older people living with frailty whilst coproduction, as a concept and policy, aims to promote equal collaboration and participation in care services. Research into coproduction for older people is often centred on service design and development, with limited evidence to suggest how coproduction of care manifests at home. This research aimed to explore the nature of care practices at home between older people and district nurses and to understand how care is coproduced and in what ways these practices shape older people's experiences of care when living with frailty at home.

A focussed ethnographic approach was used to understand the nature of care that was coproduced between older people and district nurses at home. Participants from the South of England included four older people and four district nurse pairings, who had worked together over time with home as the place of care. Data was sourced over eighteen months from a sequence of individual, semi-structured interviews, followed by an observed care encounter with each pairing, and then a final semi-structured individual interview. Thematic analysis guided the interpretation of data.

Four themes of crafting connections, care-full places, minding bodies, and heeding time constitute a concept of a mindful coproduction of care. Care at home for older people and district nurses is complex and is shaped by wider cultures of relationality, rationality and responsiveness and is further informed by social, political, and philosophical values. When the influencing cultures and values of care are not mindfully navigated this could risk coaxing, ageist, and depersonalised care. It is a mindful, care ethics approach that offers opportunities for older people and district nurses to successfully work coproductively. Care is mindfully coproduced in tiny moments, in and specific to that moment in time, where a shared understanding of home and the boundaries within it are established and respected, enabling the place of care to remain the place of home for older people. Mindfully coproducing care in district nursing practice may enhance meaningful experiences of care for older people at home.

Contents

Abstract.....	2
Acknowledgements.....	8
Declaration	9
Chapter 1 Introduction and Context	Error! Bookmark not defined.
1.1 Introduction.....	10
1.2 The UK context of healthcare	10
1.2.1 Ageing	13
1.2.2 Frailty.....	16
1.2.3 Ageing in place and district nursing.....	18
1.3 Participation.....	20
1.4 Coproduction	29
1.4.1 Definitions and understandings.....	29
1.4.2 Foundations and philosophy.....	30
1.4.3 Key features	31
1.4.4 Limitations	38
1.5 Person centred care.....	40
1.5.1 Definitions and understandings.....	40
1.5.2 Foundations and philosophy.....	42
1.5.3 Key features	42
1.5.4 Limitations	48
1.6 Shared decision making	49
1.6.1 Definitions and understandings.....	49
1.6.2 Foundations and philosophy.....	50
1.6.3 Key features	50
1.6.4 Limitations	52
1.7 Collaboration	53
1.7.1 Definitions and understandings.....	53
1.7.2 Foundations and philosophy.....	54
1.7.3 Key features	55
1.7.4 Limitations	56
1.8 Synopsis.....	57
1.9 Research aim	59
1.10 Personal interest.....	59
1.11 Summary.....	60
Chapter 2 Literature review	61

2.1 Introduction.....	61
2.2 Literature review method.....	61
2.3 Literature searching.....	63
2.4 Critical appraisal of the literature.....	70
2.5 Synthesising the literature.....	71
2.6 Personalisation, choice, and control.....	73
2.7 Care relationships.....	83
2.8 Older people and identity.....	92
2.9 Materials and place.....	98
2.10 Coproduction of care.....	100
2.11 Summary.....	104
2.12 Research questions.....	105
Chapter 3 Methodology and methods.....	106
3.1 Introduction.....	106
3.2 Philosophical assumptions.....	106
3.3 Philosophical position.....	108
3.3.1. Ontology.....	108
3.3.2 Epistemology.....	112
3.4. Theoretical perspectives.....	115
3.4.1 Care.....	116
3.4.2 Feminist ethic of care.....	124
3.5 Research methodology.....	129
3.5.1. Ethnography.....	130
3.5.2 Focussed ethnography.....	131
3.6 Methods.....	132
3.6.1 Observation.....	132
3.6.1.4 Field notes.....	137
3.6.2 Interviews.....	138
3.7 Summary.....	140
Chapter 4 Study design.....	141
4.1 Introduction.....	141
4.2 The study.....	141
4.3 Patient and public involvement.....	144
4.4 Ethics.....	145
4.4.1 Ethical considerations.....	145
4.4.2 Ethical approval.....	146

4.4.3 Consent.....	147
4.4.4 Confidentiality	148
4.5 Recruitment of participants	149
4.5.1 Accessing participants.....	149
4.6 Inclusion and exclusion criteria	152
4.7 Demographics	154
4.7.1 Local demographics.....	154
4.8 Summary.....	155
Chapter 5 Data analysis.....	156
5.1 Introduction.....	156
5.2 Framework analysis	157
5.3 Process of data analysis using framework analysis.....	158
5.3.1 Familiarisation.....	158
5.3.2 Developing a framework.....	158
5.3.5 Interpreting data	163
5.4 Rigour.....	165
5.4.1 Credibility.....	165
5.4.2 Dependability and conformability	166
5.4.3 Transferability	167
5.5 Summary.....	167
Chapter 6 Findings.....	168
6.1 Introduction.....	168
6.2 Crafting connections	170
6.2.1 Working together	170
6.2.2 Knowing	177
6.2.3 Everyday conversations	179
6.2.4 Mirroring and modifying.....	180
6.2.5 Synopsis	182
6.3 Care-full places.....	183
6.3.1 Being home	183
6.3.2 Showing home	187
6.3.3 Staying home	189
6.3.4 Medicalised home	191
6.3.5 Synopsis	194
6.4 Minding bodies.....	195
6.4.1 Person in parts.....	195

6.4.2 Losing youth	197
6.4.3 Expert in self	198
6.4.4 Synopsis	202
6.5 Heeding time	203
6.5.1 Busy.....	203
6.5.2 Throughput.....	205
6.5.3 Rhythms and routines.....	207
6.5.4 Synopsis	210
6.6 Summary.....	210
Chapter 7 Discussion.....	212
7.1 Introduction.....	212
7.1.1 A mindful coproduction of care.....	212
7.2 Crafting connections	215
7.3 Care-full places	226
7.4 Minding bodies.....	242
7.5 Heeding time	253
7.6 Synopsis of discussion	259
7.7 Research questions.....	259
7.8 Contribution to knowledge.....	269
7.8.1 Original contribution to knowledge	271
7.8.2 Key insights from the conceptual framework	273
7.9 Summary.....	274
Chapter 8 Implications, strengths and limitations, reflexivity and concluding remarks	275
8.1 Introduction.....	275
8.2 Implications and recommendations	275
8.2.1 Older people.....	275
8.2.2 District nursing practice	278
8.2.3 Education.....	279
8.2.4 Policy	280
8.3 Further research	282
8.4 Strengths and limitations	283
8.5 Concluding remarks	297
Bibliography	298
Appendices.....	348
Appendix 1	348
Worked example of observation protocol	348

Appendix 2	352
Demographic information	352
Appendix 3	352
Interview A schedules.....	352
Appendix 4	354
Interview B schedules.....	354
Appendix 5	355
Data sets of older people and district nurse pairings.....	355
Appendix 6	356
Process of study design	356
Appendix 7	356
List of risks.....	356
Appendix 8	357
Distress protocol.....	357
Appendix 9	357
Consent form for older people.....	357
Appendix 10	358
Consent form for district nurses	358
Appendix 11	359
Participant information sheet for older people	359
Appendix 12	361
Participant information sheet for district nurses.....	361
Appendix 13	363
Advertisement flyer district nurse.....	363
Appendix 14	363
Briefing note	363
Appendix 15	364
Advertisement flyer older people	364
Appendix 16	364
Analytic hierarchy model of framework analysis	364
Appendix 17	365
Worked example of using Analytic hierarchy model of framework analysis	365
Appendix 18	365
Data analysis photographs of audit trail.....	365
Appendix 19	367
Constituents of the broader cultures of care	367

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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. This thesis has not been previously submitted to this or any other university for a degree and does not incorporate any material already submitted for a degree.

Signed:

A rectangular box containing a handwritten signature in black ink. The signature is cursive and appears to be 'S. A.' followed by a long horizontal line.

Dated: 29th November 2023

Chapter 1 Introduction and context

1.1 Introduction

This research study explores the nature of coproduced care between older people and district nurses, when home is the place of care. Coproduction is a concept advocating that people and professionals work together in equal partnerships in the design, development, delivery, and evaluation of public services for quality improvement (Social Care Institute for Excellence (SCIE) 2022, Jones et al. 2021). However, before considering coproduction in care it is important to understand the background and contemporary context of healthcare for older people in the United Kingdom (UK), to understand how and why initiatives such as coproduction have recently come to the fore in policy and practice. The following sections of this chapter will provide a background and context to the healthcare in the UK and the National Health Service (NHS) in which care for older people occurs.

1.2 The UK context of healthcare

Healthcare in the UK is freely accessible based on health need through the NHS and is funded through general taxation. Responsibility for healthcare is devolved across the governments of the four nations of the UK (Anderson et al. 2022). The NHS is a complex, unpredictable, and uncertain system in which there are competing and changing demands. It is constituted by a wide range of different organisations, with varying roles, responsibilities, and specialities (NHS England 2023). NHS systems are a complex network of care processes and the quality of care for older people is largely dependent on how well the network functions and how well those managing and providing care can work together. However, the intricate system of the NHS means that services and care can easily become fragmented, resulting in a poor functioning system and a lack of quality in care provision (Jones et al. 2021).

Inequalities in the opportunities for healthy lives, health status and in experiences of care persist in the UK between different groups of people due to the way the healthcare system and the NHS is structured. This is both unjust and avoidable (Naik et al. 2020, Williams et al. 2022). The UK

healthcare system has to date, not effectively tackled the cause, or managed to narrow inequalities in health. Decades of public reforms have not resulted in a reduction in the growing need for healthcare, with inequalities in health widening (Wickens 2023, Naik et al. 2020, Kraindler et al. 2019, Boyle and Harris 2009, Boyle et al. 2010). An ageing population, rising and changing patient expectations, and emerging public health concerns, concurrent with medical and technological advances have resulted in increased financial pressures on healthcare funding and further demands on the NHS (Wickens 2023, Boyle et al. 2010).

The UK financial crisis of 2008 resulted in austerity measures for the following decade in which healthcare spending was reduced. Subsequent increased pressure in NHS provision, staff shortages, increased waiting times and a reduction in meeting performance standards occurred, prior to the outbreak of the COVID19 pandemic (Thorlby et al. 2019, Wickens 2023). Healthcare expenditure is a political choice and health inequalities can, in part, be attributed to government austerity (Tronto 2015, Naik et al. 2020). Financial constraints and a lack of capital investment in the NHS and healthcare has resulted in a short term approach to spending that risks quality in patient care (Kraindler et al. 2019). The political response to austerity in the UK since 2010 has been through the continued use of neoliberal ideologies (Pearson 2019).

Neoliberalism combined with a new managerialism first began to dominate UK healthcare in the 1980s (Aranda 2018). Neoliberalism is based on market values of individual choice, consumerism, efficiency, and privatisation as a method with which to reduce government spending (Viens 2019). In healthcare neoliberalism is structured by concepts of individual responsibility and commodification in which health, defined as the absence of disease, becomes an economic good and a commodity governed by market values (Aranda 2018, Viens 2019). Healthcare then becomes structured in a way that measures and maximises market values (choice, consumerism, efficiency) by producing more innovative and efficient care, in which people become consumers. As consumers individuals have choice in the amount

and type of healthcare they want based on personal preferences. In a consumer model of healthcare there is a shift of responsibility for health to the individual, resulting in less involvement and responsibility of the state in achieving health (Viens 2019). Instead, individuals become responsible for their own health and care in an aim to reduce financial pressures on governmental healthcare spending that have arisen from increased life expectancy, concurrent with the growing incidence and prevalence of multiple long term health conditions (Aranda 2018, Kingston et al. 2018).

Ham et al. (2018) suggest that a cultural change is needed from a neoliberal individualistic approach of personal responsibility for care, advocating for a shared responsibility for health and care. Shared responsibility for healthcare does not place a social responsibility for health back with the state but requires governments to create policy and environments in which people have the equitable opportunity to make supported choices for their health and care (Buck et al. 2018). Ham et al. (2018), argue that a shared responsibility for health and care can provide system wide transformation by developing relationships between professionals and the public to narrow inequalities in the experiences of care through support. The system wide cultural change Ham et al. (2018) suggest requires healthcare staff to work differently to involve people more fully in decisions about care.

Sobel (1995) and Ham (2010) contend that people themselves are significant primary care providers and that drawing on the assets of people is imperative for transformational change in developing the care relationships required for shared responsibility, and for sustainable healthcare. Ham et al. (2018) suggests that people do take responsibility for their health and care, but argues that more could be done, through care relationships, to draw on people's existing expertise to reduce an over dependency on services. They also contend that more is required to support others with less ability and resources to assume shared responsibility and for transformation (Ham et al. 2018). However, finite resources and historical and hierarchical imbalances of power in care relationships limit and impede any transformational change (Ham et al. 2018).

The logic for the shared responsibility for health and care is linked to the changing demographic of episodic care to the prevalence of long term conditions in Western societies (National Institute for Clinical Excellence (NICE) 2016). Long term conditions are more prevalent in older people and the multimorbidity of long term conditions is also associated with ageing (Buck et al. 2018, Williams and Law 2018). Frailty is linked to the accumulation of long term health conditions and associated with a functional decline in older age (Williams and Law 2018). However, the British Geriatric Society (BGS 2015) suggest that frailty itself is a long term condition and not an inevitable consequence of ageing or culmination of other pathologies. Concepts of ageing and frailty in the context of healthcare will now be discussed.

1.2.1 Ageing

Ageing is a social construct that has diverse cultural responses across society (Aranda 2018). A social construct is not an absolute reality but is an accepted understanding or social norm that emerges through human interaction (Bainbridge 2022). In Western culture ageing is often viewed in biomedical terms with a priority given to the organic and physiological process resulting in molecular and cellular damage that accumulates over time (Twigg 2006, Ferruci et al. 2021). Biomedical concepts of ageing can appear negative and stereotyped in terms of dependency, vulnerability, and death (Swift and Steeden 2020). Fine (2014) suggests that ageing is a cellular and a social process and cannot be considered without both elements.

The number of people aged over 65 years old is growing more rapidly than those under 65 (Office for National Statistics (ONS) 2021). There are eleven million people over 65 years old in the UK, this is predicted to rise to thirteen million by 2032 and will account for 22% of the population (ONS 2020). The East and Southeast of England house the highest proportion of people aged over 85 and over (ONS 2022). Globally, life expectancy is estimated at 15.8 years at age 60, a rise from 14.3 years in 2000 (World Health Organisation

(WHO) 2018). However, the incidence of health inequalities can lead to damaging health and social behaviours and as a result people are living into their older years with disability and long-term health problems (Aranda 2018, Conroy and Maynou 2021). The Centre for Ageing Better (2022) suggest that being older in England is becoming an increasingly worse experience for many people.

In England men can expect to live in good health and without a disabling illness to 63.1 years and women 63.9 years (Office for Health Improvements and Disparities 2022). Despite the global increase in life expectancy this has now stalled in the UK and has declined by 0.3 years for women and 0.4 years for men (ONS 2022, Centre for Ageing Better 2022). There remains a large population of older people in the UK and internationally who are living with ill health and who will require care at some point in older age (Buck et al. 2018, Nikolova et al. 2021). Local population data for the Southeast area in which this research occurred suggests that life expectancy at the age of 65 years is 18.1 years for men and 20.7 years for women. However, only 10.5 years for men and 11.3 years for women are predicted to be healthy years (Office for Health Improvements and Disparities 2022a). Table 1.1 illustrates that although life expectancy at birth in the Southeast is lower than the rest of England, life expectancy and healthy life expectancy in the Southeast are comparative with the national data.

Historically older age has been categorised into discreet age ranges (Department of Health 2001). However, older people have continued to be defined by chronological age ranges. The Health and Social Care Act (UK Parliament 2022) outlines newer models for integrated care, in this contemporary policy mandate it appears that older people remain categorised, but by wealth rather than age (Age UK 2022). A risk with the categorisation of people is the tendency to stereotype groups of people which may inform negative attitudes towards a group, potentially resulting in disempowerment (Shakespeare 2018).

TABLE 1.1 LIFE AND HEALTHY LIFE EXPECTANCY DATA
(Office for Health Improvements and Disparities 2022).

	Life Expectancy at Birth	Healthy Life Expectancy at Birth	Life Expectancy at 65 years	Healthy Life Expectancy at 65 years
England	M= 79.4 years F= 83.1 years	M= 63.1 years F= 63.9 years	M= 18.1 years F= 20.7 years	M= 10.5 years F= 11.3 years
Southeast of England	M= 78.1 years F= 82.6 years	M= 63.1 years F= 63.9 years	M= 18.1 years F= 20.7 years	M= 10.5 years F= 11.3 years
Town where research occurred	M= 78.1 years F= 82.6 years	No data available	M= 18.1 years F= 20.7 years	No data available

Culturally constructed social norms, stratified by assets, and bounded notions of age can affect decision-making in care as older people can make choices based on what is perceived as acceptable to others rather than their own personal preference (Kendall and Reid 2017). The assemblage of older people into homogenous groups can contribute to the ‘othering’ of older people through compassionate ageism (Shakespeare 2018, Eastman 2019, Centre for Ageing Better 2021). Othering is when people are defined or labelled as not conforming as part of a social group, being attributed negative characteristics or difference from socially constructed normative groups, leading to discrimination and marginalisation (Cherry 2023). Compassionate ageism stereotypes how older people are perceived in Western culture, it assumes older people aspire for youth and that ageing is something to be pitied. It places older people as in need, requiring paternalistic care, rather than as autonomous people, which can detract from individualised responses to care (Eastman 2019). Fine (2014) advocates for a social response to the vulnerability of the individual and their body in the ageing process, highlighting the importance of attentive care for older people.

1.2.2 Frailty

Fried et al. (2001) suggest a frailty phenotype is the presence of any three characteristics of weakness, tiredness, weight loss and low physical activity which produce poor health outcomes. However, Conroy and Maynou (2021) and Sinclair et al. (2022) argue that frailty is a more complex and multisystem issue. Rockwood and Mitnitski (2007) contend that frailty is a complex condition in which deficits are accumulated over time and which increase the risk of poor outcomes. Subsequently, frailty risks adding complexity in care for older people, in rising costs, hospital admissions and loss of quality of life (Kingston et al. 2018). Accumulations of functional and cognitive deficits are now widely measured through a variety of indices for frailty (Rockwood and Mitnitski 2007, Sinclair et al. 2022). Frailty services are now commonly commissioned (NHS England 2019), in which the identification of frailty aims to prevent poor outcomes, provide personalised care planning, and integrate care, so that older people can live well for longer at home (Montgomery et al. 2021, Age UK 2022).

Cluley et al. (2021) suggest that there is a further difference in clinical and lay understandings of the term frailty. The British Geriatric Society (2015) identified that frailty has differing meanings for older people, with concepts of frailty associated with dependency, the end of life and of losing control, rather than clinical frailty states. Won Won (2019) argues that concepts of frailty now replace traditional concepts of ageing in healthcare, as frailty provides a biological rather than chronological understanding of age. However, the British Geriatric Society (2015) highlight that older people do not associate with or like concepts of frailty when considering age and health status.

For this research, older people were identified as being over the age of 70 years old, concurrent with the demographic of 'older people' as socially constructed in the UK (NHS England 2019). Frailty when discussed in relation to the older people in this study, relates to the clinical health states positioned within contemporary frailty policy guidelines for care (NHS England 2019). The older people in this study did not recognise themselves

as frail, therefore I do not assign the label of frailty to them. However, the language of frailty is used in this work to place the findings of this research within contemporary literature and policy.

In England, ten percent of people over 65 years old live with frailty, increasing to twenty-five to fifty percent of people living with frailty of those aged 85 years and over (Age UK 2020). Frailty is predicted to increase in prevalence with the increase in the demographic of older people (Hoogendijk et al. 2019, O’Caoimh et al. 2021). East Sussex was estimated to have 21,400 people living with moderate to severe frailty in 2018, which is predicted to rise to 26,000 by 2028 (East Sussex Strategic Joint Needs and Assets Assessment (JSNA) 2019). Deprivation increases the risk of frailty, and East Sussex has an average socioeconomic deprivation for England (East Sussex JSNA 2019, Office for Health Improvements and Disparities 2022b). In England social care expenditure is £16 billion, the majority being spent on people over 65 years old (Nikolova et al. 2021). There appears to be a lack of specific data regarding the cost incurred for frailty in social care budgets, however Nikolova et al. (2021) assert that for older people living at home with frailty the mean costs for social care equates to £2,692 per annum compared to £330 for older people without frailty.

Care associated with frailty can be multifaceted and interventions are often required which increase the risk of hospitalisation, primary care consultations, nursing home admission and higher mortality rates for older people (Cicutto 2018, Hoogendijk et al. 2019, Conroy and Maynou 2021, Nikolova et al. 2021, Sinclair et al. 2022). However, some older people will live well into older age free of disease and unaffected by frailty (O’Caoimh et al. 2021). Although public health agendas aim to prevent chronic disease before old age so that people can live well into their older years, avoiding disease alone is not the only precursor to health (Department of Health and Social Care 2018).

Adopting a healthy lifestyle can also improve health in older age (Sakaniwo et al. 2022). This is reflected in policy agendas where there is a focus on

living well in older age for longer (Department of Health 2015). However, living well or successful ageing can be beyond the control of older people as childhood obesity, poor air quality and poor housing can result in socioeconomic deprivation in later life (WHO 2021, Centre for Ageing Better 2021, Office for Health Improvements and Disparities 2022b). Furthermore, concepts of ageing well assume that the individual is a rational being and can choose to participate in care interventions that will promote health, and that people have the available resources and want to participate in their own health and care when it occurs at home and outside of an institutionalised care setting (Zolkefli 2017).

1.2.3 Ageing in place and district nursing

Ageing in place is now a popular concept in health and social care policy internationally for older people. It is a government response to growing costs and demands on acute hospital care due to an ageing population and increasing prevalence of long term conditions and frailty in which older people are encouraged and supported to remain at home for care (Lewis and Buffel 2020). Sheppard et al. (2022) suggest that care at home is a preferred and better option for older people. However, in the UK emphasis in policy on ageing in place has not been reflected in the resources made available for service provision to meet care needs of older people in the community and primary care setting (Primary Care Workforce Commission 2015).

Older people are often, by the nature of their ill health, unable to access healthcare services outside of the home and thus require home based nursing care from district nursing services (Queens Nursing Institute (QNI) 2015, Drennan et al. 2018). District nurses form part of a publicly funded community healthcare workforce within primary care as part of the NHS that supports older people to age in place (NHS England 2015). District nursing care at home aims to prevent hospital admission and costly complex secondary based care, and to contribute to positive care experiences for older people experiencing frailty at home (Young 2017, NHS England 2019). District nursing practice is underpinned by a framework of holistic, coordinated, and integrated care in which the needs of individuals are

responded to through respecting values, choice, and preference in care (Coulter et al. 2013, McCormack et al. 2017, QNI 2019). District nursing describes the unique nature of nursing in the home in the UK (QNI 2011, Maybin et al. 2016).

The title of district nurse is awarded for achievement of the regulatory body's competencies in specialist community practice through a post registration and now post graduate degree programme (Nursing and Midwifery Council (NMC) 2022). District nurses provide for a variety of care needs to people living at home (QNI 2015, 2022). However, there has been an ongoing reduction in district nursing recruitment and retention (PCWC 2015, Health Education England (HEE) 2015, QNI 2022), which can result in the service being over stretched in trying to meet increasing demand with fewer numbers of staff (Maybin et al. 2016, Royal College of Nursing (RCN) 2013, Oldman 2014, QNI 2022). Consequently, this risks district nurses not being able to provide optimal quality care for older people at home (Maybin et al. 2016).

Oldman (2014) highlights that district nursing has almost unbounded referral criteria and incoming referrals can appear limitless, reporting that some district nurses feel unable to turn inappropriate referrals away, despite the capacity of the service to respond. Conversely, the QNI (2014, 2022) suggest that district nurses are refusing referrals due to a lack of resource capacity. This implies patient care is not being met effectively in community healthcare and may contribute to poor outcomes for older people (Maybin et al. 2016, QNI 2014, Wright et al. 2015). Importantly, at the centre of district nursing remains the older person who requires attentive compassionate and responsive care, providing an ethical imperative for a better and nuanced response to care.

To ensure enhanced care for older people, and to address the challenges in health and care provision for older people that have been highlighted, there has been a transformational shift in provision over recent decades (Aranda 2018, Ham et al. 2018). Fundamentally, change through transformation in health and care has centred on developing relationships between the public,

the NHS, patients, and staff to improve quality in care and sustainability of care provision (Ham et al. 2018). Heimans and Timms (2018) suggest that values of shared and equal power, in a shift from traditional hierarchical and paternalistic power models in care relationships, can shape different ways of working in healthcare that can improve quality and meet needs more effectively.

Change has largely been introduced through concepts of partnership working between often fragmented health and social care services, and of participation by people in their healthcare (Miller et al. 2021, NHS England 2017). Partnership with users and participation initiatives in public service provision emphasise a more personalised experience of care, which aims to overcome paternalism and consumerism (Leadbeater 2004).

1.3 Participation

The Health and Care Act (UK Parliament 2022), the NHS Five Year Forward View (NHS England 2014) and the NHS Long Term Plan (2019) all set out a vision for the NHS to work with people who use services as equal partners and in facilitating more control, choice, and participation in care. The participation agenda has been driven by continued failures and omissions in care and has become enshrined and strengthened in policy over the past twenty years.

The Wanless report (HM Treasury 2002) identified the importance of the empowerment of patients to become partners in care. A shift in the language from patient to person is evident in the Darzi report (Department of Health 2008), where the quality of care is measured by evidence that people are being involved in decision making related to their care. The development of the NHS Constitution (Department of Health 2013) stipulated the requirement for users of NHS services to be involved and consulted in decision making, with services being reflective of the needs and preferences of those using them. The Francis report (2013) illuminated failings in person centred care, with dignity, respect and compassion becoming a core focus of care delivery, and the Berwick report (Department of Health 2013a) reiterated the

requirement of greater user involvement at every level of health service delivery. The Health and Social Care Act (2012) mandated a legal requirement for user involvement with clinical commission groups in care service development and delivery. The Five Year Forward View (NHS England 2014) asserted a need for providers and practitioners to form more engaged relationships with people to promote wellbeing and prevent ill health. The Care Act (2014) and the Health and Care Bill (2022) stipulate the legal requirement for people using services at the centre of care with maximum involvement (Nolte et al. 2020, UK Parliament 2022).

Participation and patient or user engagement in healthcare remains a large scale transformation that aims to reorientate the NHS to more efficient, proactive, empowering, preventative models of service delivery and care (Ahmed et al. 2014). Concepts of participation relating to older people reflect these policy drivers and centre on older people being involved in their care, engaging, and working together with professionals to achieve beneficial and positive outcomes through choice in care (NHS England 2017a, Hedberg et al. 2022). Participation and engagement create value as people have an active role in creating care and services that are significant to them, together with healthcare professionals and organisations (Palmer 2020).

Recent healthcare policy suggests a plethora of forms in which participation can occur, suggesting ways of working that promote the participation of people in service design and delivery at varying levels (UK Parliament 2022, NHS England 2019). Arnstein's (1969) seminal text considering public participation in American planning processes identified a ladder of participation, illustrating how participation by the public can range from high to low levels of involvement (see figure 1.1). The New Economics' Foundation (NEF 2013) have developed the concept of a ladder of participation in contemporary healthcare which illustrates levels of participation, engagement, and involvement (see figure 1.2).

FIGURE 1.1 ARNSTEIN'S (1969) LADDER OF PARTICIPATION

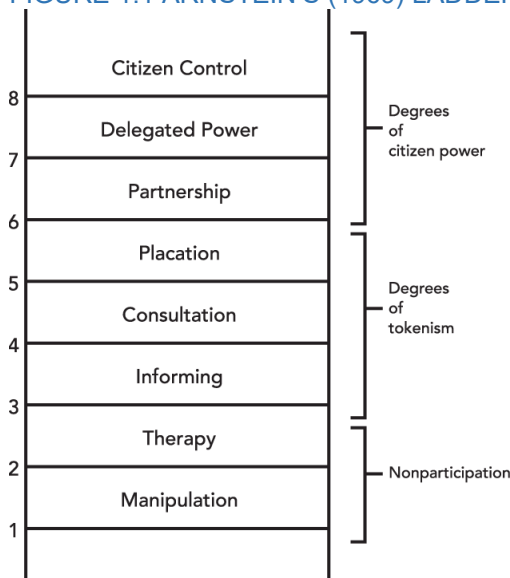
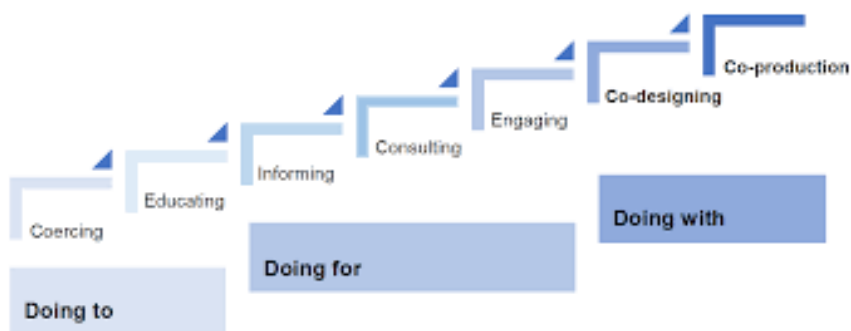


FIGURE 1.2 NEF'S (2013) ALTERNATIVE LADDER OF PARTICIPATION FOR HEALTHCARE



Participation activities for older people in healthcare can include involvement in consultations and treatments, supported self-management, user design, lived experience in research and healthcare policy development (Palmer 2020). However, the varying amount of participation and the sharing of power in any healthcare planning, intervention, decision making, and care is largely determined by policy makers, organisations and professionals and can risk not involving people at all or becoming a process of tokenistic involvement rather than fully participative with an equal sharing of power and control (Conquer et al. 2021).

Coproduction, person centred care, shared decision making, and collaboration are contemporary concepts in healthcare policy that share

understandings of user participation and engagement in care practices and contribute to the paradigm shift of people working together as partners (Hedberg et al. 2022). For example, Bright et al. (2015) in a conceptual review of engagement, suggest that engagement in healthcare is comprised of a co-constructed process between patients and professionals rather than by patient behaviour.

The concepts of coproduction, person centred care, shared decision making, and collaboration are multidimensional and complex (Hedberg et al. 2022). Exploring the relationships between concepts can be challenging due to varying understandings and definitions, rendering them open to continuous debate, validation, and evolution (Bright et al. 2015). Relationships between concepts can also vary as these can be loosely related in care policy and different practices in care can be underpinned by transferable values. Furthermore, the distinct foundations and philosophical approaches of each influences the application, adoption and outcomes achieved (Ahmed et al. 2014). The application, delivery and practice of these concepts can therefore become complicated and messy in practice, further complicated by terms and approaches being used interchangeably (Health Education England 2020).

These concepts can be misappropriated and used to describe tokenistic stakeholder engagement in care (Strachan 2018), when there is a deeper philosophy and transformational foundations to care than user involvement (Boyle and Harris 2009, NEF 2013). Collaboration and shared decision making are concepts that depict a range of overarching participatory activities in healthcare and contribute to both person centred care and coproduction (Ahmad et al. 2014, Howard et al. 2022, Douglass 2022). Person centred care and coproduction are concepts that consider with more acuity the position, equity, and experience of people in the relational nature of care, and despite their differing foundations are concepts which share some affinities as well as differences (Blunden and Calder 2020).

Both person centred care and coproduction are value driven approaches to the provision and practice of care. Both place people as autonomous agents in care, both promote individualism with the wellbeing of the person as paramount (Blunden and Calder 2020). Both place people at the centre of considerations of how care should be practiced and are a way of working collaboratively to improve health and create user led healthcare (Filipe et al. 2017, Blunden and Calder 2020). Person centred care and coproduction place emphasis on the significance of relationships in care (Batalden et al. 2016, Blunden and Calder 2020).

The overlap of concepts, processes, and practices may lead to a hybrid approach in the delivery of core skills and values in which practitioners work between and across concepts (Harding et al. 2015). This can be dependent on the context and circumstances with which they are faced in the intricacies and dynamic nature of healthcare practice, when working together with people in the context of care (Harding et al. 2015). Table 1.2 illustrates the commonalities and differences of each approach to working together in care. The dominant features specific to coproduction have been identified in green font as part of this table.

TABLE 1.2 COMMONALITIES AND DIFFERENCES IN CONCEPTUAL WAYS OF WORKING TOGETHER

	Coproduction	Person centred care	Shared decision making	Collaboration
Foundations	Economics	Psychology, from a medical model	Developed from informed consent	Disparate and fragmented services in NHS
Philosophy	Relational ethics. Emphasis on relationships, interactions, care, and maintenance. Collective/ shared responsibility for care. Sustainable. Reciprocity. Prevention. Building social networks Change agent.	Relational ethics. Empowerment. Meaningful rather than functional life as goal.	Engagement Choice Autonomy Self-determinism	Integration. Inclusivity.

Practice	<p>People as assets not recipients. Knowledge sharing Reciprocity/ mutuality Blurring of roles Facilitative. Asks people who use services for help.</p>	<p>Active patients in care and decision making. Different types of contexts require different types of centring</p>	<p>Transactional-consumerist model or relational. Professional as the expert. Trade-off between risks. One off/ episodic. Practitioner dependent. Structured.</p>	<p>Intrinsic to healthcare, not explicit in practice. Multi-system liaison and coordination.</p>
Equality / power	<p>Equitable power to people who use services. Person as expert. Equality between clinician and person. Equitable strategic power sharing Provider initiated, opportunity to be person led.</p>	<p>Move to more equal power to people who use services. Provider led and person centred.</p>	<p>Reduction in power imbalances. Increase choice for people who use services. Provider led. Empowering Informed decision making</p>	<p>Working together. No equal status between stake holders. Involvement and engagement of people who use services. Partnerships. Provider led.</p>
Policy	<p>Transformative. A new and emerging concept in healthcare policy. Coproduction can be system led in policy.</p>	<p>Basis of contemporary health reform. Embedded in contemporary healthcare policy.</p>	<p>Choice Informed decision making. 'No decision about me without me'</p>	<p>Quality improvement Efficiencies Integration. Assumed as intrinsic.</p>
Systems level	<p>Service approach. Local healthcare systems work with people to co-create conditions for service transformation. Growing the core economy. Changing the way in which services are commissioned.</p>	<p>Implicit assumption that care is produced by healthcare systems as a product for consumption. Needs to be system wide to be a continuous reality. Successful and appropriate interaction of all system components required.</p>	<p>Needs based approach. Interactions of components within a system not considered. Requires integrated services and conducive culture.</p>	<p>Components of a larger system with integrated and seamless interactions.</p>
Organisational level	<p>Services mobilise the skills and capacity of people to design</p>	<p>Policy directs person centred care initiatives.</p>	<p>Optionality in service provision and care interventions.</p>	<p>Cohesive organisations in and outside of systems.</p>

	and deliver service improvements.			
Clinical services/ point of delivery level	Individuals design their own care based on expertise. Asset based approach. Unexplored between older people and district nurses when home is the place of care. Improved working environments and culture. Humanising services.	Care is predetermined by providers. Clinicians consider they are practising person centred care, but this may not be a reality. Improved working environments and culture.	People encouraged to actively participate in care decisions.	People included as part of the healthcare team.
Stakeholders	People as experts co-creating and leading care. People as a resource who bring and create value. People have a continual involvement in delivery. Interdependence between professionals and people. Reciprocal relationships. Multiple voices and perspectives brought together.	People with autonomy and choice at the centre of care processes, who are able to self-determine. Mutual interaction in relationships.	Dyadic interaction Not inclusive of all stakeholders	May not be inclusive of all stakeholders. No requirement for equity and equality.
Cognitive/ relational Proximal/ distal	Relational. Relation of person to social context Proximal	Relational and cognitive Relation of person to social context Proximal and distal	Cognitive Not relational of person to social context Proximal / distal	Cognitive Not relational of person to social context Distal
Strengths	Focuses on the expertise of people who use services. Builds on social capital. Improved cost efficacy. Embraces different ways of framing care.	Considers the environment and context of care. Wide range of evidence available to support person centred care at home for older people with district nurses.	Participatory	Brings together multiple voices and perspectives.

	Rebuilds social infrastructures in care. Sustainable. Meaningful care outcomes.	Improved cost efficacy		
Weaknesses	Multiple definitions and interpretations. Initiatives small in scale, messy and complex and difficult to replicate. Linked to informing person centred care, but not explored as potential for transformational service provision and person led care. Lack of evidence that considers coproduction of care at home between older people and district nurses. Risks becoming rhetoric	Relies on collaboration of services/ system components. Multiple definitions and interpretations. Risks becoming rhetoric. Difficult to operationalise in a consistent way. Models are unidirectional.	Mutual respect not a prerequisite No relationship required. Does not consider holism.	Partnerships not a requirement. May exclude or marginalise some stakeholders. Scale of achievement and realities of practice difficult to establish.
Measurement	Qualitative – challenge to measure, not reproducible	Qualitative-patient experience. Quantitative metrics	Quantifiable – individual choice is realised from options. Measurable when clearly defined.	Nebulous and difficult to measure. Subjective.
Barriers	Uncertainty and discomfort with coproduction meaning and implementation. Service pressures and culture. Resistance to change. Lack of a shared understanding/ definition. Time. Knowledge, skills, and confidence to initiate.	Lack of a shared understanding/ definition. Professional attitudes and hierarchies. Organisational culture. Burn out and compassion fatigue. Time.	Staff attitudes. Professional hierarchies. Time. Practical application/ knowledge and skills and confidence to initiate. Age, frailty, ill health, health literacy, access to information, self-efficacy.k	Organisational culture. Staff attitudes. Professional hierarchies. Staffing capacity and resourcing. Time. Lack of clear definition.
Facilitators	Existing cultures of involvement	Organisational culture.	Organisational culture.	Organisational culture.

	and valuing the lived experience. Culture of honesty and transparency.			Wide and broad application potential.
Underbelly	Potential to devolve responsibility on to people. Risk of marginalisation for those in harder to reach groups/ quiet voices. Perception of involvement as being coproduction- becomes tokenistic.	May exclude or marginalise those who cannot or do not want to actively participate in care. Personhood of staff not always considered resulting in task centred approaches and demoralisation. Can be easily claimed but not achieved/ reality of practice. Inequity due to empathy and personal preference.	Cognitive bias influencing choices. Free choice is not a reality in contemporary healthcare.	Can be easily claimed but not achieved/ reality of practice. Widely considered between professionals and services, not with older people. Differing levels of collaboration for different stakeholders leading to inequity, exclusion, and marginalisation.

(Batalden et al. 2016, Batalden 2018, Elwyn et al. 2012, Elwyn et al. 2019, SCIE 2021, 2022, Palmer et al. 2018, Blunden and Calder 2020, Harding et al. 2015, Filipe et al. 2017, Leyshcon et al. 2019, Cluely et al. 2021, Greymr et al. 2021, Price et al. 2021, Morley and Cashell 2017, Ahmad et al. 2014, McCormack and McCance 2017, Perret 2006, Miller 2018, Hedberg et al. 2022, Veatch 1972, Legare et al. 2018, Howard et al. 2022, Dougalss 2022, Emich 2018, Buscari et al. 2017, Rycroft-Malone et al. 2016, Emich 2018, Morley and Cashell 2017, Howard et al. 2022)

Original in colour

The differing features and strengths of coproduction, person centred care, shared decision making, and collaboration are important to understand and consider in the context of care for older people. These will now be considered in turn, exploring the interrelationships, points of controversy, debate, and the limitations of these concepts. A synopsis of the discussion will provide a clear rationale as to why coproduction has been selected for this study.

1.4 Coproduction

1.4.1 Definitions and understandings

Coproduction as a concept has been widely applied across academic fields such as public administration, sustainability, and science technology (Miller and Wybourn 2020). However, coproduction remains a nebulous concept and can be poorly defined (SCIE 2013). There appears to be a consensus of the key features of coproduction in the literature, as listed in Table 1.2. However, there is a lack of a consistent definition of coproduction on an individual level for care (SCIE 2022). The Care Act (Department of Health 2014) and latterly the Health and Care Bill (UK Parliament 2022) offer a definition of coproduction:

"Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned, and delivered".
Department of Health (2014) p.17.

This definition is arguably system led as it omits any collaboration **or** consideration of the relationship between people, professionals, and providers (SCIE 2022). The Health and Care Bill (UK Parliament 2022) has not developed clarity or emphasis on coproduction in healthcare, however, it has reiterated that it is vital for providers to consider what is important to those who use services.

Batalden et al. (2016) consider the coproduction of health to be the interdependent work of users and professionals to design, create, develop, deliver, assess, and improve the relationships and actions that contribute to the health of individuals and populations. This definition of coproduction incorporates collaboration and equity through interdependence, making this a useful understanding of coproduction for face to face care interactions (Yuan et al. 2018). Furthermore, Minghella and Linsky's (2018) report on coproduction in mental health provision suggests a working definition of coproduction as the sharing of knowledge, skills, power and experience between professionals and people for the planning, delivery, and monitoring

of services, in new relationships that value and recognises the vital contribution all partners bring.

A lack of a recognised definition can lead to confusion as to what constitutes coproduction in a care interaction, and this has implications for how it may be practised (Yuan et al. 2018). Minghella and Linsky (2018) contend that uncertainty and discomfort with the meaning of coproduction can limit and impede its implementation in practice. Conversely, Filipe et al. (2017) suggest that a strength of coproduction is the elasticity in its definition, as this provides a diverseness in scope for what is being produced, and the field in which it can occur.

Blunden and Calder (2020) argue that healthcare is constituted by the paid and unpaid work of people, and that healthcare cannot be produced and cannot operate services, without the active participation of those who use them. Tronto (1993) asserts that care on an individualistic level is indicative of the presence of at least two people within the care relationship, who contribute to the practices and the production of care together, which is suggestive of a concept of a coproduction of care. Yuan et al. (2018) concur that coproduction cannot occur without a direct and active participation of a person and a professional. This work assumes that a coproduction of care is possible to some extent between older people and district nurses and aims to explore this concept further.

1.4.2 Foundations and philosophy

Coproduction has foundations in economics and social justice in which Noble Prize winner Ostrom (1996) argues that public services, such as healthcare, are the product of complex institutional arrangements or resource allocation which determine roles and activities and define outcomes. Ostrom (1996) contends that these arrangements are then coordinated and practiced through the participation and work of multiple people. Miller and Wybourn (2020) suggest that Ostrom's (1996) theory of collective action and responsibility is applicable to healthcare in that, patients, practitioners, providers, the public, commissioners, professional statutory and regulatory

bodies, governments, government bodies and third sector organisations work together to actively shape the end service. Cahn's (2010, 2000) seminal work in coproduction conceptualised time banking, in which people share assets, life experience and skills in reciprocal arrangements, suggests that it is through interaction and exchange that coproduction occurs and in which people gain from the experience, thus highlighting the significance of relationships in coproduction (Batalden et al. 2016, Blunden and Calder 2020).

Coproduction is a social science perspective that can provide an exploratory space to bring together different values to produce new forms of knowledge through social interactions, which can lead to meaningful healthcare experiences (Filipe et al. 2017). The dynamic, experiential, and reflective processes of coproduction are sustained by interactions, engagement, social relations, social relationships, equality, and social justice rather than a service delivery model in which predictable outputs and impacts occur (Filipe et al. 2017). Coproduction is arguably therefore a different way of learning and knowing in a politically driven healthcare system, with wider political and social factors considered (Miller and Wybourn 2020, Blunden and Calder 2020).

1.4.3 Key features

Coproduction goes beyond consultation and user involvement (Welford et al. 2022). It recognises people as assets, values the work people do in their own health and care differently and promotes and builds social networks (Boyle and Harris 2010). Like person centred care, coproduction aims to humanise services, by broadening and deepening them through participation and partnerships in care (Hedberg et al. 2020).

Blunden and Calder (2020) suggest reciprocity is core to coproduction and that all persons should recognise and respect the efforts of others with reflective commitment. Reciprocity suggests that all involved in care should benefit from the process, practices and outcomes undertaken (Barnes 2012). In coproduction and professional care relationships normative concepts of

reciprocity can be troubled by professional governance (Sandu et al. 2015). However, SCIE (2013) suggest that reciprocity in coproduction can broadly be considered as a more equal relationship. This has similarity to ideals of person centred care (Harding et al. 2015). Boyle and Harris (2010) develop this and consider a social justice and social capital lens of coproduction, in that reciprocity in care is the giving back of people who use services, through their expertise, and as assets in contributing to the design, delivery, and evaluation of services and healthcare.

Therefore, coproduction promotes sustainability as this strengthens the delivery of services in the longer term and offers a transformative approach to service delivery in that people simultaneously become providers as well as consumers, thus increasing resources (Boyle and Harris 2010, Miller and Wybourn 2020). Furthermore, coproduction offers the unique opportunity for services to mould into what it is people want and need rather than people having to fit into service provision and it provides the opportunity for people to move from a centric position in care practices to that of leading care (Murkoro 2023, Boyle et al. 2010).

The National Mental Health Consumer and Carer Forum (NMHCCF 2021) advocates that person centred care needs to be realigned to become person led care, as person led care ensures the person is directing their individual journey, which is defined by them and not the provider. The concept of person led care is not indicative of an individual responsibility for care being placed on the person but adopts a shared responsibility for health and care (New South Wales Government 2022, Ham et al. 2018). Brown (2013) suggests that coproduction facilitates person led care for older people, in which they are supported to lead their own care with a shared responsibility, through coproducing care. Given the fragmented nature of contemporary healthcare systems and a culture in which people need to adapt to the processes and customs of healthcare and professional hierarchy, coproduction offers an opportunity for equality and equity in partnerships in care at a system, organisational and point of care level regardless of setting

as care can be co-led between providers and users (Miller 2021, Murkoro 2023, Boyle et al. 2010).

Reciprocity and mutuality in coproduction recognise and validate the implicit work that people do in healthcare and the meaningful participation people contribute to their care and within care relationships, not just the work of professionals (Filipe et al. 2017). Instead, coproduction aims to synthesise knowledge and learning through the effort and investment of all participants in which material, spatial, relational, and temporal elements of care are considered to promote a sharing of knowledge, and the coproduction of new knowledge, to better enhance the experiences and outcomes of care (Filipe et al. 2017, Elwyn et al. 2019). However, coproduction should not be considered as an addition to existing care practices but as a core function and character of care that can provide new opportunities for those involved (Batalden et al. 2016, Blunden and Calder 2020, Elwyn et al. 2019).

Batalden et al. (2016) suggest that coproduction offers an opportunity to challenge the standardisation of healthcare. Standardisation of health care has reduced unintended variation, and which has improved safety and quality (Batalden et al. 2016). However, while some healthcare interventions may be applicable for the product model of delivery, a throughput standardised consumer based model fails to provide adequate solutions for the complexities of care for older people when home is the place of care, in which tailored approaches to care are required (Elwyn et al. 2019). Tailored approaches to care are individual and personal which place the person at the centred of their health and care (Ahmed et al. 2014). Coproduction promotes intended variance with individual and community differences to meet specific needs, which has similarities to person centred approaches to care (Blunden and Calder 2020).

Some transformations in contemporary care delivery such as shared decision making and some models of person centred care, can focus on individuality, with choice as a marker of achievement (Latimer et al. 2017, Siouta and Olsson 2020). As coproduction explicitly places the relationship

as central, not the individual in isolation, it recognises that it is through the improvement of relationships, social, environmental, and political factors of care, and not choice, that will improve experiences of care (Blunden and Calder 2020, Batalden et al. 2016, Murphy et al. 2013). However, constraints exist to challenging power dynamics in care due to the structural inequalities that exist in the systems in which care occurs (Blunden and Calder 2020).

Coproduction and patient centred care advocate for equality in healthcare and care relationships, valuing diversity and individual identity and preferences, encompassing choice, dignity, and respect (Harding et al. 2015, SCIE 2013). However, foundational to coproduction is the understanding that everyone is equal, and that people bring expertise and assets to their care. Person centred care recognises the expertise of users, whereas coproduction emphasises expertise as a resource for healthcare delivery (Harding et al. 2015, Boyle and Harris 2010). Turner (2014) suggests that a shift in power to those who use services does not result in equality, equality only occurs when people have equity in power.

Person centred care aims to share power with those who use services, however care continues to come from predetermined care services and clinicians may retain control through professional status (Mieres 2015). Moore et al. (2017) suggest that equity in person centred care occurs within the care relationship through choice and self-determinism. Arguably, clinical environments influence power and empowerment and impede a sense equality in care for those using services, and people defer to professionals as the 'experts' (Murkoro 2023, Wolf et al. 2017). However, Jakobsen and Calmer Andersen's (2013) suggest that coproduction goes further and can support disadvantaged users to increase productive efforts, satisfaction, and service outcomes, thus increasing efficiency and equity as well as enhancing experience.

Like person centred care, coproduction considers inclusivity and equity in the care relationship (Moore et al. 2017). Both aim to address historical hierarchies in healthcare and care relationships, with the sharing of power to

a more equal distribution to form partnerships (Siouta and Olsson 2020, Filipe et al. 2017). Partnerships are integrated in concepts of person centred care and coproduction as both seek to change the position and power of end users of care within care relationships (SCIE 2013, Siouta and Olsson 2020). Both person centred care and coproduction aim to shift power in care relationships in which people become involved in their care with an active role and a responsibility in care, shifting power from traditional hierarchical healthcare relationships (Siouta and Olsson 2020, Coulter 2016, Boyle and Harris 2009). Wolf et al. (2017) consider that power sharing implies a meaningful and egalitarian relationship between patients and professionals.

However, Thoraninsdottir and Kristjansson's (2014) concept analysis of patient perspective on person centred participation through an integrative review suggests a hierarchy of relationships in healthcare. They argue this hierarchy depicts the level of engagement and responsibility between the person and professional from involvement to partnership (Thoraninsdottir and Kristjansson 2014). Heath's (2018) commentary on patient participation considers that power hierarchies persist, and that people may not engage with care at all if there is a perceived lack of values-based care.

Blunden and Calder (2020) suggest both the person and the professional have distinct roles in care processes and that partnerships in participatory care relationships are dynamic over time. They contend that it is arguably unrealistic to present care receivers as equal to providers despite how much their perspectives may be considered. The concept of mutual and equality in care relationships is questionable as it is impossible to equally share power and responsibility in all care situations. For example, those in receipt of care will be more affected should care experiences and outcomes be suboptimal (Batalden et al. 2016). With this underpinning care interactions, it limits the foundation for equity in relationships and care encounters can then be shaped by managing risk (Blunden and Calder 2020).

Coproduction does not claim to resolve this issue but offers an opportunity for engaging with diverse and differing positions and objectives, in which

disagreement, disruption and dissonance, disadvantage, inequality and exclusion can be constructively addressed (Filipe et al. 2017). Through redefining responsibilities of power in care dyads and relationships, and making systems transparent with shared accountability, the principles of care become pluralism, reciprocity, and benefit sharing with coproduction. This provides coproduction with a policy agenda not necessarily explicitly reflected in person centred care (Filipe et al. 2017, Blunden and Calder 2020).

Coproduction challenges the hierarchy of knowledge in care, giving value to the personal experience of ill health, clinical experience, as well as a biomedical evidence base (Filipe et al. 2017). However, personal experience remains a low form of evidence in contemporary healthcare which remains dominated by biomedicine, therefore, power imbalances in the procurement of evidence may not be considered (Blunden and Calder 2020). When the evidence base that informs practice is not coproduced or is not person centric this can create a disconnect between care practices and the knowledge that informs it (Filipe et al. 2017, Blunden and Calder 2020). A distinct feature of coproduction is that it embraces a diversity of people with disparate positions and capacity placing an equality on perspectives with different knowledges being included and actively sought. There is a relinquishing of hierarchy of professional knowledge and expertise, where practitioners work in unfamiliar ways and without a reliance on traditional knowledge sources (Blunden and Calder 2020).

Coproduction can be considered as a process in which service user time, motivations and skills add value by making a desired goal more convenient, cost effective and efficient benefiting the wider healthcare system (Elwyn et al. 2019). Thus, coproduction is the cocreation of value (Ostrom 1996). Value is created by people through the opportunities for input of knowledge, skills, and experience into care practices, rather than value being created as service outputs. Batalden et al. (2016), in considering the application coproduction has to healthcare service delivery, suggest that value is created

by expanding the scope of what people can do, rather than the practice of doing something for a person by a professional.

In coproduction value is not predetermined by professionals and directed on to people in the professional coaching of autonomous decision makers (Siouta and Olsson 2020, Batalden et al. 2016). Coproductive approaches people pull resources from professionals to cocreate value (Batalden et al. 2016). Coproduction offers a 'co' approach throughout so that everyone works together in new ways (Siouta and Olsson 2020, Elwyn et al. 2019). Furthermore, coproduction promotes the cocreation of values outside of the economic, such as social justice and equity through the processes of reciprocity and mutuality and utilising an asset-based approach (Filipe et al. 2017).

Thus, care becomes the coproductive work of multiple producers, including the people who provide and those use healthcare services, such as district nurses and older people (Batalden et al. 2016, Blunden and Calder 2020). Batalden et al. (2016) suggest that in considering coproduction, healthcare is better conceived as a service than as consumable goods, as services have a different logic than that of a goods producing industry. Batalden (2018) in considering coproduction for quality improvement in healthcare, contends that in a goods producing logic, products are made which are then provided to a consumer. However, services are intricate and complex, and whereas goods and products are definitive, services are consumed and produced concomitantly, with outcomes being coproduced.

Blunden and Clader (2020) and Ham et al. (2018) suggest roles and responsibilities for the outcomes of care can vary in a service logic, with professional accountability in service provision and in responsibility for self-care by patients. Batalden's (2018) reflection of studying change and coproduction in healthcare suggests that when a product lens dominates healthcare this can risk neglecting elements that are difficult to measure in care, such as relationships. He argues that coproduction enables a service lens for healthcare, in which relationships can be built and developed

through the interdependent care work of professionals and people. Batalden et al. (2016), in their application of coproduction to US healthcare delivery models, contend that coproduction differs to person centred care in this respect, as person centred care can be constrained by the implicit assumption that care is produced as a product by healthcare systems to be consumed by people.

1.4.4 Limitations

As previously discussed, ladder models of participation indicate a level of involvement by people who use services. However, involvement and engagement are not coproduction in themselves, coproduction involves working with people with lived experience as equal partners in healthcare (Brown 2013). Historically, service user engagement could be tokenistic with professional superiority that could stereotype and marginalise older people, who could be perceived as incapable and unequal to professionals in care relationships (Yuan et al. 2018). Thus, when perceptions of coproduction are limited to involvement this risks care becoming tokenistic due to the lack of partnership and equality in care practices (Minghella and Linsky 2018).

Coproduction has recently become more prominent in healthcare policy and in district nursing practice guidance (UK Parliament 2022, NHS England 2019, QNI 2022). However, this has not resulted in the widespread practice of coproduction (Batalden et al. 2016). Instead, coproduction activities in healthcare have been small in scale, in messy, complex contexts which are unique and challenging to replicate (Blunden and Calder 2020). Minghella and Linsky (2018) suggest that service pressures, healthcare culture and resistance to change can impede the development of coproduction in practice.

Leyshon et al. (2018) contend that that coproduction can be difficult to consider in practice contexts due to existing cultures and norms in care, where models of participation and engagement have been limited to service design. Voorberg et al. (2015) consider that coproduction in care can be classed in two frameworks; one where patients take over some of the work of

healthcare professionals, or when patients participate in the production of research or service design. However, there remains a limited consensus on what the nature of coproduction is in care relationships. Specifically, the coproduction of care has not been articulated in care relationships between older people and district nurses despite coproduction being a principle of district nursing practice (QNI 2009). Furthermore, consideration is needed as to whether coproduction is a concept and process that older people and district nurses are willing to engage with. It is yet to be established in contemporary evidence if coproduction with district nurses is something that is wanted in care at home by older people who are living with frailty.

Bovaird et al. (2019) discuss a 'dark side' to coproduction, suggesting that in service development and design coproduction can devolve the responsibility for care on to the public. Furthermore, they suggest that people who contribute to coproduction in public service development are not always experts by experience, but those with the loudest voices. Real experts may be marginalised and lack confidence and ability to have their voices heard. Flemig and Osborne (2019) assert that coproduction is at risk of becoming the next buzz word in healthcare policy, becoming tokenistic and rhetoric. However, appropriate information and resources for people and practitioners, and active engagement in coproduction can work to avoid tokenism and rhetoric (Boviard et al. 2019). Lino et al. (2019) contend that coproduction can be successful with shared understandings, agendas, an openness to the process, self-efficacy, and social capital.

Boyle and Harris (2009) as early advocates of coproduction in public services argue in policy guidance for NESTA (National Endowment for Science, Technology, and the Arts), that a stronger evidence base and shared understandings of coproduction are required before it can be fully embedded and adopted in healthcare practice. Smith et al.'s (2022) scoping review of coproduction practice and research in UK healthcare suggests that an increase and a diversity of approaches to coproduction are emerging. Although coproduction is becoming more widely used in health and social care, it requires further embedding in care practices (Conquer et al. 2019).

However, there remains a lack of evidence that considers coproduction in the context of care for older people receiving care at home from district nurses. This study aims to add to the existing knowledge base on coproduction and contribute understandings of the coproduction of care between older people and district nurses.

Coproduction has some similarities with person centred care. Unlike coproduction, person centred care is a statutory requirement that mandates for choice in individualised personal care for people, from existing care provision (Care Quality Commission (CQC) 2022), rather than care being co-created (Batalden et al. 2016). The concept of person centred care and how this differs and aligns with coproduction will now be discussed.

1.5 Person centred care

1.5.1 Definitions and understandings

A substantial and developing body of global research based evidence for person centred care illustrates differing individual and organisational understandings, views, assumptions, and nuances within this concept (Harding et al. 2015). This adds complexity in defining person centred care and in considering associated and transferable concepts and models that are commonly associated with it, however, there is now a widespread acceptance of the philosophical perspective that the individual person should be conceptualised as central to healthcare delivery systems, with the ability to have an equal say in their care (WHO 2016, Nolte et al. 2020).

There is a plethora of associated and connected terms used in conjunction with person centred care, such as client, family, or patient centred, and patient engagement (McCormack and McCance 2017). Miller's (2021) literature review asserts that terminology has changed over time. Patient centred is indicative of an individual seeking care, whereas person centred care is attentive to the health and care of people in their social and cultural context (Montesanti and MacKean 2022). All related terms to person centred care align with a humanistic and ethical philosophy that people should be treated as individuals, with respect for preference, values, and autonomy, the

concept of person rather than patient signifies the focus on humanism rather than disease (de Silva 2014, Nolte et al. 2020).

However, variations in person centred care approaches exist depending on the current political discourse and agenda. Differing ways of centring and positioning in care occur, depending on how the current and future context of healthcare is understood, the priorities within government and service providers, and any financial or political challenges faced (Ham 2023, Siouta and Olsson 2020). Miller (2021) suggests that the language of patient prevails in discussions on care. This may be indicative of continuing dissonance in understandings of the philosophy, values, and practices of person centred care within complex health systems, and dependent on whose centre, and in which context of care, is being considered (Byrne et al. 2020).

As person centred care lacks a concise definition due to its multidimensionality it can be understood, applied, and practiced in numerous ways, with different emphasis and priority on different qualities and elements (Miller 2021). Person centred care can risk being interpreted as the literal definition of 'care that is centred on the person' and this becoming the point of departure in care practices (Care Quality Commission 2010). However, contemporary person centred care in the UK is widely understood as the provision of optimal care based on the needs, preferences, and values in the context of a person's life, not just as a patient, through mutually beneficial partnerships between people and healthcare professionals (Miller 2021). Harding et al. (2015) suggest three mutually non-exclusive conceptual underpinnings of person centred care:

- Person centred care as an overarching group of concepts.
- Person centred care emphasising personhood.
- Person centred care as partnership.

(Harding et al. 2015 p.9).

Person centred care as an overarching group of concepts includes shared decision making, self-management support, integration and patient information as activities and enablers of person centred care (Health

Education England (HEE) 2017, Scholl et al. 2014). The emphasis on personhood is core to person centred practice. In this people and practitioners are recognised as autonomous with rights, who are respectful, purposeful, and responsive to individuality. People are known in the context of their social reality, placing the person before disease or need (McCormack and McCance 2017).

1.5.2 Foundations and philosophy

In healthcare the origin of person centredness has developed from a medical model of psychotherapy and client centred care (Kristienbaum 2020). Carl Rogers (1951) identified client centred approaches to practice through processes of developing empathy and trust with people and in suspending professional judgement within the medical model, to appreciate the person's perspective. Engel (1977) developed a biopsychosocial model of health, shifting the focus of healthcare from a medical model, advocating for a holistic perspective of people outside of disease. Subsequently, the Declaration of Alma Ata (World Health Organisation (WHO) 1978), a pivotal development of global public health, advocated for people to have the duty and right to participate collectively and individually in the planning and delivery of their healthcare, setting the scene for person centred care. Like coproduction, the concept of person centred care has evolved from a growing ethos of engagement and participation in care philosophy and practice, facilitating a shift from historical paternalism in healthcare (Harding et al. 2015).

1.5.3 Key features

Person centred care in medicine includes the ethical imperative to consider preferences and values in dyadic professional and patient interactions for healthcare decision making (Epstein 2011). Nursing philosophy links a concept of centring to caring, in which humanism and virtue ethics focus on the whole person, and the social, environmental, psychological, spiritual, and holistic needs rather than the emphasis on cure of disease, as in medicine (Morgan and Yoder 2012, Kristienbaum 2020, Miller and Wybourn 2017, Latimer et al. 2017). Kristienbaum (2020) suggests that person centred care

practices should shift away from a focus on diagnosis and treatment plans found in biomedical models of care, thus omitting directive practices such as questioning, interpretation, advice, and coaching in care interactions. However, assessment, judgement and care planning remain central to contemporary nursing practice, with varying degrees of participation from individuals using services (Agibade 2021). Arguably, this potentially prevents people from being placed at centre of care practices in nursing as this approach of centring narrows opportunity for consideration of any influencing social determinants of health and the holistic nursing perspective (Nolte et al. 2020). Holistic nursing practice is commonly, although not definitively considered as synonymous with person centred care (McCormack and McCance 2006).

Person-centred practice reflects humanistic nursing, with a therapeutic intent to practice, and a moral core, which is practiced in caring relationships that value people as individuals with rights and recognises the social influences of health and of being human (McCormack and McCance 2017). As such person-centredness is now a widely accepted philosophy and theoretical model for nursing and healthcare systems and practice in the UK (van der Clingel et al. 2016, McCormack and McCance 2017). Miles and Mezzich (2011) argue that the philosophy of person centred care in medicine has shifted to consider two people in care encounters, recognising the influence of the clinician. This is supported by McCormack and McCance (2017) who contend that the personhood of all people in care interactions is important for relationships that promote engagement and partnerships between professionals and people.

Person centred care has long been linked with quality in healthcare in the UK, such as in the NHS Plan (Department of Health 2000), in which quality was associated with processes of care coordination. The American Institute of Medicine's (2001) report 'Crossing the Quality Chasm' identified what was then considered as patient centredness, as an aim for quality healthcare which has since influenced and shaped the provision and policy for global healthcare services (Epstein and Street 2011, Latimer et al. 2017, Ham et al.

2018). The World Health Organisation (2023) suggest it is essential to establish what is understood by quality in healthcare and to ensure appropriate measures are in place, specifically for person centred care, satisfaction, or disease related health outcomes.

Epstein and Street (2011) suggested over ten years ago that measures for person centred care were insufficient in establishing or ensuring that it was occurring as policy dictated. More contemporaneous analysis suggests that person centred care, like coproduction remains inconsistent and discontinuous in practice which may be reflective of the way in which it is measured (McCormack and McCance 2017, Turakhia and Combs 2017, Nolte et al. 2020). This illuminates that policy alone does not result in desired actions and changes in practice, and that person centred care is a complex concept which is dependent on a multiplicity of contributory factors (SCIE 2013).

However, there can often be differing assumptions of what person centred care is expected to achieve (Harding et al. 2015). Doherty et al. (2020) and Epstein and Street (2011) suggest that person centred care is associated with improved patient engagement, enhanced cost efficacy, and improving quality outcomes. Coulter et al. (2015) concur that person centred care can improve self-management and can improve satisfaction with healthcare services. Philosophically, the principle of people being involved in their care has ethical value irrespective of the potential influence this has on quality outcomes (Nolte et al. 2020).

Contemporary healthcare policy objectives continue to link quality improvement with person centred care, with a focus on improving patient experience, service delivery and population health, with prevention as an ongoing activity (HEE 2017). However, while evidence to support individual level improvement and outcomes of person centred care is available, with choice in shared decision making in a care relationship as a marker, evidence to support that person centred care at a systems and organisational level can lead to improved quality and performance remains

sparse (Nolte et al. 2020). Coproduction also aims to enhance quality improvement by consumer engagement although currently, as coproduction remains a discontinuous concept in healthcare policy there is also a scarcity of supporting evidence (Turakhia and Combs 2017, Douglass 2022).

Like with coproduction, Miller (2021) suggests that the type of outcomes that contribute to measurement of success require consideration in person centred care as these can be narrowly focussed system generated, omitting the inclusion of outcomes generated by people. Importantly Epstein and Street (2011) contend that stakeholders who are in the receipt and delivery of care should be included in the development of person centred measures and for these to capture relevance and that lead to an alignment of common understandings of the essence of person centredness in practice. As Miller (2021) suggests, these types of outcomes associated with the measurement of person centred care illuminate the intended purpose and the underpinning philosophy of the care system.

Establishing person centred care can often be complicated by health behaviours (Epstein and Street 2011). Miller (2021) suggests that it is not only patient health behaviour that shapes person centred care, but that of the clinician. This is supported by Moore et al. (2017) who contend that person centred care is dependent on the attitude of staff. Miller (2021) asserts that a commitment to the ethical and philosophical foundations of person centred care is essential for its effective practice. Both the health behaviours of people and the professional commitment of clinicians may have an indirect influence on health outcomes as a person may feel they have been respected and valued and their preferences considered, but their health may deteriorate because of their behaviour, regardless of their experience (Epstein and Street 2011, Miller 2021). The work of Epstein and Street (2011) and Miller (2021) further illustrates that, like coproduction, in care interactions there are at least two people who influence care outcomes (Elwyn et al. 2019, Miles and Mezzich 2011).

Health Education England (2017) suggest that person centred care is not specific to a role or situation but the contextual application of the right skills in the right place, illustrating that for care to be person centred it may differ for each person, depending on individual needs, circumstances, and preferences, which may change over time (Health Foundation 2014). Harding et al. (2015) contend that person centred care can reflect the individuality and uniqueness of the context of the country, disease or patient group or setting of care in which person centred care is considered. However, Scholl et al. (2014) suggest that complex debates as to what constitutes person centred care for an individual can be a distraction from implementation and practice.

Person centred care has a theoretical foundation of human potential, in which there is an intrinsic motivation to grow and develop as an autonomous being (McCormack and McCance 2017). However, the ability to do this is moderated by social, environmental, and political factors, and person centred care is structured on the premise of optimal foundations for human flourishing and growth (Murphy et al. 2013). Harding et al.'s (2015) synthesis of research and the Health Foundation's (2014) guide to person centred care do not consider the context or environment in which person centred care occurs. However, McCormack and McCance (2017) argue that a person centred culture is imperative in healthcare environments for person centred practices of care to occur.

Health Education England (2017) concur suggesting that staff attitudes and behaviours apply the underpinning value of person centred care in practice, thus informing culture in practice. Grealish et al. (2019) contend that in the acute hospital setting a culture that is not person centred can lead to task orientated care, suggesting that it is efficiencies, routine and rituals that can impede person centred care. Latimer et al. (2017) contend that person centred care is impeded by fragmentation, insufficient information technology systems, a lack of investment and a payment by results system of healthcare. These findings have congruence with McCormack's (2004) seminal work on person centred care environments for older people, who

asserts that it is the culture of the care environment which is the biggest potential constraint of realising person centred care.

McCormack and McCance (2017) suggest that for a person centred culture the macro context of healthcare requires strategic leadership and workforce development. They also contend that individuals require commitment to the job, and that the practice environment requires several prerequisites such as supportive organisational systems, appropriate skill mix, and potential for innovation and risk taking. However, for the realities of person centred care to be practised and achieved in contemporary healthcare is challenging (Siouta and Olsson 2020). Like coproduction, person centred care is constrained by the neoliberal structures in which it operates, which are counterproductive to it being realised. Therefore, the systems in which person centred care is delivered can detract from its delivery as the environment, systemic factors and resource allocation can affect the scope of its actions (Murkoro 2023, Blunden and Calder 2020). Current pressures in the NHS following the global pandemic, coupled with historical underfunding, deficits in performance, growing demand and finite resources may result in healthcare systems that are not conducive to the prerequisites for person centred practice or a healthful culture (Ham 2023, Care Quality Commission 2022).

McCormack and McCance's (2017) framework for person centred practice illuminates the need for a system wide approach that enables person centred care to become a consistent reality in practice. As Nolte et al. (2021) suggest, currently people perceive that person centred care is being achieved, when the reality is that it is not a constant, despite services adopting the value base of person centred care. Harding et al. (2015) contend that a whole systems approach to person centred care requires the successful and appropriate interaction of all system components. Byrne et al. (2020) suggest that how systems are operationalised influences how person centred care is interpreted and the opportunity for this in practice.

1.5.4 Limitations

Limitations of person centred care are in part reflective of those of coproduction. Epstein and Street (2011) highlight a potential dissonance between person centred care and evidence based practice, as evidence based research is more likely to focus on evidence at population level, rather than what is important to individuals. Epstein and Street (2011) suggest the person is the best judge of when person centred care has occurred. However, as Harding et al (2015) argue, with differing meanings of person centred care for different people, this is a challenge to establish and research. Similarly, Conquer et al. (2021) contend that coproduction does not occur unless this it is felt by the people involved. Subjective interpretations of the experience of person centred care and coproduction result in both being difficult to measure, and without tangible data of the impact and benefit amidst other competing priorities, both risk becoming rhetoric (Juhnke and Muhlbacher 2013).

Miller (2021) suggests subjective experience as a measure illuminates the hierarchy of evidence, with preference to biomedicine and quantitative outcomes. With experiences of care in qualitative research often ignored or considered less important, this has implications for healthcare systems decision making and agenda setting (Miller 2021). Disease specific research within the quantitative paradigm, and the discontinuous healthcare systems within the NHS, in which people are transferred between specialist and generalist services, exacerbates a task focussed approach to care, rather than a focus on enduring partnerships in which personhood can be considered in a holistic perspective (Pelzang 2010, WHO 2016).

The pressures on the NHS over the last 20 years have resulted in poorer outcomes and contributed to the need for greater focus on efficiencies, potentially further impeding opportunities for person centred care (Anderson et al. 2021, Ham 2023). McCormack and McCance (2017) suggest that to move from traditional hierarchical care delivery to person centred approaches requires a shift in practice. However, the realisation of person centred care cannot happen easily as the values of person centredness

clash with the contemporary context and constraints in which people are practising (O'Brien 2022, Blunden and Calder 2020).

Meranius et al.'s (2020) Swedish discursive literature review suggests that limitations of person centred care are not widely reported in contemporary research, due to its moral ethical imperative and consequent association with high quality improved care. However, the authors contend that person centred care can include inequity in provision due to personal preferences of clinicians, and that the personhood of staff may not always be considered, resulting in demoralisation and task focussed care. Person centred approaches to care may therefore potentially further exclude or marginalise some who cannot or do not want to actively participate in care or shared decision making about their care (Meranius et al. 2020).

1.6 Shared decision making

1.6.1 Definitions and understandings

Shared decision making is embedded in contemporary healthcare policy, supporting the transformational shift towards user involvement, engagement, and choice in care, with increasing recognition of partnership approaches in care which have evolved since the 1980s in the UK (Ahmad et al. 2014, Batalden et al. 2016). Harding et al. (2020) contend that shared decision making is an integral process of person centred care and of coproduction.

Ahmad et al. (2014) suggest that there is a plethora of definitions and conceptual understandings of shared decision making. Shared decision making can be broadly understood as a collaborative process in which professionals and people reach a mutually agreed position on how to progress in care situations (Ahmad et al. 2014, Miller 2018). Ahmad et al.'s (2014) literature review of shared decision making support suggests that an agreed position with which to move forward occurs through the sharing of evidence based information by professionals, with patients, who then make a trade of between risks based on personal preferences and values, to make an informed choice. Marteau (2009) suggests however, that in processes and practices of shared decision making, decisions can be made that are

uninformed. Furthermore, autonomous dependency or forced independence may occur in the process in which people rely on clinicians to make the 'shared' decision or feel unsupported or informed to make decisions (Lewis 2019).

1.6.2 Foundations and philosophy

Shared decision making originates from a model of ethical biomedicine (Miller 2018). Introduced by Veatch (1972), the concept of shared decision making shifted the practice of medicine from the morality of doing no harm, to include justice, freedom, and dignity. Drawing on the principle of informed consent, shared decision making is underpinned by autonomy and respect in healthcare relationships (Ahmad et al. 2014). However, Donchin (2000) suggests that a value-based relational concept of autonomy is required due to the interpersonal nature of the care relationships, and the complex power dynamics that constitute these relationships, which influence autonomy.

1.6.3 Key features

Shared decision making can be as a one to one patient-professionals interaction or as a multidisciplinary team context (NICE 2021). It is a structured way in which evidence can be included in consultations with people, along with the preferences of the individual so that values are incorporated into decision making, thus supporting informed choices congruent with patient perspectives (Elwyn et al. 2012). Unlike coproduction, Legare et al.'s (2018) systematic review suggests that shared decision making is professionally led, with the professional as the expert informing the patient. Ahmad et al. (2014) consider that when clinicians maintain expertise in care dyads for shared decision making that this can lead to notions of patient compliance, in which empowering people through supported decision making processes improves adherence to professional directions and preferences.

However, comparable to coproduction and person centred approaches, shared decision-making does aim to reduce historical hierarchical power imbalances between people and the professional in healthcare (Elwyn et al. 2012, NICE 2021). Ahmad et al. (2014) suggest that a shift in power within

shared decision making allows people into the domain of the clinician, as gate keepers of available options. Thus, in shared decision making the clinician is no longer the primary decision maker (Lewis 2019). NHS Kidney Care (2011) suggest that as shared decision making has developed it has been conceptualised as the middle ground between paternalistic decision making and person informed decision making. Lewis (2019) argues that the shared element of the concept is confusing in terms of who makes the final decision, or if the process leading up to decision making is shared. Ahmad et al. (2014) suggest that it is the mutuality in the agreed decision that is attributed to a shared decision.

Elwyn et al. (2012) advocate for a model of shared decision making which includes choice, options, and decision talk. This model suggests that shared decision making as a concept implies that free choice in care is available for older people to make decisions about. However, choice in healthcare is limited to what resources are available and what the service can provide rather than the choice being initiated authentically from the patient (Blunden and Calder 2020). Choice then becomes unavoidably limited in the resource poor context of the NHS, which is incongruent with the consumerist model of healthcare and the philosophy of market mechanisms, illuminating the neoliberal philosophy of healthcare provision as unsustainable (Latimer et al. 2017).

However, when choice is reduced to minimal options and the criteria for meeting choice is procedural and simple, individual choice is realised when the person decides what happens, rather than the professional. In this perspective, policy objectives are achieved as the individual has maximum say in their care and shared decision making is realised (Blunden and Calder 2020). Arguably, the reality is that providers and professionals guide any choice in care with the options that are offered, with professional cognitive bias influencing choices available and subsequent decision making (Ozdemir and Finkelstein 2018).

1.6.4 Limitations

Congruent with other concepts of engagement and involvement, professional disposition, time, and the practical application of shared decision making may hinder any shift in power to facilitate choice in care through processes of shared decision making, and clinicians require the skills to be able to make a shift to shared decision making within their practice (Elwyn et al. 2012).

Shared decision making depends on some of the same principles of coproduction, person centred care and collaboration, in that professionals and people need to be motivated and invested in developing improved outcomes and enhanced quality relationships (Ahmad et al. 2014). Further constraints can occur in processes of shared decision making if older people do not feel empowered, able or do not want to participate in decision-making about their healthcare (Bunn et al. 2018). Age, frailty, ill health, health literacy, lack of self-efficacy, and access to information can also prevent older people from participating in shared decision-making (Pel-Little et al. 2021).

Ahmad et al. (2014) suggest that shared decision making in practice can be dominated by a transactional approach of a reductionist consumer model. In this approach there is an emphasis on specific task to be undertaken to reach a desired goal, often determined by the professional. This assumes that person preference can be elicited in care interactions (Entwistle 2009). This transactional task focussed approach to shared decision making includes activities such as provision of information, providing leaflets of the use of predetermined decision aids for specific treatments and interventions in care encounters for specific pathologies and problems (Elwyn et al. 2012, Ahmad et al. 2014, Legare et al. 2018). However, preferences and the ability to form decisions is dynamic, complex, and change over time for older people (Bunn et al. 2018).

Smith et al. (2023) argue that decision making is considered as an individualistic process, but that it more often occurs in a social context, Pel-Little et al. (2021) concur that this is particularly so for older people when making decisions about care. Elwyn et al.'s (2012) study explored the

barriers of people being referred to online decision support tools for care related decision making. They contend that shared decision making is a process of individual self-determination and relational autonomy, and that autonomy is supported through and in care relationships. A relational approach to shared decision making can be developed through social interactions in the context of care that contribute to the overall relationship, in which professionals utilise empathy, listening, coaching and respect to support shared decision making (Truglio-Londrigan and Slyer 2018). However, Batalden et al. (2016) suggest that shared decision making rarely occurs in practice and care dyads remain professionally centric, in which healthcare becomes advice, evaluation and management, particularly when productivity pressures increase. However, there is an opportunity for older people to utilise care encounters as a space in which to explore ideas in a collaborative context with clinicians, in which the process of care has the potential to be coproduced (Cribb and Entwistle 2011).

Ahmad et al. (2014) suggest that a genuine collaborative approach negates the need to identify specific activities of shared decision making within care interactions and can provide a transformational shift for relational autonomy in care. However, supportive healthcare systems are required for shared decision to be a reality (Coulter and Collins 2011). Healthcare systems require a culture of collaboration, integration within resource constraints, in which costs are balanced against outcomes for shared decision making to occur, recognising that cost efficiencies are not an inevitable consequence of shared decision making (Ahmad et al. 2014). Thus, shared decision making in a systems approach and organisational delivery, comparable to coproduction and person centred care, is a concept based on ethical and quality enhancement principles rather than financial incentives (Hedberg et al. 2022).

1.7 Collaboration

1.7.1 Definitions and understandings

Concomitant with the other concepts of engagement and participation in care discussed, there appears to be a lack of a clear definition of collaboration in

healthcare, concurrent with a broad application from collaboration in the operation of healthcare systems and organisational service provision, to that of people working together at the point of care delivery (Busari et al. 2017). Howard et al. (2022) suggest that collaboration, at the most basic level is a process in which multiple stakeholders share information, identify problems, gaps or inequities, and develop improvements in care together. Emich (2018) argues that nurses require a clear definition of collaboration before it can be applied in everyday practice. Morley and Cashell (2017) suggest that collaboration has a wide use and potential application in healthcare, suggesting that collaboration is often specific to the context in which they occur and are designed and evolve around the services, organisations and people involved and incorporate processes of coordination, cooperations, shared decision making as well as partnership working.

1.7.2 Foundations and philosophy

The Health and Care Act (UK Parliament 2022) aims to ensure a healthcare system with collaboration and partnership at its core. Collaboration is central to shared decision making, person centred care and coproduction, in that it relies on people working together to achieve desired outcomes (SCIE 2022).

Collaboration has been central to healthcare policy in recent decades, where it was introduced as an initiative to improve quality and efficiency by the reduction of fragmentation, and the inefficient use of services, thereby improving patient experiences (Alderwick et al. 2021). Howard et al. (2022) in a review of US healthcare argue that constrained resources and competitive markets can further reduce quality and increase inequities in care. Ham et al. (2018) contend that these are also problems faced in UK health systems.

However, collaboration appears to have dissonance with capitalist neoliberal healthcare markets in which systems and providers compete to outperform each other to demonstrate improvement, as individualism and competitiveness are favoured in policy (Zeira 2022). Conversely, collaboration suggests that systems, system components and 'competing' providers work together to improve simultaneously to reduce costs, improve

care and quality (NHS England 2021). This is suggestive that collaboration can be professionally, or provider led, as involvement from service users in quality improvement can be dependent on the user being invited to participate (Jones et al. 2021).

1.7.3 Key features

The Department of Health and Social Care (2021) suggest collaboration is service users working together with professionals to achieve positive care outcomes. With some similarity to concepts of coproduction, person centred care and shared decision making, Morley and Cashell (2017) suggest that partnership and participation are core to collaboration in care, however, concepts of collaboration do not consider how much involvement, participation, status, and power end users of services have in the work that is being collaborated on. Seale (2016) in considering service codesign between professionals and patients, argues that for collaboration power, purpose, leadership, and responsibility is shared. Steihaug et al.'s (2016) meta ethnography of challenges in achieving collaboration in Norwegian healthcare suggests that organisational and individual factors, professional culture, knowledge and power imbalances between people and professionals, and between clinicians results in poor care experiences, particularly for older people. With a lack of equality and equity in the relationships for collaboration, this can risk a tokenistic inclusion of users to fulfil the policy requirement of collaboration and consequently becoming rhetoric (Flanagan 2019).

Collaboration puts performance into context as system components and providers can establish how well each is performing in different areas of healthcare. Howard et al. (2022) suggest that collaboration is a mechanism with which to effectively address quality and inequities, as that once healthcare organisations understand where any deficiencies are then action can be taken to address and improve quality at a local level, as top down approaches to quality improvement can lead to inefficiencies and poorer patient outcomes and experiences.

Rosen et al.'s (2018) literature review suggests that collaboration in teams can lead to problem solving, peer learning, innovation, and safer high quality care. Howard et al. (2022) contend that similarly, successful collaboration between systems and components of systems can create new value in healthcare, and that systems can flourish from equal contributions from all stakeholders through continuous improvement. This understanding of collaboration arguably has congruence with coproduction. However, coproduction explicitly values the expertise of the end user in care design and delivery as equal to professional expertise (Jones et al. 2021). Strachan (2018) suggests that coproduction is a form of collaboration, however the equal relationship with users is essential in coproduction and not collaboration, and that it is through coproduction that the transformation of the design, delivery and experiences of services can occur (Boyle and Harris 2009). Rycroft-Malone et al. (2016) argues that collaboration and coproduction are inextricably linked and although shaped by differing philosophies, that they share principles of meaningful participation, partnership, and engagement. Douglass (2022), reporting on understandings of coproduction of the British Medical Associations patient liaison group, asserts that collaborative practice is achieved through authentic partnerships but that it is coproduction that builds on the principles of person centred care and shared decision making, to provide the foundations for safe, effective, efficient, inclusive healthcare (Douglass 2022, Ahmad et al. 2014). However, the potential positive impact of coproduction for people in receipt of services remains underexplored (Douglass 2022).

1.7.4 Limitations

The concept of collaboration is integral pillar of contemporary healthcare policy and legislation (UK Parliament 2022). The Care Quality Commission (CQC 2022a) identify that a lack of collaboration in healthcare can be a significant barrier to quality outcomes and experiences of care. As coproduction, person centred care and shared decision making rely on forms of collaboration to be successful and meaningful. A lack of collaboration has a potential to impede quality outcomes and experiences and may contribute to a lack of consistent application of participatory models of care, concomitant with other contributory factors such as austerity and cost

efficiencies (Ham et al. 2018, Boyle and Harris, 2009, McCormack and McCance 2017, Ahmad et al. 2014).

Collaborative approaches to service design and delivery in the UK aim to address the whole systems of care (Coulter et al. 2013). The World Health Organisation (2010) suggests that collaboration is the integrated working of multi-professionals with patients and families to deliver high quality care. However, contemporary evidence for collaboration is largely centred on professionals working together to integrate care services and prevent fragmentation, which are core issues of contemporary healthcare delivery (Alderwick et al. 2021). This could be due to the development and implementation of integrated care systems, as stipulated in the NHS Long Term Plan (NHS England 2019), in a response to the need for cohesive and efficient healthcare systems and service delivery.

Collaboration in the everyday care interactions between people and professionals lacks centrality to current policy and literature, rather, concepts of shared decision making, person centred care and now coproduction appear to have taken precedence (Loughlin et al. 2019). Arguably, collaboration has become implicit in policy directives through these other concepts, which depend on it for their success (Hedberg et al. 2022). Emich (2018) suggests that it is through a clear shared meaning for daily practice that will facilitate development of further evidence to support collaboration with patients in nursing. As Alderwick et al. (2021) argue, insights into collaborative care practices at the point of delivery remain important. If professionals and services are unable to work well together for the efficient delivery of care provision, effective collaboration and equal partnerships with people who use services may not be a reality, thus resulting in poorer experiences of care and reduced quality outcomes.

1.8 Synopsis

Person centred care, shared decision making, and collaboration are embedded in policy and have an established and growing body of evidence with which to support it in the context of district nursing and older people's

care at home (QNI 2018, Maybin et al. 2016). However, there is a paucity of research that explores coproduction in care (Douglass 2022). The nature of coproduced care between older people and district nurses, when home is the place of care has not to date been investigated. Therefore, this research seeks to offer an original contribution to a developing evidence base of coproduction at the point of care delivery and in these care dyads at home.

This chapter has illuminated that the coproduction of care is purposeful and occurs in the everyday practices of care and is a dynamic process. Coproduction occurs in the interdependent trusting relationships and contributes to the experiences of care and care outcomes. It is the sharing of knowledge, expertise, power, respect, voices, and resources with which to progress forward together, in the coproduction of better care (Batlden et al. 2016, Baim-Lance et al. 2018, Palmer et al. 2018, Leyshon et al. 2019, Cluely et al. 2021, Greymr et al. 2021, Price et al. 2021). Therefore, it useful and of value to consider coproduction as an approach to care between older people and district nurses.

Person centred care, shared decision making, and collaboration can change the experiences of care for older people (McCormack and McCance 2017, Ahmad et al. 2014, Morley and Cashell 2017). Person centred care, shared decision making and collaboration centre on the ideology of individualism and on self rather than social and political contexts for more democratic care practices, such as coproduction. Therefore, these concepts remain unlikely to change the status quo of gender, power, politics, and inequity in the context of care (Perret 2006, Houston 2014, Tronto 2015, Boyle and Harris 2009). Coproduction promises a transformational approach to care. Exploring care between older people and district nurses may offer insights for how coproduction can shape care experiences for older people at home, how nursing practice may be informed to enhance quality through the coproduction of care and if this can offer a cultural change (Ham et al. 2018).

While person centred care, shared decision making and collaboration consider the relationship between patients and clinicians in the participatory

processes of care, coproduction has potential to explore how care relationships influence experiences and wider healthcare and social systems. As coproduction emphasises the expertise of the older person in care, this changes the status quo of care with professionals moving from fixing to more facilitative roles in care relationships (Boyle and Harris 2009, Realpe and Wallace 2010). Coupled with home as the place of care, where different power dynamics are at play to that of institutionalised care (McGarry 2009), coproduction provides a nuanced perspective with which to explore the nature of care experiences.

1.9 Research aim

This research aims to explore the experiences of care for older people living with frailty, when care occurs at home with district nurses. It seeks to understand how care practices are experienced in the context of care at home for older people. Specifically, this work aims explore the nature of care is that is coproduced between older people living with frailty and district nurses when home is the place of care.

A short account of how my personal interest in older people's care in the context of district nursing will now be presented.

1.10 Personal interest

I began to look more critically at district nursing and healthcare provision for older people when I saw a poster depicting a patient at the centre of care on it, reflecting a new direction in policy objectives. As far as I was aware the patient was already at the centre of care. However, at this time care was being devised in generic treatment plans and provided based on tasks. Choices were limited by service specifications and resource provision, which differed from the policy ideals. I began to question and explore care for older people.

Frailty was becoming common place in policy and service directives, and it appeared that when older people were considered frail, that there was more professional decision-making on behalf of older people, to ensure safety and

admission avoidance. Older people were often referred to as non-compliant in practice if they decided not to take the advice of the district nurse. I understood there to be power differentials and power dynamics in care relationships in practice and I became interested in the concept of coproduction as an understanding of working together. I wanted to know if coproduction could be experienced and occur within care relationships at home, how and if care occurred outside of a task, how coproduction could influence choices for older people, how it shaped the power dynamics of the care relationship at home, and what forces were influencing the coproduction of care, if it was happening.

These personal experiences, interests and reflections have led me to this research journey, to explore the nature of care that is coproduced between older people and district nurses, when home is the place of care.

1.11 Summary

This chapter has discussed the specific context that frames this thesis and has considered the personal interest motivating the study. Coproduction has been discussed an emerging presence in health and social care policy and considered an appropriate conceptual framework with which to explore the nature of care at home between older people and district nurses when they work together. The next chapter will provide a critique of the existing literature, identifying gaps in the body of existing knowledge to provide a rationale for the study.

Chapter 2 Literature review

2.1 Introduction

Undertaking a literature review is an essential component of research enquiry (Aveyard 2018). A literature review provides a synthesis of published literature to evaluate an existing body of knowledge on a topic area (Ferrari 2015, Torraco 2005). It is a critical evaluation of an extant body of knowledge that aims to locate a particular topic of interest for study in existing debates, identifying where limitations exist and where contributions can be made (Green and Thorogood 2018). A review of contemporary literature is therefore useful in the design and development of a primary research study in considering the current available evidence, perspectives, challenges, and gaps, providing a comprehensive understanding (Ferrari 2015, Whitemore and Knafel 2005).

This chapter presents a narrative literature review that provides a critique of the extant literature, drawing the conceptual frameworks of care and coproduction together, in the context of care for frail older people at home with district nurses. A rationale for a narrative literature review and the processes undertaken in sourcing and reviewing available literature will be discussed. A critical appraisal of the literature will be presented, highlighting key findings. Gaps in the literature will be identified and discussed, which will then inform and shape the research questions for this study.

2.2 Literature review method

Ferrari (2015) identifies two standard types of literature reviews, systematic and narrative, which differ in objectives, methods and application but may include different levels of evidence. A superiority in hierarchy of evidence often awarded to systematic reviews is from more focussed research questions and explicit methodological approaches than found in narrative reviews (Greenhalgh et al. 2018, Green and Thorogood 2018). However, an integrative approach to a narrative review can provide a relevant synthesis of knowledge from a broad range of evidence sources, relevant to complex situations and contexts, using multilayer critical interpretation and creative

judgement to inform healthcare research, policy, and practice (Greenhalgh et al 2018, Whitemore and Knafel 2005).

An integrative narrative review does not seek to generalise any findings and as I intended to undertake an iterative and interpretive review of the extant literature related to the diverse and complex nature of care for older people, district nursing and coproduction this approach was selected as appropriate (Green and Thorogood 2018, Greenhalgh et al. 2018, Ferrari 2015, Whitemore and Knafel 2005). An integrative approach to the literature review required a repeated reading of the literature, as interpretation can be subject to change over time due to shifting political and social contexts and the development of understanding, knowledge, and perspective (Green and Thorogood 2018).

Aveyard (2018) and Dixon-Woods et al. (2006) argue that integrative narrative literature reviews may not necessarily utilise a systematic approach to search methods, as the primary focus is on interpretation of a sample of evidence to inform and advance theoretical understanding. However, integrative narrative literature reviews may be presented in a systematic way, depending on purpose and context. Without a systematic and explicit method to undertaking an integrative narrative review there is a risk of error through the omission of core evidence and of potentially introducing bias (Greenhalgh et al. 2018, Whitemore and Knafel 2005).

Bias in systematic literature review is a positivist lack of objectivity suggesting that no external influences shape and inform the analysis of data (Greenhalgh et al. 2018). However, with an integrative narrative review interpretation of evidence is an essential element of the process. A structured, systematic approach with a transparent positioning of the author in the interpretative analysis provides understandings of the perspective, selection processes and the methodologies undertaken and can enhance rigor, reliability, and reduce bias (Greenhalgh et al. 2018, Byrne 2016, Whitemore and Knafel 2005).

The context of the research study has been identified in the transparent positioning of myself in the context of a narrative review. The purpose of this study is towards a PhD research degree. However, the work is informed by my personal interest in the care for older people at home and the complexities of choice, personalisation, and of participation in contemporary healthcare. My position as a district nurse and a district nurse educator further informs my position in the interpretation of the literature. To further enhance rigor a systematic approach of an integrative narrative literature review was undertaken. Although this is not a required element of the chosen approach, I considered it useful in structuring the work and to provide a foundation to capture a plethora of appropriate evidence sources (Green and Thorogood 2018).

2.3 Literature searching

This study aims to examine the complexities of care for older people at home when support is needed from district nurses, and to consider coproduction in care dyads in the context of choice and personalised care. Thus, complex, and multiple concepts require exploration and consideration in the literature review (Aveyard 2018). These concepts been outlined and discussed in chapter one.

Greenhalgh et al. (2018) advocate against a focus on explicit and specific search strategies narrative literature reviews. However, as Whitemore and Knafl (2005) suggest, well defined literature search terms can increase the rigor in the process, therefore this was undertaken. Search terms define the nature and context of the literature search and were established in a comprehensive way (Ferrari 2015).

As the literature review had no specific question and aimed to explore core concepts (Greenhalgh et al. 2018), the initial literature search at the start of the study in 2015 included deconstructing the underpinning concepts of this study, in which they became key search terms (Ferrari 2015). Although not required in a narrative review, this process can add clarity to the context and the intent of the review and help discard literature that lacks relevance

(Ferrari 2015). Care, older people, ageing, district nursing, frailty, choice, and coproduction were initial search terms. Choice was incorporated into the search to expand it and seek more data on participative care models that may not consider the term coproduction.

Electronic databases are an efficient and effective way of searching for appropriate literature, however, limitations can occur with inconsistent search terminologies (Green and Thorogood 2018, Whitemore and Knafelz 2005). Green and Thorogood (2018) suggest using electronic databases relevant to the field of study and associated disciplines. Searches using health and nursing electronic databases; CINAHL plus, Medline, Psych Info and Embase, on the University's One Search function were undertaken.

Boolean logic aims to provide consistency in searching electronic databases by using logic operators of AND, OR and NOT integrated into the search terms, which also aids the gathering of a wider base of evidence (Klein 2022). A sequence of six searches were undertaken individually using the electronic databases identified. The search terms that were used were:

- Care AND older AND people AND choice
- Care
- Care AND older AND people
- Care AND district AND nursing
- Care AND district AND nursing AND older AND people
- District AND nurs* AND older AND people AND choice AND coproduction

This process was useful to gain an oversight of the breadth and depth of the literature available that could inform the literature review (Torroco 2015) and produced a high yield of initial results. The search term 'care' reached over 3 million hits, 'care AND older AND people' scored over forty thousand and 'care AND district AND nursing' retrieved over eight thousand. The search strategies of 'care AND older AND people AND choice' and 'care AND older AND people AND district AND nursing' obtained over four hundred hits each. The lowest yield was eighty five hits which was from the search terms 'district

AND nurs* AND older AND people AND choice AND coproduction'. Table 2.1 presents a table of the search terms and hits of literature identified within the electronic databases.

TABLE 2.1 RESULTS FROM INITIAL LITERATURE SEARCH IN 2015

Search Terms	Hits	Reduced to with inclusion/exclusion criteria	Number discarded based on abstract or repeat	Number selected
Care AND older AND people AND choice	428	162	147	15
Care	3,760,481	107	105	2
Care AND older AND people	41,099	71	66	5
Care AND district AND nursing	8,050	186	177	9
Care AND district AND nursing AND older AND people	419	39	35	4
District AND nursing AND older AND people AND choice AND coproduction	85	78	74	4
TOTAL				39

Greenhalgh et al. (2018) suggest that inclusion and exclusion criteria are not a requirement of an integrative narrative review. Ferrari (2015) suggests that an inclusion and exclusion criteria is useful to focus the relevance of the literature to the context of the study. Furthermore, sources can be reduced with the use of inclusion and exclusion criteria to ensure relevance (Whittemore and Knafelz 2005). This was useful due to the plethora of hits yielded, as evidenced in Table 2.1. An inclusion and exclusion criteria were applied to the initial search in 2015, as illustrated in Table 2.2

Literature was further reduced by scrutinising the titles and abstracts following the application of the inclusion and exclusion criteria and discarded if there was found to be no relevance to the subject of study or if the search yielded duplicates (Torroco 2005). This reduced the primary literature search to a smaller and manageable amount to review. The search was reduced to a total of 39 hits as illustrated in Table 2.1. Manageable amounts of data for

the capacity of the researcher and the time available are essential for reliability (Dixon-Woods et al. 2006).

TABLE 2.2 INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Published between 2008-2009 moving to a 1-year currency in publication • Peer reviewed and academic journals • Research and literature written in English • Research and literature in human populations • Research and literature related to ageing • Research and literature related to people aged 65 years and over • Research and literature related to people aged 85 years and over • Research and literature from the UK, Ireland and EU and from countries with a similar healthcare context to the UK (USA, Canada, Australia, New Zealand, Finland) • Research and literature exploring long term conditions and chronic ill health • Research and literature exploring frailty • Research and literature undertaken in the community, acute care and residential and nursing home settings • Grey literature, policy, opinion, think tank reports 	<ul style="list-style-type: none"> • Published before 2008 then older than one year from time of search • Research and literature written in any other language than English • Research and literature in non-human populations • Research and literature related to people under 65 years • Research and literature not from the UK, Ireland, EU and from countries without a similar healthcare context to the UK • Research and literature related to end of life • Research and literature related to food, nutrition • Research and literature related to pregnancy and birth • Research and literature related to dementia • Research and literature exploring cancer

However, the structured search strategy undertaken risked missing relevant papers that were not overtly related to care, older people, choice, personalisation, coproduction, and district nursing but may be of relevance and of significance to the review. Therefore, a more organic and iterative approach to literature acquisition was undertaken, that was more aligned with the exploratory nature of the narrative review (Dixon-Woods et al. 2006).

Aveyard (2018) and Doyle (2003) suggest that intuition and subjectivity in the literature selection process can add strength to the review and can ensure a

rigorous approach through a purposive process. An organic purposive and iterative approach included secondary sources from reference lists, healthcare policy, third sector publications, searching older peoples and district nursing network websites, recommendations and networking with experts, grey literature and searching other disciplines for literature that was not obviously related to the core concepts of the study (Whittemore and Knaf 2005). This process was to identify potentially relevant literature rather than a comprehensive inclusion and identification of all the relevant evidence available, which is conducive to an integrative and interpretive narrative review, and to the nature of the subject of study (Dixon-Woods et al. 2006).

This organic and purposive process was undertaken iteratively and regularly throughout the research study, and at least annually during 2015-2022, to ensure that contemporary literature and developments in theory and practice were identified (Green and Thorogood 2018). The purposive sampling of literature enabled the selection of relevant papers and ensured a consistent iterative process throughout the study (Dixon-Woods et al. 2006, Green and Thorogood 2018). The wide range of reading and evaluation of literature facilitated more creative and analytical thinking about the core concepts of the study and allowed me to gain new insights and a more informed understanding of the literature (Green and Thorogood 2018).

This process made the literature searching process less replicable but provides an authentic and auditable account. Whittemore and Knaf (2005) suggest that a reproducible search process is not essential in an integrative narrative review, due to the interpretative nature of study. The purposive selection of literature also made the charting of literature 'hits' redundant and the counting of literature sources impossible. It was considered more important to regularly seek and review relevant sources than to undertake structured literature searches which is more aligned methodologically to systematic reviews (Greenhalgh et al. 2018, Green and Thorogood 2018, Dixon-Woods et al. 2006). However, towards the end of the study in 2022, following data analysis, a further structured electronic database search was undertaken to ensure a contemporaneous capturing of the literature.

Further electronic searches of 'care' and 'care AND older AND people' produced a plethora of hits that despite applying the same inclusion and exclusion criteria as identified in table 2.1, became unmanageable to review. The initial search had produced manageable numbers of literature in 2015, yet the subsequent search process in 2022 was a replica of the first and the audit trail was followed. It is assumed that this is due to a wider evidence base of literature becoming available and the development of the online searching systems as well as the growing emergence of the concept of coproduction in care literature and in research (Green and Thorogood 2018, Redman et al. 2021, SCIE 2022).

Revised search criteria were therefore employed in the 2022 structured and systematic search of the literature, which remained congruent to the nature of the enquiry, using the same electronic databases that were accessed in 2015, to focus the search strategy. Using the conceptual frameworks that underpin the study in a more refined combination elicited new and emerging literature relating to all the concepts, drawing them together. The refined search terms used were:

- Care AND older AND people AND choice
- Older AND people AND coproduction AND district AND nurs*
- Care AND older AND people AND choice AND coproduction

Table 2.3 provides an illustration of the yield from the refined search terms towards the end of the research study in summer 2022. This strategy produced more manageable data, although the search terms of 'care' and 'care AND older AND people' still yielded hits in the thousands, therefore these search terms were abandoned. More specific search terms of 'care AND older AND people AND choice' produced 171 hits, whereas 'older AND people AND coproduction AND district AND nurs*' scored only 29. Omitting 'ditrict AND nurs*' from this search term yielded 102 hits. Some of the searches produced hits of the same literature from the earlier searches of electronic databases and previous search terms, or that had been sourced through the organic and purposive sampling approach to literature searching.

Only two quantitative studies were identified in this search and a predominance of qualitative evidence may be explained by the enquiry into the experiences of care for older people and district nurses (Whittemore and Knafelz 2005).

TABLE 2.3 RESULTS FROM FINAL STRUCTURED ELECTRONIC DATABASE SEARCH IN 2022

Search Term	Hits (with inclusion and exclusion criteria applied)	Number discarded (based on title)	Number discarded (based on abstract or repeat)	Selected
Care	2215	Search abandoned	N/A	N/A
Care AND older AND people	3772	Search abandoned	N/A	N/A
Care AND older AND people AND choice	171	49	24	12
Older AND people AND coproduction AND district AND nurses*	29	18	4	7
Care AND older AND people AND choice AND coproduction	102	91	64	21
TOTAL				40

Sanders et al. (2018) refer to saturation in primary qualitative research, Lowe et al. (2018) suggest the same principle of saturation can apply to literature reviews and this has been adopted here. Arguably data saturation may be subjective in qualitative research and can risk limiting the inclusion of some evidence (Sanders et al. 2018, Greenhalgh et al. 2018). Due to the integrative narrative and iterative approach to literature searching employed, new evidence was captured and integrated into the review throughout, ensuring a contemporaneous account of available literature (Greenhalgh et al. 2018). Literature searching reached a natural saturation point within the time frame of the PhD study. Data in the form of literature then required critical evaluation to establish quality (Torroco 2005).

2.4 Critical appraisal of the literature

Once the literature had been selected it was critically appraised. Booth et al. (2016) suggest that the multiple perspectives, approaches and methods in research can make the assessment of rigour and quality in literature difficult. Baker (2014) suggests that use of a critical appraisal framework can help examine the relevance and strength to the area under exploration as well as the quality of the literature. Quantitative research requires validity and reliability for quality whereas qualitative research demonstrates trustworthiness through dependability, credibility and transferability (Aveyard 2018, Mason 2002), therefore different appraisal frameworks were used (Baker 2014).

The online Critical Appraisal Skills Programme (CASP) (2022) offer a selection of critiquing tools for a variety of research methods and approaches, ensuring literature is critiqued and evaluated in a standardised way. In a critical analysis of research critiquing frameworks Hannes Lockwood and Pearson (2010) found that the CASP tool for qualitative research lacked interpretative validity. Interpretative validity is the credibility and accuracy of the research under review. The qualitative CASP (2022a) tool was also found to lack an analysis of the theoretical framework used and evaluation of the outcomes. Hannes Lockwood and Pearson (2010) suggest that the Evaluation Tool for Qualitative Studies (ETQS) (Long and Godfrey 2004) provides a constructive evaluation for health and social care research specifically. The EQTS (Long and Godfrey 2004) in Hannes Lockwood and Pearson's (2010) analysis was found to integrate all qualitative research approaches and allow for conceptual judgement to be included in the critical appraisal and was therefore selected for use.

However, CASP (2022a) offers a variety of eight critical appraisal tools based on specific quantitative approaches to ensure that validity and risk have been adequately addressed (Burls 2014). Therefore, the relevant CASP (2022a) tools were adopted for use in appraising quantitative literature as appropriate.

Grey literature is that which has not been subject to peer review but may be researched based. Adams, Smart and Sigismund Huff (2017) identify that grey literature can add positive contributions to inquiry and practice in healthcare. Aveyard (2018) suggests that the tool used should be specific for the literature being reviewed, however, the EQTS framework is also applicable to grey literature and therefore was selected for use. Cottrell (2005) identified a tool for non-research-based literature, and this was utilised for this study for opinion and review pieces that were included. Similarly, the AGREE II (Agree Trust 2017) has been developed to critically appraise guidelines, useful for practice-based research, and this tool has been used where indicated in this study.

2.5 Synthesising the literature

The literature was analytically synthesised through a process used for analysing primary qualitative data (Green and Thorogood 2018). A thematic analysis approach to analysing and synthesising the literature was undertaken. Braun and Clarke (2012) suggest that thematic analysis is a useful and appropriate method with which to seek understandings of experiences, thoughts and behaviours across a data set. Therefore, thematic analysis had congruence in seeking to explore the nature of coproduced care between older people and district nurses in the literature.

A thematic analysis approach is a practical and step-based process (Kiger and Varipo 2020, Braun and Clarke 2006) in which categories and emerging themes are identified within the literature. Themes are interpreted patterned responses that are derived from data, with which to inform the research questions or concepts under exploration (Kiger and Varipo 2020). Thematic analysis of the literature was undertaken in a deductive approach, using pre-existing concepts to identify themes of interest as this was useful in focussing on aspects within the literature that had relevance to the wider enquiry (Braun and Clarke 2006). This approach also allowed for themes to emerge that were not expected or included in the conceptual framework that underpinned this literature review, such as identity and materials and place, thus providing new insights that informed the wider study.

Table 3.4 illustrates the process undertaken of thematic analysis using Braun and Clarke's (2006) step by step approach.

TABLE 2.4 THEMATIC ANALYSIS PROCESS OF THE LITERATURE REVIEW
(Braun and Clarke 2006)

Process of thematic analysis of the literature	
Step 1 Familiarisation with data	The literature was actively read and reread, with notes made in the margins and text highlighted with areas of interest or significance.
Step 2 Generating initial codes	Categories were identified within the literature which helped to organise the literature. Once a set of categories was established, these were applied to all the literature, where appropriate (using notes and coloured highlighter). Categories were then clustered together which had similar meaning or were contextually related.
Step 3 Searching for themes	Noticing themes that were frequently mentioned in the literature. Categories and literature were explored for broader significant themes that provided insight in to core concepts of study
Step 4 Review the themes	Themes were reviewed to ensure congruence with the enquiry. Categories and themes were reviewed to ensure clarity. Ensuring each theme was adequately supported by literature.
Step 5 Define and name the themes	Assigning names to the themes that reflect meaning, reviewing for overlap and subthemes emerging
Step 6 Produce the report	The literature review as presented in this work.

The themes that have emerged form an iterative review of health, social and care literature using key words relevant to the inquiry of this study are personalisation, choice and control, care relationships, older people and identity, materials and place and the coproduction of care at home.

Using the thematic analysis approach as identified by Braun and Clarke (2006) allowed for an opportunity to reinterpret and reconnect elements within the literature of the coproduction of care between older people and district nurses, enabling it to be reframed and seen through a different lens (Kiger and Varipo 2020). Exploration of the emergent themes from the

literature in the following discussion provide a wider understanding of the core issues in care, choice and the coproduction of care for older people with district nurses, when home is the place of care. The literature that has been reviewed here will be referred to again to inform the discussion of the findings of this research. The findings from the literature review are now presented in the themes that were identified.

2.6 Personalisation, choice, and control

Personalisation is a concept that considers the person as central to care design and delivery. Personalisation is a requirement of the Care Act (Department of Health 2014) and the Health and Care Bill (UK Parliament 2021), in which personalisation is identified as the choice and control over aspects of daily life when in the receipt of care. As such, personalisation, choice and control remain key elements of care policy and delivery for older people (Baxter et al. 2019).

The Department of Health (2008) defined personalisation as the way services are designed to meet the needs and preferences of people who use them, with the individual having the ability to shape services to meet their own needs and fit with their own individual lives. This implies that the person at the centre of care can identify and interpret their own needs and then go on to identify and design how these should be met (Lloyd 2010). Mol's (2008) seminal work in choice in care identifies this is not always the case. This is supported by Velzke's (2017) qualitative Scottish study which explored older people's experiences of choice in daily care needs. Velzke's (2017) study was part of wider research exploring how older people make decisions about care. It is not clear if these findings are from a specific study or secondary to the larger work. Velzke's (2017) participants were professionals and not older people limiting the credibility in reporting older people's experiences.

Needham (2011) suggests that personalisation is a way of aligning services with the preferences of those who use them, rather than a top-down approach to service design and delivery. Needham's (2011) understanding of personalisation considers the fundamental need to ensure that every person

has the access to the information and resources required to design and deliver care services. Coproduction builds on and has become an essential component of personalisation, as it incorporates equal partnerships in the personalised approach of service design and delivery (SCIE 2022).

The personalisation agenda for older people in community settings has placed emphasis on personal or individual budgets and direct payments (Barnes 2011, Miller and Barrie 2020). Personal budgets are direct payments to the person who then purchases care that is individualised and personal to them (Miller and Barrie 2020). Personal budgets form part of the marketization of social care but offer an opportunity for the coproduction of personalised care services for older people on an individual basis (Flemig and Osborne 2019). This form of personalisation highlights an example of the difference of individual and collective coproduction. Collective coproduction differs as considers groups of people working together with professionals on service design and community projects (SCIE 2022).

Needham et al. (2018) in a realist synthesis literature review, produced as part of a larger study looking at market shaping and personalisation in the UK since The Care Act (2014), identified that personalisation in the form of individual budgets and direct payments can only become a reality when there is a responsive market of providers. Needham et al. (2018) identify that in practice there are delays to accessing care, increased bureaucracy, restrictions, and confusion in the use of individual and personal budgets. This is supported by Flemig et al.'s (2019) systematic review of funding options for individualised care in Ireland. Conversely, Rodrigues and Glendinning (2015) suggest that older people with direct payments experienced flexibility and control and satisfaction in their experiences of care. These findings are based on a review of data from two empirical studies examining managed personal budgets and direct payments. However, these studies are not explicitly cited in the work, nor is how the raw data was identified, limiting credibility of this claim.

The Committee of Public Accounts (CPA) (House of Commons 2016) identified that despite the personalisation agenda in England, not every

person with a personal budget had choice and control over the services they received. Needham et al. (2018) suggest that personalisation depends on something more than the basic standard of care available being on offer and that the same service using different payment options does not equate to personalisation. The CPA (House of Commons 2016) identified an ambiguity in how personalised budgets improved care outcomes for older people, yet the Department of Health and Social Care (2022) suggest that older people considered the buying in of a personal assistant improved outcomes in care. Needham et al. (2018) and O'Rourke (2016) identify that purchasing personal assistance has the added complexity of employment law requirements and risks of safeguarding for both the older person and the personal assistant.

Davey (2020) acknowledges that take up of individual budgets by older people has been slow. McCaffrey et al. (2015) undertook a qualitative Australian study to identify what the important characteristics were for older people in consumer directed care, identifying personal budgets and direct payments were not the preference of older people. McCaffrey et al.'s (2015) work was undertaken to inform the first discrete choice experiment (DCE) in older people's care. A definition of a DCE was not provided nor was the value this method would add for older people's care. With no discussion on DCE it is difficult to assess if the methods employed are congruent with the research approach. Alakeson and Rumbold's (2013) literature review suggests that personal budgets and direct payments for older people in healthcare are service led. They identified that decisions on amounts, availability, for what conditions and for whom this can be available were made by Clinical Commissioning Groups, risking inequity in provision. Alakeson's (2016) presentation of individual budgets in mental health build on the findings of MIND's (2012) large online survey that personal budgets could be dominated by providers and professionals when there was a lack of shared value in how monies should be used, or if there was a professionally identified risk to the person. These findings indicate a paternalistic experience of care for people with individual budgets, dissonant to the principle of personalised care with which to increase personal responsibility

and independence in living well for older people (Aranda 2018). The absence or lack of service user perspectives in the development and implementation of individual budgets could contribute to the low take up by older people.

Kendall and Reid's (2017) literature review on person-centred care for older people transitioning from acute to long term care in Australia found that some older people disguised their need for care through a fear of being directed towards residential care by professionals. This suggests a lack of trust and partnership in care relationships and in decision-making about care, required for coproduction. Barnes (2012) suggests that assessment of need led by a professional that does not include the perspective is infused with professional judgement and power, dissonant to the principles of equality and equity proposed for the coproduction of care (SCIE 2022).

Wada (2016) compared the experiences of older people exercising choice in Japan and in England and suggests that in England masking care needs can result in social isolation and leave older people vulnerable and at risk. The British Geriatric Society (2015) identified that older people living with frailty in the UK conceal deficits in ability and wellbeing until crisis. Wada (2016) suggests that some older people in England may understand their needs differently to how they may be perceived by professionals and may be disempowered to assert their perspective. Wada's (2016) empirical study provides data from interviews in each country, identifying that choice for older people in long-term care has increasing emphasis in both countries. However, there is a higher demographic of older people in Japan and healthcare is funded by a social security system and not tax (Tikkanen et al. 2020). Japan has traditionally left care of older people to families rather than the state, only developing an insurance system for older people's long-term care in 2000 (Curry et al. 2018).

Older people require information to make decisions regarding care (Baxter et al. 2019). McCaffrey et al. (2015) identified a lack of information available to older people reduced their ability to participate in personalised care. Hasler and Marshall's (2013) report on increasing the use of direct payments in the

UK identified that a lack of information and challenges in accessing information created barriers and resulted in a negative experience of personal budgets for older people. These findings have congruence with Davidson et al.'s (2021) systematic review of older people's experiences of integrated care, where a lack of information reduced person-centred care. A lack of information can impede decision-making for any aspect of healthcare for older people, and these findings have transferability when considering coproduction and participatory models of care delivery (Strokosch and Osborne 2020).

Glendinning et al. (2008) and McCaffrey et al. (2015) identify that a lack of information for older people can result in a higher dependence and need for the support in making decisions in the context of personalised care. Baxter et al. (2019) explored older people's experiences of choice and control in social care when self-funding. This qualitative study used data from interviews with older people and what the authors describe as complimentary interviews with social care professionals. The analysis appears limited as complimentary interviews are not given any explanation and the aim of the study was to gain the experiences of older people. Although most older people respondents were in care homes, some participants were in receipt of domiciliary care, making the findings transferable to this work. Baxter et al. (2019) suggest that older people received a lack of personalised information and support in securing care. As information was generic older people had to rely on social capital for decision making in care. A lack of personalised information and professional knowledge sharing is counterintuitive to principles of shared decision-making, person-centred care and coproduction (Alakeson et al. 2013).

Raibee et al. (2016) suggest that social care professionals can feel ill-equipped to support older people through a lack of training in facilitating the personalisation agenda. Council workers who supported older people with direct payments reported a lack of training, and that what training was provided did not reflect or consider the needs or perspectives of older people. In addition, support workers reported their experiences of feeling

unclear on how to facilitate a user led the personalisation process. This resulted in council support workers adopting a more service led approach. Baxter et al. (2019) suggest that professionals were conscious not to overload older people with information, or to make recommendations, so not to influence decision making. Rostoft et al.'s (2020) study of shared decision-making suggests that unless shared decision making is done well in a personalised approach to care, it can make older people feel unsafe in the receipt of care. Professional unease and a hesitancy in sharing power in collaborative decision making was found to impair opportunities for the coproduction of heart failure services for older people in Sweden in Suutari et al.'s (2021) Experience Based Co-Design research.

In evaluating coproduction through time banking, Naughton-Doe et al. (2020) identified that managing risk was problematic for coproduction. Safeguarding and governance were hard to ensure in the mutual exchange of assets and strengths in time banking initiatives between members of a community. In foundational work on coproducing in public service management, Bovaird (2007) suggests that professionals can experience a challenge in relinquishing an expert role due to perceived risk. Salisbury's (2019) editorial on managing risk for older people as a General Practitioner, highlights that a balance of risk and autonomy for older people is required for personalised care, and that older people can make choices that feel risky to others, should they have the capacity to do so.

Petersen and Brodin (2021) suggest that introducing choice in the context of home care assumes that choice equates with good care. Needham et al. (2018), Kendall and Reid (2017) and Raibee et al. (2016) concur in their findings that a lack of available services to meet personal choices and preferences for older people makes choice and control in care rhetoric. O'Rourke (2016) and Rabiee et al. (2016) argue that a lack of flexibility in social care provision results in older people not being aware of when a care interaction would occur or who would be delivering it. Velzke (2017) suggests that staff shortages and service capacity disrupt choice for older people. Needham et al.'s (2018) realist synthesis reported that there was a lack of

assurance that personalised care could occur when providers were working to reduce costs coupled with poor recruitment and retention of staff. Lloyd (2010) provides an analysis of the personalisation agenda in the context of older people's care, applying a feminist care ethics perspective. Lloyd (2010) suggests that impediments in choice diminishes the opportunities for personalised care. This is supported by Barnes (2012) who argues in her analysis of care, that a lack of choice for older people risks introducing ageism and inequity in care as older people may become marginalised and disempowered.

Moran et al. (2012) reported on part of a multi-method study reviewing the use of individual budgets in England. The qualitative analysis of semi-structured interviews with social workers suggests that older people could only purchase personal care. Using monies for any care needs that older people self-identified, such as a hairdresser, was not authorised. This highlights dissonance in the perception of care need and limited choice in personalised care. Moran's et al. (2012) findings illuminate how choice and control in care risk becoming policy rhetoric when they are not realised in practice. Coproduction requires shared understandings and goals in care and an equality in power and decision-making for personalised care (SCIE 2022). Moran et al.'s (2012) evidence suggests this was not a reality. Petersen and Brodin (2021) argue in a Swedish discourse analysis of the constituents of home care, that a lack of equality in home care provision can occur when older people top up individual budgets to procure care, when others cannot, due to lack of resources. Baxter et al. (2019) also suggest inequity as self-funding older people were found to have more choice and control in care than council funded individual budget holders.

Rabiee et al. (2016), supported by O'Rourke's (2016) case studies of individual budgets being used in practice, suggest that older people were more likely to choose services and providers they were more familiar with, such as purchasing care from family or friends or carers who they knew and trusted. Petersen and Brodin (2021) suggest care procurement for older people in Norway was limited to selecting a care provider, and that older

people did not change providers. Raibee et al.'s (2016) and Velzke's (2017) highlight that in England purchasing care requires approval by fund holders, which could further limit choice if there is difference in the decision making as to where and how monies should be used. Petersen and Brodin (2021) concur that the regulation of care work for home care limits the discretion and capacity of carers to respond to the individual preferences of older people. Regulation of care work, although to protect the rights and wellbeing of all in the care relationship, can introduce discord between ideals of choice and the autonomy and individualisation for older people. McCaffrey et al. (2015) found such dissonance results in a menu driven approach to service provision rather than free choice.

Wilberforce et al. (2017) undertook a concept synthesis literature review of person-centred care for community dwelling older people. Their findings suggest that choice and control through the consumer approach of individual budgets may impair care relationships due to the transactional nature of interactions. The authors advocate for a more relational and inclusive philosophy for person-centred care. Damant et al. (2022) argue in their review of Care Quality Commission reports, that personalised care in residential care for older people is based on principles of ensuring care relationships that value personal identity and allow for empowerment in decision making. Their findings suggest that the reality of this for older people is dependent on care home staff. This may explain why some older people prefer to remain at home for care, resist residential care and can feel forced into making the decision to move to long-term care (Nord 2013, Milligan 2009, Roin 2015, Board and McCormack 2018). Wilberforce et al. (2017) suggest that personalised care for older people is achieved through an understanding of identity in care relationships and through supported decision making, suggesting that older people may benefit from person-centred care in different ways at different times due to the unique and individual nature of care requirements.

Raibee's (2013) longitudinal UK study exploring independence and choice for older and disabled people, found that care at home could constrain

choice for older people due to physical and environmental barriers. Living with disability and older age are two separate experiences (Shakespeare 2018). This study's conclusions lack some credibility in the absence of the acknowledgement of this. Seminal work by Mol (2008) in diabetes care in the Netherlands suggests that choices for older people are continually renegotiated as situations fluctuate due to health and need. This finding is supported by Glendinning (2008) and Rodrigues and Glendinning (2015) who suggest that older people prefer fewer options in care choices and make fewer active choices due to physical health, often requiring support. Needham et al. (2018) argue limited resources place a constraint on choices in care, which Hicks et al. (2012) consider to be pseudo-choice and misdirection of policy rhetoric. Mol (2008) argues that choice in care does not necessarily equate to person-centred care, and that it is the experience of care that is important to older people. This is supported by Duner, Bjälkebring and Johansson (2018) who suggest that when choice is based on which service provider to procure, older people find little value in this. These findings suggest that older people may experience 'choice fatigue' in personalisation agenda especially when experiencing fluctuating ill health and frailty. However, Duner et al.'s (2018) interview data with older people and care staff in Sweden suggest that older people wish to maintain control and choice when the need for care arises. Their study is strengthened by the inclusion of observational data of older people and staff exploring choices in and procuring care at home.

Decision making for older people can be influenced by families, particularly in the choice of place of care (Hicks et al. 2012, Wada 2016, Soderberg 2020). Older people can be guided by their family members as they did not wish to be burdensome (Wada 2016). Soderberg's (2020) study explored care workers perceptions of how older people made decisions on where to live. Soderberg (2020) suggests that families can push older people in to making decisions in care. Wada's (2016) suggests a democracy and equitable partnership in a relational approach to making choices regarding care, in which both the carer and the care recipient discuss their needs in terms of the care process. Soderberg (2020) in a Swedish study of home help

workers, asserts that remaining at home is supported for older people through a 'making it work' approach. This is suggestive of coproduction, where working together on shared goals facilitates a person-centred approach. Soderberg (2020) also suggests that change for older people in the place of care is promoted through positive reinforcement, which is arguably paternalistic and is incongruent with choice, autonomy, and freedom.

Nagington et al. (2013) and Velzke (2017) assert that the influence of professionals in undertaking choices for care and place of care were not always trusted or sought by older people, due to a perceived focus on resource allocation. This is concerning for a choice-based healthcare system as professionals are identified in policy to play a key role in supporting people in making care choices (Rabiee 2013, Rosstoft et al. 2021). However, Reed et al. (2017) in developing a practice model for end-of-life care by district nurses in Australia, identified that advocacy supported choice for older people.

Although now dated, Hicks et al.'s (2012) case study as part of a larger Canadian ethnographic study is important to consider. Using discourse analysis, the authors suggest a dissonance in the data sourced from field notes and interviews, in the experience of choice in healthcare decision making on the part of the older person and how this was described by the healthcare professionals. Hicks et al. (2012) suggest that the language of choice used by healthcare professionals was infused with power and control in the case study example. Consequently, the older person reporting being forced into making a choice which resulted in having to leave her home.

O'Neill et al.'s (2020) grounded theory study exploring the experiences of older people moving into residential care, suggests that a lack of involvement, autonomy and control results in older people feeling forced into decisions to move from home into residential care. They consider that older people experience anger, depression, and anxiety through coercive experiences. Baxter and Glendinning's (2011) longitudinal study of how older people find and use information for care, concurs, suggesting that place of

care was selected based on resourcing, the degree of dependency and the social connections older people had available. Raibee (2013) argues that choices made when dependency due to ill health were perceived as negative choices, through a lack of freedom and autonomy and control. O'Neill et al. (2020) suggest that nurses have a pivotal role for supporting person centred choice and decision making, advocating for a standardised approach to this. This lacks congruence with Wilberforce et al. (2017) and Damant et al.'s (2022) suggestion of a relational person-centeredness being unique for each older person at different times.

The literature suggests that personalisation of care has been centred on individual budgets to embed choice and control in health and social care. Personalisation for older people was synonymous with choice, however, choice in the daily practices of care for older people with district nurses has not emerged in the literature. Personalisation in the literature reviewed did not consider a concept of a coproduction of care, which warrants further investigation. How older people experience choice, information, and power dynamics in care at home and how this can inform coproductive practices of care is important to understand to inform care practices for older people.

2.7 Care relationships

Buscher et al.'s (2011) German undertook a grounded theory study explored the relationship between nurses and family care givers. They interviewed 57 family carers and 37 nurses, the lack of balance in the grouping of respondents could sway the findings, accentuating the voices of family carers. German care for older people relies on family support to compliment care systems (Curry et al. 2019). Buscher et al. (2011) suggest that the quality of the caring relationship is of particular significance for the cared for as they are unable to leave the caring relationship. Professionals can opt in and out of care relationships, which although may be enduring over long periods of time, are not constant and do not have the added complexity of emotional attachment (Phillips 2007, Buscher et al. 2011).

Maybin et al. (2016) consider 'good' caring relationships in district nursing practice and argue that these are central to quality care for older people and suggests that a relational whole person approach is required. Lagerin et al.'s (2016) Swedish study exploring district nurse perspectives of preventative health visits with older people consider that trust was essential for a good caring relationship. Care at home was found to enhance trust, however barriers to trust were perceived as a lack of nursing time. Nicholson et al. (2013) undertook a now dated narrative analysis and observational study to explore the experiences of older people living at home with frailty. The study has depth as it included unstructured interviews with fifteen older people over seventeen months although there was a lack of structure in terms of how many times each participant was interviewed. The research methods appear complicated and although published in a nursing journal, focus on psychoanalysis without a clear justification. However, Nicholson et al. (2013) elicit the importance care relationships had for older people living at home in managing the changing circumstances they faced in experiencing frailty. Zotterman et al. (2014) used focus groups to examine district nurse views on quality in care relationships in Sweden. This work was part of a larger study exploring the quality of district nursing care in Sweden. They suggest characteristics of communication, attentiveness and time were considered essential in a patient focussed approach. Similar features of respect, competence, and responsiveness and in knowing the older person were reported elsewhere in the literature (Haycock-Stuart, Jarvis and Daniel 2008, Baxter and Glendinning 2011, Waterworth et al. 2014, O'Rourke 2016).

O'Rourke (2016) discusses how care relationships for older people are not always entered into through choice but occur through dependency and need. Care relationships could result in some form of intimacy through carer involvement in the private life of older people, and through intimacy in the care of the body. Hughes and Burch's (2020) narrative analysis support concurs and discusses the challenges older people faced as they began care relationships. They suggest that for older people, strong relationships developed over time with formal carers promoted autonomy at home.

Zotterman et al. (2014) highlight that for an effective caring relationship to occur, attention to the person, a positive attitude, and a building of trust within the first encounter was required by the professional. This could lead to the person feeling cared for and have a positive impact on the experience of care. Stevens et al. (2022) suggest that the attitudes and approach of the district nurse are fundamental to forming effective trusting relationships with older people at home. Buscher et al. (2011) argue that openness, reliability, keeping promises and listening were central for a quality relationship between home carers and nurses. These characteristics appear transferable to any care relationship.

Effective caring relationships based on trust and respect were found to increase self-confidence and allowed for people to feel empowered experiences in the adapted experience based co-design study in mental health service design by Palmer et al. (2018). Abma et al. (2012) suggest that identify and dignity are integral to autonomy in a narrative case study in older people's care in the Netherlands. Although no clear methodology is stated, they discuss autonomy to be more than making decisions and is concerned with self-worth and self-development for older people. Stevens et al. (2022) explored older people's experiences of dignity with district nurses in an ethnographic study. They suggest that dignity occurs for older people in the mundane everyday encounters with district nurses, as this is when they come together. Stevens et al. (2022) argue that dignity is achieved when there is a negotiated understanding of care practices between older people and district nurses, and that dignity is created by the relationships that are formed, rather than the practice of clinical interventions. Stevens et al. (2022) do not link dignity as an experience of coproduced care for older people, however, older people actively contributed to the forming of relationships. The study highlights a tacit nature of the everyday practices of care that were important to the older people who participated.

O'Rourke (2016) discussed heteronormative assumptions made by carers could potentially discriminate against lesbian, gay, bisexual, and transgender older people. A participant shares the experiences and the challenges he

faced in accessing personalised care that allowed for his expression of sexuality without judgement in the care relationship. The work is part of a larger doctoral study, and although the inclusion of examples of transcript excerpts powerfully demonstrate experience, there is no clear methodology identified for the research. Kendall and Reid (2017) consider how identity related needs of older people are constrained by social and organisational discourses, social norms, and the cultural practices of healthcare. This suggests that class, race, and disability may also be discriminated against by assumptions made in the procurement of care at home. Kendall and Reid (2017) argue that there is scope for healthcare professionals to address this by creating the opportunity for older people to construct their own narrative around identity and need. This discussion highlights how a respect for the social identity of an older person in a care relationship can offer the opportunity for coproduction, through mutual trust and respect.

Knowing the patient was key in a care relationship between older people and home care nurses in Waterworth et al.'s (2014) qualitative exploratory study of patterns of nursing work with older people at home in New Zealand. Nurses described knowing the person as an individual as a basis on which to make decisions about care. Lepore et al. (2018) undertook a literature review on person-centred care planning in nursing homes and suggest knowing older people is essential for this to become a reality. In a domiciliary care setting Waterworth et al. (2014) argue that it is the home environment that enables district nurses to get to know and understand older people.

Haycock-Stuart et al. (2008) undertook focus groups with district nurses and managers to explore district nursing workloads in Scotland. They suggest that knowing the patient was central to the role of the district nurse, with family relationships lasting for generations. However, this work is dated and working systems have been subject to much change in the past twelve years in the UK (Maniatoplous et al. 2020). Lagerin, Tornkvist and Hylander (2016) suggest the district nursing role in Sweden is to get to know patients within their care, and to build trustful relationships. Haycock-Stuart et al. (2008) suggest that when nurses did not know the older person, this resulted in less

job satisfaction. Waterworth et al. (2014) contend that relationship formation for nurses was limited to working with other healthcare professionals rather than with older people. Although the literature did not define 'knowing' the patient, the concept of knowing older people was significant and illuminates the need to be known in care relationships.

Zotterman et al. (2014) suggest a sense of knowing was established through talking, attentiveness, and shared understanding. Kendall and Reid (2017) argue that when older people were given opportunity to talk and share life stories when transitioning from acute to residential care, this provided a foundation for social needs to be met as trust was built. Abma et al. (2012) suggest that story telling allows for an older person to feel cared for, as social and personal contact can enhance feelings of well-being. Palmer et al. (2018) contend that story telling was significant as it enabled an opportunity for shared experiences, in which knowledge sharing allows for new understandings. Palmer et al. (2018) consider that story sharing in co-productive approaches will not automatically make relationships equal or shift power imbalances for a sense of a shared experience, but that it is through listening that a recognition of the importance of each person's experience is achieved. Palmer et al.'s (2018) work is the first use of an adapted evidence-based co-design methodology, limiting its credibility as a research design.

Nicholson et al. (2014) and Soderberg (2020) suggest that social connections and social interactions are vital in maintaining wellbeing for older people at home. Heppenstall et al.'s (2014) qualitative analysis in a mixed methods study exploring decision making by older adults when moving to care homes suggests that social and reciprocal connections with neighbours and friends allowed for older people to remain living at home when experiencing the need for care. Lucas's (2013) mixed methods qualitative data highlighted that older people viewed their district nurses as the most utilised source of social support, other than neighbours. The district nurses in Lucas's (2013) study did not recognise this and did not consider the implications that discharge from the caseload would have for older people.

The older people reported the thought of being discharged was distressing, as a social connection would be lost.

Nagington et al.'s (2013) post structural discourse analysis argues that busyness in district nursing practice can be a preclusion to quality in care. Nagington et al. (2013) suggest that busyness prevents older people from participating in care or asking questions. Soderberg (2020) suggests that time pressures in care relationships impedes on the ability of older people to identify care, the autonomy and discretion of carers to give it, and that time pressures can make care task focussed. Nagington et al. (2013) consider task orientated care to be of a pseudo-quality. Kendall and Reid (2017) concur suggesting that when care became influenced by time it was rushed, leaving older people feeling uninvolved. Runciman's (2014) case study research found that district nurses needed time to be able to provide social contact and develop relationships for older people. Stevens et al. (2022) suggest that time is required for dignity to be achieved for older people in receipt of care from district nurses, but that time is not scheduled in to working practices. This discussion illuminates that time pressures in care practices between older people and district nurses can limit participatory approaches to care delivery and opportunities for the coproduction of care can be missed.

O'Neill et al. (2020) suggest that for older people a lack of involvement in care can create barriers in care relationships. Kendall and Reid (2017) assert that when nurses have a superficial engagement in care relationships that this has potential for poor outcomes for older people as needs may not be identified or attended to. Stevens et al. (2022) suggest that a lack of a working relationship with district nurses can detract from a sense of wellbeing for older people. Waterworth et al.'s (2014) suggest that workloads, poor communication, a reduction in face-to-face contact and a lack of continuity are barriers to effective care relationships in working with older people. Nicholson et al. (2014) and Stevens et al. (2022) suggest that older people found that the unpredictability of having outsiders in the home and the lack of autonomy in the inflexibility of formal care could be disruptive. Older people participants in Nicholson et al.'s (2014) and Stevens et al.'s

(2022) work contributed these factors as a barrier to engaging in care relationships when home was the place of care.

Baxter and Glendinning's (2010) longitudinal study of choice in support services suggests that when older and disabled people participants perceived that their social workers were more concerned with budgets than individual care needs, this could create a lack of trust and become a barrier to working together. This is reflective of Wada's (2016) claim that barriers occur in caring relationships when health professionals were perceived to have a more rational than relational lens in the care for older people. Zotterman et al. (2014) suggest that poor experiences in the care relationships may not be consistently reported by older people in research data due to fear of implications this could have for their care.

Participants in Nagington et al.'s (2013) work perceived the district nurse as a friend in the caring relationship. McGarry's (2009) ethnographic study examining the relationship between older people and district nurses suggests that older people and district nurses understand the care relationship as one of friendship. Older people in Lucas's (2013) study considered nurses as friends, whereas the nurses did not see this within their professional role. O'Rourke (2016) suggests that friendship is a way of understanding care relationships for older people, in which they can feel understood and with someone to rely on. This is reflective of the experiences of the older people in Lucas's (2013) study. Boundaries in care relationships between the older people and district nurses became blurred due to the intimate and personal nature of a caring relationship in the home over extended periods of time.

Nagington et al. (2013) suggest that when care centred on task there was no sense of friendship for older people. However, an understanding of friendship developed for older people over time with district nurses, in which the district nurse became a friend but retained the identity as nurse. Lagerin et al. (2016) identify that there is a balance of professional and personal identities within nurse patient relationships in which limits are set to maintain integrity, and professional boundaries, congruent with the Nursing and Midwifery

Council's professional code of conduct for nurses and midwives (NMC 2018). O'Rourke (2016) identified that carers can begin to participate in the care relationship over the terms of the employment or contract which can have potential implications of exploitation. O'Rourke (2016) considers that reciprocity can extend the care relationship, where the needs of the carer and their sense of self are validated, making the care relationship mutually beneficial (Sandu et al. 2015).

Relationships are central to nursing (Sitzman and Watson 2014), and to coproduction (SCIE 2022). Person-centred care for older people is developed on relationships that recognise and value personhood so that care can be tailored to individual needs (McCormack and McCance 2017). However, Lynch et al. (2017) suggest that therapeutic relationships are so intrinsic to healthcare practices that they are not given consideration. Morrison and Kovol's (2014) Canadian grounded theory study explored contributory factors to compassion fatigue with nine hospital nurses. The findings suggest that increased administration impacted on their ability to deliver face to face care with their patients. Nurses reported patient care was diluted with paperwork and other tasks. This is echoed by Runciman's (2014) case study of community nursing which argues that the increasing complexity and demanding nature of district nursing work leaves limited opportunities for direct patient contact and hands on care. Haycock-Stuart et al. (2008) and Runciman (2014) discuss that although identified as a nursing priority, a lack face-to-face contact may result in cues being missed that could affect the quality of care. Lytle and Ryan's (2010) literature review of older people's participation in care activities suggests senior nurses no longer undertake the face-to-face delivery of care. Kendall and Reid (2017) argue that as nurses are undertaking assessments and delegating the care on to others, this leaves less opportunity for holistic care and relationship building.

Advances in technology in the home can result in a reduced need for face-to-face care between older people and district nurses, increasing the risk of social isolation for older people. Milligan et al. (2011) draw on data from two

European studies, one consisting of focus groups with frail older people, and the other ethnographic observations and interviews from older people using telehealth at home. Focussing on data related to the UK they suggest that care is becoming more virtual and from a distance for older people living at home. Fine (2014) argues in his critique of policy on care for ageing, that social contact is essential for the interactive relational process of care to occur. Nakrem et al.'s (2018) qualitative analysis of healthcare professional's relationships with patients, when using digital medicine dispensers suggests that technology in the home is essential for effective finite resource management. Milligan et al. (2011) suggest that use of telecare and technology should be negotiated in care for older people, as an adjunct to direct patient care, rather than as a replacement of face-to-face contact between older people and nurses. Care for older people at home is complex with multi factorial issues to consider for participatory, inclusive, and person-centred approaches to care. This highlights the implications for the opportunity for the coproduction of care at home, as a principle of coproduction is working together.

Glendinning (2008) discusses how processes of negotiation were used in the planning and delivery of care for older people. Zotterman et al. (2014) consider how district nurses act as a negotiator or advocate for older people, as well as undertaking practices of negotiation in the process of care. McGarry's (2008) suggests that negotiation is a pivotal part of the nurse patient relationship. McGarry's (2008) findings illustrate how district nurses aim to deliver evidence-based care interventions whilst negotiating what is acceptable and tolerable for older people in their everyday lives at home. Alftberg's (2021) findings from the ethnographic study of medicines management in Swedish care homes suggest that a process negotiation in a care relationship facilitates a social interaction between nurses and older people, thus negotiation can be perceived as a form of care. Wada (2016) argues that processes of negotiation illuminate that care is centred on a social interaction and how the social interaction is experienced will inform the experience of care for older people. Arguably, these findings suggest that processes of negotiation are indicative of processes of participation in care and decision making by older people. Mol (2008) suggests negotiation in

care relationships is a dynamic and ongoing process of tinkering. Mol's (2008) concept of tinkering is reflective of a coproduction of care, in which processes and practices of care are modified and adapted between an older person and a district nurse, together. Leyshon et al. (2019) suggest in a case study of coproduction and volunteerism, that coproduction itself is a process of negotiation in the wider context of healthcare.

The literature highlights relationships are important in care for older people. A consensus was reached of the prerequisites for 'good' relationships. Care relationships were necessitated out of need rather than choice for older people; however, effective care relationships were empowering for older people. Trusting and knowing were significant in relationships for older people with health and social care professionals, and relationships provided a social connection.

Omitted from the literature was an understanding of how relationships could influence opportunities for coproduction between older people and district nurses when care occurred at home. How care was experienced by older people, an exploration of the negotiation of care, how older people and district nurses come to know each other, and how this shapes coproduction within care was not evident within the literature.

2.8 Older people and identity

Lund and Englestrud (2008) undertook an observational study of the use of a senior centre by older people in Norway, examining threats and thriving in older age. Norway differs to the UK in that although healthcare is free, from the age of 65 people must pay a ten percent charge of healthcare costs. There is limited social care available meaning care for older people incurs costs (Schonfeldr et al. 2020). Lund and Englestrud's (2008) study is useful in considering attitudes to ageing in Norwegian culture, where some negative attitudes to ageing remain prevalent (Jakobsen 2022, Jakobsen and Lind 2022). Lund and Englestrud (2008) suggest that some older people made a determined effort to distance themselves from others who they perceived as older or frailer than themselves. While the participants acknowledged the

inevitability of ageing, they appeared to not want to recognise this within themselves, despite using a senior centre. This may be due to stereotyping and ageism or a preference not to address one's own ageing. The participants did not refer to themselves as being young but appeared to wish to maintain an identity of healthy and active in ageing. Ward and Gahagan (2010) and O'Rourke (2016) suggest that efforts to maintain an identity of ageing well could be reflective of the marketization of healthcare where there is a focus on ageing well and to maintain independence so not to appear as a burden in society.

Fine (2014) asserts that care routines for older people often involve the work on or of bodies. Twigg (2000) describes this process as body work. Fine (2014) suggests that body work can result in the practice of care being physically demanding for older people and includes considerable emotional labour, interlinking the social and physical aspects of care. Lund and Englestrud (2008) argue that the social constructs of Western society focus on youth and being young as preferable to being older. This raises complexity to the understanding of the body for older people, as consumer culture draws on being able to retain youthfulness. This highlights a tension between the physical process of bodily ageing and the culture of youth and ageing well (Fine 2014). These discussions illuminate the physical and emotional effort that practices of care can have for older people. When care policy objectives include participatory models of care such as coproduction it is important to consider the impact these may have for some older people.

Nicholson et al.'s (2013) observational study suggests that older people can and do respond to the physical ageing of their bodies. This is through exercising, taking breaks, and pacing in attempts to maintain physical ability and activity. Taking care of the body also extended to eating and dietary habits to improve wellbeing. Lund and Englestrud (2008) suggest that participation in self-care and caring activities can be perceived as trying to age well by maintaining independence for as long as possible. Nicholson et al. (2013) suggest that for older people experiencing frailty there is a need to balance previous and future realities of independence through adapting

personal routines and rituals. Nicholson et al. (2013) and Lund and Englestrud (2008) suggest that older people actively care for their bodies in the processes of ageing and frailty. Nicholson et al.'s (2013) work indicates that ageing and frailty need to be considered in the coproduction of care to ensure that care is individualised and adaptive for older people's needs at home.

Abma et al. (2012) suggest that for older people, remaining at home for care did not automatically equate to maintaining identity. Maintaining identity included having a sense of self-worth, dignity, and integrity and for older people this could be a challenge when living at home, as these may not always be considered or valued by visiting healthcare professionals. Palmer et al. (2018) suggest that story-telling by older people allows for a sense of identity to be established. Storytelling for older people is to have their voices heard in care, which is congruent and central to ideals of person-centeredness (McCormack and McCance 2017). The Queens Nursing Institute (2013) suggests that within district nursing practice holistic care aims to provide a platform for older people to share their stories, maintain a sense of identity, wellbeing, integrity, and dignity, facilitating integrated person-centred care and coproduction (QNI 2009).

Buscher et al. (2011) consider the professional and personal identity of the home care nurse in Germany. The personal identity of the nurse was identified as having consideration and personal feelings about ageing for older people. Whereas the professional identity of the nurse was concerned with an image of being in charge, and less so of the experience of ageing at home. The professional identity and behaviour of the nurse has implications for the coproduction of care as coproduction aims to provide a shift in professional power dynamics (Palmer et al. 2018). The context of home-based healthcare in Germany appears to be a different model to the UK. Prior to 2012 in German primary care general practitioners worked in isolation without nursing support and funding was centred on hospital-based care (van Loenen et al. 2016). Unlike the UK, home-based nursing remains a

relatively new concept in German healthcare and Buscher et al.'s (2011) work coincides with this change.

Strick et al. (2021) suggest that occupation is a key to a meaningful life for older people with dementia. Lund and Englestrud (2008) and Abama et al. (2012) identified occupation for older people as the need to be busy, active, and useful. The feeling of being useful for older people was associated with having worth in society and busy promoted an identity of youth. Older people considered that busyness through occupation would prevent becoming a burden on others. This is further indicative of the pressures on older people to be perceived as actively ageing or ageing well in society (Barnes et al. 2013). The coproduction of care requires the occupation of older people through active participation which could contribute to wellbeing.

Nicholson et al. (2013) suggest that occupation through routines is important for older people in maintaining identity. Stevens et al. (2022) concur that routines are important for older people to maintain a sense of dignity. Buscher et al. (2011) suggest that the work of paid carers disrupts the daily care routines of older people as when carers established a routine to ensure needs were met, the routine of the carer took precedent over those of older people. Buscher et al. (2011) and Suhonen et al. (2011) argue that this can destroy trust in the care relationships. Trust has been identified in the literature review as foundational to coproduction (SCIE 2022).

Chifu et al.'s (2022) quantitative analysis monitored the daily routines of older people using assisted technology. The rationale for this study is not clear and the complex algorithm of sequencing and subsequent findings are hard to evaluate. However, Chifu et al. (2022) suggest that daily living routines for older people at home can reduce stress and anxiety. Nicholson et al. (2013) discuss routine as daily rhythm, and that having a routine for people living at home with frailty in UK provides a sense of grounding. Nicholson et al. (2013) suggest that maintaining routines at home is vital for the wellbeing of older people living with frailty. However, routines can be particularly hard to maintain due to the difficulty in accommodating others in the home. Participants reported that daily routines were structured around events such

as lunch or television shows, but district nurses or carers would interrupt routines as there was no identified schedule to their visits. Nicholson et al. (2013) suggest that the forming of routines is a response to becoming older in the personalising of time. Chifu et al. (2022) suggest that routines support a sense of safety and security for older people living at home for care, especially when there is a threat of cognitive decline.

Morrison and Korol (2014) discuss that from a nursing perspective, having control over working routines increased job satisfaction. Morrison and Korol (2014), Nilsson et al. (2008) and Koivunen et al. (2014) suggest that information technology was useful for nurses organising daily work routines and allowed for flexibility in the process, providing some control over working routines. However, as these studies did not consider an older person perspective and any implications for identify and wellbeing, these studies present a service centred approach to care practices.

Contemporary healthcare is fragmented with a plethora of services which older people may access. Disease specific, frailty, rehabilitation, home care and district nursing services may all be in place for an older person at one time. Maybin et al. (2016) in their report on quality in district nursing, suggest that district nurses undertake the coordination of care for older patients and assist in the navigation of complex health and social care services, for an integrated and seamless experience of care. Waterworth et al. (2014) suggest that the organisational and practice cultures of district nursing prevent the seamless coordination of an integrated approach to care. Haycock-Stewart et al. (2008) discuss the cultural norms in which district nurses refer to their patients when discussing care needs such as 'leg ulcer' or the 'pressure sore' undermines the complexity of practice and the older person's identity, which is contrary to the philosophy and principles of district nursing (QNI 2009). Complexity is difficult to quantify in nursing practice (Gordon 2005).

Outcome measurement in primary care demonstrates efficiencies (NHS England 2015, Cramm and Nieboer 2016). Nagington et al. (2013) argue that

quantifying and measuring outcomes has become a predominate focus of contemporary health and social care provision, to evidence efficacy and cost efficiency in a culture of finite resource allocation. They suggest that district nursing actions become inefficient and unproductive if they are unmeasurable. However, this is difficult as the role and work of district nursing is multifaceted with a need to address health, social and psychosocial needs in an unpredictable and changing environment (Maybin et al. 2016).

Suhonen et al.'s (2011) Turkish quantitative study exploring nurse perceptions of individualised care suggests that nurses are practicing with a lack of congruence between need, an older person's identity, and the objectives of the organisation. Morrison and Kovol (2014) and Nagington et al. (2013) suggest that the measurable outcomes for service providers can become undesirable for nurses as they are centred purely on the physical practice of caring. They argue that it can be the small practices of care that can improve quality of life for older people that often accompany a task in the patient's home that forms part of holistic care and identity formation, that goes unmeasured. Arguably, the coproduction of care is a tacit and nebulous practice that could evade objective measurement. The literature reviewed suggests that as objective measurement is important to service providers, coproduction may not be readily integrated into district nursing service provision.

These discussions have highlighted that older people work to dissociate with age and dependence in preference to ageing well. Telling their own story was important for older people in care for maintaining an identity. Keeping busy was important to age well, and to prevent older people from feeling burdensome. Routines were important to older people, and these could be disrupted by care. Nurses had professional routines which took precedence in care at home.

Further exploration of the experience of disruptions and constraints in the contemporary context of care for older people at home and how these influence the experience of identity and the nature of coproduced care is

needed. There appears to be a paucity of research that seeks to articulate or measure the tacit nature of care that is coproduced between older people and district nurses, and how this can inform identity for older people.

2.9 Materials and place

The current context of health and social care delivery is to support people to live well at home for as long as possible, as this is perceived to be the most cost-effective place of care for older people (Lagerin et al. 2016). Board and McCormack (2018) suggest that the meaning of home is complex and difficult to articulate, yet home has emotional and attachment implications for older people. Sixsmith et al. (2014) argue that the home environment is particularly important for older people as home can provide security and feelings of wellbeing. Board and McCormack (2018) suggest it is in the home where control and personal choices occur.

However, Stevens et al. (2022) identified that some older people faced challenges for older people when the space of home and the clinical space merged. Nicholson et al. (2012) identified that it could be a challenge for some older people to adapt to home being the place of care which could result in the refusal of outside help. Furthermore, O'Rourke's (2016) case study suggests that receiving care in the home was untenable in the absence of a satisfactory relationship with a non-judgemental carer.

Haycock-Stuart et al. (2008) suggest that the sense of a workspace or environment for district nurses is not always physical, as it is not contained or bounded and is often perceived as limitless. Additionally, district nurses are often working in unpredictable and unknown environments in which they are a visitor (Haycock-Stuart et al. 2008). McGarry (2009) identified that respect for an older person's home and how they live in it is essential in developing care relationships. Lagerin et al. (2016) suggest that home is a safe place where care relationships can be built. Nagington et al. (2013) and Damant et al. (2022) argue that the experience of home as a safe place, the opportunity for building relationships with it, and experiences of care are influenced by the attitude and behaviour of nurses and carers.

Board and McCormick (2018) explored the meaning of home. They suggest that older people marked the territory of home with personal effects and possessions. The older people in Board and McCormick's (2018) study considered personal possessions as a visual presentation of self, thus creating a sense of identity. However, Nicholson et al. (2012) suggest that when older people require care at home, the personal living space can become filled with equipment for care. O'Rourke (2016) suggests that when professionals overtake a personal living space with equipment this can limit a sense of identity for older people.

Nicholson et al. (2012) suggest that older people felt shame in using mobility equipment and tried to hide this from others. Older people hid equipment such as wheelchairs and walking sticks from visitors or stopped seeing other people because of the equipment within the home. Milligan et al. (2011) suggest that the use of technology in the home for healthcare can make it an unrecognisable space for the people living there. Their European ethnographic data of older people's experiences of telecare suggest that equipment in the home can raise tensions as to whether this makes the home environment a pleasant place to live, as the place of home becomes a place of work for professionals, and this shifts the experience of power. Appliances and gadgets can form part of care practices for older people, in the form of material technology when they are used with human interaction to preform and inform care in everyday practices (Wajcman 2004, Shove et al. 2012). Material technology should therefore be considered for the coproduction of care at home with older people.

This discussion highlights how home becomes the place of work, when it becomes the place of care, blurring boundaries of space. Home and the things in it were important, however, there was an absence in the literature of how material objects affect the care relationship and the nature of care produced and this is worth exploration in contemporary community care contexts. The literature that considers the use of technology and equipment in the home appears limited. To further inform care practices it would be of

use to explore how older people experience the use of technology within their homes, and how this contributes to a coproduction of care.

2.10 Coproduction of care

As this study has developed, and with an iterative review of emerging literature it has been evident that research in coproduction has evolved since the commencement of this work. In the initial literature review, evidence pertaining to coproduction was limited to co-design and co-development of service delivery. There was initially minimal contemporary evidence available that explored coproduction in social interactions and that was centred on the coproduction of care. This was surprising as coproduction in care was highlighted in the Wanless Report (HM Treasury 2002) and by the QNI (2009), as a principle of district nursing practice. The extant literature that considers coproduction in care and with older people will now be discussed.

Bradley (2015) provides an overview of literature that focusses on mental health and coproduction in the UK, although a literature review methodology is not discussed. A lack of structure or systematic approach to the work further limits the credibility of the conclusions. However, Bradley (2015) suggests that coproduction in mental health services is a means for family and carers to support patients, as services shift to self-care models of delivery. Bradley (2015) argues that an expertise by experience can facilitate a coproduction of knowledge for care.

Hartford-Kvaal et al. (2019) discuss a need for change in culture for coproduction in their qualitative study of participation in care by intermediate care patients. They evaluated participation in care using the European Framework of Patient Participation (Dent and Pahor 2015). This framework considers levels of choice, coproduction, and voice. Kaveal et al. (2019) found a range of variation in feelings of empowerment to disempowerment in the patient participant group. This finding is indicative that participation, and thus coproduction, are not a static entity, but are a dynamic and continual process. As Bovaird et al. (2019) suggest, coproduction occurs during practice.

Remillard-Bollard et al. (2017) discuss coproduction in relation to city planning and how older people can be included in the development of 'age friendly' cities. They suggest that in the process of planning and design that coproduction requires commitment and asset and resource sharing for a strength-based approach and suggest that barriers to coproduction include limited resources. However, Remillard-Bollard et al. (2017) do not include an older person perspective or older people's experiences of coproduction, limiting the work. Palmer et al. (2018) consider coproduction in terms of co-design. They suggest that commitment and resources are required to effectively facilitate coproduction in their narrative appraisal of coproduction initiatives from a medical perspective. Palmer et al. (2018) conclude that coproduction in practice is a 'mutually acceptable way of moving forward together'.

Soto and Strain (2018) discuss coproduction as a framework for practitioners and people to use to enhance diabetes self-management. The work is identified as a review article, however, there is no structured literature review and as such appears as opinion. Soto and Strain (2018) discussed allowing a person to understand their diabetes, to better engage, and allowing full ownership to actively participate. This appears to be physician led and the paternalistic tone of the language is counter-intuitive to the philosophy of coproduction. Soto and Strain (2018) do not discuss the process or principles of coproduction as applied in practice. While a concept of equal participation from healthcare practitioners and patients is considered, this is rather superficial as no indication of how this can be achieved, or how this is experienced by people with diabetes is included.

Rohnsch and Hamel's (2021) German study has no clear methodology stated but uses a qualitative approach to evaluate a pilot study in which older people used day care facilities that were shared with nursing home residents. Rohnsch and Hamel (2021) identify patterns of coproduction that suggest how older people and their families use day centres. The patterns identified were to; actively contribute to the coproduction of care with professionals at the centre, carers withdraw from care responsibilities in the centre, or carers

use day centres for social support. The understanding of coproduction in this study appears to be the integration of professional support into care arrangements. Therefore, the findings and discussion of the research give tenuous links to any coproduction of care, despite the aims of the project being to explore how meaningful coproduction can be implemented.

Price et al. (2021) provide worked examples of integrating coproduction in medical education in America, with equity appearing as a core component to coproduction. In a Welsh study Holland-Hart et al. (2018) identify barriers to coproduction in healthcare as a lack of awareness of the term of coproduction, time, poor communication, and people's self-efficacy to coproduce. Additionally, Holland-Hart et al. (2018) suggest that facilitating equal partnerships in care were problematic, as patients approached professionals for help, and professionals held the power and knowledge to provide support. Price et al. (2021) suggest that in professional care relationships there will be some inequity as knowledge, power and experience will not be equal. Price et al. (2021) drawing on the seminal coproduction work of Ostrom (1996) suggest that equity in the coproduction of care relates to equity in respect, knowledge, voice and access to shared resources. This understanding of equity in coproduction clearly sets out the foundations of working relationships for coproduction that are not evident in Soto and Strain's (2018) discussion. Palmer et al.'s (2018) concept of 'moving forward together in a mutually acceptable way' may be more achievable in the context of care, as not all knowledge and access to resources will be equal for all. However, equity in voice and respect for older people is paramount in care and coproduction.

Leyshon et al. (2019) discuss a spatial context of coproduction in their work of volunteering in older people's care. Leyshon et al. (2019) identify how the space in which coproduction occurs can limit participation and accessibility due to maintaining confidentiality in care. This was found to reduce equity, power, and inclusivity in coproduction. Leyshon et al. (2019) suggest that coproduction becomes an add-on to care if some contributors are not included in the physical space where coproduction occurs.

Yuan et al. (2018) investigate social aspects of coproduction by older people, seeking to identify types and scales of coproduced activity. Yuan et al. (2018) suggest that coproductive activities for older people include a variety of social activities for wellbeing, regardless of place of care, in which they can develop a sense of productive social ageing. However, a taxonomy or scale of coproduction was not elicited in the work, despite this being an identified aim.

Baim Lance et al.'s (2018) research suggests that care that is coproduced contributes to the experience of quality care. Elwyn et al. (2019) concur and argue that coproduction connects people and powerful ideas together for healthcare outcomes. Baim-Lance et al. (2018) suggest that the coproduction of care happens in the everyday nature of care interactions, and that to present coproduction as an approach for patient partnerships conceals what people already do in the unavoidable nature of coproducing care every day. Price et al. (2021) concur, suggesting that as people manage interventions and technologies which are complex and potentially dangerous, they are competent partners with clinicians in coproducing health. These findings suggest that the coproduction of care does occur in care relationships and interactions, emphasising the significance of exploring the nature of coproduced care between older people and district nurses when home is the place of care.

Cluely et al. (2021) in a co-design approach, included older people living with frailty in the development of care pathways for emergency care. The authors discuss differing levels of coproduction as identified by Osborne et al. (2016), these being pure coproduction, co-design, co-construction, and co-innovation. Cluely et al. (2021) suggest that coproduction can mean different things and that different processes can be used depending on context and desired outcome. Gremyr et al. (2021) adapted Osborne et al.'s (2016) framework for coproduction in healthcare contexts. Gremyr et al. (2021) suggest that (pure) coproduction in healthcare is:

“The joint act of a service user and professional in supporting and generating better health” (Gremyr et al. 2021. p ii28).

Based on these findings it is suggest that the coproduction of care is a purposeful activity undertaken with intent, where aims and objectives should be agreed at the commencement of any coproduction, and that fluidity and dynamism to goals should be renegotiated in equal partnership.

The literature reviewed suggests that evidence of how coproduction is experienced in the context of care at home remains limited. This highlights coproduction is under researched in the practice and processes of care for older people, with a distinct lack of exploration of any concepts of coproduction of care with district nurses and older people. However, Gremyr et al. (2021) present a useful application of coproduction for healthcare contexts and practice which could enhance understandings of coproduction on an individual care interaction level.

Insights from this review have considered coproduction in care interactions. Price et al. (2021) suggest that members of the public can be competent partners in the coproduction of care, Leyshon et al. (2019) identify coproduction as a process of negotiation in a wider context, and Palmer et al. (2018) suggest that in care interactions, coproduction is a way of moving forward together with mutuality. These insights illuminate the complexity of coproduction in the practice of care and highlight the inclusive nature of coproduction in care interactions.

2.11 Summary

The literature review has identified gaps in current evidence and knowledge as to if, and how, older people experience a coproduction of care at home with district nurses. There is a lack of insight within the current literature as to the nature of coproduced care. What is less evident within the body of literature is research that examines the nature of care that is coproduced in care dyads and interactions. Similarly, contemporary research that investigates district nursing and, or the care of older people appears to have focus on concepts of person centred care, rather than coproduction. Further knowledge is required to understand the experience of choice for older people at home when care is coproduced, how care, choice and

coproduction are informed by broader cultures of care and how power and control is experienced for older people when home is the place of care.

2.12 Research questions

Based on the gaps found in the extant literature this research aims to answer the following research question:

‘What is the nature of coproduced care between older people and district nurses, when they work together in the care relationship?’

Secondary questions will also be explored within this work, these are:

- a) How is care coproduced between older people living with frailty and district nurses?
- b) What is the experience of choice and coproduced care in district nursing services for older people living with frailty?
- c) What are the broader cultures of care shaping the experiences of older people living with frailty and district nurses?
- d) How are the issues of power and control experienced in the coproduction of care between older people living with frailty and district nurses?

The following chapters will present the methodology, methods and data analysis processes that were undertaken for this.

Chapter 3 Methodology and methods

3.1 Introduction

This chapter will discuss the reasoning for the philosophical approach of this study. It will provide an outline of the philosophical assumptions held and will discuss the theoretical perspectives that underpin the research. The chapter will then discuss the methodological approaches that informed the research study, the methods employed, data collection and data analysis. This chapter will present the rationale for the use of a focussed ethnography.

3.2 Philosophical assumptions

A research paradigm is a guide for research practice that reflects the world view of the researcher. It is the lens that provides the philosophical orientation for the research (Kivunja 2017). As a nurse, I position myself within the philosophy of the social sciences which seek to understand social life, to promote social justice, equity, and universal human rights through the study of society and human behaviour (Denzin and Lincoln 2011).

The philosophy of social science is within a qualitative and an interpretive paradigm, which seeks to understand the lives and experiences of others. It assumes that the social world in which we live is not governed by absolute truths but is shaped through meaning and human agency (Bevir and Blakely 2018). A principle of an interpretive paradigm is that reality is socially constructed by those who experience it, and that multiple realities exist which can be explored through human interactions, and between researchers and participants (Kivunja 2017). Knowledge is collaboratively constructed through the social interactions in the processes of research between the researcher and the participants (Losantos et al. 2016, Parsons 2021). Research within the interpretive paradigm explores context specific complex and multifactorial dynamic social practices, processes, and interactions to make sense of them, and to elicit meaning and new knowledge (Losantos et al. 2016, Pelz 2016, Parsons 2021). Thus, an interpretive approach is congruent with which to explore the nature of care that is coproduced between older people and district nurses, when home is the place of care.

Knowledge of the social world of others and the social world in which we interact and exist, is elicited through the understandings of both the researcher and the research participants, as these interact and impact on each other (Secules et al. 2021). Dodgson (2019) argues that all researchers are connected to, or part of the research process to some degree, which suggests potential for the researcher to influence the research process. Collins and Stockton (2018) consider that our understanding of the world is filtered by our own beliefs and assumptions. As a human, district nurse, educator, and researcher I have preconceived ideas and understandings of the world, which have the potential to influence the research process. This is particularly important to consider as I have an in-depth knowledge and experience of the context of study and the social cultural circumstances of the topic which shapes my understanding of the world. Collins and Stockton (2018) assert that there is a complex relationship between a researcher's beliefs, their interpretations of the world, knowledge and experience and the ability to consider and contemplate these when undertaking research processes. Dodgson (2019) suggests that reflexivity is essential for a self-awareness of the potential influence on the research process. This is considered in chapter 10.

Holmes (2020) suggests that the incorporation of a researcher's perspective into the research process can provide context and critical reflection through an awareness of their influence on the process. However, there must be transparency in the research processes, with the findings and analysis presented as a result of the social and subjective construction that has occurred between the researcher and the participants (Losantos et al. 2016, Parsons 2021). As my philosophical position has influence on the research processes and the outcomes, I will now discuss my positionality. Positionality considers my world view and my ontological perspective; the nature of social reality and what is knowable, and my epistemological perspective; my beliefs and understandings of the nature of knowledge (Holmes 2020).

3.3 Philosophical position

My philosophical ontological position is that of relativism. The epistemological position I hold is that of social constructionism. These philosophical understandings will now be explained. How these positions will guide answering the research questions in an interpretive and meaningful way will be discussed (Mason 2002).

3.3.1. Ontology

Ontology is the philosophical study of the nature of being human and of human reality (Moon and Blackman 2017). An ontological perspective considers the nature of reality, assimilating assumptions, and beliefs of how the world is constructed, what constitutes reality and how reality is understood (Hillier 2016). Significant ontological debates exist in considering social reality and its existence, conception, and interpretation, whether reality is a common social one or if there are multiple realities depending on context (Ritchie and Lewis 2005). Defining and articulating reality is a complex challenge (Holmes 2020). The concept of ontology considers the existence of and relationships of social beings interpreting the social world from their own perspective to construct a social reality (Al Saadi 2014).

Peltz (2016) and Denzil and Lincoln (2011) suggest that there are no objective observations of reality, and that these are contextual to the social situation in which they occur, between the observed and the observer. Observations of reality are impossible to abstract from the social setting from which they occur and need to be interpreted in context for meaning to be found (Peltz 2016, Byrne 2022). I concur with this and the post structuralist position, that the only lens into the life and experience of other people is filtered by social class, gender, ethnicity, and language (Denzin and Lincoln 2011), with an emphasis on the role of power, knowledge and language in human action (Fox 2014).

3.3.1.1 Relativism

The ontological perspective of relativism aligns with an interpretive paradigm and best describes my understanding and perspective of reality. Relativism

rejects the positivist stance and challenges objectivity as it rejects the notion of absolute truth. As a relativist, I consider that there are multiple constructions of realities, which are contextual to social constructs that influence our experiences (Green and Thorogood 2018). Social reality is therefore value laden, multiple, and subject to interpretation depending on context (Burr 2015).

Relativism rejects the existence of an external reality, that anything without social constructs and language that brings it into being exists. Language constitutes reality and reality is embedded in language (Lostanos et al. 2016). Therefore, social reality is constructed by culture and society, where humans are socialised into norms, beliefs, and shared values. Reality can therefore be understood by enquiry, description, and insight into the experiences of self and others (Burr 2015).

It is within the ontology of relativism that an understanding of how coproduced care is constructed and experienced within the cultures and care practices of district nursing with older people will be elicited. The ontological perspective of relativism for this research asserts that there will be multiple realities in the experience and nature of care for older people and for district nurses, and that these experiences are open to multiple interpretations, and therefore multiple truths (Lincoln et al. 2011).

3.3.1.2 The problem of relativism

Denzin and Lincoln (2011) identify a contradiction in a relativist perspective. In making judgements on practices and behaviours, whilst concomitantly maintaining that there is no one reality, there is no opportunity to determine what is right or wrong. However, interpretations in a relativist stance are non-foundational, in that they have no foundations in absolute truths (Ritchie and Lewis 2005).

Denzin and Lincoln (2011) suggest that relativism accepts that as humans we cannot escape the condition of how we exist in the world. Relativism provides a recognition of a human construction of reality within time and

place. Social processes of knowledge construction and of reasoning in social interaction allow for judgements between humans to be agreed. Kolbel (2009) argues that even when disagreements occur that as there is no absolute truth, as there can be no right or wrong.

The problem with relativism is that in challenging objective universal truths, with multiple realities either nothing can ever be definitely known, and that all descriptions of reality are equally true and valid (Andrews 2016).

Hammersley (2009) argues that if reality is constructed within particular social groups, such as older people or district nurses, then this has cultural reference to this group only. This suggests that relativist researchers will only present one reality of the world, and although this may be useful, it may lack value through a lack of transferability. Hammersley (2009) opts for subtle realism. This considers an independent reality, independent of our perception of it, with no direct access to it (Andrews 2016). However, as reality can only be considered through language and social constructs, what is understood as reality for a particular context, is for that context, and will not be the reality elsewhere for other people (Jupp 2006).

3.3.1.3 Cultural relativism

Madden (2010) suggests that a concept of cultural relativism identifies that each group of human beings has its own world views. This is not to place people into homogenous groups, but to recognise that distinct groupings of people, such as older people and district nurses, have their own cultural understandings, experiences, and meanings.

Culture is a broad concept which includes the customs, norms, beliefs, knowledge, and language of a social group, which informs a collective set of values and social practices (Thompson 2017, Cole 2019). Culture is the integrated pattern of human behaviour and knowledge (Burr 2015).

Culture is a distinct entity from social and economic structures of society but informs and is informed by them. Culture shapes social relationships, actions, experiences in society and influences social order. In doing so culture informs how as humans we make sense of the world and how we

interact with it (Cole 2019). As such, culture is of significance for the construction of social life and social relationships. Culture organises and constructs society (Cole 2019).

Cultural relativism is a principle in which the practices, beliefs and values of a culture must be seen from the perspective of that culture. Cultural relativism suggest that each culture or group should be understood in its own terms, and that these terms are not applicable or transferable elsewhere, to other groups. Cultural relativism aims to avoid ethnocentrism as no one culture is superior (Nickerson 2022). Pelzang and Hutchinson (2018) identify that there is a risk of researchers use their own cultural norms when exploring other cultures if there is a lack of understanding of the political and sociocultural dynamics. Cultural bias is avoided by not judging others by one's own cultural standards, but to seeking to understand the culture or group on their own terms. Cultural relativism asserts that there is no universal truth of right or wrong or ethical or moral practices, but socially constructed cultural codes (Nickerson 2022).

Denzin and Lincoln (2011) suggest that the challenge for researchers is to defend morality and moral judgements outside of natural science foundations, which then has social and political implications. Further complexity is added in considering morality outside of one's own cultural standards. As I consider moral judgements and morality core to this study, I draw on the theoretical perspectives of care and care ethics Please see section 3.4.

Relativism highlights the complexity and the social nature of individual realities and how tensions may occur between the realities of those in receipt of care, and those providing care. An ontology of relativism is therefore concomitant with this research as it does not aim to discover a fact or single reality or fact but seeks to explore the nature of care, to understand how and if coproduced care occurs within care relationships, and what the nature of coproduced care might be.

To capture the intricate and complex nature of the experiences of care and coproduction an appropriate epistemology was required that reflects the research objectives and that aligns with my underpinning understanding and belief of the construction and meaning of knowledge (Mason 2002). My epistemological position of social constructionism will now be explained and discussed in relation to this research study.

3.3.2 Epistemology

Epistemology is the enquiry into the nature of knowledge (Benton and Craib 2011). Interpretive epistemologies are well linked to the social sciences and encouraged in nursing research (Dyson and Norrie 2010, Zeeman et al. 2014). Adopting an interpretive epistemology will aim to build understanding and uniqueness of individuality and make sense of being human in socially constructed context (Crotty 2003). The philosophical position of social constructionism is congruent with my beliefs on how knowledge is constructed and the meaning of knowledge.

3.3.2.1 Social constructionism

Social constructionism is synonymous with the theoretical perspective that knowledge is constructed cognitively, through the interaction with each other, objects, other matter, and the external world (Burr 2015). Gergen (2009) asserts that within a social constructionist position, our knowledge of the world depends on how we approach it within the intricate web of social relationships that we hold as humans. As unique individuals, with a plethora of relationships, all people construct and interpret meaning and experience the world differently, influenced and shaped by culture and through the social nature of being human (Burr 2015).

Social constructionism is somewhat synonymous with relativism in the belief that there is no absolute truth. However, social constructionism considers that what we may consider to be 'truth' is a contemporary accepted way of understanding the world (Burr 2015). Social constructionism proposes that reality is formed by constructs in everyday practices, discourse, and social interaction, and is socially contextual. Therefore, social constructionism

produces knowledge that is individual, social, shared, learnt and multiple, with emphasis on the complexity of social relationships on which it is formed, which are dynamic and changeable (Burr 2015, Jupp 2006).

Constructions of knowledge are therefore linked with social action, and each construction will evoke a different response, which may include or exclude others (Burr 2015). Cultural understandings of ageing are slowly changing as our socially constructed knowledge of what it is to be older develops, and social actions are challenged. As Burr (2015) suggests, social constructions of knowledge are entwined with dynamics of power which inform social action of the acceptability and permitted ways of being in the world. This is applicable to older people in care interactions with healthcare. Historical social constructions of the knowledge of ageing and what it is to be older, as was also seen for disabled people, allowed for oppressive practices that marginalised people into homogenous groups (Shakespeare 2000, 2018). As socially constructed knowledge has developed, so has social action to address such practices, as seen in the Health and Care Bill (UK Parliament 2022), to improve integrated care for older people. Social action continues as champions for older people's care challenge the Health and Care Bill's (UK Parliament 2022) lack of adequate action on the care cap (Age UK 2022). Policy directives for person-centred care and shared decision-making, and more recently coproduction aim to rebalance power in care relationships, challenging historical professionally dominated care interactions (Elwyn et al. 2019). Values of equality in care relationships, empowerment and collaboration and participation now inform policy for social action in the care of older people.

Social constructionism as the epistemological position for this research will provide a framework on which cultural assumptions and understandings, constructed knowledge and care practices for older people can be explored. Through the experiences of older people and district nurses the nature of coproduced care can be explored in the context of home-based care.

3.3.2.2 Critique of social constructionism

Critiques of social constructionism are founded in the positivist realist paradigm. Ratner (2006) suggests that social constructionism works to create 'local truths' and eliminates 'real' truth. That it leads to accepting dangerous beliefs in dogmatic cults of divergent social groups, where any belief system is chosen that suits the group, due to uncritical thinking. As Zielke (2006) suggests, what Ratner (2006) fails to understand in his quest for objective truth is that social constructionism encourages diversity in understandings and dialogue, which can then inform moral practices.

A further problem with Ratner's (2006) perspective on social constructionism, is that he considers the discourses produced through a social constructionist lens as lacking in evidence. This suggests Ratner (2006) does not value the relational construction of knowledge in social groups. Social constructionism is diverse in its approach and therefore cannot be reduced to a process mapped guideline (Gergen and Gergen 2012). Through discourse and dialogue social constructionism creates a culture of knowledge development in which understandings of what works well, as well as identifying problems, from a diversity of perspectives so that understandings are shared (Gergen and Gergen 2012, Galbin 2014). This is of significance when considering a shift in power to realise person-centeredness in care, as shared understandings which are constructed which can then inform meaningful practices of care for older people as their voices are heard.

Social constructionism lends itself this study as it considers that knowledge is constructed collaboratively and cognitively in complex social networks through social interactions and language (Burr 2015). Social constructionism suggests that knowledge is influenced by culture and that by exploring culture it is possible to find new contemporary ways of understanding the world and social contexts (Burr and Dick 2017). New knowledge and understanding can inform social action and inform care practices and rebalance power in care relationships, as suggested in person-centred approaches to nursing. Social constructionism allows for a diversity of understandings and perspectives for knowledge development (Nickerson

2021). Therefore, older people's voices which are not often heard in the construction of knowledge, can inform, and enhance coproductive care practices.

3.4. Theoretical perspectives

Theoretical perspectives provide a guide for the study, in which existing useful and relevant theories are integrated to provide a structure and lens with which to explore new knowledge (Anfara and Mertz 2015). Theoretical perspectives frame qualitative research to explain how the study relates to existing theory, and therefore position me, as a researcher, within the work (Merriam 2009, Glense 2011, Crawford 2019). Consideration of theoretical perspectives in research makes explicit the theories that guide and construct thinking in the organisation and analysis of the data, identifying how new ways of thinking may influence the connection of the study to an existing body of knowledge (Maxwell 2013, Collins and Stockton 2018). A theoretical perspective situates and connects the relationships of the theories explored in the study, to develop further understanding, explanation and new meaning (Crawford 2019).

in considering appropriate theoretical perspectives with which to support a research study, Merriam (2009) suggests that the framing theory should originate with the disciplinary orientation of the field of study. Although this study is concerned with the discipline of nursing, it is more significantly concerned with care, with care considered as being core to nursing practice (Karlsson and Pennbrant 2020, Mudd et al. 2020).

Many nursing theorists consider the centrality of care for nursing theory. Watson (2009) suggests that caring is central to nursing, Roach (1984) considers that caring is unique *in* nursing, whereas Benner and Wrubel (1989) assert that nursing *is* the practice of caring which is guided by morality and care ethics and responsibility. Boykin and Schoenhofer (1993) identify that caring is a human activity suggesting that nursing is nurturing persons through care. Humanistic nursing theories emphasise the importance of the relationships in care (McCance et al. 1999). Grounded in

humanism, Watson's (1979) theory provides a framework for nursing in which care is examined and enacted in nursing through transpersonal relationships (Sitzman and Watson 2014). Transpersonal relationships acknowledge the co-presence of the person and the nurse in care (Watson 1985). Caring science in nursing theory is the humanistic processes of care and of care experiences (Sitzman and Watson 2014).

Care theory is centred on exploring care relationships to understand how and why moral decisions are made (Mays 2023). Moral decision making from a Kantian ethics perspective is a normative, rational, and logical approach or centred in Bentham's consequentialist utilitarianism (D'Olimpio 2019). However, an ethic of care considers care and compassion as moral, with real-life decision making as contextual and influenced by relationships held with other social beings and the material world, and thus offers a lens to understand caring activities (D'Olimpio 2019, Sander-Staudt 2017).

Care and feminist care ethics therefore offer an appropriate theoretical lens with which to understand the relational nature of care and the coproduction of care and to explore the political influences this has. This study seeks to understand morality and power in care relationships and how these shape the nature of coproduced care. How the theoretical perspectives of care and care ethics interlink, frame, and support this study will now be discussed.

3.4.1 Care

Care is nebulous and ambiguous, with a plethora of meanings and applications (Philips 2007). As care is surrounded by philosophical, ethical, political, and economic debates, concerning its definition, delivery, funding, and whose responsibility it is to determine these factors, care remains an evolving theory which is shaped by multiple discourses, and social and cultural values (Mol 2008, Barnes 2012).

Tronto (1993) suggests that to care implies to reach out to something or someone other than self, and that care infers some sort of action. Care can be associated with understandings of kindness and positive meaningful relationships. However, care can also be infused with ambivalence and

conflict and complicated by behaviour, emotion, feelings, and need illustrating that care is fundamental to everyday human life (Tronto 1993, Barnes 2012). Noddings (2002) contends that care as the human condition depends on care by others, in care relationships, for survival. However, despite the presence of care in everyday life, Bowden (1997) contends that that care is invisible, with its significance to the everyday undervalued. Feminist research aims to make visible the unpaid caring work of women, to highlight the work unpaid carers do, the impact this has on them, and the resources unpaid care work can save governments (Barnes 2012). Arguably, care becomes visible when it becomes a commodity and a product of industry.

Tronto (2010) contends that as care is a normative concept and that it is purposive, that care it should be integral to social development and social justice. Theoretical work on care has largely been considered in the US in and political contexts for a collective responsibility to care (Kittay 1997, Tronto 1993, Held 2006), due to the lack of a welfare state. In the UK and Europe although welfare systems are well established but are only beginning to develop a shared responsibility in the delivery and practice of care (Barnes 2012, Ham et al. 2018).

Political decision making influences how care is organised, funded, allocated, delivered, and experienced, it decides who is responsible for care and what care will be constituted by (Tronto 2015). As such, the UK healthcare system contests and shapes the nature of contemporary care (Aranda 2018). Political decision making shapes morality as policy documents place a legal and normative authority on care and can make assumptions about care experiences and practices and can push the complexities of care out of the public sphere, as policy influences daily life and how we live in relation to others (Greenswag 2017). Care can therefore be understood as dynamic and socially constructed through interactions, relationships, policy, and regulation (Green 2012, Philips 2007).

The political context of care can marginalise people who undertake care work, people who receive care, and people who need care, by how it is socially constructed (Burr 2015, Tronto 2015). Sevenhuijsen (2003) argues that the normative nature of care to the everyday is not only relevant to the analysis of social policy but is important due to the interdependency we have on others. How care is conceived at a political level then influences how people respond and relate to each other, for example, how older people may be valued or not, and how they are considered in society.

Barnes (2012) suggests that society evaluates others by their capacity to, and how they care. Political determinants of care shape how society is perceived and judged by others in the way that it produces care, as can be seen with the recent pandemic and the care practices that impacted older people (Tronto 1993, 2015, Barnes 2012). The example of the pandemic and the experience of some older people illuminates that older people are not always valued in society and that quality of care for older people is not consistently optimal or a political priority concern (Amnesty International 2020). This is further highlighted by the lack of political redress by government following its failings in the pandemic, and the ongoing challenges faced by older people post pandemic of unmet health and social care needs (Amnesty International 2020, Bottery 2020).

Barnes (2012) contends that care can be understood as a way of conceptualising personal and social relationships, care as a practice and care as being comprised of a set of values or moral principles necessary for human flourishing. Barnes' (2012) conceptualisation of care has congruence with a coproduction of care which is based on cooperative reciprocal relationships for effective cocreated social practices with which to improve the delivery and experience of care (Boyle and Harris 2009). Barnes' (2012) three understandings of care theory will now be considered in relation to this study.

3.4.1.1 Care as a way of conceptualising social and personal relationships

Care aims maintain relationships by promoting the well-being of the cared for and the care giver, which can have a short and long term influence on health, through a complex network of social relations (Sander-Staudt 2023, Umberson and Montez 2020). Social networks refer to the refer to the web of social connections that surround a person, including those for health and care (Umberson and Montez 2020).

Noddings (1984) suggests that there are three elements within a dyadic caring encounter, in the context of older people and district nursing this would indicate that the nurse is motivated and attentive to the needs of the older person, and that this precipitates the nurse to perform a caring task for the older person. The older person then recognises that the nurse has cared for them.

However, the context of caring relationships in healthcare is not linear as Noddings (1984) suggests, despite their often dyadic nature as they are full of human, political and social complexity (Umberson and Montez 2020, Lynch et al. 2020). Care is relationally led in a way that does not apply well to market led, political dictates. Care relationships are distinct ethically informed relations in social life, that can take on many differing cultural manifestations with the intent to co-create the health and well-being of others (Lynch et al. 2020).

3.4.1.2 Care as a practice

Nursing theory is concerned with the practice of care (Mudd et al. 2020). Tronto (1993) suggests that care is a practice, as it requires interrelated thought and action directed to an end. Noddings (2002) theory of care contends that caring is a moral attitude, which she describes as a natural caring, this being a form of caring that does not require an ethical effort to care. Noddings (2002) argues that this is women's experience of care.

Ungerson (1983) challenges the emphasis on altruistic motivations for care, suggesting that assigning altruism and a disposition for care can obscure the

work that is involved with care. Tronto (1993) contends that caring work may be undertaken without a caring disposition, in which the activities of care are perceived only as tasks and part of a job. She suggests that care is more than a disposition and good intentions and argues that care requires a deep and thoughtful knowledge and understanding of the context in which it occurs, requiring a social and political perspective and ethical action. Tronto (1993) further contends that care only occurs when the disposition and the activity of care are both present. Fisher and Tronto (1990) assert that care work can be hard, challenging, difficult and unpleasant, regardless as to whether it is professional or unpaid care work. Barnes (2012) suggests it is important to recognise what it is to do care, what the process and practice of care involves, for the work of care to become visible and valued.

In analysing care practice of care in the United States, Fisher and Tronto (1990) identified four intertwining phases in their theory of the process of care. Although Fisher and Tronto's (1990) theory of the process of caring suggests that caring processes can be directed to others as well as things and places, to demonstrate how this theory can be applied to care between older people and district nurses, I have annotated the following context:

1. Caring about; *requires the district nurse to recognise the older persons need for care. Once a need is identified, it does not equate that an older person must respond to or that the district nurse will go on and address that need.*
2. Caring for; *taking care of. This step is the caring process and involves the district nurse assuming some responsibility for the identified need and determining a response, and the acknowledgement that a caring act is required.*
3. Care giving; *is the physical work of care and involves the district nurse meeting the direct needs for care and usually requires that the district nurse comes in to contact with the older person.*
4. Care receiving; *that the older person will respond to the care received. This may be through feeling better, acknowledging the act of care, an improvement in condition.*

Caring about can be individualistic or on a social or political level. Caring about is individually shaped and can be socially and culturally influenced by what someone will care about. In caring about the identification and assessment of need is complex and can have political implications in the interpretation and reasoning of need. Caring for is a taking of the responsibility for the things to ensure maintenance and repair. Care giving requires a response to care need and requires the work and undertaking of tasks that are involved with caring. Care giving raises questions of good care practices and the conditions in which care occurs. Care receiving is the response to the caring process by those to whom it has been directed (Tronto 1993, Phillips 2007, Barnes 2006).

Care receiving requires a response as this is the only way to know if care needs have been met, and that care is not complete until all needs have been met, indicating that the process is cyclical and recommences with newly identified needs (Fisher and Tronto 1990, Tronto 1993, Barnes 2012). Fisher and Tronto's (1990) four phases of care interlink, and each phase determines the next and may occur in a care dyad or wider and more varied contexts of care (Barnes 2012). Furthermore, the processes of care may not occur in sequential order and be intertwined and further complicated by human behaviours.

Fisher and Tronto (1990) also identify a selection of specific preconditions that they consider as ability factors for care to occur. Ability factors include time, material resources, knowledge, and skill, with each phase of the caring process requiring one or more ability factor. Care is further complex when ability factors contrast each other, for example when district nurses have knowledge and skill but lack the time and resources needed for care (QNI 2022). Care processes and the ability factors for care can be further disrupted through fragmented care services which lack integration, and in which people may not work collaboratively (Fisher and Tronto 1990, Steihaug et al. 2016).

However, what is not considered in Fisher and Tronto's (1990) theoretical model of care is the opportunity for coproduction. While the model provides an application to dyadic, social, and political contexts of care, it does not offer the opportunity for the coproduction of care and appears unidirectional, with passive care recipients. The ability factors considered by Fisher and Tronto (1990) are arguably requirements for the practice of care in the UK, in any given model, due to the nature of healthcare systems and delivery, but they are also the elements required in an asset based approach to care, which allow people to be coproducers of their care (SCIE 2015).

3.4.1.3 Moral considerations for human flourishing

Tronto (2015) suggests that 'good' care is the meeting of needs and providing the conditions in which people can feel safe in the world. This concept is linear in that it is indicative of a passive person who is dependent on others to create the conditions to feel safe. It does not acknowledge people as active coproducers of the requirements to feel safe in the world. Furthermore, there is no absolute universal standard of what constitutes 'good' care (Himmelwaite and Plomien 2014). Standards of care accord with the values of society and are culturally specific which are subject to change and are determined in time and context (Philips 2007, Tronto 2015).

Failings in care for older people are widely reported (Francis 2013, Kirkup 2015). Such failings suggest that the concept of care is not realised as caring in practice, and that care can only be achieved when the moral principles and values of care are embodied in practice (Barnes 2012). However, nurses do not always achieve optimal care for older people (Gamble and Ion 2017). Tronto (1993) suggests that what is perceived to be care can often be something else. Barnes (2012) argues that carers who fail to meet identified care needs, or who are abusive of older people are not providing care, despite the job title or role they are working in, highlighting that care can also become narcissistic, martyrdom or self-sacrifice, depending on the motivation of the care giver.

Barnes' (2012) suggests that motivation for care is not always derived with an ethical and moral intent. Motivation lacks a standard definition as it is conceptualised depending on the theoretical stance used, in broad terms it is the drive to act, through a physiological need or in response to desired personal or social outcomes (Zarzycki and Morrison 2021). How clinicians experience their job can impact on individuals and influence motivation and how care interactions are performed, with paternalistic values being included in care practices, skewing opportunities for the equal sharing of power (Ocloo et al. 2020). Fisher and Tronto's (1990) theory of the practice and process of caring omits consideration of the motivation required to care.

The care theory that I have discussed is largely drawn from feminist philosophers. Care remains a key feminist concern as it remains gendered and is deeply unequal (Barnes 2012). One of the core concepts to feminism is that of equality. Rather than this meaning the same, equality in feminism is to place an equal value on difference (Burr 2015, Philips 2007, Shakespeare 2018). Despite shifts in conceptual understandings and social norms of care in which women are no longer considered more suited to caring, gender is a key predictor of professional care working and race and socio-economic background is indicative of those in society who will undertake the 'dirty work' of care (Twigg 2000, Tronto 2015, Barnes 2012, Philips 2007). Gender is still considered of some relevance to this study due its associations with care and as most older people will be women in the UK (Office for Health Improvements and Disparities 2022). Thus, care remains unequal in a society that is committed to the principles that everyone is equal (Tronto 2015).

It is the broader concept of age and of older people as marginalised group that I consider has equivalence with feminist theory (Phillips 2007). A feminist perspective suggests that social, cultural, and political factors influence people's lives, as well as gender (Syed 2022). Feminist theory is fundamentally associated with concepts of difference and subjectivities and aims to explore the difference in the context of care for the marginalised group of older people who receive care at home (Radtke 2017, Green and

Thorogood 2018). Older people can be placed as different or othered in society by wider societal discourses of ageism, as mirrored by the disability model for health and social care (Burr 2015, Philips 2007, Shakespeare 2018).

Care theory offers an understanding of the practice, relationships, and moral nature of caring, however it is limited in that it does not wholly consider the complexity of power inherent within care relationships, and how power dynamics may be experienced in the practices and delivery of care (Philips 2007). Inequities of power exist for older people, as healthcare enforces and reproduces constraining structural forms through social and cultural norms, political processes that restrict the empowerment of older people (Green 2012, Al-Thani 2022). Care then becomes infused with subjective experiences, social and personal values and is associated with culture, power, and politics (Green 2012). A feminist care ethics is based in this relational and political ontology, it considers relationships in all power situations and focuses on how interactions, organisational structures and societal and political influence and shape experiences of power in care (Barnes et al 2015). To understand the complexities of care and the imbued power within care relationships, I draw on the theoretical perspective of a feminist ethic of care.

3.4.2 Feminist ethic of care

Nursing and feminism seek to empower and improve through human action (Francis 2000). Drawing feminism, nursing and care together is the theory of feminist care ethics. Care ethics is concerned with the complexity of care. It explores and addresses the intricacy of moral decision making, the relational nature of care, power dynamics in care relationships, and how care is experienced on an individual, societal, philosophical, and political level (Tronto 2015, Barnes 2012).

Care, nursing, and nursing care have long been associated with a gender based notion of women's work and women's morality (Philips 2007). Although care ethics is not synonymous with feminism, Gilligan (1982) and

Noddings (2002) argue that traditional approaches of justice ethics have male bias, whereas care ethics is founded in equality (Gilligan 2011). With similarities to Boyle and Harris' (2009) concept of coproduction, Gilligan (2011) argues for equality and equity for all voices in an ethic of care. Where coproduction aims to challenge social inequalities through inclusivity (Brown 2013, Boyle and Harris 2009), a feminist perspective of an ethic of care pays attention to gender and inequalities, aiming to understand and challenge social and political practices that can oppress, marginalise or disadvantage (Norlock 2019).

Gilligan's (1982) seminal research in care ethics advocates for a 'different voice' in moral decision making, suggesting that ethics and care occur through relationships and interactions rather than by reference to abstract principles. A feminist ethic of care challenges traditional moral theory as male-centric and as omitting values and virtues of care, which although usually associated with women are a human strength regardless of gender (D'Olimpio 2019). Barnes (2012) concurs that care and care ethics are entwined in the everyday social interactions in which moral decisions are made, that in a relational approach to ethics, appropriate responses arise in and through different situations and relationships. Therefore, relationships are fundamental to moral decision making in the context of care in ensuring equality for those who may be marginalised, vulnerable or dependent (Heplar 2022).

Care ethics has been developed within political and moral philosophy and widely applied in nursing, social work, education, and social policy that draws on care ethics to explain care as a practice and as a set of moral principles to guide practice (Barnes 2012). Tronto (1993) argues for a political ethic of care and Sevenhuijsen (2000) uses care ethics to evaluate policy. In drawing on a feminist ethic of care, I largely pull on Tronto's (1993) ethic of care for this study. However, my theoretical perspective differs in that I use care ethics as a lens with which to explore the nature of care that is coproduced in care relationships, in the social and political context of care at home between older people and district nurses. I consider the implications for practice and

the delivery and experience of care for older people, rather than to offer a detailed critique of policy from a care ethics perspective. Like Barnes (2012) my work is focussed on the importance of care in the context of everyday lives however, I am particularly concerned with the significance of coproduced care in the everyday care interactions between older people with district nurses.

Tronto (1993) argues that care ethics must be considered in a moral and political context, and that to consider care ethics as women's morality dismisses care as an instinctive or cultural behaviour. Tronto (1993) asserts that the practice of care is more complex than that and is entwined in the structures of political and societal power, and that a set of moral principles alone is insufficient for the judgements required when considering the practice and processes of care. She argues that the practice of care ethics requires some specific moral qualities. Diverging from understandings of motivation for care to inform care practices, Tronto (1993) contends that a general '*habit of mind*' (p 127) is required to inform the phases of care theorised by Fisher and Tronto (1990), and to inform a care practitioners moral being. Tronto (1993) suggests that the four phases of care produce four ethical elements of care:

- Attentiveness
- Responsibility
- Competence
- Responsiveness

Caring about requires an attentiveness to others and an attentiveness to need. Tronto (1993) argues that attentiveness requires the suspension of the thoughts, concerns, and goals of the care giver to be attentive to another. A lack of attentiveness to care is a moral failing, which may be through wilful ignorance, or developed through habits of ignorance (Tronto 1993). An inattentiveness to the needs of older people can be evidenced in the failings in care in Mid Staffordshire, where habitual practice resulted in neglectful practice, through a cognitive ignorance to the need for care (Francis 2013). Wilful ignorance of the needs of older people is evident in the Morecombe

Bay enquiry (Kirkup 2015). For nurses a lack of attentiveness to the needs of others and omissions in care delivery contravenes professional codes, thus highlighting that attentiveness in care is an ethical requirement of nursing practice (NMC 2018).

Tronto (1993) suggests responsibility is an ethical dimension of care that evolves from the process of caring for. Caring for requires people to be responsible, noticing and taking responsibility for care needs (Barnes 2012). Caring can be assumed through the recognition of the need for care, or through cultural, social, political, or perceived obligation (Tronto 1993). Responsibility for care in nursing is a formal duty through the paid nature of professional care work (NMC 2018, Philips 2007). Tronto (1993) argues for responsibility over obligation in the political context of care, as a more flexible concept in which people are interdependently responsible for each other, rather than obligated through gender, social class, culture, or ethnicity. A moral category of responsibility is conducive with a shared and collective responsibility for care in which trusting reciprocal relationships facilitate coproduction for cultural change (Ham et al. 2018, Batalden 2018).

Tronto (2015) later argues for a fifth phase of caring, 'caring with' as a democratic ideal, suggesting that care can be reciprocated by others, over time, when needed, facilitated by trust in society, social and political institutions, and social justice. Tronto (2015) does not suggest that all people must contribute to the care of others through equal distribution of care acts, but that the responsibilities for care become equally allocated, ensuring that all people can participate. However, Barnes (2012) contends that not all people are equally resourced with which to care, and not equally provided with what is required to care.

In the third phase of care, care giving, Tronto (1993) argues illustrates the moral importance of competence, aligning it with moral consequentialism. As highlighted in the Mid Staffordshire (Francis 2013) and Morecombe Bay (Kirkup 2015) examples, the intent to provide care and the assuming of the responsibility to provide care does not equate that the need for care is met.

The undertaking of care work should be done with competence if to achieve the desired outcome, as to practice outside of competence will not achieve optimal care (Tronto 1993).

Responsiveness relates to how the receiver of care responds to the care that has been provided to them (Barnes 2012). Tronto (1993) differentiates responsiveness from reciprocity, as the consideration of the other persons condition as they express it, rather than the putting of self into that position, thus not assuming that the other is like the self. Responsiveness is therefore concerned with how receiving care is experienced and what it means to the individual to be in receipt of care (Barnes 2012). The ethical perspective of responsiveness illuminates the multiple perspectives in the experience of care and the importance of the perspective of the person who is in receipt of care (Tronto 1993, Boyle and Harris 2009). To ascertain responsiveness in care, to ensure that care has been met, the care giver must be attentive to the care recipient's response, illuminating the cyclical nature of the ethical imperatives for care, that Tronto (1993) refers to as the 'integrity of care'.

The four elements of an ethic of care suggested by Tronto (1993) further illuminate the centrality of power to care relationships. It is within the professional power of a clinician to be attentive or inattentive, to clear their thoughts of their own goals so to focus on the person. An awareness of the potential for poor care, omissions, and abuse is a moral concern of nursing (Ions et al. 2019). Thus, the professional has power to take responsibility for care, or to claim a lack of responsibility due to a lack of ability factors, or to pass responsibility back to the person in an individualistic approach to care (Tronto 1993, Barnes 2012, Ham et al. 2018). Power is also balanced towards professionals in terms of practising with competence, highlighting how care receivers must trust in the competence of providers to deliver care (Tronto 1993).

Sevenhuijsen (2003) adds trust to the four moral principles of an ethic of care. Trust emphasises and provides opportunity for care givers and care receivers to engage in an equal dialogue about needs, responses, and

experiences of care, and how the circumstances of inequality can influence these (Barnes 2010, Boyle and Harris 2009, Brown 2013). As illustrated by Kittay (1997), it is in the context and situatedness of care interactions that professionals can learn from people and where trust can develop.

Thus, the theoretical perspective of care ethics has congruence for this work as it is concerned with understanding the importance of how care is delivered and provided (Green 2012). A lens of a feminist ethic of care provides a perspective with which to explore power, systems, and structures in older people's care and district nursing practice.

The next section of this chapter will discuss a methodology of a focussed ethnography and its congruence with a theoretical perspective of care and care ethics which provide the lens for this study.

3.5 Research methodology

Methodology for qualitative research is the comprehensive approach of the fusing of the research design, ensuring that methods and analysis affiliate with the theoretical and philosophical foundations of the study (Kramer-Kile 2012). A positivist, quantitative method was discounted as the study aimed to understand people's behaviour, beliefs, and values in care interactions. A qualitative interpretive methodology allows for the study to occur in the natural everyday environment in which care occurs, the subjective influence of the researcher can be considered and supports a relativist orientation (Green and Thorogood 2018). Furthermore, the voices and perspectives of participants can be included in a qualitative interpretive methodology (Squires and Dorsen 2018). A qualitative interpretive inquiry supports a social constructionist epistemology as the processes of the nature of coproduced care for older people and how they come to experience this can be explored. How older people are affected and how power is experienced, and what shapes the care relationships with district nurses can be investigated, seeking to understand how the realities of care for older people and district nurses are constructed (Green and Thorogood 2018, Squires and Dorsen 2018).

Various methodologies were considered but given the focus on the exploration of culture, ethnography appeared to be the approach that most aligned with the nature of the inquiry, to explore the nature of coproduced care between older people and district nurses, when home is the place of care.

3.5.1. Ethnography

Ethnography has a value as a social research methodology (Hammersley and Atkinson 2017). This research study lent itself well to the methodology of ethnography as it aimed to develop an understanding of cultures, values, and beliefs in the coproduction of care between frail older people and district nurses at home (DeChesnay 2015).

Archer (2009) suggests a feminist lens and ethnography are a viable intersection of theory and practice as the researcher can be situated in the world of research and nursing practice, using reflexivity to consider the influence these have on each other, and the implications this may have for the findings of the research. Ethnography aligns with an interpretive paradigm and ontological and epistemological approaches of relativism and social constructionism (Silverman 2011). A relativist ethnography does not seek objective truth, but rather the multiple realities of care (Mason 2002). Ethnography and social constructionism provide a lens to understand the behaviour, norms and beliefs of people, and the cultural exchanges between two groups where practices are formed (Davies and Jaimangal-Jones 2020).

Concepts of ethnography can be ambiguous as can lack clear definition (O'Reilly 2009). Definitions can be multiple and with differing perspectives with there being many diversifications from its original approach (Hammersley 2017). However, ethnography is fundamentally concerned with the description of social life, to illicit learning and meaning from the everyday perspective of participants to understand behaviour, culture and social norms (Reeves et al. 2013).

Ethnography has foundations in anthropology and the study of culture (Creswell 2007). Traditional ethnographic studies require extensive periods immersed in the field of study to holistically describe the social and cultural life of a community (DeChesnay 2015, Madden 2010). This is an unrealistic undertaking in applied settings due to time and funding constraints (Madden 2010, Higginbottom et al. 2013). Similarly, in applied settings ethnographic research is undertaken in the clinical working day and private hours and activity are separated to maintain professional and ethical boundaries by nurse researchers (Holloway and Wheeler 2002). Therefore, a focussed ethnographic approach was selected for this work.

3.5.2 Focussed ethnography

Focussed ethnography is a recognised variation of traditional ethnographic methodologies (Agar 2006). It allows for an interpretative approach and in-depth exploratory study (Gustafsson et al. 2013). Focussed ethnography is recognised for use in social research and specialised field of study such as nursing and clinical practice (Wall 2015). Focussed ethnographies are characterised by short intensive if not extensive periods of study in the field (Knoblauch 2005). The methodology can be employed by researchers to study specific practices within nursing care with a useful application for healthcare. Focussed ethnography retains the characteristics of traditional ethnographic approaches allowing for the complexity of care to be explored in context, and for practice to advance (Roper and Shapira 2000, Robinson 2013).

Focussed ethnography is useful when researching specific groups of people who are dispersed, isolated or hard to reach such as underrepresented, socially dispersed and often socially isolated frail older people (Speirs et al. 2014). The methodology also enables a focus on healthcare practices in limited time frames, whilst allowing for the researcher to become immersed in the culture of the setting (Roper and Shapira 2000, Charlette et al. 2019). A focussed ethnography enables the researcher to identify specific areas of study to explore in-depth, with predefined research questions and objectives with which to understand the behaviours, beliefs and values of older people

and district nurses in the coproduction of care at home (Robinson 2013, Taylor et al. 2015, Charlette et al. 2019). It can facilitate a systematic process of identifying patterns of behaviour in social interactions within a defined context, with which to interpret new meaning from a certain theoretical perspective, so that the nature of coproduced care can be understood from the voices of the participants (Agar 2006, Robinson 2013, Higginbottom et al. 2013). It provides an opportunity for a focus on specific cultural influences and processes within a group to uncover shared understandings and practices, and how these are shaped and institutionalised (Robinson 2013). Focussed ethnography allows for the researcher to capture:

‘Complexities in common situations’ (Roper and Shapira 2000. p.9).

A research methodology needs to reflect the context of study and fuse together the theory and method for a comprehensive design (Kramer-Kile 2012). A focussed ethnography allows for the use of multiple research methods for data collection (Wall 2015). The methods employed for this study will now be discussed.

3.6 Methods

Ethnographic methods of the observation of participants in their everyday social setting, in conjunction with the use of semi-structured interviews and field notes from observation allowed for the exploration of the nature of coproduced care between older people and district nurses, when home was the place of care (Nightingale et al. 2014, Higginbottom et al. 2013). Focus groups were discounted for this study due to perceived accessibility issues for older people who were housebound (Forstat et al. 2020).

3.6.1 Observation

Observation in focussed ethnography provides the opportunity to gather rich descriptive data of the lives of the participants in the local and situated context of study (Robinson 2013). Tetley (2013) undertook observations of older people in day centres and suggests that older people cannot be expected to produce information on demand in interviews and suggests that

observations are an effective way of enabling storytelling and accessing individual and unique experiences. Observation enables people, places, and practices to be considered (Green and Thorogood 2018). A familiarity with nursing in the home as the field of study allowed for focussed field visits (Higginbottom et al. 2013). However, an unfamiliarity with the geographical setting and NHS organisation allowed for an open-mindedness with which to approach data collection (Roper and Shapira 2000).

3.6.1.1 Observational role

There is a continuum of roles for the observation in ethnographic work, as illustrated in figure 4.8.1 (Vinten 1994). I was aware, from my philosophical positioning, that I was not a pure observer, as my interaction with the participants and the field would influence the data. My role as an observer was more interactive. I participated in interactions through chatting and passing equipment, whilst undertaking core ethnographic activities by making notes and asking questions. However, as I did not contribute to the practices of care but observed these, participant observer appeared to best explain my observational role (Wind 2008, Green and Thorogood 2018).

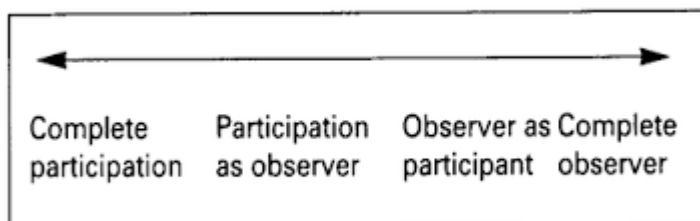


FIGURE 3.1 CONTINUUM OF RESEARCHER ROLES IN OBSERVATION (VINTEN 1994)

However, as I was participating in the research process through social interaction, this raised some ambiguity for me in the role of a participant observer. Wind (2008) undertook ethnography research in a hospital setting as an ex-nurse. Wind (2008) suggests that a negotiated interactive observation is a nuanced way to consider the role of the researcher in observations when there is an 'insider' knowledge of the context, but as an 'outsider' of that social world. Wind's (2008) concept of negotiated interactive observation allows for a credible role of researcher in the field to create trust and rapport and the opportunity to participate. As Wind (2008) highlights, in care settings there are minimal roles that a researcher can adopt to be in the

field as a participant observer, nurse, patient or visitor. I was none of those and had to position myself as researcher for veracity and transparency in the field. An awareness of this provided openness and sensitivity of my presence in the care interactions could produce some subjectivity, through my knowledge and preconceptions, but also that there was a risk I could unsettle the relationship between older people and district nurses through any perceived judgment on the interaction (James 2013). Similarly, I was aware that my presence could shift the dynamic of the care interaction in how the participants reacted to me and in how the care interaction was enacted (Wind 2008).

3.6.1.2 Emic and etic roles

An aim of an ethnographic methodology is to provide an account of the setting that reflects the perspective of the participants. Emic accounts provide realities of the culture and social and care practices from the perspective of older people and district nurses (Molgaard et al. 2021). An etic researcher perspective adds value as it allows for the outsider view of the mundane and everyday which can be taken for granted by the participants, and therefore can provide rich accounts (Green and Thorogood 2018).

However, my position as an insider or outsider in the research process was complex. Lawler (1991, 2006) in her seminal nursing ethnography suggests that an insider knowledge is required for appropriate questioning and data analysis, combined with a theoretical framework to make sense of data. I held an emic or insider position as a district nurse and was therefore familiar with the field and context of study, however, I was an outsider to the care interactions I was investigating and to the coproduction of care. Kreiner and Joshi (2021) suggest that the undertaking of research in familiar settings creates the position of the liminal researcher who does not fall into a category of insider or outsider. As a researcher within a highly familiar setting that has personal meaning to me, due to the nature of the study, drawing on a position of liminality, as district nurse I had a unique vantage point that connected me with the participant group without belonging to it (Keiner and Joshi 2021).

Although I could not ‘un-know’ my knowledge in district nursing, or switch off my past experiences, through the practice of research processes, integrating the roles of clinician, educator and researcher offers the opportunity for a richer cross disciplinary lens (Hamilton 2015). A cross disciplinary lens provides the unique opportunity to notice intricacies within the experiences and care practices of the older people and district nurses, that otherwise may be missed by an observer without my experience in these spheres. With familiarity of social situations there is a risk of an unconscious inattention (Morris 2017), in which social norms and cultural practices are accepted without question as can be seen from the enquiry into poor care at Mid Staffordshire (Francis 2013). Drawing on tacit my knowledge, skills, and experience as a district nurse and an educator in a liminal space facilitates my opportunity for a deeper consideration what is being observed and heard within the data. This can allow my perspective, understanding, preconceptions and bias of care for older people at home with district nurses (as described in section 1.10) to be explored, questioned, challenged, and reframed (Rutherford and Pickup 2015).

Undertaking research from a liminal position can enhance the credibility and transparency in the research process, as it can support me in being less likely to reach unsupported conclusions and able to consider multiple perspectives (Hamilton 2015). Reflexivity was therefore imperative to enable me to consider and address my pre-existing knowledge and preconceptions of the field of study, and allowed me to detach from my insider knowledge, reducing potential researcher bias, clarifying, and balancing my emic and etic role in observation (Higginbottom et al. 2013, Green and Thorogood 2018). Reflexivity within this study is further discussed in chapter 8.

3.6.1.3 Observation protocol

To ensure relevant and rich detail was captured during the observations of practice, a protocol was developed for logging information (worked example in appendix 1). A protocol is a predetermined form on which to record descriptive and reflexive notes during observation which contributes to data (Creswell 2007). Spradley’s (1980) seminal ethnographic work suggests that

culture can be explored by observing the individuals, the activity, and the setting, which is arguably a generalised approach. Whitehead (2006) advocates for an observation protocol with categories that align to specific research question to capture culture. Therefore, a protocol was designed based on the work of Creswell (2007) and Whitehead (2006), which included prompts to record descriptive and reflexive observations on activities, language, behaviours, interactions, knowledge, choice, and relationships (appendix 1).

Although Whitehead (2006) identifies the categories I utilised for the protocol in a workbook for students of ethnography, these were not specified on the example protocol provided, rather there was opportunity for free text and reflective notes. It became apparent on use that the structured design of the protocol I had formulated was not useful in the practice of ethnographic observation. Ethnography aims to capture rich description of the field of study (Mason 2002), however, the observation protocol risked interrupting this. It was challenging to assign notes to the relevant boxes on the form during the observation. As O'Reilly (2009) asserts, there is a paucity of methodological texts that provide information on how to undertake and record field work, which can compel researchers to adhere to structured frameworks and miss significant events and occurrences in the field.

Mulhall (2003) suggests that there are two broad forms of observation, structured and unstructured. The use of the observational protocol I originally developed provided an overly structured approach for the nature of enquiry being undertaken. Balcom et al. (2021) suggest that structured observation is more conducive with a positivist research perspective, rather than within the naturalist paradigm of qualitative research. Salmon (2015) contends that structured observation is useful to record physical and verbal actions. Mulhall (2003) and Montgomery et al. (2020) concur that structured observation is useful when specific information is needed in answering a defined research question, or with which to code behaviours or responses. The structured protocol for observational data recording risked distorting the findings in an

interpretive study through a positivist approach, and therefore required revising (Balcom et al. 2021).

O'Reilly (2009) suggests written field notes in a notebook are a useful and valuable tool for observational data. Therefore, the structured protocol was abandoned and instead field notes and sketches were made in a notebook. Unstructured observation and the use of field notes enables the recording of the everyday practices and processes and for the spontaneous and unexpected to be easily captured in ethnographic field work (Balcom et al. 2021, Corman 2017).

3.6.1.4 Field notes

Field notes are a written documentation of the notes, drawings, intellectual ideas, and emotional reflections that are created in the field work of observation in ethnography (O'Reilly 2009). Green and Thorogood (2018) contend that field notes are a useful and appropriate source of data collection for ethnographic observations.

Emerson et al. (1995) suggest the use of jottings and full notes in ethnographic field work. Jottings allow for field notes to be made during the period of observation. Jottings were made during the observations of the care interactions between older people and district nurses, however, to maintain focus on the interaction as it occurred, some notes were made immediately afterwards (Creswell 2007). This also ensured that I maintained a presence in the care encounter, and did not appear rude, distracted, or disinterested and was able to contribute to the conversations that occurred, but was able to maintain accurate and contemporaneous records of the field work undertaken (O'Reilly 2009).

Full notes were made immediately after the field work of observation. Full notes included an in depth description and account of the care encounter observed (Emerson et al. 1995). The field notes provided detailed impressions of the care encounters observed, and with personal reflexive notes of my thoughts and feelings provided an authentic representation of

what was seen, heard, smelt, and felt (O'Reilly 200). As can be seen in appendix 1, it is the unstructured free text of field notes that more richly capture the intricacies and uniqueness of the observation.

Observations alone within a focussed ethnographic approach can make data unwieldy and lack focus (Green and Thorogood 2018). Using interviews in conjunction with observation addresses this problem and adds credibility to the findings (Hammersley and Atkinson 2017). As interviews and observations add depth to exploring what is occurring in the social situation and how it is understood by the participants (Green and Thorogood 2018), semi-structured interviews were also used.

3.6.2 Interviews

In depth interviews provide an opportunity for specifics in relation the research questions to be discussed. Interviews also offer a space in which details from observations can be clarified (O'Reilly 2009). Interview data sought to present explanations of the experience of, but not direct representations of, coproduced care, by providing an account of what people say (Green and Thorogood 2018). Interviews are context specific and a construction between participant and researcher of the social world under investigation and therefore do not seek to provide an objective truth but a subjective understanding and explanation (Miller and Glasner 2011).

Ethnographic interviews are relaxed and informal in approach yet follow the formal research processes of the study design and data collection that has been approved by the relevant ethics committee. An informal approach is developed through rapport (O'Reilly 2009). Robertson and Hale (2011) argue that actively listening to personal information can generate respect and provide the foundations for rapport and a relational context for interviewing older people in research contexts. Dejonkheere and Vaughn's (2019) guide to interviewing older people suggest that rapport provides a relational approach which is required when interviewing older people in research processes. As Robinson (2013) suggests, rapport was developed through preliminary interviews which collected demographic data and facilitated a

sense of familiarity with the participants before the research began (see appendix 2). Building rapport enhanced the opportunity for the natural behaviour and usual social interactions of the participants to occur in my presence once the data collection commenced (Nightingale et al. 2014).

Interview styles differ depending on the methodology and study design (O'Reilly 2009). Descriptions of interviews differ from text to text and appear interchangeable (Green and Thorogood 2018). For this study, structured, semi-structured and unstructured interviews were considered to compliment the observation data. Structured interviews are fixed questions and do not allow for further exploration of responses (O'Reilly 2009). These were therefore discounted. Unstructured interviews were considered to elicit a rich data in a narrative style (Mason 2002). However, it was perceived that the discussion may lose focus and may not address the research questions fully. Semi-structured interviews allow for specific questions to be asked to explore the nature of care and coproduction, allowing the participants to determine their own responses so that the information and data that was produced maintained participant perspectives throughout (Green and Thorogood 2018). Semi-structured interviews allow for additional questions to be asked as they arise and for checking clarity in responses. This method also allowed me to actively listen to responses and to prompt further depth and elaboration (Green and Thorogood 2018).

Greenwood's (2009) reflection on interviewing older people asserts that appropriate terminology is essential. Interview schedules (appendix 3 and 4), for this study were designed in collaboration with older people to ensure appropriate terminology (see section 4.3). However, the interview questions were formed in relation to the overall aims and objectives of the study. The actual research questions were not asked in the interviews, but these formed a topic guide using everyday language, non-leading and non-judgmental open questions (Green and Thorogood 2018). Nightingale et al. (2014) suggest that the researcher can potentially disturb the relationships of participants through the questioning and exploration of their interactions. I was able to reflexively draw on my professional knowledge and experience in

advanced communication in complex situations and apply this to the research setting (Madden 2009, Green and Thorogood 2018). All interviews conducted were individual, private, and confidential. District nurse interviews took place at an NHS trust base. Older people were interviewed in their own home. Due to the potential vulnerability of older people being interviewed alone at home, they were advised that they could have a friend or relative accompany them for this process if they wished.

3.7 Summary

This chapter has identified and discussed the philosophical and epistemological positions held that underpin this work. It has discussed how the research is guided by the theoretical perspectives of care and care ethics. The selection of a focussed ethnography methodology and its congruence to the ontology and epistemology of the research, and the methods used have been discussed. The next chapter presents the study design, which precedes a discussion of data analysis in chapter 4.

Chapter 4 Study design

4.1 Introduction

This chapter will explain the design of the study. It considers recruitment and selection of participants, the data collection process, and the ethical considerations for this research.

4.2 The study

The study design was a three-phase focussed ethnography which included a sequence of an individual semi-structured interview with each participant (appendix 3), an observation of a care interaction between a district nurse and an older person in the home, followed by a second individual semi-structured interview for each participant (appendix 4). Data was collected over a period of eighteen months duration.

Four district nurse participants were recruited and then subsequently four older people were recruited (see section 4.5), one for each district nurse, making four pairings. One older person, Dot, became unwell and was unable to complete the interview B. Data from Dot's interview A and the observation were included in the analysis. Table 4.1 presents the data set pairings.

TABLE 4.1 DATA SET PAIRINGS

District Nurse	DN number	Older person	Age of older person	Older person (OP) number	Pairing	Data set
Polly	DN 1	Dot	96	OP 1	Polly and Dot	Data set 1
Amy	DN 2	June	82	OP 2	Amy and June	Data set 2
Kate	DN 3	Bill	71	OP 3	Kate and Bill	Data set 3
Erin	DN 4	Flo	92	OP 4	Erin and Flo	Data set 4

In summary, each district nurse was paired with an older person (identified from their caseload). Box 4.1 illustrates the process taken with each data set. This process occurred for each of the four data sets (appendix 5). Appendix 6 presents a process map for the stages of this study.

BOX 4.1 PROCESS OF THE THREE-PHASE STUDY FOR EACH PARTICIPANT

- Demographic information was sought for each participant.
- Each district nurse had an individual interview A
- Each older person had an individual interview A
- Observed care interaction between each pair
- Each district nurse had an individual interview B
- Each older person had an individual interview B (excepting Dot (OP 1))
- Each participant was offered a closing telephone call.

Purposive sampling in focused ethnography ensures that participants are identified and selected by their capacity to provide rich information and thick description relevant to the study (Roller and Lovrakas 2015). However, the intricacies of qualitative research prevent a clear set of guidelines for the sample size of participants due to the pluralism of methodologies, theoretical and epistemological and ideologies within the paradigm (Vasileiou et al. 2018).

Roller and Lovrakas (2015) assert that in a focused ethnography the number of sites to be observed needs consideration in determining sample size. The number of observations was largely determined by the practicalities of the study. This included consideration of the resources and time available, as well as the breadth and depth of the research objectives and population group (Morse 2000, Roller and Lovrakas 2015). Although this study has a wide breadth in considering older people and district nurses, the resources and time were limited due to a part time academic award, which dictated the opportunity for observation. Furthermore, time and the accessibility of the participants was of prime consideration (Roller and Lovrakas 2015). The observations were in the home of the older people participants who were receiving care from district nurses which can be personal, intimate, and unpredictable. The participants were also experiencing long term health conditions and frailty. Therefore, the appropriateness of repeated observation needed careful consideration (O'Reilly 2009). One observation was identified as appropriate to capture rich in the care interactions between

the participants. Although limited in number one observation would provide data from four sites of observation, as each observation occurred in the home, thus adding to the richness and diversity in data (Roller and Lovrakas 2015, Latimer 2000).

Vasileiou et al. (2018) identify that the gold standard for determining sample size in qualitative work is that of data saturation, when no new codes or themes emerge from the data. Noble and Smith (2014) suggest that in qualitative research depth of data is more important than recruitment of large samples of participants. Vasileiou et al. (2018) concur that data accuracy is more significant than the number of participants and that a transparent rationale for the sample size is required. Morse (2000) suggests that the more useable data that is obtained from each participant, the less participants will be required and that some data collection methods will collect richer and more useable data than others, further reducing the sample size of participants.

Morse (2000) suggests that it is the scope, nature, and topic of the research that determines the number of participants. As this study has predefined research questions and is specific to the nature of care that is coproduced between older people and district nurses, making the topic clear, Morse (2000) suggests that less data is needed to reach saturation. As the study design is a three-phase focused ethnography it is longitudinal in style (although not a longitudinal research design), with data collection methods of two semi-structured interviews and one participant observation, less participants are required (Vasileiou et al. 2018). Green and Thorogood (2018) suggest that 6-10 participants is satisfactory for a single interview study in qualitative research. Morse (2000) concurs this number of participants is sufficient to provide the richness of data required for a focused ethnography. Therefore, a purposive sample set of 8 participants was identified as appropriate for this study. This would produce data from sixteen individual semi structured interviews and four observations, in which there would be two participants, equating to a set of 20 data sources.

The inclusion of observation reduced the sample size due to the amount of data that would be produced (Vasileiou et al. 2018). It was important to include observation of the care interactions in this study, as a core method of ethnography and to capture a real time pattern of interacting, due to the relational nature of the inquiry of working together and coproduction, although time in the field would be limited (Wall 2015). The participants would be seen in action together to compliment the recounting of experiences in interviews (O'Reilly 2009).

The pairings of older people with district nurses aimed to provide a lens for the depth of the relationships experienced, intending to capture the history of the relationship and the relational nature of working together over time (Womack et al. 2016). Although it would have been of interest to include a non-dyadic approach to the study design for a wider cultural picture and richer detail (Wall 2015), this study provides a detailed layer of fine detail need to understand the complexities of coproduced care between older people and district nurses, as this is an unknown area. A larger study would risk losing rich detail and presenting surface views (Morse 2000). As Womack et al (2016) suggest in their ethnographic case studies of partner dyads in American occupational therapy research, more layers to the study and a nuanced design for future work with different combinations of people and larger numbers will be present for different understandings. It is acknowledged that this study will represent the experiences of the eight participants, differences would be expected to emerge with different people participating (Mason 2002).

Each stage of the study design process will now be briefly explained.

4.3 Patient and public involvement

Public and patient involvement in research planning and design is a critical moral and ethical consideration. Involvement of public representatives from the groups included in the study can add to meaningful research (BGS 2018). The research design process included collaboration with Age UK, a national charitable organisation for older people, in which I worked with a

consultative group of older people. Consultation with district nurses was achieved by working with district nurses and practice educators in a local NHS community healthcare provider in the west geographical area. Both consultative groups reviewed publicity material, interview schedules, observation protocols and participant information sheets documents for design, language, jargon, and terminology. Bagley et al. (2016) suggest that this process ensures that the documents are participant friendly and relevant.

Following consultation, changes were made to font and colour for ease of reading on the flyers, and some wording was changed on the participant information sheet for improved clarity. Further feedback and clarification on the changes made were sought from the consultation groups. Feedback was received positively on the documents and no further changes were identified prior to seeking ethical approval. Both groups agreed to remain as a consultative resource throughout the duration of the study should any further advice be required on any subsequent documentation.

4.4 Ethics

4.4.1 Ethical considerations

Vulnerability was considered throughout to ensure participant wellbeing. Older people living with frailty and requiring care can imply potential issues of vulnerability. Older people living with frailty were included in this study to ensure that the views, perspectives, and experiences of older people were heard and valued, and with which to inform care practices (McMurdo et al. 2011, Barnes 2012).

Some data collection occurred in the home, and this produced a risk of lone working. Visiting homes was necessary due to the participant group and is supported by Jokinen et al. (2002), who suggest that working with older people at home provides a balanced and trustful relationship in research processes. Risk (appendix 7) was managed in accordance with the university's policy for research ethics and safety. A distress protocol (appendix 8) was available should a participant become upset from the telling of personal and emotive stories. Safeguarding for older people was

managed via trust policy and guidelines and the NMC (2018) code of professional standards and behaviour.

Capacity to give informed consent to participate which was assumed in all participants (Department of Constitutional Affairs (DCA) 2005). Mental capacity fluctuates and can be impaired with medical conditions and must be assessed by a healthcare professional, for each specific decision, should it be questioned (BGS 2015, DCA 2005). I hold the ability to assess and determine capacity through extensive advanced level nursing experience, however, this was not required. If there was a concern of capacity the research interaction would have been stopped, rescheduled if appropriate to do so, and the participant withdrawn from the study if issues of capacity persisted. If there was doubt in the provision of informed consent any existing data would have been excluded from the study (Shaw et al. 2015). If a change in capacity or health status had been identified this would be referred on to a predetermined person, agreed with the NHS trust research and development team (DCA 2005). These situations did not occur. Older person one (Dot) withdrew prior to interview B due to physical health. No personal information was retained in relation to the participants. The district nurse participants acted as gate keepers of older people's personal information and only given names were discussed with me. I held addresses of the older people for the duration of the study only and sought consent by telephone to visit on each occasion. Informed consent was sought as an iterative process throughout (see 5.4.3) (Gupta 2013).

4.4.2 Ethical approval

The study was approved by the University of Brighton's Research Ethics Committee as part of a PhD study. The study received external approval from IRAS the NHS Health Research Authority (HRA) in February 2018. Minimal changes were required to the study materials to gain ethical approval for the study by the HRA. This included being explicit in the documentation that the study would not include older people in receipt of palliative care. The participant information sheet for older people was altered to include the sentence 'you may ask a friend or relative to be present during

you interview'. Clause five of the consent form for older people was further broken down into smaller statements. The advertisement to recruit older people participants was amended from 'you will need to be able participate in all phases of the study' to 'ideally you would be able to participate in all phases of the study'. Documents for the study were annotated with the University's logo and address. There were no adjustments required to the study design.

4.4.3 Consent

Informed consent is a legal and ethical imperative in which people should not be coerced or persuaded to into research (Green and Thorogood 2018). Consent was sought and obtained for all participants who voluntarily responded to the invitation to take part in the study. Each participant was given the opportunity to take time to further consider participation, however, all the participants gave informed consent at the initial meeting.

In gaining initial informed consent I systematically went through the consent form with each participant (appendix 9 and 10), to ensure understanding and the capacity to consent (DCA 2005). Verbal consent was accepted for any participant who was unable to provide written consent, due to physical health or dexterity, and a note made on the consent form. Participants were advised, and it was reiterated in the participant information sheet (appendix 11 and 12), that they would be able to withdraw from the study at any time without giving a reason, with no implications to their care or work role (NPSA 2011).

Consent to participate was more complex than the linear process described. Crowhurst (2013) asserts that consent is a dynamic process during data collection. Kara et al's (2022) ethnographic study in social work highlights that ongoing consent is of particular importance in contexts where power dynamic can be imbalanced or intricate. They suggest that consent can be erratic when working in homes, where consent and access require specific attention. Crowhurst (2013) suggests that reflexivity and reflection allow

researchers to manage the unpredictability of access and consent when working in homes.

4.4.4 Confidentiality

Confidentiality practices were followed that utilised the university's research ethics code, the NHS code for confidentiality, and the NMC (2018) professional code of practice. No personal health records were accessed or included for data analysis.

All data collected was coded to ensure anonymity and protect confidentiality (McGarry 2009). All identifying personal information was anonymised and participants were assigned a pseudonym (DeChesnay 2015, NSPA 2011, NMC 2018). The district nurse participants were given a pseudonym and a pre-fix of DN, followed by a number to pair them with the older person they worked with. The older people were given a pseudonym, a prefix of OP and a number to pair with their district nurse. The district nurse and older person were not made aware of each other's pseudonyms to ensure confidentiality.

All hard data was stored in a locked filing cabinet within an academic office in the School of Sport and Health Sciences at the University, with a card code entry to the office. I undertook all transcribing. Digital data was recorded on to an audio voice recorder and then uploaded on to a secure, password protected, online platform (One Drive) and was password protected. Data storage met compliance with the Data Protection Act (DCA 2018). Only my supervisory team and I have had access to the data. Data will be destroyed after ten years as per university policy. Destruction will be through shredding of paper and deletion of digital files and audio recordings.

Consideration for the participants after the completion of the study included a recognition that participants may be upset or affected by the writing up of findings (O'Reilly 2009). It is the researcher's responsibility to the participants to portray veracity throughout the research process and in documenting the findings (Dimitrios et al. 2020). However, utilising ethical research practice

and confidentiality aimed to ensure that participants were not negatively affected by any publications or findings (Aull Davies 2008).

An anonymised summary of findings was offered on completion of the study, as a way of closing the study, but it was also recognised that some participants did not wish to be informed of any findings which was also respected (Aull Davies 2008, O'Reilly 2009).

4.5 Recruitment of participants

Participants were sought in two local community health trusts geographically located in the East and West of the county in which this study took place. Both trusts were initially included in the study to provide wider access to more participants. However, the participants were recruited from one trust (East), as these were the first to respond.

McMurdo et al. (2011) suggest that successful recruitment of older people starts at the planning stage of research. Fudge et al. (2007) consider practical issues for recruitment, such as access. Accessibility for this study was concerned with accessing participants at home, as opposed to older people being able to access the study.

4.5.1 Accessing participants

Liaison with the NHS trust research and development departmental leads within each organisation ensured the required governance was in place. Practice development facilitators for district nursing acted as gate keeper to the trusts. Gatekeepers provided permission and access to the field and participants, however, did not contribute to any of the research processes undertaken (O'Reilly 2009).

McMurdo et al. (2011) advocate for the use of flyers and advertisement material with which to recruit research participants in primary care. Advertisement flyers were circulated to district nurses via the gate keepers within the NHS organisations (appendix 13). The flyer directed them to contact me for further information. The district nurses who responded to the flyers were previously known to me as district nursing students at least four

years prior to the commencement of this study, in my role as a district nurse educator. As I had not worked as a district nurse in the East trust, I had no ongoing professional or personal relationship with those who wished to participate. No district nurse who was not known to me contacted me to participate in the study.

The previous connection with the district nurse participants has the potential to introduce bias to the study (Smith and Noble 2014). Bias in research is the potential distortion of findings and results (Polit and Beck 2008). This was a potential issue as, as a researcher I was closely aligned with the sample of participants and this had potential to influence data collection, introducing bias through the relationship dynamics (Polit and Beck 2008, Smith and Noble 2014). It is acknowledged that responses to interview questions by district nurses may have been different if we were not known to each other in any capacity and may have been influenced because of a perceived expectation to what the 'correct' or required responses were. Molgard et al. (2021) suggest an emphasis on the role as a researcher and highlighting the focus and purpose of the study can ensure clarity, expectations, and processes in research can mitigate this and this was therefore ensured.

However, as bias is term more commonly associated with quantitative research, due to the subjective nature of qualitative research rigour and trustworthiness are further considered in qualitative research (Galdas 2017). Transparency and reflexivity contribute to an academic rigorous approach to research, therefore, accounting for any potential bias in sampling strategies is essential (Galdas 2017, Smith and Noble 2014). There were no alternatives to support the recruitment of district nurses, and it is a limitation of this study that the district nurse participants were previously known to me. However, trustworthiness can be assured by the ethical approval of the HRA, the openness of the identified limitations within this study and mu reflexive account and considerations of rigour (Smith and Noble 2014). Rigour is further discussed in section 5.4.

I met with the district nurse and further explained the project and provided a participant information sheet. Informed consent was then sought. The nurse was then provided with a briefing note (appendix 14) and an information and advertisement flyer for older people (appendix 15). The nurse and I then discussed the PRISMA 7 frailty assessment scale (British Geriatric Society 2015).

The PRISMA 7 scale (BGS 2015) is a recognised and validated assessment tool that can be used for the identification of the potential risk of frailty in older people. It was selected for its ease of use (Hoffman et al. 2020). If a person scored 3 or more on the scale, they were perceived to be at risk of experiencing frailty (BGS 2015). This tool was used for purposive sampling and identification of potential frailty at the commencement of the study and was not reused or referred to again.

BOX 4.2 PRISMA 7 FRAILTY SCALE (BGS 2015).

The PRISMA 7 scale (BGS 2015)

Are you more than 85 years old?

Are you male?

In general, do you have any health problems that limit your activities?

Do you need someone to help you on a regular basis?

In general, do you have any health conditions that require you to stay at home?

In case of need, can you count on someone close to you?

Do you require a stick, walker or wheelchair to get about?

The nurse was asked to identify three older people from the district nursing caseload who met three of the PRISMA 7 (BGS 2015) criteria, then to pass the flyer to the first of the three older people using the briefing note. Forstat et al. (2020) suggest older people are likely to respond to written information requesting participation in research. The flyer directed older people to contact me for further information, in doing so I sought permission and visited them at home, provided a participant information sheet, discussed the study, and sought informed consent to participate. If an older person did not respond to the flyer the district nurse was asked to pass the flyer to the second older person previously identified, to be repeated until four data sets were recruited. Three potential older people were identified to increase the feasibility of the study. However, recruitment of older people to the study was

not as challenging as the literature had indicated (McMurdo et al. 2011, Forstat et al. 2020). The first older people that were approached me were recruited.

It is acknowledged that there is a further limitation to this study in the recruitment process for older people. There was a potential for the district nurse participants to select their preferred patients for inclusion in the study, risking the further introduction of potential bias. There was also a risk that the older people approached may feel obligated or compelled to agree to participate due to being in receipt of and dependent on care from the district nurse suggesting participation. However, the procedure and practice of informed consent in the recruitment of participants aimed to reduce the potential bias (Gupta 2013, Smith and Noble 2014). Recruitment of older people to the study and the acquisition of informed consent was undertaken without the presence of the district nurse. Older people could have a friend, relative or carer with them during the recruitment processes, and consent was gained on an ongoing and iterative basis (McMurdo et al. 2011) All participants were advised that they could withdraw from the study at any time without giving a reason, and any withdrawal of an older person would not be discussed with the district nurse (Gupta 2013). As I was unable to identify any other way of accessing the participant cohort of frail older people this potential bias and limitation could not be avoided. The transparency of the limitations identified in the recruitment process of this study aims to improve rigour and trustworthiness (Galdas 2019). District nurses identifying older people on their caseloads to participate in this research did facilitate pairings who were well known to each other and who had an established caring relationship, contributing to a richness of data for this study.

4.6 Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied. Box 5.3 illustrates the principal inclusion criteria for district nurses.

BOX 4.3 PRINCIPAL INCLUSION CRITERIA FOR DISTRICT NURSES

- Will be employed by an NHS trust which is included as a setting for the study
- Will be working with frail older people
- Will be willing to participate and share experiences of care
- Will be able to give written informed consent to participate in the study
- Will have held the community specialist practice qualification in district nursing for at least six months on commencement of the study

Forstat et al. (2022) and McMurdo et al. (2011) suggest that exclusion criteria can limit the participation of older people in research processes due to co-morbidities. Exclusion criteria were limited to end of life and dementia, as were not appropriate for the nature of the three-phase study. Box 5.4. illustrates the principal inclusion criteria for the frail older people cohort.

BOX 4.4 PRINCIPAL INCLUSION CRITERIA FOR FRAIL OLDER PEOPLE

- Have been in receipt of district nursing services for at least six months
- Be willing to participate and share their experiences of care with district nurses
- Be able to provide informed consent (written or verbal)
- Be able to communicate in English
- Be aged 70 years or over
- Be willing for the researcher's supervisory team to have the address of interview location for lone working purposes
- Obtain a score of 3 or more on the PRISMA 7 scale for frailty (BGS 2015)
- Hold capacity with which to provide informed consent (DCA 2005)

There were no exclusions in terms of ethnicity or gender. A specific exclusion criterion for this study was that the participants needed to be able to communicate in English, due to my limited ability to communicate in any other language and lack of interpretation services. It is acknowledged that this could potentially limit cultural diversity to the study (Fudge et al. 2007). Consideration was given to using communication boards. These had potential to be included due to my experience in using them. However, as it would have been difficult to capture data for analysis using this method of communication in the research design, these were excluded. This is a potential limitation of the study due to lack of inclusion of people who could be key contributors with valuable insight into the concepts being explored. However due to the time and resource restrictions of this research being a part of a PhD study, this was considered necessary.

4.7 Demographics

Each participant was asked to provide their demographic information to establish social and workings circumstances relevant to the participant group, should this have any implications for the research findings (O'Reilly 2009). Fudge et al. (2007) suggest that cultural divisions can prevent older people from participating in research. It is impossible to know if any older people would not have responded to the flyer due to perceived cultural issues, as the older people who did respond were the first to be approached by the nurses. All participants were white British, all four district nurses were female, three older women and one older man participated.

4.7.1 Local demographics

There was an increase of 19.5% of over 65s in the Southeast in 2021 and the local population increased 0.9% to 91,100 in 2021. The Office for National Statistics will not publish data on ethnicity from the 2021 census until November 2022. Data from the 2011 census identifies that the Southeast of England has a predominately white population of 90.4%, higher than the national average for England which is 85.4%. This demographic data (table 4.1) illustrates why a more culturally diverse sample set was not accessible for this study.

TABLE 4.1 ETHNICITY DATA ENGLAND AND SOUTHEAST (ONS 2020A)

	Southeast	England
White	90.6%	85.4%
Asian	5.2%	7.8%
Black	2%	3.5%

TABLE 4.2 POPULATION BY GENDER IN LOCAL AREA (ONS 2021)

	Women (total)	Men (total)	Women Over 70 years	Men over 70 years
Southeast	4,674,617	4,542,648	747,629	512,806
East Sussex	288,064	270,788	61,475	51,008
Local town	47,268	45,286	7,605	6,304

The ONS (2021) data on gender illuminates a higher number of women in the county and town where the research took place (table 4.2), which further explains the demographics of the data set.

4.8 Summary

This chapter has presented the research design and the research processes undertaken for data collection. The process and framework used for the data analysis in this study is considered in the next chapter.

Chapter 5 Data analysis

5.1 Introduction

This chapter will explain the process of data analysis that was undertaken. The data analysis method of framework analysis (Ritchie and Lewis 2005) will be explained, with a rationale for its use and its congruence with the philosophical and theoretical positions held. A brief account of the process, with examples from the data will be presented. Rigour in data analysis will be considered.

The process of data analysis in qualitative research is to present an organised representation of the data that is authentic, rigorous, and transparent (Mason 2002). Qualitative data analysis can be challenging due to the plethora of messy complex and diverse data collected (Green and Thorogood 2018). O'Reilly (2009) suggests that ethnographic data analysis is an inductive, interpretative, and iterative process between the researcher and the data, in which the development of new ideas, insights, meanings, and understandings occurs.

Noble and Smith (2014) consider that identification of an appropriate approach to data analysis can be challenging for qualitative researchers due to the multiplicity of models and approaches available. I selected the framework analysis model of data analysis (Ritchie and Spencer 2005). Parkinson et al. (2016) suggest framework analysis is now increasingly used in health and social science research when there is an experiential focus that produces large amounts of data. Framework analysis is useful in generating practice-based outcomes, when there is a limited timeframe, for researchers with competing demands who must stop and start analysis (Green and Thorogood 2018, Srivastava and Thompson 2009, Agarwal and Sutton 2011). Gale et al. (2013) contend that the framework method is adaptable for use with semi structured interviews and observational field notes, thus aligning it with this focussed ethnography.

5.2 Framework analysis

Framework analysis is a method of qualitative data analysis that originated in applied policy research (Ritchie and Spencer 1994). It is a method of data analysis that allows for moving past description in analysis, to the development explanatory accounts, seeking applications to wider theory, with the possibility of theory generation (Srivastava and Thompson 2009). The framework analytical model (Ritchie and Lewis 2005) used can be found in appendix 16.

Thematic analysis is core to the framework method and is a process of interpreting qualitative data in a structured and systematic process to identify patterns, differences and relationships that can provide a description (Smith and Firth 2011, Gale et al. 2013, Ward et al. 2013). Processes of thematic analysis are synonymous with social constructionism as they allow for the exploration of the ways in which interactions, experiences and realities occur in localised and situated contexts (Braun and Clarke 2006). Using a thematic analysis within a framework approach enabled me to examine the data to elicit how coproduced care was constructed, the experience of the nature of care and what meaning this had for the participants, in their social lives. It was possible to explore the political influences in the data and how culture and philosophy shaped the social experiences of coproduced care. The theoretical perspectives of care and feminist care ethics provided a lens for the nature of care experiences of older people to be explored, and to illuminate what informed the nature of care for older people in social context of home with district nurses.

The processes of framework data analysis are presented in table 5.1, as outlined by Ritchie and Lewis (2005). A process map of the working of the stages for this study is presented in appendix 17.

TABLE 5.1 STAGES FRAMEWORK ANALYSIS (RITCHIE AND LEWIS 2005)

Stages of Data Analysis in Framework Analysis
1. Familiarisation
2. Developing a framework
3. Labelling
4. Developing a working analytical framework
5. Applying the analytical framework
6. Charting the data into the framework
7. Interpreting data

In using Framework analysis (Ritchie and Lewis 2005) for data analysis, I reached stage 6 before encountering some challenges. At this stage Braun and Clarke's (2019) thematic analysis became more useful, this will now be explained.

5.3 Process of data analysis using framework analysis

5.3.1 Familiarisation

The familiarisation stage allows the researcher to become immersed in and fully aware of the raw data. Familiarisation with the data included reviewing interview transcripts and listening to the audio-recordings of interviews to re-emphasise a sense of what was important and of concern for the participants in their experiences (Parkinson et al. 2016, Gale et al. 2013, Ward et al. 2013).

5.3.2 Developing a framework

Identifying a framework aims to organise data so that it can be easily retrieved later in the analysis process (Ritchie and Lewis 2005). An analytical framework was developed inductively from the data through a process of labelling the data, as discussed next (Parkinson et al. 2016).

5.3.2.1 Labelling

A label that describes what has been considered as important by the researcher (Gale et al. 2013). The data from the interview transcripts and the observational field notes were ascribed by hand with interpretive labels that described what was seen to be occurring in the data in relation to older people's experiences of care with district nurses (Ritchie and Lewis 2005). The data was then reviewed again, and the labels assigned were refined and re-assigned until a preliminary set of 85 labels were devised (appendix 18) (Gale et al. 2013).

The labels were then organised into groups or domains. An iterative process of reviewing the labels for conceptual meaning and repetition produced a working set of 49 labels grouped into fourteen domains (table 5.2). A photographic audit trail of the iterative process can be seen in appendix 18.

5.3.2.1 Developing a working framework

Richie and Lewis (2005) assert there are more steps to framework analysis before themes should emerge, however, concurrent with Ward et al. (2013), early themes began to gradually develop at this stage of the process as seen in appendix 18.

TABLE 5.2 FINAL ANALYTICAL FRAMEWORK

Final analytical framework	
Label	Domain
Difficulties Together Listening Understanding	Working together
Friend Knowledge Trust Familiarity	Knowing
Chatting Histories /past	Everyday conversations
Recognition Respect Reflective behaviour	Mirroring and modifying
Going Staying Place	Being home
Private Organisation	Showing home
Stuck Housebound Safety Preferred place	Staying home
Equipment Stuff Materials	Medicalised home
Difference Problems Labels Object	Body in parts
Fit Changes Independence/ dependence Frustrations	Losing youth
Agency Person knows best Recognition Role Negotiation Nurse knows best Deciding Convincing	Expert in self
Busyness Priorities Time	Busy
Discharge Moving on to the next Self-care	Throughput
Routines Occupation	Rhythm and routines

5.3.3 Applying the analytical framework

The framework was applied allowing the data to be seen together, noting of anything of significance (Ward et al 2013). Table 5.3 provides an example of the domains of 'expert in self' and 'knowing' in the application of the framework to a brief extract of an interview transcript.

TABLE 5.3 EXAMPLE OF APPLICATION OF FRAMEWORK FOR ANALYSIS TO TRANSCRIPT

Flo interview B page 1	
Transcript	Application of framework. Labels from domains of 'expert in self' and 'knowing'
<p>HM: ... to talk about the visit that has just happened Flo and to ask if this is a typical visit from the nurses</p> <p>Flo: it is more than typical when she does it (Erin) she will really, you know, she really puts her heart and soul into it, you see how she cleans it, the others are very good, they clean it and this sort of thing but they don't put the effort in that she does, I mean she creams it and all that sort of thing which they don't, they cream around the parts that they have got to but she creams every other part of my leg do that the skin doesn't get too boggy or crispy yeah, no, she is always an exceptional visit when she comes and it always feels better because it always feels cleaner and she is the best one for bandaging taking time the best one</p> <p>HM; do you think she is, it's is different because she is the team leader, because she is the district nurse with the qualification or</p> <p>Flo: probably that's helping that she has got the qualifications because, I can't say that she is any better but she has got a better way with her and she knows what she is doing and she will look and she will turn your leg almost upside down whereas the others will look and say oh yes that's nasty at the back and they just do little bits that need to be done but she will really go to town and clean it all round, she always does that little bit extra.</p> <p>HM; how often does she come? How often do you see her</p> <p>Flo: maybe once a month because I think she is so busy with new people and others that are worse, mind you when it was bad I used to have them every day and when it was really bad she came you know twice a week but as it has improved, there are others who are worse than me now so I see her about once a month. But it is always lovely when I see her standing in the doorway because I know it is going to be done properly</p>	<p>Knowledge</p> <p>Trust</p> <p>Familiarity</p> <p>Knowledge</p> <p>Trust</p> <p>Knowledge/ negotiation</p> <p>Familiarity</p>

<p>HM: do you feel reassured that she is keeping that over all</p> <p>Flo: yes, that she comes at least once a month to see to it, yes, cos I know if anything goes wrong, I mean the girls, if anything goes wrong they put it on their thing and they talk about it lunch time, when they go to lunch and then she comes the next day to see what was wrong so she keeps an eye on me even though she doesn't always come she goes by whatever the girls tell her, which is her job I suppose, but she knows what she is doing, oh yes she does. You wouldn't get one over her (laughs)</p>	<p>Trust</p> <p>Knowledge/ nurse knows best</p> <p>Familiarity</p>
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Original in colour

5.3.4 Charting the data into a framework matrix

Gale et al. (2013) suggest using a matrix for each domain and transcript to organise and summarise the data. Table 5.4 provides an example of a matrix for the domain of knowing for one participant.

TABLE 5.4 BRIEF EXAMPLE OF FRAMEWORK MATRIX

Framework Matrix for domain of Knowing				
	Friend	Knowledge	Trust	Familiarity
Kate DN 3	they see us as friends A8	<p>one day they can be totally unsure about something and then they see it the second time they built on that knowledge,A1</p> <p>saying to someone you're not as important, your need isn't as great A3</p> <p>nine times out of ten they are right, they know their bodies better than we do A6</p> <p>rather than sort of taking the lead themselves, they wait for you A6</p> <p>they haven't quite grasped the IT A7</p>	<p>they emotionally attach to you and then it is really difficult to get out A5</p> <p>respectful relationship I would say it is a partnership A6</p> <p>if they know you were coming back A9</p> <p>trusting, very trusting, because I was able to deliver what I said I would A13</p>	<p>you can see that that has made a difference to their day A6</p> <p>we have got one patient who is particularly wanting to see one nurse A9</p>

Hackett and Strickland (2018) suggest that interpretation in framework analysis is to develop themes by reviewing the matrix and making

connections and links between domains and participants. However, at this stage of the data analysis process the charting and mapping of the data into a framework matrix became challenging as it interrupted the process of interpretative analysis of the data. Charting data into a matrix was focussed on organising data (Ritchie and Lewis 2005). However, this impeded my thinking as the interpretive nature of data analysis was stifled as creativity and reflexivity were limited by processes of organising, limiting my sense of immersion in the data and of understanding the data (James 2013). The use of charting made it difficult to get a full sense and understanding of the data set as a whole, as it became fragmented. Reviewing the transcripts and field notes was more useful for interpretation as the matrix was for the organisation of data rather than analysis (Parkinson et al. 2016).

Noble and Smith (2014) suggest that despite the multiplicity of models and approaches to qualitative data analysis that there are core commonalities. These include immersion in the data, developing codes or labels, linking codes, identifying themes and pattern formation and the provision of illuminating description of what is occurring with the data. Noble and Smith (2014) account of data analysis omits the stages of charting and matrixing data found in framework analysis. Noble and Smith's (2014) core aspects of data analysis has similarities with Braun and Clarke's (2019) stages of thematic analysis approach to qualitative data analysis. Braun and Clarke's (2019) thematic analysis model was utilised in the analysis and synthesis of the literature review of this study and was found to be useful and allowed for interpretative analysis, without the challenge of charting. Ritchie and Lewis (2005) contend that a process of thematic analysis is key to framework analysis. As I was finding charting and use of a matrix interrupted interpretative thinking, Braun and Clarke's (2019) framework for thematic analysis was adopted. This is an approach to qualitative data analysis that is congruent with answering research questions that relate to people's experiences, views, and perceptions (Brule 2020).

Braun and Clarke's (2019) reflexive thematic analysis framework is a six phase process, as presented in Box 5.1. Stages 1 and 2 had been

completed as they were congruent with the initial stages of framework analysis, with the difference of labels being redefined as codes together in domains, this had enabled the generation and creation of early themes, as can be seen in appendix 18. The process of applying the framework and of developing matrices was abandoned and the interpretive processes of phases 4-6 of Braun and Clarke's (2019) model were followed instead.

BOX 5.1 REFLEXIVE THEMATIC ANALYSIS BY BRAUN AND CLARKE (2019).

Reflexive thematic analysis

Phase 1- Familiarisation with the data

Phase 2- Generating initial codes (labels and domains)

Phase 3- Generating themes

Phase 4- Reviewing potential themes

Phase 5- Defining and naming themes

Phase 6- Producing the report.

5.3.5 Interpreting data

5.3.5.1 Generating reviewing and defining themes

Interpretation of data was iterative until patterns and themes began to make sense in relation to the research questions. The research questions provided a framework for the development of themes, as themes emerged that captured anything that was perceived to be significant in answering these (Braun and Clarke 2006, Gale et al 2013, Parkinson et al. 2016).

James (2013) suggests that qualitative data analysis is an imaginative process. Imagination has tension with veracity in data analysis, however imaginative processes do not to make data into something it is not but make sense of it through a creative and in-depth grasp (Hammersley 2017, Green and Thorogood 2018). Drawing on understandings of the coproduction of care, and the nature of care in the relationships and experiences within the data, analytical concepts of the imagined the reality of life for older people and district nurses were developed (James 2013).

When the narratives within the data were placed within a broader context, they were then shaped by my experience and knowledge, the theoretical frameworks of feminist care ethics and the caring science of nursing, and my

philosophical positioning. What constituted the coproduction of care for older people with district nurses when home was the place of care began to emerge, constituted by the domains (James 2013). This created a picture of a cultural reality of the coproduction of care for older people with district nurses (Mason 2002). Relationships and the place of care were important within the data for care and opportunities for coproduction, care for centred on the bodies of older people in the home, and time was a clear contributor for coproduction. The generation of themes were beginning to be created (Braun and Clarke 2019), and the important constituents for the coproduction of care had thus been identified however, these did not explain how coproduced care was experienced with enough clarity or depth as the themes were not capturing an explanation of the nature of care. Iteratively returning to the data with a subjective critical reflexivity, framed again by the research questions (West 2011), a comment was noted from Erin (DN 4):

'You have to be mindful' (Interview B page 8)

An analytical imagining (James 2013) of the mindful attentiveness to the relationships, place of care, bodies, and time as the constituents of coproduced care further developed the themes generating explanation of the data (table 5.5). When care was coproduced between older people and district nurses' connections were crafted in the care-full place of home, where the bodies of older people were minded, and caring time was heeded.

TABLE 5.5 THEMES AND CONSTITUTING DOMAINS

Themes that constitute the nature of coproduced care	
Theme	Domains
Crafting connections	Working together Everyday conversations Knowing Mirroring and modifying
Care-full places	Being home Showing home Staying home Medicalised home
Minding bodies	Person in parts Losing youth Expert in self
Heeding time	Busy Throughput Rhythm and routine

The placing of the data and the emerging analytical concepts in the broader context of the research questions, philosophical position and theoretical frameworks provided explanations of coproduced care, how it was experienced and what was shaping and influencing this (James 2013). Narrative patterns emerged outside of the domains and themes of the cultures of care that influenced care experiences, which are given further consideration in the next chapter. Rigour in the research process will now be discussed.

5.4 Rigour

Rigour in qualitative research includes evidence of trustworthiness that the analysis and interpretation of the data uncovered has been undertaken in a systematic and careful approach (Noble and Smith 2015, Johnson et al. 2020). Rigour in qualitative research is related to the trustworthiness and quality of the work (Korstenjens and Moser 2018). Methodological rigour for this research study was addressed through consideration of the position of self as a researcher in the methodology chapter (see section 3.6) Rigour is further considered here using the four criteria identified by Lincoln and Guba (1985); credibility, dependability, confirmability, and transferability.

5.4.1 Credibility

Credibility refers to assurance of truth of the data and the interpretation of data, evidenced through a transparent audit trail (Hackett and Strickland 2018). Credibility relates to the extent in which the research results mirror the views of the people under study, with plausible information drawn from the participants and an authentic interpretation of original views of the participants presented (Korstjens and Moser 2018). Credibility is further demonstrated through the authenticity of the interview transcripts and observation protocols, providing a 'believability' of the data (Lincoln and Guba 1985). Korstjens and Moser (2018) suggest that credibility in qualitative research can be evidenced through prolonged engagement, persistent observation, triangulation, and member checking. Box 5.2 identifies how credibility has been assured within this research study.

BOX 5.2 CREDIBILITY USING KORSTJENS AND MOSER (2018)

Activities for credibility	Actions taken
Prolonged engagement	Examples were elicited in the interview data, and points of clarification were sought in both the interviews and observations. There was a long lasting engagement in the field with a three stage approach to data collection over 3 months for each pairing that was initiated with a preliminary meeting that developed rapport and trust between me as the researcher and the participants.
Persistent observation	Developing labels, domains, and themes to help examine, understand, and explain the characteristics of the study. An iterative process to data analysis which included re-reading, review and refinement of concepts and understandings
Triangulation	Different data collection methods were used which included field notes from observations and interview transcripts. There were four data sets of participants and eight participants which provided a range of views, experiences, and perceptions.
Member checking	Issues and points of clarity were followed up throughout the three-phase approach to the study.

5.4.2 Dependability and conformability

Dependability and conformability relate to the evidence of a clear audit trail and documentation of the research study. This can be demonstrated within this study by the clear and transparent discussion of the steps and processes taken within the study design, how the research processes were undertaken, the data analysis process that was utilised, and the development and reporting of the findings (Korstjens and Moser 2018). The study is replicable in its methodology, methods, and design. However, interpretation and findings may differ due to the subjective nature of enquiry, similarly different participants would have differing experiences due to multiple realities of care. Transparency is evidenced in the account of moving from raw data to themes, findings, and analysis (Noble and Smith 2015). Ethical approval from the HRA gives some credence to the robust and dependable design of the study (Korstjens and Moser 2018). Confirmability is evident as the concepts and theories derived within the research are reflective of the voices of the participants (Korstjens and Moser 2018).

5.4.3 Transferability

Transferability is a process of displaying rich descriptive data so that readers can apply this to other contexts. Use of quotations and excerpts may allow for others to draw their own conclusions as to the transferability of the findings to other contexts (Green and Thorogood 2018). Rich description has been provided in the context of the findings and the description of experiences, but this has been strengthened with an in-depth description and analysis of the context in which the participant experiences of care occur, which is within the home. The transferability of the research is therefore improved as the descriptions made can be understood by those who were not part of undertaking the research, or by non-participants (Korstjens and Moser 2018).

5.5 Summary

This chapter has explained the approach and process and data analysis undertaken, and how labels, domains, and themes were identified. The next chapter will present the findings of the data.

Chapter 6 Findings

6.1 Introduction

This chapter discusses the findings from the analysis of the data and presents the four themes that emerged from this process. The data will be presented using an overview of the domains and themes. The chapter will explore the experiences of care and the nature and extent to which these constitute the coproduction of care, illuminating meaning and understanding in the data, drawn from the participants.

Due to the intricate nature of the data sets, these are re-presented here (table 6.1). Within this chapter, all participants are referred to by their allocated pseudonym.

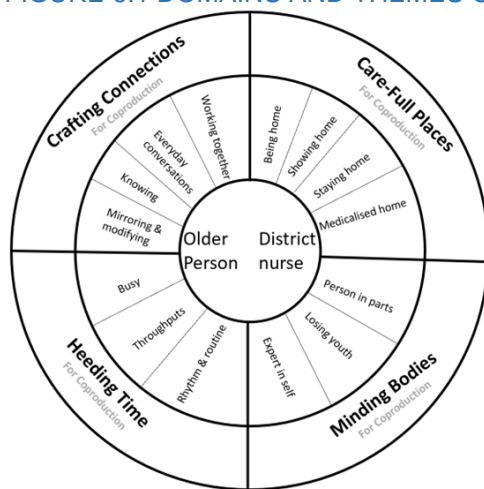
TABLE 6.1 DISTRICT NURSE AND OLDER PEOPLE IDENTIFIERS AND PAIRINGS

District Nurse	DN number	Older person	Age of older person	Older person (OP) number	Pairing
Polly	DN 1	Dot	96	OP 1	Polly and Dot
Amy	DN 2	June	82	OP 2	Amy and June
Kate	DN 3	Bill	71	OP 3	Kate and Bill
Erin	DN 4	Flo	92	OP 4	Erin and Flo

To provide illustrative examples from the interview data, quotations will be used. The quotations selected present authentic accounts from the participants in the context of what they are describing. In places, the quotations are in depth. This is to ensure that the voices of the participants are heard and to demonstrate that the findings have emerged from analysis of the data. Field notes and notes from the observation protocol are also referred to, which provide an illustration of the rich ethnographic observational data that formed part of the analysis (Creswell 2007). Excerpts from the field notes are presented in boxes in the text.

Following the detailed analysis of the data fifteen domains were identified, informing the development of the four themes which are presented in this chapter. The following illustration (Figure 6.1) demonstrates how the older person and district nurse were central to this study and conceptualised as being situated together in the context of care. Figure 6.1 identifies the fourteen domains that were identified within the data. These are illustrated as surrounding the older person and district nurse and depicts how these domains constitute the interpretative themes that subsequently emerged in the analysis of the data.

FIGURE 6.1 DOMAINS AND THEMES OF COPRODUCTION



The four themes that emerged from the data and that are constituted by the fifteen domains are:

- **Crafting connections**
- **Care-full places**
- **Minding bodies**
- **Heeding time**

The findings are presented in each of the four emergent themes in turn. This linear and static presentation of the themes is not reflective of the complex processes and practices of care and of coproduction that were found in the interpretative analysis of the data but have been separated out here for clarity in their explanation. The four themes of crafting connections, care-full places, minding bodies, and heeding time will now be presented in turn.

6.2 Crafting connections

The theme of crafting connections considers the value and importance placed on the connections and relationships. The domains within this theme consider how relationships were formed, maintained, and developed over time and how the relationships informed the coproduction of care at home. Crafting connections draws on the data and identifies how care was experienced by older people when they worked and interacted together with district nurses. The theme of crafting connections emerged from the following domains, which will then be discussed in detail:

- working together
- everyday conversations
- knowing
- mirroring and modifying

6.2.1 Working together

Human interactions and social connections allowed the older people and district nurses to come together, in the context of care, forming relationships when they worked together. The connections that were crafted in the care interactions were significant to both the older people and district nurses. Relationships appeared established and somewhat deeper than that of a traditional nurse patient interaction found in an institutionalised setting, as they occurred in the home of the older person and had developed over time, with a familiarity and amity that was noted in the observation of the care encounters. All the older people except Dot used the nurses' name. Bill beamed a smile and his eyes appeared to light up when Kate entered his flat as they greeted each other.

Erin opens the door to Flo's bungalow, the door is on the latch, and calls out 'hello, it is only the nurse, it's me, Erin'. Flo sounds distressed as she said, 'oh please, I am in here'. Erin shoots me a concerned look and we turn right off the small hallway into the lounge. Flo is sitting in her chair; she is holding the telephone receiver to her ear and is holding up a torn birthday card for Erin to see. 'Look' she says and passes Erin the card. Flo has tears in her eyes and reaches out for Erin's hand, which she offers, and Flo grasps and squeezes it. Erin holds Flo's hand and crouches down at the side of her, as Flo explains that she is on the phone to the post office to complain about the ripped up envelope and birthday care she has received. Erin tells her not to worry and to take her time, and crouches there holding Flo's hand in both of hers, waiting for Flo to finish. When Flo puts the phone down, Erin gives her a hug as Flo tells her the story of what has happened to upset her. (Observed visit 4 Flo and Erin)

Dot and Polly did not seem to hold the same sense of amity as the other pairings, which was evident on the observed visit.

Polly used the key safe to let us in to Dot's house. The hallway is dark and large, there is a big oak sideboard to the left and boxes of nursing supplies on the floor. Polly doesn't call out to announce our arrival. As we are standing in the hallway, Dot came to meet us in the hallway, as she did so she was calling out from the back of the house, asking who was there. Polly shouted, 'it's the nurse'. As Dot enters the expansive hallway Polly says hello and introduces me although Dot and I had already met. Dot nods her head in recognition and mutters hello, then turns around and holding on to the furniture (the sideboard, a door frame and then the kitchen counter), walks back through the kitchen to her dining room at the back to the house. (Observed visit 1 Dot and Polly).

Although there was not the same sense of amity between Dot and Polly, there did appear to be the established relationship that could be seen in the other older person and district nursing pairings. In the interview preceding the visit Polly explained how she considered that the relationship with the older people was an important foundation for working together:

'If you don't have a relationship with them, I don't know how, if you don't have that chat and empathy and that in your relationship with them, how do you provide with full holistic care, if you don't know about them and what they are feeling and how they are, so its building that relationship probably the most important thing, it is the nicest thing for me' Polly DN 1 Interview A page 17.

Bill explained how he felt working together was important for his care, how he thought that Kate shared an understanding of what he needed, and how this contributed to a connection that was crafted over time and was central to care at home:

"We work together, we have to erm, otherwise we wouldn't get nowhere ... they know me so well that erm, you know, we speak the same language you know, they know what I need and I know what I need and when you have been working with them for as long as I have, erm as the patient nurse relationship you know, you can't help but develop a relationship ... if they don't develop that relationship with the patient then neither of us, then things aren't going to work you know." Bill OP 3 Interview B page 3.

When Bill and Kate worked together, they appeared to seamlessly undertake certain activities, without prompting or discussion.

Bill stopped what he was doing with his computer game when we arrived and got up, with what appeared to be some difficulty, rocking forward and back until he was able to push himself up to stand from the arms of his chair, on doing so he reached to the other side of his desk for his crutches which were leaning against wall. The west facing floor to ceiling windows are closed and there are no curtains, and the sun is really streaming through into the lounge. Dust particles circulating in the air and the room feels stuffy and hot and smells stale and musty. The room has been divided in half by the furniture in it, with a hospital style bed against the wall next to the window with shelving on the opposite wall housing a stereo which is on with the radio playing, there is also a television which is on with the sound off, and some books and boxes. The computer desk is at the other end of the room by the kitchenette, with a desk chair in front of it. To the side of the desk is Bill's Parker Knoll style chair with spilt plastic seating, and next to this is a commode, both which section off this part of the room from the bed area. Under the commode is a half full urinal bottle resting in a saucepan, presumably to prevent it tipping over and further staining the carpet. Kate prepares the dressings she needed, laying them out on the floor on a dressing field, which appears to further limit the space for Bill to manoeuvre himself. He is a tall man with a wide girth and negotiates this small area as he moves around across the room on his crutches towards the bed. Kate pumps the bed up using the foot pump so that Bill can sit perched on the edge with his legs extended. I worry that he is going to slip as he has no shoes on, and the bilateral bandages on his feet are soaked through with exudate, and Kate has put a plastic backed sheet under his feet. (Observed visit 3 Bill and Kate).

Bill has previously told me has had polio as a child which has resulted in lifelong mobility issues and multiple hospital admissions as a child and into adulthood. Bill chatted and joked while he moved around his room, seemingly short of breath at wheezy at times, Kate was absorbed in what she was doing but maintained the conversation with Bill.

Dot appeared to know what was expected of her in terms of working together as she immediately moved to expose the part of the body which Polly wanted to work on before any pleasantries, she rolled up the sleeve of her cardigan and went to lift her skirt.

Dot is stood at her dining table holding on to it with both hands, her skirt is lifted over her back, and her underwear is round her knees, her back is facing the garden. Polly is attending to Dot's pressure areas, as she does this, Polly asks Dot questions, one after the other about pain, food, toileting, shopping, and visitors. Dot mutters monosyllabic or one word answers, saying mostly yes or no, and she rolls her eyes at me. Polly finishes what she is doing and helps Dot with her underwear and to readjust her skirt. Before Dot sits down on her dining chair, where she spends most of her time, she removes the plastic covered cushion that Polly has put there a few moments before. Polly leans on the dining room table with one hand, the other hand was on her hip, and she tells Dot that she needs to use her cushion, or her bottom will get worse. Dot nods, but does not look at Polly, and looks past her how to the garden and comments that her carer has put too much bird food down. (Observed visit 1 Dot and Polly).

Amy and Erin discussed how they tried to craft a connection with the people they visited, through building a rapport in getting to know people. The district nurses used the home environment and the things in it to facilitate an

attentiveness to what was important to the older person, on which to build rapport and a relationship. Amy noted a magazine on June's trolley and asked June about what she was reading and what she had watched and enjoyed on television that week. Erin asked Flo about her family, using the birthday cards and gifts in the home as prompts to do so. There was clearly an established relationship and rapport as the older people and district nurse pairings chatted about things that they were aware they had in common, Kate and Bill discussed experiences of being publicans, and June and Amy discussed animals and dogs they had each cared for. However, Dot and Polly discussed equipment as there was a lack of personal affects in Dot's home for Polly to use to craft a connection.

Dot's house is big. There is all the usual furniture for a home, but it looks sparse in the big space. There seems to be a lack of decoration to the home, only a calendar on the kitchen wall. There aren't any personal mementos or ornaments to see, and there aren't any photographs. (Observed visit 1 Dot and Polly).

Erin suggested that crafting a connection provided for the opportunity of working together, facilitating cooperation, reciprocity, and participation with older people, which she associated as being patient centred:

'Building a relationship and having a rapport means they are more involved in their (care), you are making sure that they are ultimately involved in that decision about their care, erm, they trust you they are more likely to cooperate with you and more likely to give feedback, be it negative or constructive or positive, and otherwise, how can you, it is not patient centred if you don't do that' Erin, DN4 Interview A page 4.

The district nurses spoke of participation and cooperation when working together with older people, however older people did not speak of the care interactions in this way. They described being able to connect and get along with the district nurse as a priority for their care so that their preferences and choices were considered. June explained how the actions and attitude of a district nurse, and the willingness for a reciprocal relationship affected the opportunity of working together as it influenced the connection and the care experience she had. It was the attitude, attentiveness, demeanour of the district nurses, and how they presented themselves philosophically that improved her experience of care:

“... If it is someone you can align yourself with then you think she knows what she is doing or she is caring or whatever you are glad they have come but if it is someone who bursts in and is sit down be quiet and do what I say sort of attitude, well that is different isn't it... So, if you can build a so-called trust or relationship that's different isn't it, oh some are so nice ... it is alright when you know someone is coming who you like isn't it?” June OP3 Interview B pages 11 and 13.

June's account illustrates how she had to work at building relationships with the district nurses even when she did not feel a connection with them. However, when there was a connection, the care interaction in June's home appeared less invasive to her, which then enhanced her experience of care:

“Some are wonderful and can't do enough for you, you look forward to them coming” June OP 2 Interview A page 2.

June described the relationship she had with Amy, as one that had been crafted and developed over time, as a friendship:

“.. It is quite bonding really... If you can build up a nice relationship with someone, they become your friends for life, don't they? ... but it has taken a period of time” June OP 2 Interview A page 3.

When it was perceived by the district nurses that older people did not want to participate in care regimes, then there was no opportunity for the crafting of connections as there was limited opportunity for social interaction and working together. This risked the district nursing service being withdrawn. The district nurses discussed how this was supported in practice with a specific policy, in which the service would not continue if older people did not participate in the care regimes as prescribed by the district nurses, demonstrating how an interdependence between nurse and person was required and recognised by the nurses, for care to occur:

*“... Oh the patient refused, that isn't an option anymore, you need to go down every avenue, do they fully understand what it is you are expecting, what the outcome will be, ...so it is about making them very aware of, and then we have the **** policy.., you've got to investigate every avenue and when it's completely exhausted (laughs) then you*

do have to say actually we are not benefiting you in anyway, unless you are willing to engage in doing this this or this then we are not going to come and visit you anymore” Erin DN 4 Interview B page 2.

Erin described how working together with older people to facilitate participation in care could be a tension. She discussed how she felt she had to try and negotiate with older people to establish participation, although she recognised that participating in care was not always what was wanted by older people:

“...I think sometimes people just want you to take over and do it all, erm they are more challenging... I feel more determined to make them engage really, you know, this is what we are willing to do... then this is what we need to do but you have got to sign up to it as well, erm it is not all down to us or the healthcare professional, you have got to take some ownership of it as well. It is difficult sometimes...” Erin DN 4 Interview

B page 2.

Amy explained how she tried to encourage June to use the upstairs of her home, although June made it clear that she did not want to, following the death of her husband. Amy felt that going upstairs would contribute to the care of June’s legs, so she tried to negotiate this with June:

“I know she has lost her husband and she just said that was one of the reasons she why when we was first talking to her about why doesn’t she sleep upstairs...maybe encourage her to start going upstairs a little bit more...but if we could get her going back upstairs and she says she has got equipment upstairs to help her with her mobility, she has got hand rails, if that can be made a bit safer for her then...” Amy DN 2 Interview A page 3.

June was not going upstairs and resided wholly in the bay-fronted sitting room of her semidetached house, which overlooks a well-kept garden and well-presented street.

June sits and sleeps in a faded, worn, red fabric recliner chair opposite the window and her television set. The room is full of June’s belongings and the equipment needed for her care.

To June's left is a wall length fire surround which is covered with books and carrier bags which look like they have come from a pharmacy. The hearth is covered in folded up newspapers, papers, and books. There is no fire, The mantelpiece has photos of June with her husband and photos of some dogs. Next to June is a cantilever table, covered with papers, magazines, cosmetics, her telephone, cups, and plates, next to this is a mobility trolley, also covered with cosmetics, creams, papers, cups, air freshener, pens, and a meal on wheels meal container. The other side of these is an oxygen compressor, there is tubing trailing around the floor and the nasal specs are hung over the back of the recliner chair. There are wires over the floor for the telephone, the oxygen and for a plug-in radiator, boxes and boxes of dressings are on the floor. There is a sofa against the wall, it is covered in boxes of incontinence pads. There are more carrier bags and boxes scattered around.
(Observed visit 2 June and Amy).

On the visits undertaken as part of this study, all the older people were observed participating in their care, contributing to working together with the district nurse, in doing so the older people appeared to work to provide a hospitable space in the home and in their schedule for care to occur. During the visit Flo explained to me how took off her bandages in preparation for the nurse's visit, she described how she could be sat with no dressings on her legs for a while and how she did not like to look at them or the smell she felt they had, and how she worried that people, other than the nurses, may come in and see them. Erin told her it was ok to wait until the nurse came to take them off, but Flo said she didn't like to keep the nurses waiting as they were so busy. Bill took analgesia prior to his visit. Flo got supplies ready, June directed the nurse to where equipment and dressings were, and stopped what she was doing or watching on TV. On the observed visit June was eating her meals on wheels lunch out of the foil tray, which has been delivered just as we arrived, just before eleven in the morning. She put it to one side on her mobility trolley, and turned her TV off using the remote that was balanced on the arm of the chair. Bill moved from the chair to the edge of the bed, Dot exposed her body part that required treatment before being asked and used her pressure relieving mattress as she was instructed.

The actions that were taken by the older people demonstrated how they contributed to the everyday practices within their care and reciprocated in the building of a connection with the district nurses. Bill discussed the active role he felt he had in the crafting of connections with district nurses:

"... If I can't send them away smiling then I haven't done my job properly" Bill OP 3 Interview B page 2.

The older people in this study were not passive in their care. During the observed care encounters passivity was not welcomed and constant instruction and encouragement on the actions older people could take to improve their health or condition to gain independence were weaved into the interaction. It appeared that it was through crafting connections and sense of knowing each other that this process of participation was negotiated.

6.2.2 Knowing

The older people in this study described that being known to the district nurses gave a sense of safety and trust. This was valued by older people as it provided a sense of being cared for. Being known appeared to be achieved through recurrent care interactions and through the rapport and relationships that had been developed. The district nurses identified that some of their work was away from the home of the older person and was office based, triaging on the telephone, undertaking admin tasks, and staff management issues. The district nurses identified that a lack of a co-presence with older people limited the opportunity for crafting connections and knowing older people. When there was a co-presence in the home time was spent together, and the process of knowing one and other occurred. Some of the older people described positive experiences of care when there was a familiarity of a district nurse whom they felt they knew, and was present with them in their home:

“... It is always lovely when I see her standing in the doorway” Flo OP 4

Interview B page 1.

“... They come in smiling, how are you today... maybe it is not such a bad day really (laughs)” Bill OP 3 Interview A page 14.

For older people, the crafting of connections with district nurses through a sense of knowing was perceived to be part of the care that was experienced. Being known provided a sense of security. Dot said she felt secure and safe knowing that she was being checked on to make sure she was ok.

Polly tells Dot she needs to check on some things, having already checked Dot's pressure areas on her bottom and elbows. Polly walks through the house and goes upstairs and looks at the mattress. She checks the pressure on the monitoring device and leans on it with both hands, pushing it up and down. There are two pressure relieving cushions in Dot's lounge

and one in the dining room, none of them are on a chair. Polly places each of them on a chair, Dot follows behind Polly and takes them off, she puts them behind her sofa. Polly moves to the boxes of dressing supplies which are in the hallway, she rummages in this, telling us what there is and what is missing. (Observed visit 1 Dot and Polly).

For Bill, the relationship gave him a sense of being known as an individual and that this offered reassurance for him in his ill health. Bill was known to both Kate and Amy:

“That they know me so well that erm, you know, we speak the same language you know, erm, you know, they know what I need and when you have been working with them for as long as I have, erm as the patient nurse relationship you know, you can’t help but develop a, they come in and they will turn round and, they know straight away if I am not right, they just look at you and know, they see you every day, they see you frequently” Bill OP 3 Interview B page 3.

When an older person was unknown to the nurse, and there had been no opportunity for the crafting of a connection, some of the older people explained that the nurse had relied on them to inform them of what to do in terms of the care task. This gave the older people opportunity to demonstrate their expertise and knowledge. When there was no connection, despite trying to provide a hospitable space of care in their home for the nurse, Bill and Flo described that some of their care encounters had been negative:

“I have only ever had one situation ... where a nurse was quite aggressive, I have never seen her since, since that one occasion and she come down here with her colleague and erm, she was doing the whole thing wrong and when I tried to guide her, she got quite nasty about it” Bill OP 3 Interview B page 2.

“Because I knew she was doing my legs wrong and I told her and she more or less said, well I know what I am doing, but she wasn’t putting bandages on she was just putting the top thing on and went and left it like that and doesn’t do my legs any good as there is no support there, I haven’t seen that one since” Flo OP 4 Interview B page 6.

Older people provided welcoming space of care within their own homes to the district nurses, even when there was no familiarity or connection. The

older people in this study were knowledgeable experts in their own care, from Bill and Flo knowing how their wounds should best be tended to, to knowing what they did and did not want as part of their care from the district nurses.

Amy is standing in front of June who is sitting in her chair, her legs have just been redressed. Amy gently approaches June, asking her how she would feel about going upstairs to sleep on a hospital bed. June rolls her eyes and laughs. June emphatically and firmly tells Amy no, but seemingly makes a joke out of it. June's lips tighten and her eyes and voice has hardened as she says no and does not appear to be amused. There is a distinct feeling of an underlying tension in the room, and Amy responds with lightness in her voice and gently says that she understands, but must ask about this, as she thinks this will be best for her. June abruptly changes the subject begins to brightly explain to us the problems she has been experiencing with her telephone and turns the conversation. Amy does not push the subject further, and asks June questions about her medicines, picking a packet of blister packs which are taped up in a carrier bag, on the mobility trolley. (Observed visit 2 June and Amy).

When older people and district nurses began to know each other and the expertise of older people was not reciprocated, this impeded the opportunity for connections to be crafted.

6.2.3 Everyday conversations

The sense of knowing or of being known to each other was contributed to by the everyday conversations that occurred in the care interactions. The district nurses were observed using everyday conversation to build rapport and craft connections with older people. For older people everyday conversations were part of the connection that occurred with the district nurses and formed part of the care they experienced. Bill, June, and Flo all discussed how they enjoyed a chat with the district nurses when they visited:

“... When they come they say oh hello it's you and we have a little chat ... only for 10 minutes but it makes a world of difference” June OP 2

Interview B page 10.

Kate and Bill chatted about homemade jam and growing vegetables, Flo and Erin discussed shoe shopping and June and Amy discussed pets and the local area. Dot and Polly's conversation was more focused on her carers, the interventions Dot required and the equipment she was using. However, the everyday conversations that occurred were centred and focused on the older person this gave an individual and personalised approach to the care

interaction and experience of care. Erin recognised how small attentive moments spent together in everyday conversation with older people produced and shaped care within the interaction:

“... Holding their hand or whatever that might be, it’s about making that person feel that you genuinely care. Which I do” Erin DN 3 Interview B

page 5.

When Erin attends to Flo’s leg they talk about the wound, Flo’s skin, and the dressings they are using. As she works, Erin tells Flo what she is seeing, doing, and thinking, that the wound is smaller, the skin is drier, that she thinks she will use the same cream and dressing again. Flo is paying attention, trying to move so she can see the back of her leg. Flo tells me what Erin does well, and what other nurses miss when they come, she says what a difference it makes to her when she feels that the nurse takes care and pays attention to her leg. Erin pauses in between what she is doing with the leg to look at Flo. Once Flo’s leg is covered over Erin checks Flo is happy with the bandaging and they chat about other things, TV shows or Flo’s family, friends, and neighbours. Flo tells me that s Erin always spares the time for a chat with her, saying how much she looks forward to it. She sighs and frowns when she says goes days without seeing anyone. Erin looks up and smiles at her and clasps her hand briefly. (Observed visit 4 Flo and Erin).

The attentiveness of the everyday conversations that occurred appeared to lead to an understanding of friendship by June and Flo, both stating how they felt the district nurse was their friend. However, the district nurses saw the relationships with older people as a professional relationship, not as a friendship:

“Here’s my friend they will say, if they have got somebody with them particularly..., erm, it’s hard not to say, well I am not your friend (laughs), erm, but you also don’t want to encourage it at the same time, it is a balance act, it really is...” Erin DN 4 Interview A page 7.

Erin discussed that the concept of friendship was contested but left unchallenged with the older people so as not damage the opportunity for everyday conversations and crafting of connections that contributed to the experience of care.

6.2.4 Mirroring and modifying

During the everyday conversations it was evident that that the district nurses assumed a temporary persona or identity depending on whom they were socially interacting with, to craft a connection. The district nurses appeared to

instinctively mirror or modify their behaviour to the personality, countenance, or the priority of need of the older person they were visiting.

Polly mirrored the need to check and survey Dot, as Dot reiterated that it was important to her to feel seen and checked on to feel safe. Polly did not appear to explicitly recognise that she mirrored Dot's need be checked upon, or that this is what Dot expressed to be important:

“So, its checking, making sure ... we might be in there 20 minutes having a conversation to check if we can make sure everything is ok, are the carers ok, can we look at the bed, checking the catheter bag, everything is alright, making sure ...” Polly DN1 Interview B page 4 and 5.

Kate become jovial and jokey with Bill, as Bill's priority was to have a laugh. Unlike Polly, Kate recognised that she modified her behaviour to mirror the countenance of humour that Bill prioritised:

“(Some nurses have) ... a more professional persona type of thing and others that would take a more relaxed attitude in someone's house and that would be the ones who have been out for a little while and be more relaxed, when you are new to the community you, you're worried how you are going to come across because you are in someone's house, you become more lax as you become more experienced but I think you are more relaxed, umm, with your approach ... it is just knowing and reading body language I think goes with experience until you know” Kate DN 3 Interview B page 4.

The mirroring and modifying may reflect an attuned and response to care and a shared understanding of care need. This social practice of mirroring and modifying appeared to elicit an interpersonal relationship and for the creation and crafting of a connection in the care interaction. This provided an opportunity to connect for coproduced care.

The older people in this study appeared to consciously make modifications to their behaviour and mirror responses to different district nurses, noting what they will do and will not do depending on who is visiting them. Bill identified that the laugh and joke he could have with some nurses, was not mirrored by all nurses, and a jovial interaction was modified accordingly:

“ ... It depends on the individual nurses you know, I mean, you see, the sort of banter and carry on we have” Bill OP 3 Interview B page 2.

June stopped whatever she was doing to allow the nurse to undertake her task. Dot repositioned herself so her buttocks could be examined when she saw Polly enter the room. Flo ensured her leg was washed and ready to be attended to.

Flo doesn't have any bandages on her legs, she is sitting on her chair, with her legs exposed, and there are extensive ulcers visible to both her lower limbs. Erin tells me Flo showers before the nurses come, so that she can give her legs a good wash. On the arm of the chair are some tubular bandages that Flo has washed. There is a big cardboard box next to Flo's chair, Flo moves this from the wardrobe in her bedroom to the lounge in preparation for the nurse's visit. (Observed visit 4 Flo and Erin).

These examples indicate that the older people were aware, responsive, and skilled in their understanding of care with district nurses, through the connections that had been crafted. It is also exemplified how older people worked, through mirroring and modifying behaviour, to craft connections with district nurses when home was the place of care and how their domestic and social routines were stopped or re-ordered to accommodate what the district nurse needed to do, when she needed to do it. The older people in this study worked to contribute to the everyday practices of their care.

6.2.5 Synopsis

This theme has identified how the social connections between older people and district nurses are central to the care interactions that occur in the home, and for older people and district nurses to work together. The everyday conversations in the care encounters that occurred allowed for a sense of knowing and being known which in turn fostered a trust on which the coproduction of care could begin to occur. Behaviours and countenance were mirrored and modified in the care interaction for opportunities for coproduction. Home was central to the crafting of connections in the processes and practices of care.

6.3 Care-full places

The theme of care-full places is related to the situated nature of care within the home for older people and the home as a workplace of district nurses. It illuminates the centrality of home to the practices and processes of care between older people and district nurses. It reflects the different meanings and value home held for the participants and how home was experienced as care was coproduced. The theme of 'care-full places' emerged from the domains of:

- being home
- showing home
- staying home
- medicalised home

The domains that were developed from the data provide evidence of the significance of the concept of home. Home had strong emotional attachments and meanings for older people, which became more complex when home became a place of care. When the place of home became a space of care for older people it became care-full with the equipment, people and resources for care to occur, but also in the sense that the activities and processes of care filled the space in a literal and imagined way which informed and influenced the experiences of care for older people.

6.3.1 Being home

The older people in this study discussed being home, and how their lives were centred in and on their homes as they were restricted in their ability to leave them. Flo and June were very keen to be able to get out of the house when able:

"I have been stuck here cos I can't go out much, well I can't go out at all" June Older Person 2 Interview A page 1.

"If I can walk better, stand better, and not have breaking out legs you know running with sores virtually water, and burgh and mucky things, and I can go out can't I, that will be the best side of it" June Older Person 2

Interview B page 7.

“(If) I can get out, I can get a pair of shoes on and even just walk to the shop up the road. I miss the shops.” Flo Older Person 4 Interview B page 4.

Bill faced away from his window, which was not at street level, and described how his computer provided him with a sense of connection with the world outside his flat. However, being able to see out of the house appeared important for the female participants in this study.

Dot has turned her chair away from the table and is facing the patio doors which overlook her garden. She has a pair of binoculars next to her which she uses for bird watching and tells me she sits and watches the birds all day.

Dot gazes out of the window throughout the visit, even when Polly is talking to her. (Observed visit 1 Dot and Polly)

Flo wanted to be able to see out of the net curtains that covered her lounge window, to see people passing, even though this was uncommon as her bungalow faced a green and was well set back from the road. June chose to reside in her front room as this overlooked the street, she lifted herself up in the chair to see what was going on through the jardinière net curtains that provided a clear view to the outside. Dot discussed how she liked the thought of going out, but this was for a sense of freedom rather than the actual experience of going outside.

“Well, I had to give up driving, I had to give up my car, obviously that was a big thing, but I had to do it as I realised, I was not as sharp as I ought to be, a couple of little things happened that shouldn’t of done, so before anything serious turned up, I gave it up...I did it voluntary you know, so I suppose you lose your freedom there, but I am ok here ... I can’t get out at all. If I could, I wouldn’t” Dot Older Person 1 Interview A page 4

and 10.

Older people did not identify themselves as ‘housebound’, however, they were identified as housebound by the district nurses. The term housebound centred the older person as being home, and the home as a workplace for the district nurses. The district nurses described that a housebound status was something that had to be maintained by older people:

“So our service is strictly housebound, it is our first criteria is, are you housebound, so when our referrals come in we pick up the phone and

say to the patient and we say are you housebound and they say yes, and we say do you go out at all, well I go out to get my hair done on a Wednesday and someone takes me shopping on a Friday, so if they need to see somebody for a one off visit we're like, I am very sorry but you are going to have to go to the practice nurse" Polly DN 1 Interview B

page 8.

Some of the district nurses spoke of working to support the older people to be able to go out, removing the status of being housebound. Older people not being at home related to independence by the district nurses:

"Seeing someone who has healed and has gone into hosiery and then who is now going back out, who was housebound for five years, erm, to being proactive in their care and getting them out" Amy DN 2 Interview A

page 9.

Older people not being at home for care highlighted an incongruence in the preferred place for the coproduction of care. Older people wished to remain at home for care, whereas the district nurses worked to move the place of care to outside the home. There appeared to be a lack of a shared understanding for the preferred place of care. Older people wanted care to occur at home, with the option of being able to go out for social activities if they were able.

Some older people discussed their preference to be at home. Being home for June was residing in the front room of her house, sleeping on a recliner chair. June was emphatic that this is where she wanted to be in her home, refusing to sleep in another downstairs room on a hospital bed as suggested by Amy:

"I don't want the bed, but they won't take it away. It's been suggested more than once, take that sofa out and put it in there and put the bed in there. And that little room is only small in comparison, I don't want, I don't like that room but I... they say oh you'll have the garden to look out on, through the patio window, but I like it in here, watching the coming and going and of course there is the TV here, and then they

say, oh we can move this, move that, I mean (sighs) All you want is a quiet life you know” June Older Person 2 Interview B page 2.

This appeared to be tiresome and exhausting for June as she made repeated efforts to refute this incursion on her choice. This process moved from negotiation to a coercive persuasion, where the coproduction of care was not possible:

“... Them throwing this at me; you must have a bed, with the bed you’ll be right and get well and all this that and the other, so they throw it at me, and I will throw an answer back. I think it is all just an excuse to get me to use the bed, but I am arguing, if I am so much better than I was, certainly my legs, not all other places but my legs, why do they worry” June Older Person 2 Interview B page 7.

This highlighted that older people actively strived to retain a sense of being home as their homes became revealed to others, as they became care-full. June had arranged the possessions she wanted around her, although there was a lot of stuff surrounding her in her living space, these were the things she needed. Bill resided in one room and had arranged everything he needed for daily living around his computer desk. Dot liked to sit watching the birds, the table beside her had her binoculars, newspaper, and puzzle books on, with completed and half-finished sudoku puzzles. Flo’s home appeared well presented and cared for.

Flo’s bungalow is very clean and neat and tidy. The lounge is bright, although it is quite gloomy outside, and it is decorated with a burgundy red soft furnishings and cream paint. There is a lot of furniture in quite a small space, there is a dresser behind Flo’s recliner chair, next to the archway to the kitchen area. Flo’s chair is in the middle of the room, next to another armchair, with a table in the middle and to the right of Flo. The telephone and Tv controls and an empty mug on a coaster are on Flo’s right. There is a reading lamp to her left. Both chairs are opposite a television stand and a sideboard all in shiny dark mahogany wood. There is a sofa to the side of the room where I sit, Erin is kneeling on the thick cream carpet. There is a variety of keepsakes, ornaments, and framed photographs which were interspersed with flowers and birthday cards on all the surfaces. There is a Zimmer frame in the far corner of the room (Observed visit 4 Flo and Erin).

Flo discussed how she maintained some household chores and used this activity as occupation to keep busy, spending time tidying and organising her bungalow.

6.3.2 Showing home

The homes of the older people became both public and private spaces when home became the place of care. Homes were made visible and public to the district nurses, by the necessity of needing care. This presented the older people with no choice but to show their homes.

The homes of older people were accessible to the district nurses as a place of work. The homes were accessed by the district nurses using either a key safe, door codes or by just opening the door. The home then became public and on show. The arrival of the nurse could be unannounced, as there was no specified time for the nurse to call. On each visit the nurse let us in to the home of the older person they were visiting, calling out or ringing the bell to announce our arrival. Some of the district nurses noted the peculiarities of home as opposed to institutionalised settings for care delivery:

“... You need to be respectful of their home” Amy DN 2 Interview A page 8.

“They (older people) are in their own home then you are an invited guest really ... I think you give you it time as well, when you are in someone’s home than if you were on a ward... I think that is the big difference, you are both equally putting into that relationship whereas in hospital I don’t think that is the case” Erin DN 4 Interview A page 6.

When the district nurse arrived in the home, older people stopped what they were doing so that the nurse could commence their work. The older people did not complain about showing their homes, or the interruption to their activities when their homes became care-full. Flo discussed how she was caught out by a delivery man who called round with some supplies the nurse had ordered but not advised Flo of, resulting in Flo showing more than her home:

‘... he opens the door and I am standing here in the nude (laughs)... you see well, I wasn’t expecting him, I didn’t know I had any medicine to come (sighs) so that was that...’ Flo OP 4 Interview A page 5.

Flo made light of the situation but her tone and sigh at the end of the story indicated that this showing of herself was not something she found amusing

and was bothered by it. Flo's account demonstrated that she had experienced a lack or loss of privacy that is usually associated the safety of home, when it became shown to others, and that this erosion of the boundaries of the public and private was something that she had to negotiate. Flo also discussed how she felt unable to remain in her dressing gown and was up and dressed early. This was not directly linked to this encounter but demonstrated that Flo felt she needed to be ready to receive callers at any time.

Bill did not mind people coming and going and his home being on show, despite the equipment he needed for toileting being clearly on view by his seating area, and in full view of the window, limiting his privacy and dignity. Bill credited always having an open house and being a publican as contributory to not minding people coming and going. For Bill, the district nurses provided a care-full reassurance in living in older age and ill health at home:

"If I could manage without them I would but erm, it is nice to have the back up there, it is nice to know if you have got a problem, you know and you're not feeling, I mean I have had lots of times when I am feeling really rough like, and they will check you out" Bill OP 3 Interview A page

3.

Some older people negotiated some boundaries over which areas of their home could become care-full and shown to the district nurses, as June discussed in reference to using her bed upstairs:

"... When she was trying to persuade me, I am sure they are probably treating me for the best intentions cos they say I will be better in there than sleeping elsewhere. Maybe I will be, but I am doing alright at the moment, thank you very much ... once you go to bed, you go to bed in many respects. And I am determined, I'm not!" June OP 2 Interview B pages 2-3.

Bill's home was a studio flat. Each area of his home was shown, and he had no private space. All of Dot's home was on show to Polly who accessed all areas checking on equipment. Dot repeatedly referred to showing her home to others for care as experiencing intruders, although she did not describe this as an unpleasant experience for her, it was not something she enjoyed:

“... I don’t like intruders. They (district nurses) are good to me, they come in and they, do, no, no they are all friendly and chatty and we talk about things different things, and no one comes in like a starched uniform and starts, that’s out, all that, they come in and they are all friendly” Dot OP 1 Interview A page 2.

Some older people had learnt to live with the intrusions and incursions that disrupted the space of home when it became on show to others:

“... (They) have got to find out, and they can only find out about me if you visit can’t you” Dot OP 1 Interview A page 2.

“... Well, you can’t do much can you (sighs) except please go I don’t want you here” June OP 2 Interview B page 11.

“... And they have helped me to stay at home, erm, I am sure they have done as much as they can” June OP 2 Interview A page 9.

However, on the observed care encounter it appeared that Flo tried to limit the visibility of care in her home.

Flo has placed her Zimmer frame in the corner of her living room, out of sight. She has tried to cover over the pressure relieving cushion that is on her recliner, and her box of dressings is tidied away as soon as the care encounter is over. (Observed visit 4 Flo and Erin).

It appeared that older people felt these encroachments on and disruptions to their space were unavoidable in being able to stay at home.

6.3.3 Staying home

An essential priority for older people in this study was to stay home for care. The only other option from staying home was associated with living in institutionalised care and this was highly resisted. Although she could not do all she wanted to, such as driving, walking a dog, or shopping, for June staying home meant she had control over her life and could exercise her autonomy:

“I like doing things I want, how I want, when I want in MY (emphasis) home, and never, as for a nursing home, good kind people there may be there, don’t get me wrong, but it’s not me. I hate that, I would hate

that... Being in my own home means very VERY (emphasis) much to me, very much" June OP 2 Interview A page 6.

June had everything she needed to enjoy herself, to live daily and that was important to her, around her. The district nurses, carers or visitors brought things to June that she wanted or needed from the other areas of her home, or from outside. Amy fetched a coffee cup, a bowl of water and the post for June during the visit, her meal was brought in, and the pharmacy dropped off another bag of supplies.

Dot said did not want to leave her home under any circumstances, despite experiencing a sense of intrusion by visiting district nurses and carers.

"I have everything I need to make me happy in my own home... I like being in my home, I never get fed up of being here... I live a quiet life and don't interfere with anybody and that leads to a health life doesn't it. Be happy in your home, that is all". Dot OP 1 Interview A page 4 and 12.

For Bill, staying home was incredibly important and although he was unable to leave his flat due to his mobility and health issues, staying at home was associated with freedom, a loss of which he felt would have a devastating impact for him:

"I mean, I would rather be dead than go into a home, I really would, I couldn't stand it as the environment would kill me, the claustrophobia would. I couldn't stand it" Bill OP 3 Interview A page 12.

Erin explained how older people's autonomy was influenced by the threat of not being able to stay at home and how this could affect decision making and choices, as choices become professionally driven dictates in care:

"... They don't want to feel like they are a burden, so yeah, they will normally go along with any and everything to stay in their own home."

Erin DN 4 Interview A page 9.

On the observed visit Amy used the possibility of becoming unwell as a negotiation strategy, rephrasing, and reiterating the potential negative outcomes to convince June to go use the hospital bed or to go upstairs.

Erin highlights how autonomy is reduced as choices are forced upon older people when they are under the threat of losing the opportunity to stay at home for care:

“It is not that you are blackmailing them, you are being honest. You are telling them if we don’t do this, you may well end up in a care home. Or you need a stair lift, but you haven’t got the finances for it, so you do, you know you have got work around whatever, their particular circumstances” Erin A page 9.

Erin appeared to recognise the tensions of honesty and coercion in her statement as she explained how she differentiated this activity from blackmail to something she felt was more socially and culturally acceptable. In this quote Erin also highlights how medical and daily living equipment could be required for older people to stay at home for district nursing care.

6.3.4 Medicalised home

The homes were observed to have been shaped by the older people so that they could live in them as well as possible. The homes were filled with personal possessions. However, the homes were also care-full, equipment to aid daily living, with medicines, dressings, incontinence pads and appliances were arranged alongside belongings for contemporary domestic life, which medicalised the homes of the older people in this study.

Amy is rummaging through the various boxes and bags looking for what she needs for June’s care. Despite the volume of equipment and supplies in the house Amy can’t find what she needs and goes out to her car to get some tape and other bits. June is waving her arms around to emphasise the disruption and amount of stuff in the room as she tells me the other rooms are full of stuff too. (Observed visit 2 June and Amy).

June described how her home had become care-full and medicalised, and how she felt this encroachment on her home was necessary:

“... Well, she spent a lot of her time looking for equipment and gear, it’s spread all over the place and such a lot of it. And since you came, ten minutes before, another bag of stuff there, dressings I think, special dressings that they hadn’t got last time... (sighs) well you wonder what they, well you wonder if there is anything left in the store

where it is all kept to be honest, there is so much of it, but that is probably good care and attention. Also, erm, and my legs they go through different stages, and they need different things for different places as we go along the trail” June OP 2 Interview A page 1.

“(The) nurses, they deliver stuff, I am sure there is more here than in their offices, all this stuff” June OP 2 Interview B page 11.

Erin discussed how she recognised that homes could become medicalised as they became care-full:

“... You need to be mindful you are in somebody’s house, and it is not a hospital ward” Erin DN 4 Interview B page 8.

Erin recognised the tension between the home for the older person and a place of work for her as a district nurse, and the differences in the place of care, and that the home was different to a hospital where it is usual to find equipment.

However, some professionally driven changes in medicalising the home were initiated by the district nurses when they identified risk:

“It can be that you go into patient who is in, you know, need of everything and you start saying oh you know, we can provide you with a bed that goes up and down, we can provide you with a chair that reclines, and they are like oh no I don’t have the money for that and we are like no we can just provide them for you ... So, make sure a top to toe assessment, asking them questions making sure that we are covering all the assessments that are on system one, so we will be doing MUST and Purpose T and pressure ulcer assessments, erm, then generally finding out what it is that we can provide for them, the need that they have”. Polly DN 1 Interview A page 16.

Kate described how managing risk could be a process of negotiation with older people, tinkering with ideas, considering the preference of older people when contemplating medical equipment in the home:

“She doesn’t want two (syringe) drivers, we need to look at all her medication you know, so she knew that there was a process and knew that we were trying to not get her two drivers and that was the absolute last thing that we were going to have to do, so, but yeah, no

it wasn't a quick fix, it was like, ok, what if we took this out and did this, how do you feel about this..." Kate DN 3 Interview A page 10.

Flo discussed how she adapted the medicalisation of her home to suit her, by using a cushion cover:

"... (Carer) made that cos I kept moaning about this plastic as I kept slipping off it and I am sure that is what had me over that day, you see my foot caught underneath it and down I went. She made it for my birthday, and I haven't slipped once, as I could feel myself slipping forward, so there you go, lovely, this is what she made (fluffy cover for pressure relief cushion)" Flo OP 4 Interview B pages 3 and 5.

Erin asks Flo about the cushion cover, she is frowning. Flo says it is a birthday present and she is really pleased with it, Erin does not look like she is, but she doesn't say anything
(Observed visit 4 Flo and Erin).

Erin described in her interview how she had noted the cushion cover and how this was incongruent with the risk she had identified, and how she would work to negotiate this care with Flo:

"... I won't tell her she has got to take it off, what I will say to her is, so that she knows why. If she wants to have that on, then she needs to get off the chair more often that is the negotiation" Erin DN 4 Interview B page 6.

"... 'Cos it is her house, she likes it, it is a gift, erm, and yes, it is a barrier and it is not going to help erm, but yeah instead of I think it is just about making sure she is going to engage in doing what is best for her". Erin DN 4 Interview B page 7.

Erin recognised and respected the concept of Flo's home and her autonomy to make decisions, however, Erin alluded that her professional knowledge is paramount, and that Flo should concede to what Erin advises to mitigate risk. The medicalisation of the home could occur without any attentiveness to the implications for the older person living in the home, as it was filled with equipment. June explained the disruption and intrusion she felt over the encroachment of equipment in her home and the lack of choice she experienced with this:

"... Without being too ungrateful I am not too interested in the bed, I don't want the bed, but they won't take it away... my house looks like a

builder's yard now, the dining room has disintegrated and half my dining room, more than half the dining room is piled up in the garage, ergh, I don't think about it... I mean (sighs) you might as well move home in the end" June OP 2 Interview B page 2.

Having a care-filled medicalised home was not something the older people enjoyed. Most of the older people tried to reduce the medicalisation of their living environment, thus maintaining a sense of home. On the observed care interaction Polly put a pressure relieving cushion on Dot's chair, Dot moved it and put it away. Flo tidied everything out of sight to try and restore her own order into her own home. Erin described how she and Flo discussed equipment in the home:

"When she was on antibiotics as well, so there was another very large plastic box, so I asked her about it, I said, we need to have this in the house so that we have got everything available so that we don't have to keep carrying things in all the time, is that agreeable to you, yes, she said, but I don't want it in the middle of the lounge, I said ok so where can we find a space where it is going to fit, she said, in the wardrobe, so that is what we did" Erin DN 4 Interview B page 8.

Erin appeared to know what Flo wanted and found acceptable in her home what she did not and described how listening to Flo enabled this. Embodied listening gave Flo and Erin the opportunity to work together to identify a shared understanding of what was needed, and how Flo felt about it so as not intrude on Flo's sense of home. This illustrates an example of how Flo managed the interchange between the private and public spheres as her home became care-full and remained home like. This illustrated how Flo and Erin were able to work together in equal partnership in the coproduction of care to limit the disruption of the space which was reflective of June's home and her account of her experiences of the medicalisation of her home and space.

6.3.5 Synopsis

This theme illuminated how being home was central to the experience of care for the older people in this study. The homes of the older people were

on show and the private place of home was made public when home became the place of care. Staying home was paramount for older people and was associated with autonomy, power, control, and agency by the older people. The homes of the older people were medicalised, as they became full of the equipment needed for care, the homes became care-full. The medicalisation of home had influence on the sense and experience of home for older people. Medicalisation of the home occurred when district nurses identified risk. When there was opportunity for the older people and district nurses to work together, and when the district nurses were mindful of the experience of home for older people, there was an opportunity for care to be coproduced.

6.4 Minding bodies

The theme of minding bodies considers how care was experienced by older people. This theme considers how the bodies of older people were attended to, managed, and navigated at home. The experiences of older people's bodies in care processes and how this influenced the coproduction of care at home is explored. The theme of minding bodies is constituted by domains that reflected the experience of the care of bodies and the nature of embodied care. It considers how older people experienced their bodies in older age and in frailty states, and how their bodies were responded to by the district nurses. The theme of minding bodies emerged from the categories of

- person in parts
- losing youth
- expert in self

6.4.1 Person in parts

Care centred on bodies, focussing on the parts of the older person that required attention. Flo discussed how she felt when Erin attended to her leg. Flo appreciated how time was taken and the attentiveness to detail, time and touch had significance for her when receiving care at home.

“When she does it (Erin) she will really, you know, she really puts her heart and soul into it, you see how she cleans it, the others are very good, they clean it and this sort of thing but they don't put the effort in

that she does, I mean she creams it and all that sort of thing which they don't, they cream around the parts that they have got to but she creams every other part of my leg so that the skin doesn't get too boggy or crispy yeah, no, she is always an exceptional visit when she comes and it always feels better because it always feels cleaner and she is the best one for bandaging, taking time, the best one" Flo OP 4

Interview B page 1.

In the observed care encounters, there was a prominence of throughput in service delivery by the district nurses, where the emphasis was on the nursing task, getting to the next patient, or on discharging older people from the case load. The district nurses, excepting Erin, got straight to the task of care when we visited. The district nurses washed their hands on entering, or used alcohol gel, then, dressing supplies were opened and spread out as chat and conversations occurred within the established relationships, with older people making their contributions to the everyday practices of care and making hospitable spaces in their living environments for care to occur. Nursing assessment questions were interspersed between the general chat of the everyday. When the nursing task was complete the district nurses cleared up and packed things away and began to close the care encounter with talk of which day the next one could be expected.

Erin however, stopped to listen with embodied intent and to reassure and connect with Flo, together in the moment to reach a shared understanding of care need, before any nursing or clinical intervention occurred. Erin described the tensions she experienced when managing the competing demands of her work could become about parts of the person, focussing on the nursing task:

"... You have gone in, and you have dressed the wound, but have they eaten today, are they toileting ok, have they got any pain, and yeah you can ask all those questions while you are doing what you are doing, but I feel distracted from them as a person then and so they are just the wound" Erin DN 4 Interview A page 11.

June described how she felt when care was focussed on a task:

During the observed care encounter, Dot described how her care could feel organised by the parts of her body.

Dot stands at the dining room table and rolls up the scuffed and torn sleeve of her lilac cardigan, then goes to lift her skirt and says, ‘what do you want this time, my arse or my elbow?’ (Observed visit 1 Dot and Polly).

All the district nurses expressed an awareness that care for older people at home could be focussed on body parts and tasks. However, Erin discussed how it was important not to focus solely on the nursing task:

“I want them to know that it’s not that I am just coming to do the leg ulcer. So, it is asking them about you know, what they did for a living, all those things that make them the person that they are, not just this ailment that they have got or, and I try not to focus too much on their illness either, it about everything else that is going on around them” Erin

DN 4 Interview B page 5.

This illustrates a contradiction in how Erin wanted to care for older people, but how older people became a person in parts, and how this could impact on the experience of care for older people.

6.4.2 Losing youth

The physical decline experienced through ageing processes and the loss of youth were discussed by older people in relation to the impediments they felt these placed on their bodies and the ability to undertake certain activities. However, these experiences were not linked to concepts of frailty. On meeting the older people who participated in this study they were asked if they considered themselves to be frail, none did, and all were emphatic that they were not.

The district nurses all discussed a priority within their work to promote self-care and independence for older people with independence equating as discharge from the service and as the goal of district nursing care. The importance of and value held in independence was discussed by the older people in this study. June stated what independence meant for her in addition to being at home:

“Being happy within myself... and erm, making my own decisions I think is.... independence I suppose” June OP 2 Interview A page 7.

Older people also expressed a hope not to become dependent on others when requiring care. June discussed how she felt she lacked any choice in what she perceived to be inevitable increasing dependency through loss of youth:

“I like my freedom and I like my independence and while I can cope with it, please leave me alone. There will probably come a time when I shall have to give in ...” June OP 2 Interview B page 12.

June wears a hospital style nightgown, the type that is open at the back, although it is daytime, and her carers have already been to assist her with washing and dressing. June’s catheter leg bag is wrapped around the bandage to her left leg, and there is another bandage to her right leg. There is a slight smell of stale urine mixed with the scent of lily of the valley. When Amy kneels to attend to June’s legs, despite her plastic apron, her black trousers become covered in wet talcum powder that June has sprinkled on the floor, she says to cover up a leak from her catheter bag when the carer didn’t close the tap off. (Observed visit 2 June and Amy).

June described how she experienced her body:

“I mean, you don’t like being stuck here in one room with your legs striped and all the kerfuffle going on down there and then the catheter, then the boobies” June OP 2 Interview B page 13.

June’s comments highlight how she felt the impairments she experienced impacted on the agency she had in choices in care, resulting in a sense of powerlessness over her bodily needs, and how her body was minded and cared for at home.

6.4.3 Expert in self

The older people in this study described a sense of knowing what they liked, what they wanted and how things should be done in their care and to their bodies. Thus, older people were conceptualised as experts in self. When there was a recognition and appreciation of the older person as an expert by the district nurse, this provided shared understandings and opportunities for older people to exercise agency and participate in choice and decision making. This allowed for opportunities of working together and for care to be coproduced. Flo’s described how she felt she was an expert in self:

“... In a way my word is as good as theirs, cos I have watched her do it” Flo OP 4 Interview B page 4.

Bill discussed how his expertise facilitated the coproduction of care at home, when working with student nurses:

“I have sat down here with nurses and actually helped to instruct the students on how to put it back, cos they are my legs you know” Bill OP 3 Interview A page 2.

Bill described using his expertise in self for shared decision making:

“She considered possible options you know and you know what is like, this often happens like, ideas get kicked around and they come in and they say, oh this isn’t working or we have tried this, and this sounds like ... the other day ... when I had the infection, we had a golf ball size thing on there and erm, jointly we decided to put a kerramax up against it to dry it up” Bill OP 3 Interview B page 4-5.

These examples highlight that when older people felt valued as an expert in self, by the district nurses, this provided a sense of equality in the shared use of power and control in the care relationship, with the opportunity to coproduce. Empowerment and being valued in the equal participation of care enhanced the experience of care for older people in this study. However, equal power in the coproduction of care was not a consistent experience for older people when working with district nurses. Some older people described a lack of power, autonomy, and agency in the care of their bodies, despite their expertise in themselves and what they wanted.

Flo described the effort she had to make in exercising her choice not to have a cushion in her home, which she clearly did not like or want, and which remained a contention for her in her care, and that she capitulated due to the persistent persuasion she experienced:

“... For months I argued about having one of these (cushion)... they were going on and on and on, we will have to get you, they said, a cushion, so in the end I thought alright I will have a cushion” Flo OP 4 Interview B page 5.

June recounted the work she had to do to exert power in the care of her body with the district nurses. This mirrored the work she did to deter Amy from discussing the bed and her going upstairs, that was observed during the care encounter. June described care experiences at home, in which she felt cajoled, coaxed, and even bullied into choices and making decisions by some district nurses:

“Oh yes, you must stick up for yourself ... because you could be brow beaten, you know what I mean? So, you have to, yes you do have to... They sort of come up with anything (laughs) but I am sure they are probably treating me for the best intentions... They keep saying... So, they just do their best to coax you or bully you sometimes, I often say to them in fun, you are not coming here to bully me, I can be just as sharp as you can... some of them, that’s their manner. Not all, some are very firm and some just sort of casually slip it in, but yes some are bullies. Yes. Yes, they are” June OP 2 Interview B page 3.

June felt she was coaxed and coerced in to making choices and decisions about her care at home. June considered that this was done with the nurse acting in her best interest. However, that June felt bullied signifies concerns for her experience of care. June’s account of her care indicated that she considered herself less powerful than the district nurses in minding her body, and that she actively had to defend her choices if her decisions were not congruent with that of the district nurse, as was apparent in the tense discussion over the bed that was made light of during the visit. It appeared that to joke about it was the most comfortable way for June to exert her power and maintain an established and comfortable relationship with Amy.

In minding bodies some tensions were raised for the district nurses when the older people made decisions, which were incongruent with a professional nursing judgement. Amy discusses how she feels she must repeatedly respond to such decisions:

“...And they are adamant that they don’t want it it’s on each visit, each visit we must go over it and if you change your mind, you know,

but you know we do have to respect their choices, at the end of the day” Amy DN 2 Interview A page 10.

Amy did not appear to appreciate how tiring and disempowering repeatedly defending choices was for June and could be for older people. What was deemed to be unwise decisions made by older people was seen as essential risk management by the district nurses, providing the rationale and justification for the repeated revisiting of these choices during the care encounters. Amy articulated her underpinning philosophy and approach to care:

“We work really hard, really hard at trying to make life better for someone” Amy DN 2 Interview A page 10.

Amy’s statement appears to indicate that she feels she does her best for the older people she works with and is oblivious to a practice of compassionate coaxing.

Polly drew on the paternalistic language of coercion and forcefulness when working with Dot, but had attempted to extricate herself and her practice from this language:

“We offered the hospital bed which originally Dot had declined ... I don’t think we coerced her into having it (laughs) ...she kind of went along the lines of do you think it is for the best then?” Polly DN 1 Interview A page 1.

“So, it is just going in and being a little bit more, not forceful cos that is the wrong word, a bit more spending time to, so actually spending that time to pick apart what the issues are around why she is denying the bed” Polly DN 1 Interview B page 9.

It was evident that Dot had conceded to Polly’s response to risk as the bed was in her home and Dot was enjoying using it. However, Polly’s behaviour in the care encounter as well as her language paternalistic at times which further detracted from any sharing of power.

Polly seems to exude busyness; she bustles and there is a brisk business like approach to what she does. She seems to go quickly from one thing to the next, moving the direction of

conversation, such as it is, too. Polly stands with her hands on her hips when she is talking to Dot, who is sat in her chair. (Observed visit 1 Dot and Polly).

Any choices, decisions or coproductive activity that occurred from coaxing with a compassionate intent appeared to be as a concession and acceptance of professional advice by older people rather than evolving from a place of equal understanding and knowledge sharing. This is illustrated by the following example. Erin articulated how she felt that she could offer her professional expertise in the care relationship in the form of transparent advice but alludes that there was an expectation that the older person should 'go along with' this. This indicated that for older people, the participation in the care of their bodies started from a place defined by the district nurse and not as a coproduced or shared practice:

"...And sometimes choices are limited, it might be about resources, it is usually about resources to be fair It should be joint, it really should be joint (decision making). You go in with what you expect, your expertise, you can advise the patient but they have to get on board with it or otherwise they are not going to get involved in it, they are not going to go along with what you think is probably the best thing for them" Erin DN 3 Interview A page 10.

The district nurses described how they were governed by a local policy which stipulated that if older people did not want to 'go along' with the nurse's advice there was a requirement for the person to sign a disclaimer to this effect. This demonstrated the further emergence of asymmetric power dynamics within the relationship and in minding bodies in the care encounters. This limited any opportunity for coproduction as it indicated that older people were disempowered in choosing if and how they participated in their care. Such imbalances in power relationships are contrary to the ethos of equality and partnership, and do not allow for a coproductive approach to older people's bodies when care is received at home.

6.4.4 Synopsis

The theme of minding bodies illuminated how care of older people focused on the person in parts by the district nurses, and how this was experienced

by the older people. Losing youth was associated with experiences of a lack of power and choice in how their bodies were cared for at home. An expertise in self, allowed for participatory and coproductive care between older people and district nurses. When expertise was not recognised or valued this could reduce power and autonomy for older people, which impacted on the experience of care. When risks were managed by district nurses, this could result in experiences of being coaxed for some older people. Coaxing was utilised to convince and could result in older people feeling persuaded to adhere to a nurse led agenda, skewing power dynamics. Such techniques to convince lack congruence with the ideals of self-determinism, collaboration, shared decision making, person centredness and the coproduction of care with older people.

6.5 Heeding time

The theme of heeding time considers how time influenced and shaped opportunities for the coproduction of care for older people at home. It emerged from the domains identified within the data which illustrated how the practices and process of care and the coproduction of care were temporally ordered, when home was the place of care. The theme of heeding time illuminates the embedded understandings and experiences of time for older people and district nurses, and how these differ in home-based care. The theme of heeding time reflects the centrality of time within care practices. The theme of heeding time emerged from the categories of

- busy
- throughputs
- rhythm and routine

6.5.1 Busy

Time was experienced differently by older people and district nurses in this study. For older people time was plentiful, they discussed having too much time. All older people spoke of having idle time and of looking for occupation to keep busy, often to relieve loneliness:

“I go to bed about 11 and by 3 o’clock I have got the kettle on making a pot of tea and I am reading or if there is any rubbish on the tele I will

watch that, and then at six o'clock, right it is time that you moved, and I will go round and have good wash and dress... no I don't feel lonely. I don't allow myself to be lonely, if I begin to feel lonely then I get up and start sorting a drawer or doing a cupboard or find something to do" Flo OP 4 Interview A page 3.

For district nurses there was a time compression, they all discussed how they continually tried to find or make time and that they had more work to do than time to do it in:

"It's so busy. That you are not able to do what you want to do anyway. It's a bit frustrating". Polly DN 1 Interview A page 12.

All the participants spoke about the nurses being busy, and older people identified that they did not want to take up the nurses' time. In the observed visits every district nurse told the older person that they were busy. On each observed encounter the district nurses, excepting Erin, exuded a sense of busyness, through the bustle and time limited throughput approach they set to the visit by the focus on the task. The district nurses had a pleasant but business-like manner, briskly moving straight to the task in hand as they exchanged pleasantries with the older people they were visiting, steering the conversation to what they wanted to know, openly and blatantly changing the subject if there was a more pressing issue they wished to explore. Flo discussed how the busyness of the district nurse was indicative of the limited time that was available to spend with them:

"I think she (Erin) is so busy with new people and others that are worse..." Flo OP 4 Interview B page 1.

Flo's experience highlighted that she felt that other people's needs took precedence on the time of the district nurse.

June discussed how she felt time impacted on what some district nurses would do as part of her care, highlighting that some would wash her leg and others would not. This was attributed to the nurse's busyness.

Amy tells June she is going to get a bowl of water to wash her legs and disappears out into the kitchen. She comes back with a washing up bowl of warm water and a towel. She kneels

on the floor in front of June and removes the bandages and puts June's feet in the bowl to soak. Amy gently washes June's right leg before changing the water and doing the same to the left. They chat about things, June's gardener, Amy's dogs, some cream that hasn't arrived. (Observed visit 2 June and Amy).

June said she had learnt not to ask for a leg wash so as not to spoil the atmosphere and dynamics of the care encounter, despite this being important to her:

"... Some nurses wash your legs more than others. Some don't wash your legs at all... Some will spontaneously do it and some as I say, I don't think they have heard of water... I have (asked) (sighs) but it doesn't always work... but I have learnt over a long period of time it is not worth arguing with them, over a silly little fact when they are in charge you know because it just spoils the whole event" June OP 2 Interview

B pages 7-8.

June's experience indicated that there were asymmetries in the power dynamics where older people felt unable to state a preference on how time was utilised within their care at home. Erin discussed how she negotiated and navigated the demands of limited time, and how attentiveness allowed for a copresence with Flo, in the moment, to elicit a shared understanding of care need:

"... So I think it is about making that moment ok the minute you go in, it's not, you know, I need to do this, I need to get on, it's not making her feel rushed, it is about supporting her in whatever she is doing in that moment, so she needed to feel she was ok on the phone and that we weren't waiting around for her or any of those things" Erin DN 4 Interview

B page 1.

Erin considered that slowing down, deferring a sense of busyness, and focussing on the older person, holding back the demands on her time from the interaction, in the moment was important in care practices at home.

6.5.2 Throughput

The district nurses discussed how they felt their time was pressured by unbounded service referral criteria, coupled with the outputs they needed to achieve. This gave the district nurses a continued focus on the discharge of

older people from their caseloads, facilitating a throughput of older people. The older people did not discuss any dissatisfaction at the idea of being discharged, Bill and June both felt that the nurses would return to see them again if needed. However, the older people had been in receipt of care from the district nurses for several years, with ongoing chronic health needs for which discharge would be unlikely. Kate considered how unpleasant it would be for a patient new to her caseload to have discharge discussed with them before any care or treatment had occurred, as this may lead to feelings of being a burden. Polly felt that this was necessary to manage expectations and reduce patient numbers on caseloads, in a throughput approach due to the service capacity:

“If I am coming out to see a new patient, we always say to them, the minute you become not housebound... we will be looking to discharge you to the practice nurse as soon as you can get into a car and get to there or walk if you are within distance”. Polly DN 2 Interview B page 7.

Polly discussed discharge from the district nursing service with Dot at the end of our visit, as the wounds to her elbow and buttocks were healed, however, she noted that unless Dot had her catheter removed the nurses would need to return for this.

Polly examines Dot's catheter bag and suggests, that it could potentially come out now her wounds were healing. Dot almost snatches the catheter leg bag away from Polly and puts it back under her skirt. Dot, who hasn't been greatly communicative to this point seems to almost blurt out that she had been incontinent as a girl and that it was awful for her mother trying to keep her clothes clean and from smelling of urine, and that no one had wanted to be her friend because of it. Polly appeared surprised to hear this, as if it was new information, and looked taken aback. Polly appears to visibly soften, and she takes her hands off her hips and crouches down at the side of Dot and says, 'I'm sorry that happened to you'. Dot looks at her for what feels like the first time during the visit and nods. (Observed visit 1 Dot and Polly).

Polly demonstrated that she has listened to and heard Dot. Polly did not push the issue of the catheter further, telling Dot that after the next visit she would ask the carers to check the equipment and her catheter every week, and that the district nurses would come and check on her every three months when they routinely changed the catheter.

The district nurses spoke of allocating nursing care in terms of units, which was a process of providing an older person with an allotted amount of time

for their care. The units of time allocated were determined by the care task required, thus making nursing care, and the use of time in care, a commodity as throughput became a priority:

"... You are concentrating on getting that leg washed and dressed and going to the next one" Erin DN 4 Interview A page 11.

This example illustrates how Erin identified how the pressures of time brought a focus to the throughput of care, which focussed on the task rather than the holistic needs of the older person.

6.5.3 Rhythms and routines

It was acknowledged by the district nurses that the timing of visits to the older people in this study were based on the schedule of the nurse and not around the rhythms and routines of older people. Amy and Kate discussed how they tried to accommodate choice in the time of visit. They identified that it was not always possible to give choice as the timing of the visits was based on other workload priorities. Kate recognised how this left older people suspended in time and that older people lost control of any time schedule:

"We try to, we try to, you know, it's horrible ... having to think I have to wait around, cos they have to wait around all day, and they listen for the doorbell, I had one lady yesterday she said, I have been waiting all day for the doorbell to ring, and I thought I am really sorry, I didn't get there until like quarter to five so you know, you are very aware that these elderly people are literally just waiting for you to come so it's horrible" Kate DN 3 Interview A page 3.

Polly discussed tensions in how service delivery was incongruent with the rhythms and routines of older people:

"... can't tell them when we are going to come and in some respects a lot of them probably don't, that's horrible, as it sounds like they don't need to know when we are coming cos they are housebound, but if I was expecting a visitor and I am thinking oh they might come one day or the next week to look at me or to help me, that would be horrible wouldn't it ... so, we don't need to (let them know) because they are a housebound patient so we can just turn up. But they still, can't, they

can't pick a day as they wouldn't know whether I could go on Tuesday or Wednesday" Polly DN1 Interview A page 7.

However, some consideration was made of the other plans or routines that the older people might have outside of the care interaction:

"Some of them do have very set routines, cos the hairdresser comes at this time and the carer comes at this time and if you are having to come back you are having to doge carers and things like that, and they like a nap in the afternoon, and you interrupt their flow and then, and I would be quite annoyed if I was patient, I would think oh I had half an hour this afternoon or two hours this afternoon where didn't have any carers coming in I could have had a relax but now the nurse is coming, the nurse has got to come back because she hasn't got the right dressings and you know, I would find that quite annoying" Kate DN 3

Interview B page 2.

This placed district nursing routines as preferential and of greater importance to those of older people, which is dissonant with understandings of equality and equity in coproduction. All older people had established rhythms and routines, some of these were dictated by bodily needs such as eating and toileting which could be interrupted by the need for care, impacting on privacy and the control older people had in the use of their time.

Furthermore, some of these activities required support, the older people all received carer's visits and June received meals on wheels both of which were provided with approximated timed appointments. Some older people had social engagements which were important to them, Flo received visitors and telephone calls and Bill played games online. Unscheduled visits for care from the district nurses could interrupt these events.

Older people organised their routines around time. June joked that her life revolved around food as meals gave a structure and time frame with which to mark the day, although her lunch was before eleven in the morning. When Flo described her day to me it was structured and broken up by clock time. The importance of the structure of time was apparent on scheduling the

interviews with older people and determining a convenient appointment. On the observed visits the older people were involved in activities that formed and structured their time.

We arrive at Bill's block of flats and he buzzes us up. When we go inside Bill is in the middle of an online live computer game, he says it is part of a tournament, but he switches it off. Bill says he was going to have a nap after the game, as he had been up until the early hours of the morning on a web based game. Kate realises she has forgotten to call him to say she was on her way so Bill could time the taking of his painkillers to coincide with the visit. Kate apologises, Bill smiles and tells her not to worry. (Observed visit 3 Bill and Kate).

Dot said she was doing sudoku but had heard us come in so came to see who it was as she was not expecting anyone. Flo was on the telephone to the post office trying to complain about an opened and torn birthday card that had arrived. June was eating, putting her meal to one side, unfinished to Amy could redress her legs.

Before we leave Amy disappears to the kitchen again, she comes back with a cup of coffee. She hasn't asked, it seems this is the usual routine. Amy places it on the trolley, next to the half-eaten lunch still in its metal food trays. It must be cold; we have been with June for nearly two hours. (Observed visit 2 June and Amy).

Only Flo finished what she was doing before the nursing intervention began, June, Bill and Dot had their social and domestic schedule re-ordered to accommodate care. The observed care encounters illuminated that despite reporting having a plethora of idle time, all older people in this study occupied their time with activities and were busy.

Occupations gave structure to what Flo described as very long days. Breaking up the days with activities was important, and this provided something to look forward to. Flo identified how the erratic district nurses schedule could be disruptive for her:

"They usually come around that time on Friday they were held up and they didn't come until about half past three and I was just at the point, and that is a bind, if they don't turn up" Flo OP 4 Interview B page 3.

However, Erin did not appear to fully recognise the implications that waiting could have for Flo:

'... She wants to do her own washing and showering and she takes all the dressings down and has a really good wash (laughs) because she sees that as part of her responsibility, she has been quite easy to engage in that process and she's, and she seems to be very aware of

how busy we are, and that's not us saying oh we've got to go we're busy, she just knows that we are out there doing what we are doing, so she is really good and engaged...' Erin DN 4 Interview B page 2.

The active participation in her care could leave Flo without dressings for long periods of time, as her care was temporally ordered by the district nurses.

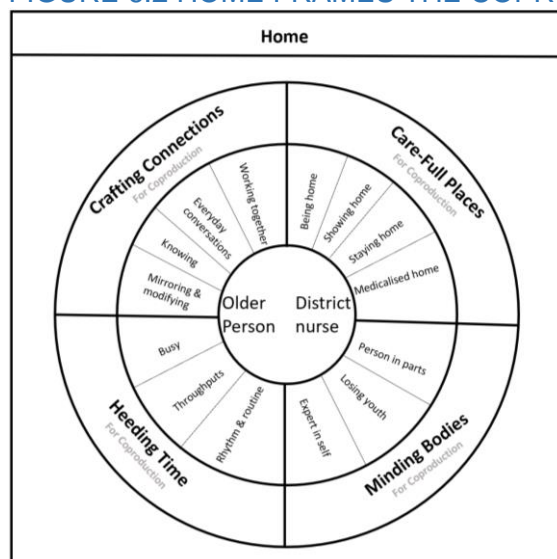
6.5.4 Synopsis

The theme of heeding time illuminates how the concept of time influences care at home between older people and district nurses, and how each experience time differently. Throughput was a response to busyness for the nurses. Care interactions were scheduled around the work of the district nurses, and this did not consistently consider the rhythms and routines of older people. Waiting for the district nurses disrupted the routines of older people at home.

6.6 Summary

This chapter has described the themes and domains that emerged from the data. The findings have empirically shown four interlinking and intricate themes which occur between older people and district nurses, when home is the place of care. Figure 6.2 identifies how home frames the fifteen domains which together constitute the four themes.

FIGURE 6.2 HOME FRAMES THE COPRODUCTION OF CARE



The next chapter will discuss the four themes in relation to their significance with extant literature and implications for practice. The theoretical concept of home will be drawn upon to further explain and answer the research questions. The chapter will articulate the nature of care that was coproduced between the older people and the district nurses.

Erin described how there was a necessity to be *mindful*. I suggest that it is a mindful coproduction of care that occurs between older people and district nurses when home is the place of care. The concept of the mindful coproduction of care will now be further explained.

Chapter 7 Discussion

7.1 Introduction

This study aimed to understand the nature of care that is coproduced between older people and district nurses when home is the place of care. This chapter will present a conceptual framework of the mindful coproduction of care as an original contribution to knowledge. I will argue that the four themes of crafting connections, care-full places, minding bodies, and heeding time constitute a mindful coproduction of care that occurs in the home, when older people and district nurses work together. I will also suggest that care at home can become unmindful.

This chapter asserts that the coproduction of care, mindful or not, is shaped by the important concept of home and it has concomitant social, philosophical, and political influences. In reviewing the findings within the extant literature, I will suggest that the concept of a mindful coproduction of care cannot be fully understood unless the broader contemporary cultures of care are considered. I will discuss relationality, rationality, and responsiveness as the broader cultures of care to further explain this. This chapter will position the conceptual framework of a mindful coproduction of care in the context of existing theory. It will illuminate how a theoretical underpinning of care ethics can shape the opportunities and experiences of mindfully coproduced care at home for older people. The original contribution to knowledge will be discussed and the research questions will be answered. The chapter will conclude by presenting the key insights from the conceptual framework of a mindful coproduction of care.

7.1.1 A mindful coproduction of care

The coproduction of care that has been identified in this study has been conceptualised as mindful coproduction. Mindfulness originates in Buddhism and Buddhist practices and has been widely adopted in contemporary Western healthcare (Brass 2016, Tomlinson et al. 2018). Tomlinson et al. (2018) identify that to be mindful can be either a momentary state or a dispositional trait. Chmielewski et al. (2018) define the practice of mindfulness as:

“A process of intentional paying attention to experiencing the present moment with curiosity, openness and acceptance without judgment”.

Mindfulness in healthcare is widely reported as an intervention for patients, or as a technique for healthcare practitioners to use to alleviate stress and burnout (Demarzo et al. 2015, Brass 2016, Lomas et al. 2018). However, mindfulness is not widely considered as a practice of nursing and care. Sitzman and Watson (2014) applied a concept of mindfulness to the ten Caritas Processes of Watson’s (1985) caring theory. This application appears to be an attempt to embed the Caritas Process in practice through identifying parallels with Watson’s (1985) theory using case studies and creative art activities. As McCance et al. (1999) suggest, the work of Sitzman and Watson (2014) appears to make some of Watson’s (1985) confusing articulation and attempt at application of theory to practice and the dated language of caring science more accessible. For example, ideas of loving kindness are replaced with concepts of mindfulness teachings such as compassion (Sitzman and Watson 2014). Arguably, the language of compassion is more intrinsic to nursing than it is to mindfulness.

Furthermore, the Caritas Processes of nursing are attributes of caring that characterise the transpersonal relationship central to Watson’s (1985) caring theory. Watson’s (1985) theory recognises two people in the caring relationship. However, Watson’s (1985) theory of nursing and the Caritas Processes (Sitzman and Watson 2014) are focussed on professionally driven factors of knowledge base, clinical competency, virtue ethics and the philosophy and individual qualities of practitioners for ethical practice (Falk Raphael 2000, Ward and Barnes 2016). An ethic of care, however, offers a critical perspective to explore the environments in which care occurs, the power relationships that embody the provision and receipt of care and to understand the experience of care relationships with others (Bowden 1997, Barnes 2012).

The mindful coproduction of care between older people and district nurses recognises two people within a care relationship and is conceptualised as a

conscious and intentional attentiveness to self, other and the context of care. It provides an explanatory shift in understanding experiences of care that happen in the everyday interactions between older people and district nurses when home is the place of care. The mindful coproduction of care incorporates and adds to Chmielewski et al.'s (2018) definition of mindfulness, as attentiveness is on and is shared with the other person in the care interaction.

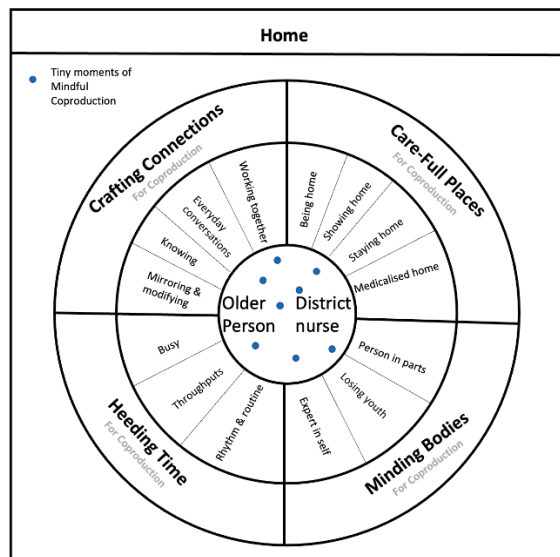
Unlike Watson's (1985) nursing theory and Sitzman and Watson's (2014) Caritas Processes, when care is mindfully coproduced, care receivers are not passive recipients. Barnes (2012) suggests that social policy perspectives to care have largely focussed on carers, care work and the experience of care giving. This has similarities to Watson's (1985) nursing theory, which has largely centred on the art, science, and practice of nursing. However, Tronto's (1993) theory of care ethics highlights the need to address the relational aspect of care and the universal experience of receiving care (Kittay 1999, Barnes 2012). The process and practice of mindful coproduction requires a relational co-presence with others for a conscious and artful navigation of the influences on care at home.

Mindfully coproduced care counters the norms of mainstream coproduction and participative care models as it is entwined with subtle distinctions and difference. It transcends traditional models of participation and partnership in service design and delivery and of coproduction, as it is concerned with the complicated, messy, and rich practices and processes of care that occur in the home between older people and district nurses.

The coproduction of care was observed as happening in tiny moments which illuminates that mindful coproduction was not a constant practice in care interactions. When care was seen to be mindfully coproduced in this study it occurred in tiny moments as the older people and district nurses worked together in the home. This finding has congruence with that of McCormack et al.'s (2011) research in person centred care, who suggest that person centred moments are small individual ad-hoc experiences of person

centredness, and that person centred care is inconsistent. Figure 7.1 illustrates tiny moments of mindful coproduction between older people and district nurses in care relationships at home.

FIGURE 7.1 TINY MOMENTS OF THE COPRODUCTION OF CARE IN THE HOME



The themes that constitute a concept of a mindful coproduction for care at home between older people and district nurses will now be discussed and positioned within the context of existing theory and extant literature.

7.2 Crafting connections

Caring connections and relationships can often occur within a dyad between the care giver and the care receiver, as suggested in Noddings' (1984) theory of care (Rand et al. 2022). This is reflective of a model of district nursing for older people living alone (Maybin et al. 2016). However, Noddings (1984) theory of care is individualistic as it does not consider complexities of professional care work. Tronto (1993) suggests that to assume care is dyadic omits the understanding of how care functions socially and politically as a culture, how it is ongoing and not episodic.

The older people who participated in this study described how they worked to connect with the district nurses who visited them at home. Gott et al. (2004) examined homebased care at the end of life and reported how older people tried to form relationships with healthcare professionals, and how older people could find the presence of nurses in the home to be intrusive, as the

connections were forced and not formed through choice. Jarling et al. (2018) consider that a sense of intrusion intensifies for older people when they consider the care provider to be a stranger or not known to them.

Neither of these studies consider the length of caring relationship over an enduring period, which McGarry's (2009) ethnographic study of older people with district nurses found contributed to valuable connections. Guest and Corrigan (2018) identified that the duration of relationships led to familiarisation in care experiences for older people in the UK. In Jarling et al.'s (2018) qualitative interpretative Swedish study, the intrusion experienced by the receipt of care was likened to feeling like a guest in one's own home, in which a sense of homeliness was lost. As a sense of homeliness is important for wellbeing and wellness for older people this remains paramount when considering care at home (Galvin and Todres 2013). Both Gott et al. (2004) and Jarling et al. (2018) suggest the experience of intrusion or a sense of homeliness for older people can be lessened when influenced by feelings of friendship with care providers.

Jarling et al. (2018) contend that when older people in receipt of care felt liked by care providers, this was linked to a feeling of friendship. The older people in this study did not consider being liked specifically but described their relationships with the district nurses as that of friendship. This is congruent with previous ethnographic work in district nursing (McGarry 2008), which aimed to define the relationships held with older people. McGarry (2008) based on ethnographic interviews with district nurses conceptualises these social connections as professional friendships. However, this perspective suggests that the connection is nurse led and does not incorporate any consideration of equity or partnership in the care relationship, which is foundational to the theory of and understandings of coproduction (Boyle and Harris 2009). As care is socially and collaboratively coproduced by formal and informal networks with professionals and friends, different types of friendships may occur in care; those explicitly identified as friendships, or those that are friend-like (Proctor et al. 2014, Barnes 2012). Buckley et al. (2023) contend that social circles and friendship provide

support in accomplishing coproduction and that friendship is key to coproducing.

The district nurses in this study did not concur with the concept of friendship with older people. This finding differs from the work of Lagerin et al.'s (2016) Swedish study of district nurses undertaking preventative home visits. Lagerin et al. (2016) suggest a sense of knowing older people provided a sense of 'almost' friendship from a district nurse perspective. Nagington et al. (2013) who interviewed palliative care patients and their carers argue that a friendship can occur between district nurses and older people. However, Friedman (1993) contends that if a nurse depicts that they are not the friend of an older person, the older person cannot consider the nurse to be their friend, due to the lack of mutuality and reciprocity in the relationship.

As an ethic of care emphasises the relational nature of care, there is a need to understand the differing types of relationships in the provision and receipt of care (Barnes 2012). Care ethicists Bowden (1997) and Friedman (1993) both illuminate the significance of friendships in care, however the concept of friendship is not considered in healthcare policy directives or in nursing theory. However, there is a need to understand the significance of friendship in care relationships to support the diversity of care and coproduction. A theoretical perspective of an ethic of care to the context of friendship offers a way of understanding care as an embodied practice within care relationships, which can challenge normative concepts of friendship (Barnes 2012).

Importantly, Barnes (2012) highlights that friendship is voluntary, as friends are not ascribed but chosen and that friendships are based on reciprocity and are predominately equal relationships. Reciprocity in the concept of friendship arguably has some parallels with the core components of relationships within coproduction theory (Buckley et al. 2023). However, reciprocity in caring friendships is not based on the expectation of mutual exchange as in the theory of coproduction, but as Barnes (2012) contends, the omission of feeling like a burden for older people or of being passively dependent on the provider of care when it is required or offered.

Unlike coproductive relationships where people come together for a shared purpose, friendships are formed in the context of other relationships (Barnes 2012, Boyle and Harris 2009). Barnes (2012) suggests that friendship is hard to define due its diversity in types and understanding, it being a fluid concept and how it is determined by the quality and the nature of the relationship. Healy and Sanders (2018) assert that friendship includes mutuality, respect, and informality, as friendships are not shaped by the cultural and societal norms of family relationships or the rules and regulations of professionally dominated care relationships. Understandings of friendship are concomitant with trust (Bowden 1997).

Barnes (2012) suggests that it is within trusting relationships that are understood as friendships that older people may feel confident to display any vulnerability, as friendships are not infused with power differences that may be found in other care relationships. Bradley's (2015) literature review of coproduction in mental health services contends that working coproductively can only occur from open and honest dialogue that occurs in trusting relationships. This is reflective of the conceptual framework for a mindful coproduction of care, which draws on Barnes' (2012) care ethical perspective that connectedness in care relationships is developed when there is familiarity, openness, and trust.

Bowden (1997) asserts that like understandings of friendship, a care ethical approach to caring relationships requires an attentiveness and responsiveness. This aims to ensure that care practices are based on the preference of the care receiver and what they want, and do not want, rather than cultural norms, and professionally determined rules, rituals, and routines. Drawing on Tronto's (1993) ethic of care, attentive and responsive care practices reflect the conceptual framework of a mindful coproduction of care, where what is distinct, and individual is determined through a meaningful, shared, and equal connection between older people and district nurses.

Friedman (1993) suggests that the concept of friendship characterises being able to focus on the uniqueness of another, therefore when older people felt an attentiveness in their care from the district nurses, and a sense of being cared for, this may have been understood as friendship. England and Dyck (2011) consider that when care at home increases, a sense of loss of control of home can occur for older people. Barnes (2012) suggests that feelings of friendships with nurses become increasingly important for older people when they experience this. Loss of control was not explicitly linked with friendship in this study, yet all the older people had experienced some disruption and alteration to their home environment through the receipt of district nursing care, and autonomy and control was of great importance in care at home.

Codes of professional practice for nurses (NMC 2018) do not offer the permission for the forming of friendships or friend-like relationships with older people by district nurses. Participative, collaborative working relationships are integral to healthcare policy (Coulter et al. 2013). As McCormack and McCance (2017) advocate, collaborative and collegiate relationships are essential between professionals to ensure that there is a culture of working together, so that all feel valued and can flourish within the workplace. However, care relationships between older people and district nurses at home were not found to have the shared understanding of a working relationship that is shared between colleagues, yet policy suggests older people should be participative and collaborative with district nurses in their care at home (Coulter et al, 2013). Such working relationships reflect the underpinning principles of coproduction theory (Batalden et al. 2016).

Slay and Stevens (2013) suggest that coproduction illuminates the blurring of roles required for trust when working towards a shared endeavour. This study has highlighted how the blurring of nurse- patient and collegiate-caring relationships which embrace a care ethics perspective such as Barnes' (2012) concept of 'friend like' relationships which are meaningful to coproduction and the conceptual framework of mindfully coproduced care for older people with district nurses. Care ethics illuminates the constraints of following abstract moral rules in professional ethical behaviours, as this may

fail to engage with the nuances and complexities of care relationships with older people. Care ethics necessitates a sensitive appreciation to the context and uniqueness of care practices (Kwan 2023). Without these distinctive collaborative and participative relationships mindfully coproduced care, even in tiny moments, risks becoming rhetoric when home is the place of care.

McCormack and McCance (2017) have developed Seedhouse's (1986) concept of healthfulness. Healthfulness offers an understanding of individual wellbeing, in that healthful relationships can facilitate the maximising of potential in peoples lived experience of care. Healthful, for McCormack and McCance (2017), considers a wider context than physical health alone and embraces holism, but goes further to consider healthfulness as a culture where people and staff flourish within the relationships that are formed. The healthful relationships that McCormack and McCance (2017) suggest are required for care are built on rights, mutual respect, self-determinism, dignity, and autonomy. These ideals are core for improving older people's experiences of care, as highlighted by Francis (2013). Drawing on care ethics, this study has illuminated that further to the important foundations for healthful relationships identified by McCormack and McCance (2017), that when older people experience care at home trust, attentiveness, and mindfulness were equally important for coproduction in care relationships with district nurses and could contribute to social capital in care (Needham 2009). Connections between older people and district nurses that are based on McCormack and McCance's (2017) healthful relationships and trust, attentiveness and mindfulness can help facilitate a negotiation of the complexities that shape care when it occurs at home.

This study identifies that despite the different understandings of the definition of the caring relationship, that a connection and being known was fundamental for mindful coproductive care practices to occur. Care practices can be understood as being produced on a framework of relationships that connect and engage people together (Lynch et al. 2021). Waterworth et al. (2014) explored nursing support for people at home and identified that a sense of being known was paramount for those in receipt of care.

Relationships with longevity and familiarity between older people and district nurses have long been reported in the literature with longer term caring relationships enhancing social connections for older people (McGarry 2009, Corbett and Williams 2014). Feeling connected and known to each other has been widely identified as fundamental to establishing relationships in multiple contexts of care, including district nursing (McGilton and Boscart 2007, Haycock Stewart, et al. 2008, McGarry 2008, 2010, Lytle and Ryan 2010, Corbett and Williams 2014, Waterworth et al. 2014, Zoterman et al. 2014, Lagerin et al. 2016, Kendal and Reid 2017).

The conceptual framework of a mindful coproduction of care highlights the significance of everyday conversations within the relationships between older people and district nurses. Pulcini's (2013) care ethics perspective on human interaction suggests that mundane social actions allow for attention to be given to everyday life for older people. Corbett and Williams (2014) suggest the non-clinical chat of everyday conversation can provide a mutuality of understanding of each other. However, if conversation is clinically steered without the opportunity for the mundane everyday through a structured nursing assessment, then the opportunity for equity and the sharing of knowledge and power is lost, and the foundations for coproduction diminished (Falk Raphael 2000, SCIE 2013). Everyday conversations in this study worked to avoid a depersonalisation of older people. Although the identity of 'patient' was ascribed to older people by the district nurses, the individual with a unique identity was seen and valued in the everyday care interactions, allowing opportunities for the mindful coproduction of care (Twigg 2000, Peace et al. 2006, Ward 2015), as depicted in the conceptual framework (figure 7.1).

Identity is a dynamic and a continual process of flux which is continually reconstituted in the home, through social and discursive practices and changing social discourses (Butler 1990, Davies and Harre 1999, Burr 2015, Ward 2015). Noddings (2000) care theory suggests that identity is determined and developed by the relationships people have with others. Ward (2015) contends that identity is associated with a sense of belonging.

In a care ethics perspective identity is relationally constructed in which people develop an understanding of self in relation to others, materials, and technologies, and the commonalities, attributes, and difference experienced (Ward 2015).

Ward (2015) asserts that care ethics understands that the needs and experiences of older people can only be understood by an understanding of how their different dimensions of identity intersect, such as ageing or being older, and of frailty or ill health. Coproduction contends that equality in care relationships can offer an opportunity for people to inform care practices shaped by their own identity (SCIE 2022). The findings of this study are suggestive that the mindful coproduction of care through a care ethical lens can facilitate equity for older people in care relationships in which identities other than patient can be enacted, such as woman, ex-publican, friend. The way in which identities are constructed and positioned can shape how roles and status in care relationships are given equity, credibility or become marginalised or othered as identities for people when the receipt of care, other than that of patient, can become under threat (Ward 2015, Guest and Corrigan 2018).

Knowing older people as individuals, not just as patients was important to the district nurses. The relationships the district nurses held with older people were perceived to positively influence care and the experience of care, when the relationships were considered as 'good'. This emphasised that the care relationships were important, however it appeared unrealised by the district nurses that the relationships held with older people were more than a vehicle to effect concordance in professionally prescribed care regimes (Felzmann 2012). This is reflective of the participants in Hartley et al.'s (2022) study, in which clinicians did not recognise the connections formed with children and young people where perceived and experienced as part of their care. Watson's (1985) philosophy and theory of transpersonal nursing suggests that it is the caring relationship that is central to nursing practice and the core of promoting health. The relationships that were held with district nurses, for the older people in this study, formed part of their experience of care. It was

the everyday conversations and the attentive moments of time together that were coproduced and were valued by older people but could go unnoticed by some of the district nurses.

The study's findings and the framework presented suggest how care practices were formed through mirroring and modifying of behaviour by district nurses in response to the implicit care needs of older people. Mirroring is term used in psychology to describe how individuals mimic the behaviours, dialect, behaviour, and body language of others in social interactions to build connection (Drescher 2023). Personality or behaviour mirroring is dependent on ethical intent, context, and motivation and is used in caring and social sciences to establish rapport as a therapeutic technique of limbic synchrony (Kelly 2017).

Coproduced care occurred when what older people presented a need in the care interaction which was mirrored, acknowledged, and responded to by the district nurse. Examples of this were having a laugh, feeling safe, feeling listened to or having a friend. When these values were mirrored in care practices by the district nurses, coproduced care allowed for feelings of being valued, validated, and recognised as a human being to occur for the older people, in which they experienced 'good' care (Fox 2013, Tronto 2020).

Mirroring and modifying as a practice were a conscious effort made by district nurses in response to care need, however, some district nurses were unaware they were mirroring behaviours and need in the care interaction. Jeon and Lee's (2018) review of research on mirror neurons suggest that these are activated when an individual performs an action and then notices a mirrored response, providing a mechanism for human capacity for empathy, understanding, and developing connections. The conceptual framework presented in this study illuminates the practice of mirroring as important for coproduction of care, as it is through this process that shared understandings of need and preference were established which are fundamental to coproduction (Batalden et al. 2016)

As care is socially constructed and individual, what constituted meaningful or 'good' care for one older person in this study was not valued equally by another older person, as is recognised in a theoretical framework of person-centredness (McCormack and McCance 2017). Mol (2008) suggests that 'good care' is not a defensible ideal, but rather it is shaped, invented, and adapted through practices every day and that this is a continual and dynamic process. Mol's (2008) theory offers the opportunity for the inclusion of concepts of coproduction, providing the opportunity for care to be shaped and created in partnership, with equal value on the contribution of all involved.

Therefore, good care is not a principle but shaped over time by people (Aranda 2018). The focus of theory in nursing is to improve practice by positively influencing care for patients (Wayne 2023). As such it is the primary objective of all care interactions, to give and receive good care (Mol 2008). Maybin et al. (2016) identified three characteristics of good care in district nursing practice, these being caring for the whole person, the continuity of care, and the professional manner of staff. Arguably these characteristics underpin standards for pre-registration nursing (NMC 2018) and do not reflect the complexity of care theory or the specialism of care practices at home for older people and of district nursing (QNI 2019), or what the conceptual framework presented illustrates as a mindful coproduction of care.

Furthermore, any morality and moral decision making in care practices has been omitted from Maybin et al.'s (2016) characteristics of good care. The concept of caring lacks depth of consideration, whereas caring and nursing are inextricably intertwined (Lachman 2012). Watson's (1985) transpersonal nursing theory advocates for a moral commitment and intentional connection between nurse and patient, as was evident in some of the care interactions in this study. Good care cannot therefore occur without a moral position of caring, and as such the application of a care ethics perspective is arguably fundamental for nursing practice (Noddings 2000, Lachman 2012).

A care ethics perspective has not been considered in Maybin et al.'s (2016) work on quality in district nursing practice. Any relationality between a district nurse and a person in receipt of care has not been considered as a characteristic of good care, neither has the active participatory role of a person in their care, which the conceptual framework has presented as intrinsic to the coproduction of care at home. Moving from an obligation based ethics, to a responsibility based ethic of care, the relationship is the starting point of care, rather than a clinician determined agenda (Tronto 1993).

Maybin et al. (2016) introduce a dualist or binary thinking to concepts of care with the notion of good care. Binaries are politically charged when considering care, assuming a clear-cut division between good and bad, or mindful or unmindful, when the nature of care is far more complex and dynamic (Aranda 2018). To receive 'good' care would be the optimum, however, to receive care that may not have been as good, does not necessitate it as bad. This places the experience of good care on a continuum (McCormack and McCance 2017, Lachman 2012, Twigg 2000).

Tronto's (1993) theory of care ethics asserts that a continuum of care deconstructs dualistic reasoning and refocuses the nature of care as constructed in the social interaction in a spatial and temporal context. Relational care ethics aims to shift from obligation to a habit of care, with the starting point being what can be done to best meet the caring responsibility (Tronto 1993). Although not care ethicists, Gastmans (2006) and Little (1998) both develop Tronto's (1993) habit of care through a moral orientation, to consider the best way to care for a person in the moment (Lachman 2012). Tronto's (1993) theory of 'good' care is applicable to the findings of this study and the conceptual framework presented, in that mindfully coproduced care can be considered on a continuum and is specific to an individual older person in a moment in time at home with a district nurse. Nursing as a profession has traditionally leaned towards biomedical science to support its philosophy and practices (Lachman 2012). A biomedical focus can leave little time for compassion and coproduction in care practices

(Seedhouse 2017). Older people's experiences and everyday realities cannot be considered in the same objective approach as the biomedical science that shapes and informs nursing theory and practice (Green 2012). As care is core to nursing theory, I suggest that care ethics could become more explicitly entwined in the consciousness of district nursing as an underpinning theory to the complex practices and process of working with older people (Noddings 1984, Watson 1995, McCance 2003, Lachman 2012). It is argued that with care ethics underpinning care practices at home between older people and district nurses this could provide the attentive relational co-presence that is required for the mindful coproduction of care, particularly when care is delivered outside of clinical institutions, and home is the place of care.

7.3 Care-full places

This study and the conceptual framework that has developed from the findings suggest that it is significant to consider the place of care, specifically care at home in the mindful coproduction of care. As Leyshon et al. (2018) contend, environment and place are of fundamental consideration for effective coproduction to occur.

The district nurses in this study used the place of home and the things within the home, to come to interact with and relate to older people (Latimer 2000). Congruent with this study, Hartley et al.'s (2022) critical realist research of therapeutic relationships between professionals and children in mental health services, asserts how clinicians use things such as film to find a common ground on which to get to know a client and develop a connection. This finding is supported by McGarry (2008) and Corbett and Williams (2014) who suggest that district nurses interact with older people through the home and the personal belongings in it. Robb et al.'s (2023) analysis of how people interact with the material world suggests that people relate to and know each other through houses and workplaces.

Barnes (2006, 2012) argues that care has been theorised to consider a wider perspective than a set of tasks within a care dyad, to include broader

understandings of care relationships within wider environments, and the significance of care in everyday lives (Barnes 2006, 2012). New materialism theory in social science argues that materials and technologies as well as human interactions construct the social world, producing meaning and practices in care (Fox 2016, Latour 2006, Martin et al. 2015, Brownlie and Spandler 2018). Thwaite's (2023) analysis of material culture contends that belongings can tell stories about people.

McGarry (2009) suggests that the home environment allows for an unfiltered knowledge of and access to the lives of the older people and that artefacts in the home provide cues to identity. Board and McCormack's (2018) research illuminates how possessions inform identity for older people. Peace et al. (2006) argue that it is within the home where identity is formed, through language in social interactions and where it is individually expressed, through the presentation of the home. McDonald et al. (2020) suggest that from a general practitioner's perspective, that the homes of older people allow for intuitive observations and insights into the life of an older person on which to base assessment and clinical decision making. Relationality within a care ethical lens appreciates connections between people, things, and their interests. The findings of this study illustrate this relational ontology. It is through the understanding and appreciation of the importance people place on each other, things, and interests which provided a basis for older people and district nurses to meaningfully interact and coproduce care (Kwan 2023, Github 2023, SCIE 2017).

Being home was important to older people, who were housebound. Housebound determines an older person as unable to leave their home to seek care elsewhere and as such may require district nursing services at home, depending on need (NHS England 2015). The status of housebound is informed by service commissioning frameworks for district nursing (NHS England 2015, Fanning 2019). It allows for a boundary to be drawn on district nursing caseloads (NICE 2015). District nursing caseloads, reflective of the ones discussed in the findings of this study, are reactive in response to need and therefore can fluctuate and become unpredictable, increasing in size and complexity and contractual commissioning arrangements mean that district

nursing caseloads become a 'catch all service' that are unable to limit service capacity or utilise a waiting list system (QNI 2014, Harper-McDonald and Baguley 2018).

The referral criteria of housebound can offer some reprieve with increasing workloads (Morris 2017). However, a consequence of placing boundaries on referral criteria arguably results in district nurses limiting flexibility in the interpretation of what can constitute housebound. This can have implications for older people's experiences of care and opportunities for the coproduction of care as there is a lack of shared purpose and understanding of need at the outset of care (SCIE 2022). Furthermore, as the starting point for care when bounded by referral criteria and system requirements, comes from deontology and principlism and not from a responsibility based care ethics, a different moral imperative of care develops (Tronto 1993, Edwards 2009, Lachman 2012). An imperative for care which omits relationality then lacks congruence with care ethics and nursing theory (Lachman 2012, Younas, 2020, Miller 2021). However, this study has highlighted that referral boundaries could become blurred when there was a shared understanding of need which did not fit with rigid criteria and neglected to consider the older persons as an individual.

There is a paucity of empirical research that supports the finding that district nurses will offer some flexibility when negotiating the concept of housebound and the boundaries to their caseloads, this study adds to the existing evidence base. The Audit Commission (1999) advocated for referral criteria for district nursing caseloads, to ensure safe working systems, which has been subsequently supported by the QNI (2009, 2014, 2022). However, the NMC do not assure standards related to appropriate staffing in nursing contexts (NMC 2016). Nationally district nursing referral criteria have been developed depending on geographical area, for adults over the age of eighteen who are housebound (Bowers and Cook 2012, Bain and Baguley 2012, Harper-McDonald and Baguley 2018).

Bowers and Cook (2012) suggest that caseload criteria can be negotiated when it is agreed on clinical need, or when the intervention is deemed more

appropriate to happen at home. Bain and Baguley (2012) argue that assisted trips anywhere for older people are incongruent to the definition of housebound and if undertaken this removes the need for district nursing care. Bain and Baguley's (2012) system and outcome based perspective lacks an ethic of care as they do not consider what it is to be older and living with frailty. Furthermore, this detracts from humanistic nursing theory as philosophies of holism are not considered, with no mutual understanding of what is important to older people in their care on which to build the connections required for coproduced care (Jasemi et al. 2017, SCIE 2022). Being able to leave to home for assisted trips to the hairdresser or to go shopping should arguably be celebrated as a care activity or as an expression of identity or independence for older people (Twigg 2000, Moilanen et al. 2021).

In a phenomenological study examining student district nurse responses to referral criteria, Young and Reid (2021) suggest that district nurses foster their own interpretations of appropriate referral criteria. In a large Canadian ethnographic study of home care provision, Angus et al. (2005) found that care providers disregard organisational logic and improvise when managing the ambiguity and complexity of care in the home. Olsen et al.'s (2019) findings of their meta-ethnography of 94 literature pieces related to healthcare at home and person-centred care, assert that healthcare providers working in homes experience tensions in organisational policy and individualised care. Reflective of this study, this suggests that, culturally, care ethics may implicitly inform practices of individually negotiating boundaries to care services with older people in responses to care when it is needed at home. However, the application of a care ethical lens to practice can be dependent on the individual clinician and their philosophical response and attentiveness to need. The need for care places the power for the care encounter with the district nurse, to choose a care ethical response (Lachman 2012, Jackobsen and Lind 2022).

This study exposed a dissonance in understanding, meaning and experience of independence between district nurses and older people. For the district

nurses, independence was centred on older people returning to a status of 'not housebound' with older people being able to leave the home for the receipt of care. Independence appeared focused on a traditional, outdated, and biomedical understandings which do not consider the context of home based care (Davis et al. 1997, Seedhouse 2017). Biomedical concepts of independence are associated with health or an ideal state, thus introducing a dualism of independence and dependency (Ward 2015). Care ethicists recognise dependency as integral to the human life course (Phillips 2007). Although older people may live well with altered disease states, frailty, and impairment which may cause some fluctuating dependence, in biomedical terms they may not be considered as 'healthy' (Kittay 1997, Seedhouse 2001, BGS 2015). District nurses risk further developing and embedding dualisms with older people being ascribed identities as dependent receivers of care or as independent, as was previously noted in disability studies (Silvers 1997, Foot et al. 2014, Ward 2015).

Maybin et al. (2016) suggest that maintaining independence for older people is core for district nursing practice. Similarly, the Dutch Buurtzorg model of district nursing advocates for practices which makes patients independent (Sheldon 2017). However, these discussions omit to discuss what constitutes independence outside of a biomedical model of care, and what independence can mean to older people living with frailty at home. Bodker et al.'s (2019) ethnographic study in Danish care homes suggests that narrow and political understandings of independence such as not receiving home care also needed to incorporate enabling arrangements for older people, as to be free of care was not a reality.

Hillcoat-Nalletamby (2014) used qualitative data that was part of a larger quantitative Welsh study, to understand the meaning of independence for older people across care settings. A large qualitative convenience sample selection of 91 interviews and a review of the literature elicited fourteen understandings of independence. Only two of the fourteen related to physical or biomedical limitations such as needing help, or not being as able. Two understandings of independence in Hillcoat-Nalletamby's (2014) work

reflect how the older people in this study experienced independence, which was being able to stay at home and to be able to make decisions. This study adds to the body of existing evidence to support a wider understanding of independence for older people. It suggests that when there is a shared understanding of independence in care interactions that transcend physical ability then this can shape meaningful care for older people at home.

Contemporary policy directives for healthcare for older people are centred on independence, however, lacking is a consideration of a continuum of dependency states. A continuum would be more reflective of the complex fluctuations and variances of ageing and frailty rather than a dualism, as dependency and need vary and change over time (BGS, 2015, Bodker et al. 2019). Policy directives with an ethical responsibility for the dynamic nature of dependency would ensure a morally attentive response to care needs as all people will experience vulnerability, frailty, and dependency at some stage of life (Tronto 1993, Sevenhuijsen 1998). However, dependency and vulnerability does not only occur at differing life stages, such as a decline with ageing. Importantly, this study has illuminated, dependency and vulnerability fluctuated from moment to moment for the older people in this study, in differing situations, interactions, activities and care processes and practices at home. Thus, any coproduction of care required a moment to moment mindful response to changing dependency and need.

Kittay (1997) refers to the increasing need for care with the advancement of age as 'inevitable dependencies.' However, Tronto (1993) asserts that understandings of human nature require a shift from being limited to that of dependence advocating that human interdependence better reflects the human condition as care. Interdependence is recognised within the theoretical perspective of an ethic of care and adopts a relational approach to understandings of concepts of independence in care (Phillips 2007, Barnes 2012). Interdependence is indicative of the collective responsibility for care that Ham et al. (2018) advocate. Barnes (2012) argues that despite the physiological process of ageing indicating a potential for increased care

need, care should not be distinguished specifically for people by their age, impairment, or dependency, as this creates othering.

Kittay (1999) considers interdependence as an intricate linked network of social relations for social cooperation in care, drawing on the moral practice of caring in a connected and attentive response to need in moments of dependency and vulnerability (Green 2012, Phillips 2007). Older people valued independence in choosing to be at home, however, as Kittay (1997) suggests, this required interdependence in a relational context with others to exercise their autonomy to do so (Green 2012). A care ethics perspective embraces a concept of autonomy that centres on the individual, connecting them to what is important to them, transcending concepts of health as being disease free, and therefore creating a personal autonomy for older people through interdependence (Ward 2015, Green 2012). In doing so older people were able to share their understandings of independence with those who provide care in response to need so that personal autonomy could be realised (Barnes 2012, Seedhouse 2017).

The findings presented in this study illustrate how the mindful coproduction of care contributes to a personal autonomy and meaningful care experiences for older people. Professional autonomy is also a consideration in coproduction. SCIE (2013) suggest that coproduction can provide a greater level of autonomy for front line clinicians in designing individualised and tailored care for older people. Holland-Hart (2018) asserts that autonomy in coproduction enhances shared outcomes. Goodwin's (2019) discussion on coproduction of water services in Ecuador contends that autonomy is increased for those who coproduce. However, Jakobsen and Lind's (2022) research of older people's stories of home care in Norway suggest that good care encounters provide more autonomy for people and poor encounters will limit it. Seedhouse (2017) argues that personal autonomy should be maintained and not reduced in care experiences and suggests that by respecting and honouring choice and preferences for older people receiving care at home personal autonomy can be a consistent reality. With this ethical

and moral intent, meaningful and mindfully coproduced care has the potential to occur in more than tiny moments.

For older people, the autonomous decision to live at home and remain at home for care is reflective of the wider literature of ageing in place (Rowles 2000, Wiles et al. 2011, Milligan 2009, Roin 2015, Board and McCormack 2018). Concurrent with the findings of Angus et al.'s (2005) work, older people in this study were resistant to the idea of residing in care homes and expressed how they felt the care they received at home allowed them to avoid residential nursing care. The evidence that supports older people's preference to continue to live at home suggests a relational importance of the home and the attachment felt to the home by older people (Barnes 2012).

Redesign and reform of health, nursing and care services has dominated health policy since the NHS and Community Social Care Act (1990) which led a shift away from institutionalised care (Hawkins and Stewart 2002, Morris 2017). Concurrent with an NHS and social care system that is under increased pressure, contemporary policy objectives direct support services to be delivered in the community setting, with 'care closer to home' and for older people to be able to 'age in place' (Department of Health 2006, Ham 2014, Wiles et al. 2011, Monitor 2015, NHS England 2019). Such initiatives place older people living at home for longer and avoiding the increased costs of institutionalised care (World Health Organisation 2021). Home then becomes central to the construction of health and social care policy for older people, and older people's experiences of care and coproduction become shaped by policy (Barnes 2012).

Social, political, and cultural concepts of ageing risk identifying older people as a homogenous group, with no recognition of the individual or of diverse needs (Wiles et al. 2011, Shakespeare 2018, Centre for Ageing Better 2021). The understanding of older people as a homogenous group assumes that home is the most appropriate place for care for all older people, at all stages of the later life course, regardless of health or social care need (Shakespeare

2018). Healthcare policy that advocates home as the ideal place of care is based on the underpinning assumption that home is the best place in which to age and to receive care (NHS England 2014, Monitor 2015, NICE 2015, Bennett et al. 2018). Such policy assumes the principle that every home is suitable and adaptable for care, and that older people are attached to and wish to remain at home for care (Peace, Holland and Kellaheer 2006, Milligan 2009, Sixsmith et al. 2014).

As such policy stems from a position of utilitarianism and not the moral imperative of care ethics, there appears little consideration within government initiatives of the political effects of care when home is the place of care. With similarities to Sixsmith et al.'s (2014) study of older people's perspectives of ageing and home, this study has highlighted how political influences of care infiltrate into the private space of home and shape and can manipulate the experience and meaning of home. The concept of a mindful coproduction of care adds to this knowledge, as it illustrates how the experience of care at home can impede or contribute to experiences and outcomes of coproduced care for older people with district nurses. When older people maintained a sense of home when it became the place of care, opportunities for the coproduction of care could occur. The conceptual framework illustrates the intricacy and interdependence coproduced care has with complex and dynamic social and political influences that shape care.

Home provides a familiarity and allows for preferences, power, control, empowerment, and comfort to be realised for older people as they remain central to decision making processes (Smith-Carrier et al. 2017, McCormack and McCance 2017). Board and McCormack (2018) suggest in their study exploring the meaning of home and the implications of care for older people, that feeling at home is achieved through the control and choice of how and where to live. These findings are reflective of this study, as all older people were able to exercise their autonomy in the choice to live at home. Board and McCormack (2018) contend that having personal possessions and familiar things around was important for the meaning of home for older people. Concurrent with the work of Peace et al. (2006), the older people in

this study worked to make their homes homelike. A sense of homeliness was created with a shaping of the immediate environment by the positioning of personal effects and things that were important. This has been conceptualised in the literature as a marking of territory to retain a sense of self, with material items connecting older people to their histories and home (Shenk et al. 2004, Peace et al. 2006, Angus et al. 2005, Oulasson et al. 2013, Board and McCormack 2018).

Peace et al. (2006) suggest that when a home also becomes a place of care, how home is experienced can become disrupted. The older people in this study experienced some unsettling of their home environments as home became the place of care. Pickard and Glendinning's (2002) comparative ethnographic study of older peoples care from lay carers and nurses in the home suggests that the disruption of the home environment blurred the boundaries of place when nurses worked in the home. Barnes (2012) suggests that when technologies for care are brought into the home environment, this can limit space. This risks the home environment becoming centred on the practices of care, and organised by district nurses as treatment locations, which detracts from the embodied place of home that is treasured and controlled by older people (Peace et al. 2006).

Ethics relate to knowledge of how to live a good life, an ethic of care infers knowledge of caring for a good life (Tronto 1993). Fisher and Tronto's (1990) theory of care contends that environment contributes to being able to live in our worlds as well as possible. When the safe place of home becomes disrupted by nursing activity this can limit the ability to live well for older people. Jakobsen and Lind (2022) suggest that rather than the district nurse being a guest in the home, the older person becomes a guest in their own four walls. Watson's (1997) theory of caring science contends that humans cannot be separated from self, other and nature. The conceptual framework presented indicates that when the home environment is valued as entwined with the self or identity of older people, coproducing care may contribute to the maintenance of a sense of homeliness when home becomes the place of

care. However, some older people resisted the encroachment of care within their home environment (Barnes 2012).

Healthcare is becoming increasingly digitalised with a higher reliance on devices with which to deliver care. Nakrem et al. (2018) in a Norwegian study of digitalised care at home consider that devices could increase time and cost efficiencies in home care. However, this removed the relational nature of care and as a result healthcare professionals could not develop relationships and trust with patients. Hoffman (2013) suggests that digital equipment in the home can be intrusive for older people, emphasised by any surveillance of health. Nakrem et al. (2018) healthcare provider participants did not consider the intrusion of equipment and how this can impact on privacy or the ethical issue of surveillance. The study did not include the perspective of older people and the experience of home was not considered. Norway has a New Public Management ideology, Nakrem et al.'s (2018) work contributes to the efficiency, low cost delivery and public service quality enhancement requirements of the Norwegian welfare state, however, it omits to consider the implications for the experiences of care for older people and the influence digital technology at home may have on privacy, dignity, and sense of self.

Thomson et al. (2013) undertook a qualitative study exploring older people and carer experience of equipment in the home, in which technologies emphasised the nursing presence. Technologies such as medical devices had social impact for older people, who found them embarrassing when other people visited. Angus et al. (2005) suggest that older people were troubled by the change in the aesthetics of the home which caused an ambiguity in the experience of home as it became a place of care. Olausson et al. (2013) recognised in their research examining the use of space in ICU for wellbeing, that when spaces become medicalised there was a constant tension between wellbeing and ill health, with a continued reminder of deficit, need and dependency. This is reflective of when homes become medicalised in this study. As Olausson et al. (2013) suggest, when homes became disordered, this transformed the experience of home and some of the home environment became unfamiliar. Pickard and Glendinning (2002) identified

the consequence the medicalisation of space could have for family members. This was not considered in this research as the older participants all lived alone.

However, these studies do not consider the opportunities for the coproduction of care that the digitalisation and devices can offer to support older people to continue to live at home for care. Inclusive digitalisation in service provision may help mitigate inequalities in care provision that arise from being housebound (Mistry and Jabbal 2023). Any digitalised healthcare requires coproduction to ensure it is what is required by users and that care can be coproduced through its use, without it being compromised (Batalden et al. 2016). To maintain a sense of homeliness when home is the place of care, any technologies or digitalisation for the practices of care require a mindful approach.

Philips (2007) contends that when home becomes the place of care, it is subject to change in how it is experienced as a private or public space. Tronto (1998) asserts that care has traditionally been an area of private life, however when care is needed at home, the private sphere of care at home becomes public. Binaries of private and public spaces suggest that that place is either one or the other. However, when home becomes the place of care for older people and made public to others, the understanding and perception of privacy of home can be troubled (Milligan 2009). Normative understandings of home suggest that home provides a private space where people can shut out the outside world and maintain a barrier to others from entering the space (Milligan 2009, Mol et al. 2010, Byrne 2020). This study illustrates that the normative understanding of home was not the experience for older people when in receipt of care from district nurses.

When the homes of older people became care-full the home became public and were exposed to others. Angus et al. (2005) argue that when care encroaches on the private and domestic space, maintaining a sense of home can then become complex for older people to navigate, as the use and meaning of home is changed, and privacy is lost. A literature review by De

Albuquerque et al. (2018) identified that knocking on doors and reaching a consensus of when it is permissible to enter a private space is good practice for maintaining privacy for older people in care homes. These practices are widely accepted social norms and would arguably be expected as a general courtesy in domestic homes.

Privacy is a fundamental human right, as is the right to receive respect for the privacy of home (European Convention on Human Rights Article 8, 1950). When privacy is lost, dignity can also be lost (De Albuquerque Green et al. 2018). Maintaining privacy is core to ethical nursing practice (NMC 2018). This was seen to be practised in the delivery of the care task, with the dignity and privacy of the older person considered and respected within the care interaction. However, considerations of privacy did not appear to consistently extend to maintaining the privacy and dignity of home.

Care ethicists assert that daily practices of care will be enhanced if the morality of the everyday life, such as respect for privacy are embodied in an ethic of care (Tronto 1998). Mutual respect for what is important for older people, such as home and privacy, is a concept embedded in care ethics, nursing theory of caring science and person centred care, and the philosophy of coproduction (Tronto 1993, McCormack and McCance 2017, Palmer et al. 2018). This study emphasises the need for a moral approach, which starts from a position of care to the human requirements of privacy, which extend beyond the body and principle based ethics.

Privacy of space was integral to the experience of home for the older people in this study (SCIE 2020). However, access to the older people's homes was at the district nurses' convenience, which impacted on the experience of privacy for older people. Merilainen et al. (2010) found in their observational study using DVD recordings of patients in an intensive care unit, that nursing activities could violate personal territory. This has greater relevance to the home environment for older people with the added pertinence of the emotional attachment to and experience of home as a place of personal sanctuary (Byrne 2020).

Byrne's (2020) commentary illuminating the changing experience and meaning of home in the pandemic for Irish tenants has relevance to the care experiences of older people. When older people's homes become openly accessible to another, feelings of control could be undermined, and home could become a place imbued with social and power relations. The expectation that older people could be always available for care is suggestive of inferences of ageist practice, in that the experience of home for older people has less importance than the time and work of the district nurses. A lack of control felt by older people in the access to home, and their accessibility for care to others is suggestive that power dynamics are skewed towards the district nurses, who hold professional status, expertise, and knowledge. Balances of power dynamics skewed towards district nursing is contrary to coproduction and equity (Palmer et al. 2019).

Care theory and nursing literature do not widely the issue of power in care relationships (Tronto 1993, Molina-Mula and Gallo-Estrada 2020). For example, Noddings' (1984) care theory is limited as it does not consider issues of power in dyadic care relationships (Fisher and Tronto 1990). In such relationships the terminology of care giver and care receiver is infused with power and powerlessness. For example, care giver implies the action of one person in response to the dependency of another, and assumes that a person is willing to care, and that the receiver is dependent on the care giver to perform care tasks, which suggests potential connotations of unequal power within care relationships (Philips 2007, Tronto 1993). This study illustrates that concepts of power are more complex than traditional understandings of dominance when considered from a theoretical perspective of care ethics, a social constructionist ontology and a lens of coproduction (Vosman 2014, Burr 2015).

Foucault (1986) suggests that power is everywhere and inherent in all relationships, even the relationships people have with themselves. Subjectivity, the way we relate to ourselves and how we relate to things and mirror other people, are all informed by power (Taylor 2011). Foucault (1986) argues that the power to act in a certain way or to be controlled is dependent

on social discourses and knowledge, which make social norms. A discourse is a set of meanings, statements and stories that produce a particular way of representing a version of events or concept (Burr 2015). Power is not possessed but an effect of discourse. Foucault's (1986) theory asserts that power is exercised when people who are defined in a certain way or categorised conform to the dominating discourse. It is the defining of something within a discourse that brings power and produces knowledge. Categorising people as old or frail brings an inequity of power with a dominant discourse of young and healthy (Centre for Ageing Better 2021). Older people within a dominant discourse of health conform to ageing well. However, as there are multiple discourses, dominant discourses can also be resisted (Burr 2015).

Institutional and cultural discourses have social practices within them which produce knowledge that control society. Foucault (1986) argues this is disciplinary power. Hierarchical powers such as medicine and healthcare dictate what practices are normalised, and thus people conform to norms, in which they are controlled by a disciplinary power. Healthcare professionals use the power of assessment, clinical judgement, and surveillance to ensure patients conform (Burr 2015). As Willig (2001) identified, in a biomedical discourse doctors and nurses have power over the bodies of patients. People conform to discourses, which are in the interests of government to maintain, through the scrutiny of others and by self-scrutiny, and accept what can be done to them and what they can do (Burr 2015).

Older people described how they had learnt and worked to manage the district nurses and equipment in their homes. Older people gained knowledge on how to interact well in the care relationship without causing conflict and negotiating any perceived conflict. Thus, practices of care were produced through knowledge which were empowering and offered some control for older people in their experiences of receiving care at home. Concepts of empowerment and control, care for older people have been reformed and embedded in policy, moving away from traditional delivery approaches of 'doing to', to a model that promotes 'working with' older

people (Department of Health and Social Care 2012). Although multidimensional, empowerment in healthcare is characteristic of resilience and of possibilities of health, rather than disease and dysfunction (Raibee 2013). Models that facilitate this underpinning shift in delivery and provision include concepts of coproduction (Leysdon et al. 2018).

Coproduction can be disruptive to healthcare practitioners such as district nurses, as there is a shift in the power and control of interactions, changing the way in which care occurs and is experienced (Elwyn et al. 2019). This shift of power can be uncomfortable for district nurses. Comparable with the experiences of mental health practitioners in Dalgarno and Oates (2018) case study research, some of the district nurses experienced reticence in relinquishing power within coproductive care interactions due to an incongruence with traditional understandings of professional role, expertise, and knowledge in care dyads. Normative understandings of power dynamics between nurses and patients are asymmetrical as they are based on concepts of dependence in a professional context (Delmar 2012). Power will remain an issue in care relationships due to the interdependence of human beings (Tronto 1993). Delmar (2012), drawing on her research exploring trust and power in care, asserts that when power is understood in a dependency context, there is a risk of paternalistic practices in care, excesses of care, or of ambivalence.

Hayes and Jackson's (2020) contend that the theoretical perspective of care ethics can support practitioners in the identification of power imbalances and support them to redress these. Arguably, a consciousness of an ethic of care in district nursing practice can work to ensure the equal distribution of power for opportunities of coproduction. This study adds to existing knowledge through empirical data of care ethics and power at play in the context of care at home for older people.

However, there were missed opportunities to coproduce care when the lack of sharing of knowledge and power prevented a sense of control over their home for older people. As Delmar (2012) suggests, a sensitive attention to

the underlying power dynamics that occur in professional relationships can help embed an ethic of care. A lack of empowerment and control detracts from the safety and security and sanctuary of home for older people. Sixsmith et al. (2014) suggest that to be at home is to be at ease. Feelings of insecurity can equate to feeling unvalued and uncared for, dehumanising older people (Galvin and Todres 2013, Barnes 2012). Leyshon et al. (2018) discuss the importance of the spatial context of coproduction in their study of volunteerism and coproduction. Their work highlights how professional and organisational barriers can be overcome when coproduction is considered outside of a consumer model and an institutional setting. This can work to reshape the roles and relationships of people within the coproduction dyad (Bransden and Honigh 2016). Leyshon et al. (2018) argue that care spaces, including that of home, can become less clinical and return to a more socialised space. This study and the conceptual framework presented suggest that a mindful coproduction of care can work to rebalance power in care relationships so that when home becomes the place of care, it also remains the place of home for older people.

7.4 Minding bodies

The care of older people by district nurses in this study was centred on the body, which is a long-recognised concern of nursing theory and practice (Lawler 2006). Body care is core to nursing theory and essential for the health, care, wellbeing, and dignity of older people (Rosendal and Overgaard 2022). More recently concepts of embodiment in nursing allow for bodies to be understood in terms of relational experience, as bodies that have agency but are shaped by the social, political, and cultural influences of the contexts in which humans exist (Aranda 2018). Ageing discourses shape how older people perceive themselves and their bodies in relation to the process of ageing and the socio-cultural policy mandates to 'age well' (Pack et al. 2019). Pack et al.'s (2019) ethnographic study sought to explain positive ageing for older people. They found that body work was undertaken by older people as a response to avoid vulnerability, decline and the potential need for care, rather than to age agelessly and conform to healthcare policy.

Watson's (1979) theory identifies healing as harmony between mind body and spirit. However, Watson's (1979) theory appears to lack a consideration of the cultures of care, the external environments of care and the co-participants in care interactions, which McCormack and McCance (2017) have identified as important. McCormack and McCance's (2010) framework of person centred nursing asserts that the context of practice influences opportunities for person centred care, suggesting that the workplace and the physical work environment are significant to person centred care becoming a consistent reality. This study illustrates that cultures of care inform and impede the opportunities for coproduction. Cultures of care were shaped by socio-political and philosophical influences. These factors have been illuminated in this study as having an influence on the bodies and experiences of care for older people living with frailty and their potential for 'healing' through nursing care at home. As this study has highlighted, care for older people does not occur in a vacuum and has many influencing and contributory factors, making care messy and complex.

Watson (1979) suggests that a patient is an agent of change and primarily responsible for healing to occur which is arguably congruent with contemporary neoliberal discourses of ageing well (Falk Raphael 2000, Aranda 2018). Such widely accepted neoliberal discourses create social norms of ageism (Aranda 2018), therefore it is perhaps somewhat unsurprising that some innate ageist practices were seen in the findings of this study.

This study has illuminated the individuality of the experiences of care for older people and their bodies. It was elicited that older people can experience their body as an object in the context of care at home with district nurses. Core to Watson's (1997) theory of caring is that humans cannot be treated as objects. Such experiences further highlight the inconsistency of tiny moments of mindful coproduction for older people. When older people experience feelings of being objectified, this has connotations of ageist practices that the NSF for Older People (Department of Health 2001) aimed to eradicate. Arguably, continuing ageist practices are somewhat

unsurprising as contemporary healthcare policy directives for older people's care centre on frailty and frailty states which appear to have replaced age determined criteria for care (NHS England 2014a, BGS 2015, BGS 2019). This has the potential to reintroduce new forms of ageism into care systems and practice.

The district nurses in this study described how care for older people was determined by a clinician based perception of need for nursing care and how any resulting care focussed on task. Knowledge, technological advancement and increasing demand have contributed to the need for efficiencies and effectiveness in care, often measured by quality indices which have largely improved outcomes for those in receipt of care (Busch et al. 2019, Lovatao et al. 2013). However, the quality agenda has also resulted in the standardisation of care through protocols such as treatment plans (Fernandez-Basanta and Movilla- Fernandez 2022). Standardisation of care through treatment plans further detracts from a humanistic nursing philosophy and an ethic of care, as the focus of care shifts to the task.

Maybin et al. (2018) suggest that task focussed approaches can restrict holism and limit care. The intricacies of care for the bodies of older people at home are much more complex than the neoliberal discourse of efficiency allows for (Aranda 2018). Older people living at home experience bodies with complex health and social care needs that require holistic care that extended beyond the care of a task (Lawler 2006, Naess et al. 2019). Sharp et al. (2017) suggest in their critical ethnography of Australian acute surgical settings that care can become task centred when efficiencies and throughput are the focus of rationed care delivery systems. As evidenced in this study, holism, although core to nursing theory, could appear difficult to achieve. This may be in part due to fragmented healthcare systems, financial constraints, and efficiency objectives (Nash 2016).

A task focused approach can predominate in working environments in which there is an emphasis on efficiency. Task focused efficiency driven care is troubled by ideals of holism and participatory models of care, such as

coproduction. Holism and coproduction can slow down care practices as require time and consideration (Sharp et al. 2018, Boyle and Harris 2009). Thus, care for older people can become dehumanised when it is centred on task efficiencies (Austen and Hutchinson 2021, England 2023). This study and the conceptual framework provided concur with Sharp et al.'s (2018) ethnography of barriers to person centred care. District nurses require an awareness of the social and political cultures that influence care practices at home, so that care can be undertaken mindfully and philosophically with older people.

McCormack et al. (2011) suggest that workplace cultures need to be understood on an individual level before any change or practice developments can occur to enhance person centred care. This study highlights that when home is the place of care informing culture can become more complex as the individual workplace is the older person's home and the workplace is subject to flux. Furthermore, the traditional control of the physical care environment is lost as quality measures found in other institutions require sensitive navigation and negotiation when home is the place of care (Twigg 2000). McCormack et al. (2011) suggest that when the built environment and aesthetic environment of institutionalise settings become more homelike this can shape opportunities for person centred care. Arguably, then care of older bodies at home should be consistently person centred. However, as this research has shown, the medicalisation and experience of the people and resources for care in the home can disrupt the experiences of care and impede opportunities for coproduction. The conceptual framework presented contributes to theory on the space of care as it suggests that further to the physical and aesthetic environment, it is the embodied environment that influences the experience of care at home for older people.

Neoliberal efficiency discourses also work against theoretical concepts of care ethics as neoliberalism is juxtaposed to the understanding of interdependency and considers people as rational self-serving individuals without any social obligations to each other, environments, or materials, and

instead focuses on universalism (Fotaki 2023). When a culture of rationality that influenced the context of care was attended to, a shift from being mindful to that of doing tasks and efficiencies was prioritised (Sharp, McAllister and Broadbent 2017, Seedhouse 2017). District nurses may translate the overarching discourse of legislation, policy, and practice to the lives of older people living at home with frailty (England 2023). In doing so district nurses may unknowingly further embed the discourse of neoliberal efficiencies in a wider responsiveness to care, by conforming to the system of delivery. A possible unawareness of capitalist rationalism that influences the care of older people's bodies, or lack of a collective and empowered voice can leave nurses unable to speak out (Lawler 1999, Sharp, McAllister and Broadbent 2017).

However, congruent with Johnson's (2023) ethnographic research in care experiences for older people in institutionalised care, this study illuminates that it is not necessarily economic resources that result in meaningful care for older people. Time pressures impacted on the experience of care for both older people and district nurses leading to the prioritisation of certain tasks (Eaton 2000, QNI 2022). The emotional, immeasurable, and meaningful aspects of care can be relinquished as the urgent takes over the important (Johnson 2023, Morris 2017). Nursing and care routines can become sped up and care dehumanised as the older bodies become products of an assembly line, with caring acts undertaken as quickly as possible with little attention to the embodied nature of care (Johnson 2023). Like Mol's (2008) work in diabetes, this study explored care practices to explore how coproduction is at work and the practices involved. This study, like that of Mol (2008) illustrates that the collective approach of a one size fits all in healthcare has the potential to omit an attentiveness to the specificity, detail, and difference and to the conditions in which older people live. This study further highlights how the embodied nature of care is constrained and enhanced by the material and social world (Aranda 2018).

As McCance (2003) identifies, meeting the physical needs of care alone does not necessarily equate to a caring experience. Fahrewald et al. (2005),

in considering the teaching of caring in the US, contend that caring can be best demonstrated by a nurse's ability to embody five core values of nursing, which they consider to be human dignity, integrity, autonomy, altruism, and social justice. In the UK the Department of Health suggest that the 6 Cs of compassion, care, communication, commitment, courage, and competence are the core values of nursing practice. Roach's (1984) theory of nursing first considered the five Cs of caring in which conscience was identified as a moral awareness in the practice of caring. Conscience has been dropped in the Department of Health's (2012) reimagining of values within nursing which arguably detracts from an underpinning motivation, personal philosophy, and an ethical intent to the practice of care in the professional context of nursing.

The meeting of care need with competence is further complicated by insufficient ability factors, as suggested by Frisher and Tronto (1990), such as resourcing. Inadequate resourcing can lead to poor care and does not absolve the moral responsibility for competent care by provider organisations (Barnes 2012). It is unacceptable for organisations to argue that staff, policies, and procedures are in place if older people become dehydrated when their need for fluid is not recognised, if there remains a lack of resources for competent care (Tronto 1993, Barnes 2006, Francis 2013).

Lachman (2012) suggests that care needs can either be responded in a biomedical approach of a task and one more thing to do, or in a care ethics approach with commitment, attentiveness, and mindfulness. Sharp et al. (2017) and Tang et al. (2019) assert a dichotomy between the intentions and actions of nurses and suggest that caring becomes undervalued in a busy clinical technology infused environment. This could explain in part, why the conceptual framework offered illustrates that mindfully coproduced care occurred inconsistently and in tiny moments for older people, and why when other demands are more pressing, care risked becoming focussed on task or unmindful. This study highlights that it was not the care of the task that was important to older people, but the connection with district nurses which provided the validation of being an equal, knowledgeable, and powerful coproducer in their care, with control over their bodies.

Conflict occurred when risk was addressed in care encounters. Conflicts in care may occur when there is a disagreement on what a care need is, and in the prioritisation of care needs, between the care giver and care receiver. Nursing theory advocates assessment of need which precipitate professional judgement (Falk Rapheal 2000). Agibade (2021) suggests that assessment in nursing is the collection of data from a patient, for analysis of information with which to identify need or problems. Furthermore, care need can be socially determined (Himmelwaite and Plomien 2014). Both socially determined need and clinical assessment result in judgement (Falk Raphael 2000). Forsgren and Bjorkman's (2021) conversational analysis of nurse patient interactions in self-management support suggests that disagreements can occur in the identification of need when there is an incongruence in professional and personal knowledge. Further divergencies can then occur in negotiation and shared decision making, with power differences influencing decisions and limiting or facilitating the coproduction of care and knowledge (Forsgren and Bjorkman 2021).

Fisher and Tronto's (1990) model of care appears to be untroubled by such complexity and assumes that the process of care is free from disruption and conflict. Tronto (1993) considers conflict in the care processes identified and alludes to conflict in judgement between nurses and doctors. Tronto (1993) suggests that it is the doctor who 'takes care of' the patient and the nurse that 'gives care', with nurses unlikely to challenge a doctor's judgement. This is debatably now an outdated understanding of interprofessional working in healthcare, as traditional hierarchies are slowly being challenged and collaboration, integration and cross disciplinary working are becoming normative (Dodkin 2021). Cullati et al. (2018) suggest in their Swiss hospital based research of health care professionals' experience and perceptions, that conflicts in healthcare teams can negatively influence quality of care. Professional codes dictate that nurse's question and challenge judgement in advocating for and in the best interests of the patients with whom they work (NMC 2018).

District nurses are bound by codes of practice with which to maintain the safety of the older people with whom they worked and as such risk management formed part of the care that occurred (NMC 2018). The exclusion and minimising of risk can construct an identity for district nurses of that of being a good nurse (Barnes 2012). This is reflective of Murray's (2009) work, where the absence of risk for children enabled mothers to construct their identity as good parent. The district nurses in this study described how they worked to local policies that considered that if an older person experienced an adverse outcome due to a risk factor, then this indicated an absence of care on their part. As such any risks could be escalated as a safeguarding issue calling professional nursing practice into question.

The NSF for Older People (Department of Health 2001) stipulates that older people should be able to determine their own level of personal risk, when making informed decisions about their bodies and their care, regardless of the emotive nature of their response to risk (Murray 2009, Barnes, 2012). In practice, twenty years on, it appears that the ideal of self-determining personal risk continues to raise tensions, in which choice and coproduction in care risk becoming rhetoric rather than a reality. For district nurses, care is a response to need that is objectively identifiable through their professional training and experience (Tronto, 2013, QNI 2015). Conversely, if to care becomes to accept risk and a persons' choice to decline nursing intervention this has potential to become contradictory to professional codes (Boldt 2017, NMC 2018).

When healthcare professionals seek to mitigate physical harm to older people, there can be a process of ensuring the psychological wellbeing of those who care for the older person, but less so of the older person themselves. This is particularly so if the individual's response to risk is not the same as that of the care providers (Salisbury 2019). Safety is low on the hierarchy of human needs, whereas esteem is higher (Maslow 1943). Care ethics posits that taking care of people's bodies extends beyond safety (Ley 2023). Rather than focussing on safety alone, a care ethical lens to a

coproductive approach to care shifts the power in the care relationship to ascertain what is important to make life more liveable and provide a focus on autonomy and freedom in the individual nature of choice in care (Mol 2008, Aranda 2018, Salisbury 2019).

This study has illuminated that coproduction offers a care ethics based approach to a humanistic, connected individualised decision making processes in care. This differs to transactional concepts of shared decision making in which there is a deliberative reasoning which may not consider the complexity of care for older people living with frailty at home (Alakeson et al. 2013, BGS 2015, NHS England 2021). In coproductive approaches professional bias does not influence care decisions for older people (Wilton 2021). The framework of a mindful coproduction of care illustrates the context of the environment of home and the social complexities in which the wider and broader influences and cultures are navigated and negotiated in partnership.

The district nurses in this study could employ what appeared to be a strategy of coaxing older people. Being coaxed was described by older people in decision making or in care interventions. It appeared that the practice of coaxing was done with a moral intent with which to conform to the biomedical ethical principles adopted in healthcare of beneficence and non-maleficence, and to nursing standards of practice (Beauchamp and Childress 2009, NMC 2018). However, as discussed, this study has indicated that when an older person determines not to concur with the advice or intervention determined by the nurse, this can place the nurse in a morally challenging position (Haddad and Giger 2023).

Although paternalistic notions of coercion are outdated and prohibited in nursing care (NMC 2018), the tactics employed under the guise of supporting choice risked developing into something similar. In a response to mitigate risk, the practice of coaxing appeared to be constructed in a more justifiable way by the district nurses, making it socially, ethically, and culturally acceptable to them. The danger is that such practices limit choice and

autonomy with a new label to convince and coerce older people to participate in nursing dictates of care. This finding is reflected in the medical field of practice. Hughes et al. (2013) discuss that cajoling in their ethnography study of dementia care, became coercion when the values of older people were not considered in decision making, when the context of care was not given attention, and by the language used in the care encounter.

Green and Sawyer's (2010) large study of Australian risk policy identified that risk management in care for older people is further complicated when it is negotiated in the unregulated context of home. Transferable to the context of nursing, social work practitioners and older people often do not have a shared understanding of what is perceived as acceptable risk when home is the place of care (Green and Sawyer 2010). However, the perspective of risk from the older person's perspective was not presented in the findings of Green and Sawyer's (2010) work, limiting its credibility.

Soled (2021) argues that nudging can either balance autonomy and beneficence or can infringe on a person's voluntary choice but conversely also considers that nudging is justified if there is a public health justification to the manipulation of individual choice. Choice is a welcomed ethical and moral imperative in contemporary healthcare and is a celebrated ideal that should work to move the care of older bodies away from coercive practices. However, the introduction of choice in care has complexities (Mol 2008, Fotaki 2014, Department of Health and Social Care 2020). Choice in UK health policy indicates that choice will equate to care (Mol 2008, Fotaki 2014). However, Mol (2008) suggests that the ideal of choice should not transcend the ideal of care, as care for older people is experienced as more than choice.

For the district nurses in this study, information on choice was limited to, providing what was wanted by the older people in terms of equipment and technologies and in the mitigation of risk and to enhance opportunities for self-care for older people at home. Thus, choice could be limited to neoliberalism rather than being underpinned by respect, dignity, and

compassion in the practices of care (Jesus et al. 2016, McCormack and McCance 2017. McCormack and McCance (2017) contend that respect and inclusivity can enhance a sense of personhood and what is important to people in care. Bosco et al.'s (2019) meta-ethnographic research in dementia care suggest that coproduction can further enhance a sense of personhood in care through the active participation in social, civil, and political life. Congruent with the findings of this study, Toersen (2023) argues that the coproduction of care offers opportunity increased autonomy and control for older people, further enhancing dignity.

Mol (2008) asserts that choice in healthcare is a way of organising interactions, practice, and of understanding people through working together. In this study care extended to how older people lived, felt, and thought in the care interactions in the home. It is argued here, that for district nursing practice with older people at home, a logic of choice should complement a logic of care (Mol 2008). The two logics enable a mindful approach to the coproduction of care, so that care is meaningful for older people. Mol's (2008) framework of care ethics is reflected in the conceptual framework of a mindful coproduction of care, as older people valued the care that was coproduced with the district nurses, be this to feel safe, to have a chat or a friend, as this was meaningful to them. Care that was coproduced between older people and district nurses was more than what was done to bodies in the form of tasks and physical care, as the nature of care was embodied.

Older people coproduced care as they responded to their care needs through contributing to the care of wounds, participated in the use of equipment, in taking medication and in the self-surveillance of their bodies, their health and wellbeing (Foucault 1986). This understanding of participation for coproduction is supported by Baim-Lance et al. (2018) who suggest in their American ethnography exploring the coproductive practices in an HIV clinic, that coproductive practices can be invisible, as they occur every day as people work and manage their bodies and care needs in ill health. Mol (2008) asserts that older people are not passive or docile in the care of their bodies. Importantly the older people in this study coproduced

care within a relational context, with the district nurse, with home and with the technologies of care, with a shared knowledge of how they understood and experienced their bodies in older age, living with frailty at home.

This study has illuminated that care for older people at home with district nurses can centre on a responsiveness to bodily need and task despite the embodied nature of care that has been highlighted within the conceptual framework of a mindful coproduction of care. Cultural, social, and political influences risk shaping an ageist approach to care for older people when a focus on experiencing choice overtakes the importance of the experience of care. However, when care ethics underpin practices of mindful coproduction of care older people may gain further opportunities to experience meaningful care of their bodies at home, as time and attention is given to the embodied nature of care.

7.5 Heeding time

The concept of time is complex within the context of care (Tronto 2003). Adams (1993) contends that time is circular in the daily rhythms of care and linear in the process of past, present, and future. Tronto (2003) suggests that time is a social construction through clock time and calendars, yet beyond human control as is evidenced through the human life course. Although clock and calendar time is a constant, the experience of time may be subjective and embodied as fleeting or dragging (Tronto 2003). Toombs (1990) and Tronto (1993) contend that how time is experienced for older people is largely un-shareable due to its subjectivity, thus the individual lived experience of time is incompatible with a measured objective time. Toombs (1990) describes a phenomenological perspective of the experience of time in ill health and suggests concepts of a lived time and of an objective time in the experience of illness.

Caring relies on time. The commodification of care does not allow for anything outside of the planned task and can shape the embodied nature of care for older people (Stevens et al. 2022, Tronto 1993, 2013, Lawler 2006). Older people and district nurses must then decide what becomes important

to attend to in the allocated time (Barnes 2012). Nagington et al. (2013) suggest that capitalist efficiencies in district nursing relate to the task that is carried out and the time it can be done in. Therefore, efficiencies become contested when care falls outside of the allotted time of the task. Care that is not measurable, or can be performed by someone else, or is perceived as insignificant, becomes inefficient when socio-political demands and rationing shape care. Thus, the philosophy of nursing care and an ethic of care can struggle to compete (Barnes 2012). Furthermore, time compressions in practice leave no time for reflection on practice which allows for learning and development (Barnes 2012, Francis 2013).

Johnson (2023) argues that scheduling and resourcing structures such as caring time, tasks, and activities determines who or what is valued in care interactions. Such approaches are system centric and can negatively shape the experience of care for older people. This study highlights that attention to how time is utilised, valued, and managed in care interactions, outside of neoliberal contexts is important for care experiences for older people. Tronto's (2003) feminist care ethics perspective contends that heeding time is important as how we consider care time in the present will shape how time is used in care in the future. As this study suggests, attention to the experiences of caring time now is imperative for enhancing older people's care at home with district nurses in the future.

Increased demand can potentially deflect an ethic of care and district nursing attention away from the care interactions with older people (Maybin et al. 2016). The increase in demand has been associated with faster throughput from acute services, with earlier discharges exacerbating the situation (Harper-McDonald and Baguely 2018). Kolehmainen et al. (2010) in a mixed methods systematic review of client care models across community services identified throughput approaches of the movement of people through the care process. A throughput model of delivery employed in acute hospital services promotes a timely discharge from a clinical facility in which time and space are critical to meet care for older people (SCIE 2022). The concept of a mindful coproduction of care highlights that in response to demand there is

a risk that district nursing can emulate acute care service models to facilitate speedy discharges from caseloads to try and relieve pressure on an already depleted service (SCIE 2022, QNI 2022). Tronto (2003) argues that such throughput models of service delivery follow a capitalist system approach of time compression through the strict adherence to clock time in which there is a general speed up to maximise efficiencies which leaves no time for a care ethical response to human need. As this study highlights, caring practices cannot easily conform to time as a normative control. Yet care services remain based on capitalist models of time and efficiency and not care ethical concepts of nurture and maintenance (Tronto 2003).

Models of throughput in home-based care do not consider the unpredictable nature of living with frailty in older age, the significance of the enduring relationships created in care processes, or a wider holistic perspective of care needs for older people (Mol 2008, QNI 2011, Barnes 2012, BGS 2015, QNI 2022). Some of the district nurses discussed a discharge focus for productivity, while acknowledged as important in a capitalist culture and system, such throughput models of service delivery for older people at home can be uncondusive to the coproduction of care due to a time limited care interaction and a lack of focus on the older person as an active member of the interaction. Healing and recovery are familiar terms in healthcare and a core concept to nursing and care theory (Sadathoseini et al. 2023). However, the district nurses in this study supported older people at home in enduring and continuing care relationships (Maybin et al. 2016, QNI 2013). Due to the prevailing nature of disease pathology and resulting care needs healing and recovery is not always possible, with goals being to live well in older age rather than for healing (Mol 2008, Barnes 2012, QNI 2019). Therefore, throughput models of discharge lack congruence with the nature of district nursing and the nature of frailty and fluctuating needs over periods of time (BGS 2015, NHS England 2015). Models of service delivery when home is the place of care require careful deliberation and design so that they are reflective of the needs of the older people who use them (Brown 2013).

Productivity driven models of care risk limiting a co-presence of the nurse in the care interaction, which Leyshon et al. (2018) contend is a precursor to successful coproduction. Currently frameworks for practice such as shared decision-making, person-centred care and coproduction risk becoming an 'add on' outside of the task due to the limits of time, as nursing actions become unimportant and unviable if unmeasurable. Effective working models of service delivery are beyond the scope of this study. However, it is recommended that time and opportunities for coproduction are integrated when designing and implementing workforce systems for district nursing.

Buscher et al. (2011) suggest a culture of busyness in homebased care. This could be attributable to a time compression for district nurses which results in a culture of busyness (Nagington et al. 2013). Concurrent with this study, Stevens et al. (2022) highlight how older people undertook work prior to the nurse's visit to save time for the nurses, due to an awareness of nursing busyness. This supports Twigg's (2000) theory of care in which the moral claim on time is lessened when the time of the professional is not paid for, thus older people can feel obliged to conserve the time of district nurse. The reductionist units of organised time make the problem of time in care visible as time is allocated in relation to the physical task, not to the person (Barnes 2012).

Comparable to the findings of this study, Nagington et al.'s (2013) argue that district nurses can find it difficult to pause or slowdown from a state of busyness and efficiency. The conceptual framework of mindful coproduction illustrates the complexity of demands and the important and interrelated dimensions of care for older people that can influence a sense and culture of busyness in district nursing practice. Despite the clear difference time spent with older people made to the experiences of care, it was unclear if a resistance to slowing down was due the complexity of demands, to the perceived professionalism that Buscher et al. (2011) identified in appearing busy, or to avoid further work being allocated within a service that is widely recognised as under pressure and understaffed (Oldman 2014, Maybin, Charles and Honeyman 2016, QNI 2022).

Nagington et al. (2013) contend that if the reductionist principles of measuring are omitted, then busyness may cease to structure the culture of district nursing. This could allow for the less tangible but important nature of coproduced care to be a reality for older people. Barnes (2012) suggests, that within an ethic of care, if nurses consider a lack of time is available to coproduce care outside of the prescribed task, this becomes a political issue that should be publicly debated. It is a moral and professional concern of district nurses to alert others to the concerns of time in care, although tensions exist in how this can be effectively done (Tronto 1993, Barnes 2012). This responsibility extends beyond individual district nurses as they undertake the daily rituals and practices of care with older people at home. An ethic of care makes the responsibility for care a collective, social, and political concern (Tronto 1993).

Dahlin-Ivanhoff et al. (2007) consider lived time for older people through the exploration of the meaning of home with older people in Sweden and suggest that the routines of daily life provide a sense of home and security. Wider literature has identified how the social ordering of time within the rhythms of the day can bring a sense of satisfaction and pleasure to older people (Valentine 2001, Fox 2013). The everyday routines of the older people in this study were constructed around the rhythms of the body and its needs, such as food and mealtimes and washing, which provided the organisation of other domestic tasks within the home (Latimer 2001).

Nicholson et al. (2013) identified in their narrative analysis of older people's experience of frailty at home, that the daily rhythm of routine was important for older people living at home as it provided a sense of security, dignity, identity, and self. However, concurrent with the findings of Nicholson et al. (2013) and Stevens et al. (2022), this study illustrates how the routines for older people became disrupted by the schedule and presence of the district nurses. Structure and routine in daily life for older housebound people has been illuminated as important for maintaining a sense of wellbeing during the global Covid-19 pandemic (Age UK 2020). However, the routines of older people at home were not a priority for the district nurses in this research.

When the rhythms and routines of everyday life of older people do not take precedent over the work structures of district nursing, this can risk a further dehumanising of older people (Butler 2004). Stevens et al. (2022) suggest time is essential for dignity, yet as discussed, time to ensure dignity is not allocated in the norms of district nursing practice with older people. This study has highlighted how intrusion of the home could impact on dignity for older people as privacy was disrupted, this was intensified when personal rituals became secondary to the requirements of the district nurse. When the significance of daily human rituals are not acknowledged or valued, this exposes further complex power arrangements in the provision of care within the home (Barnes 2012).

Ungerson's (1987) early work in feminist care ethics argued for an enhanced focus on rights in care, and a consideration of whose rights should take precedence in informal caring relationships. Ungerson's (1987) theory is of value over thirty years later in contemporary care dyads. Consideration of whose right it is to determine the time of care visit should be contemplated as these impacts on privacy and routine, and the experience of home for older people. This study suggests that care ethics and coproduction may offer a shared opportunity for determining care practices that protect privacy, rituals, routines, and the experience of home for older people.

Stevens et al. (2022) suggest quality time over quantity of time in district nursing can enhance dignity and care experiences, thus suggesting that a mindfulness to time is required. This study has illuminated that heeding time together in the care-full place home is essential for the crafting of connections in which bodies can be attentively minded and care coproduced. As McCance (2003) contends, taking time in the processes of care is important. The conceptual framework of mindful coproduction builds on McCance's (2003) theory and suggests that taking time in the processes and practices of care together is part of the experience of care for older people at home. Furthermore, taking time can facilitate a coproductive and egalitarian framework for care. However, twenty years on since McCance (2003)

illuminated the importance of taking time in care, throughput continues to take precedence in a rationed culture of healthcare.

7.6 Synopsis of discussion

The discussion chapter has presented the findings of this study within extant literature and the theoretical perspectives of the caring science of nursing, care, and care ethics to elicit new meaning and understandings of the nature of coproduced care between older people and district nurses when home is the place of care. The research questions of this study will now be answered, and the original contribution to knowledge will be presented and key insights from the conceptual framework will be presented.

7.7 Research questions

‘What is the nature of coproduced care between older people and district nurses, when they work together in the care relationship?’

The nature of care that was coproduced between older people and district nurses was mindful, occurring in tiny moments as they worked together in the home. When mindful care was coproduced, it was experienced by the older people in this study as meaningful care that was embodied. It occurred in, and was specific to, that moment in time and to the care relationship and the context of home in which it occurred.

The nature of coproduced care was evident in the everyday reciprocal relational practices of care activities, older people worked hard to contribute and coproduce care with district nurses, be this crafting relationships, making physical space for care at home, relinquishing some privacy, conforming to the nurse’s time frames, tending to wounds, taking tablets, using equipment.

The relationship that was formed between older people and district nurses formed part of the care that was coproduced. It was the social connections that were crafted in the care relationships which older people valued, and which allowed for the mindful coproduction of care. When there was a social connection within a human relationship, this allowed for an embodied nature

of care to be mindfully coproduced. For the older people in this study the coproduced embodied nature of care was to feel safe, to have a friend, to have a laugh. It was the embodied nature of care which was experienced as meaningful care by the older people in this study.

Mindfully coproduced care extended past the physical care of bodies, and the embodied nature of care. Care was also attentive to the relational significance older people held with their homes and the socio-material components within it. It was a mindful consideration of the home and of the material and social structures of home that enabled opportunities for the mindful coproduction of care. As the home and the spaces and boundaries within the home were attended to in the processes and practices of care, and the resources for care in the home were mindfully considered, home, when it became the place of care, remained the place of home for older people.

When care was unmindful, power was unbalanced in the care relationships. Older people could then experience coercion and coaxing which negatively shaped their experiences of home and of care. Care could become unmindful when risk management was prioritised over care and the older person's preferences. When the broader influencing cultures of care were not mindfully attended to this could challenge the underpinning philosophy of district nursing. This could lose prominence in care practices as other demands took attentiveness away from the ethic of care.

a) How is care coproduced between older people living with frailty and district nurses?

Care that was coproduced was constituted through a crafting of connections that occurred in the care-full place of home, where bodies were attentively minded, and time was heeded. Care that was coproduced occurred in partnership and some core prerequisites were required from both the district nurses and older people. The prerequisites of the district nurses have been listed in box 7.1. Older people actively contributed to the mindful coproduction of care. These contributions have been listed in box 7.2.

Care is coproduced mindfully, requiring a fundamental crafting of a connection. Older people and district nurses connected and formed friend like working relationships which had inferences of an intricate reciprocity for care as they became established and enduring with a sense of knowing each other. A mindful coproduction occurs within the care interactions when the older people and district nurses work together and are co-present in the moment. District nurses contribute to this through the mirroring and modifying of their behaviour to reflect the needs of older people. When district nurses are attentive with an embodied listening within the everyday conversations of care this elicits a shared understanding of care need, and the coproduced relationship forms part of the care for older people.

When district nurses value the place of home and the things in it older people can be valued as experts in themselves as their bodies are minded. When the concept of home is mindfully considered, older people can be understood as more than a person in parts, in which identities and processes of ageing are recognised and valued. A recognition of the interdependency of ill health and ageing enables a negotiation of the complex power dynamics and older people can become empowered. This requires the nurses to slow down and lose the sense of busyness with older people, and in which the rhythms and routines of older people can be attended to with care. Critically the district nurse requires the underpinning philosophical and theoretical position of an ethic of care with which to embrace mindful care so that it can be coproduced.

BOX 7.1. DISTRICT NURSING PREREQUISITES FOR THE MINDFUL COPRODUCTION OF CARE.

District nursing pre-requisites for the mindful coproduction of care

- Crafting connections
- Established relationship
- Reciprocity
- Attentiveness to the older person
- Co-presence, together in the moment
- Embodied listening
- Shared understandings of care need
- Recognition of interdependency
- Shared use of power
- Philosophical and theoretical position

The conceptual framework of a mindful coproduction considers how the older people in this study work to prepare for care and to provide and create a space of care within their homes for the minding of their bodies. As homes of older people became care-full older people surrender the private sphere of their homes. Older people are required to show and medicalise their homes for the coproduction of care, a main objective of which was to stay at home. The medicalisation of the home could disrupt the space as it became the place of care. How time was heeded was not within the control of older people and domestic and social routines became reordered by older people for care to occur. Older people accommodated the busyness and throughput approach to care and contributed to the use of time in the district nursing schedule through the contribution and participation in minding their bodies. The older people in this study contributed greatly to the coproduction of their care. Mindful care was coproduced in the home, in a space of care that has been created together and maintained by the older person.

BOX 7.2 CONTRIBUTIONS OF OLDER PEOPLE TO MINDFULLY COPRODUCED CARE

Contribution of older people for the mindful coproduction of care

- Crafting connections
- Shared understanding of need
- Creating a hospitable space of care
- Experiencing a disrupted space
- Domestic and social re-ordering
- Loss of privacy
- Loss of control of use and time schedule
- Developing reciprocal relationships
- Contributing to the everyday practice of care

Coproduced care between older people and district nurses was not considered in dualistic terms but conceptualised as on a continuum. How coproduced care was experienced on the continuum is informed by frailty, wider political, social, and cultural influences and the philosophy and values held by the nurse.

The care that was coproduced in this study navigated the broader cultures of relationality, responsiveness and rationality that were seen to pervade the context of care at home, providing a cultural sensitivity in care for older

people. Please see research question 'c' (below) for further details. Care that was coproduced considered the wider socio-political influences of care for older people (see figures 7.2 and 7.3). Policies, processes, procedures, practices, and social norms were mindfully navigated and adapted when home was the place of care.

b) What is the experience of choice and coproduced care in district nursing services for older people living with frailty?

The language of coproduction was not recognised in the care interactions between older people and district nurses. Person-centred care and personalisation are more widely used when district nurses considered choice for older people in care. There appeared to be some confusion in the understanding and application of the concepts of personalisation and person-centred care, as the district nurses understood that these occurred through the nursing presence in the care interactions at home and through the offering of choices to older people, such as in dressings or equipment.

For the older people in this study choice in wound dressings or equipment was not important. Older people valued the ability to exercise autonomy in their care, for their bodies, in their homes and in their lives. Autonomy was possible for older people when there was a reciprocal relationship and the opportunity for the mindful coproduction of care, where what was important for older people was identified and actioned together with the district nurse. The choice in care that was significant for older people was to be able to remain at home for care.

The choice to stay at home for care and to be able to make their own decisions was the understanding of independence for older people. There was dissonance in the understanding of independence between older people and district nurses in this study. The district nurses considered independence for older people as being able to leave the home. This lack of shared understanding negatively shaped choice and coproduction, as care goals were not shared.

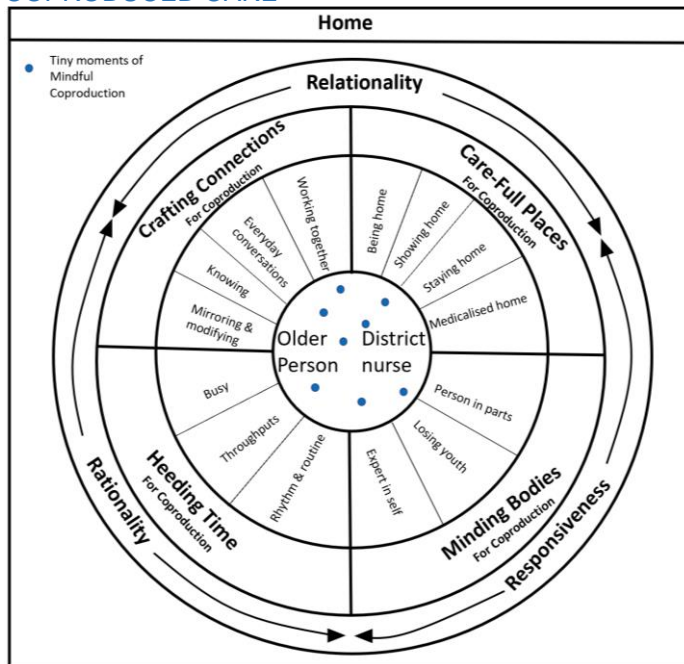
District nurses considered the limits of choice they can offer older people as a lack of resources, particularly the availability of time and how time was allocated. The district nurses appeared to be accepting of this. Older people were not able to influence or inform the use of time as this was within the district nurses' power. Choice for older people did not extend to having any influence on when the care interaction occurred with the district nurse or how this affected their daily ordering of life and routines and rituals. District nursing schedules took precedent over those of older people as the socio-political context of healthcare and the broader cultures of care placed efficiencies over the requirements of everyday living at home, and the experiences of care. Older people did not have the power to change or influence this.

Choices for older people in care were shaped by a priority of risk management by the district nurses. Managing risk was influenced by wider policy and social norms. Older people had limited opportunity to exercise autonomy and choice when there was a perceived risk identified by the nurse, and if this choice did not conform to the district nurses' advice or intervention. A practice of coaxing could occur as a strategy by district nurses to convince older people in their choices about care.

c) What are the broader cultures of care shaping the experiences of older people living with frailty and district nurses?

Broader cultures of care influenced and shaped the opportunity for the mindful coproduction of care. The broader influencing cultures of care illuminated in the findings of this study were conceptualised as the **relationality**, **rationality**, and **responsiveness** of care. These influencing cultures shaped care-full places and how connections were crafted, bodies were minded, and time was heeded. The influencing cultures of care were not linear or straightforward and each intricately influencing the nature of coproduced care. Figure 7.2 illustrates how these cultures of care influence the themes that emerged which informed the care experiences of the older people in this study. A list of the constituents of each culture can be seen in appendix 19.

FIGURE 7.2 THE BROADER CULTURES THAT INFLUENCE THE NATURE OF COPRODUCED CARE



The culture of **relationality** relates to the connectedness within the care interactions that occurred between the older people and district nurses in this study. Connections were shaped by humanistic nursing theory, an ethic of care, and by social and cultural norms within the day-to-day care encounters. The conceptual framework in diagram 7.2 demonstrates how connections were also formed through the homes of older people, the things in it and the practices and materials of care. Congruent with the findings of Maybin et al.'s (2016) research of quality in district nursing, as the district nurses responded to the wider political, social, and philosophical demands within their work whilst forming and maintaining connections with older people, this shaped the experience of the care interaction and the ongoing relationship. The findings of this study have congruence with that of Leyshon et al. (2019) as the connections between older people and district nursing were fundamental for coproduction. When social and political demands became dominant forces in the practice of care, over care ethics and a personal and a professional nursing philosophy of connecting with older people, foundations for the coproduction of care were limited (Boyle and Harris 2010, Seedhouse 2017). Care then risked becoming unmindful.

Political and social demands were seen to emerge from the capitalist and neoliberal context of healthcare (Tronto 2003. Aranda 2018). Capitalism and

neoliberalism provided a culture of **rationality** in the experiences of care for older people working with district nurses. Finite resource management in service provision in which older people become consumers of care has resulted in the commodification of care (Sturgeon 2014). Care as a commodity makes goods or services marketable, thus the human body becomes something which must be kept in good working order through consuming care (Edwards 2000, Corrigan 1997). The rationalisation of health care into a commodity which is consumed has influenced care discourses as time and money become compressed and limited in efficiency drivers (Sturgeon 2014, Tronto 2003). As such, any opportunity for a mindful coproduction of care is determined by time, resources and efficiencies in care and care becomes a political issue in which an ethic of care is not a priority (Tronto 1993).

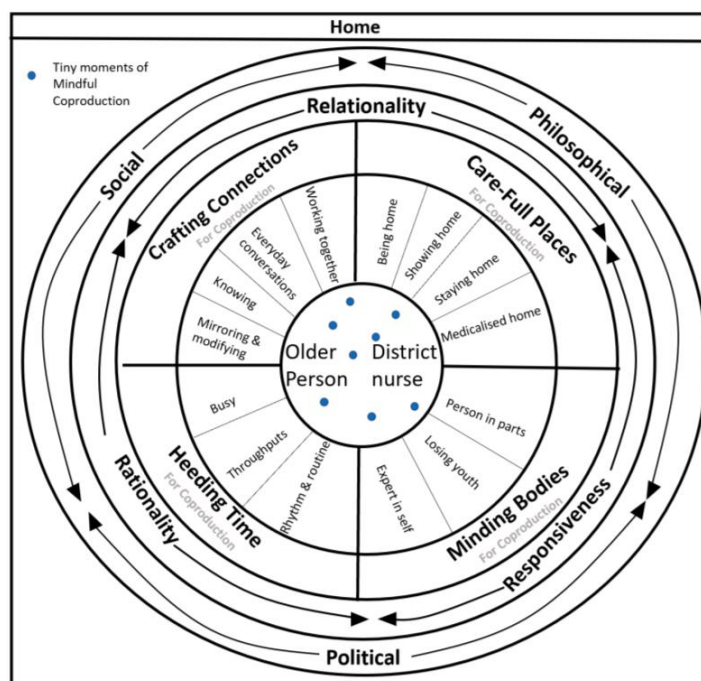
A culture of **responsiveness** relates to the way in which care need is responded to (Tronto 1993, Barnes 2012). The responsiveness to care is shaped by the cultures of rationality and relationality and the way in which these inform care practices (Tronto 1993). The conceptual framework of a mindful coproduction to care suggests that an ethic of care shapes an attentiveness to care which provides opportunities for care to be mindfully produced between older people and district nurses, together in the moment. When care is mindfully coproduced the home and the things in it contribute to the practices of care. When there is an unconscious inattention to care responses, care can become task focussed. Task focussed care risks becoming unmindful in which coaxing with a compassionate intent may be used as a new way to convince.

The conceptual framework of a mindful coproduction of care and the broader cultures of care that influenced it were further shaped by the socio-political context in which healthcare exists. The political agenda of healthcare and the social norms and practices that form society shape the cultures of care and frame the context in which care occurs (Tronto 1993, Barnes 2012). The political forces within health and care contribute to the culture of rationality through the competitive finite markets of capitalist efficiencies (Aranda 2018). In turn, how care services are delivered are informed by such policies.

Socially constructed norms and practices shape the relational inferences in care and how care need is responded to, and how older people respond to care (Tronto 1993, Barnes 2012). This study illuminates that the priority of the values held by the district nurses are subject to change as competing demands are navigated and negotiated within their work and within the culture of district nursing (Seedhouse 2017). This is not fully considered within humanistic frameworks of nursing theory.

In addition, the philosophy, and values of nurses as individuals and as a nursing theory driven profession inform the cultures of responsiveness and relationality in care practices, and how these and the culture of rationality are navigated in the processes of care and coproduction at home. Figure 7.3 pictorializes how the socio-political and philosophical underpinnings of care practice shape the broader cultures of care and the nature of coproduced care when home is the place of care. The processes of navigating the broader cultures of care illuminated how the mindful coproduction of care was only visible in tiny moments and explained why it was not consistent.

FIGURE 7.3 SOCIAL, POLITICAL AND PHILOSOPHICAL INFLUENCES SHAPE CULTURE AND INFORM THE NATURE OF COPRODUCED CARE



d) How are the issues of power and control experienced in the coproduction of care between older people living with frailty and district nurses?

There were complex power arrangements when home became the place of care for older people. Power relationships were unbalanced and skewed towards the district nurses. When this is acknowledged in the coproduction of care with older people, power can be rebalanced within a reciprocal relationship that facilitated respect, knowledge, a sharing of resources and equality.

Older people had to share and show the place of home when home became the place of care. Older people's experiences of home could become less important than the workplace of the district nurse. Home became imbued with complex social and power relations and older people could experience a lack of control over their homes. Care ethics facilitated a mindfulness to care, with power being shared and older people being empowered to have control over their homes.

Older people worked to form relationships in care with district nurses, these relationships could be forced by the experience of ill health and frailty. When older people considered that there was a lack of connection with district nurses then they could experience a sense of the home being intruded upon. This could reduce feelings of power and control which negated a sense of homeliness for older people.

Processes of nursing assessment are based on judgement, although this is a professional judgement, it is an objective approach. Older people could lack autonomy in care when decision making was challenged when dependency occurred. Decision making could become practitioner dominated based on nursing judgement and perception of risk, which disrupted the place and experience of home for older people. Older people were unable to determine their choice in risk and their view was not perceived as an expertise in self, in a risk adverse culture of district nursing and healthcare. Coaxing was employed as a tactic to convince in a guise of supporting choice, risking

becoming coercion when the values of older people, the context of care and the language used were not given mindful attention.

Care of the bodies for older people could result in an experience of feeling objectified when care is rationed and becomes task focussed. Interruption of the rhythm and routine of daily life impacted on the experience of dignity for older people at home, when it became the place of care.

Regardless of physiological and social implications of frailty and ageing, and the potential of striving for the unobtainable, older people were expected to comply with policy and self-care and adhere to a nursing agenda of independence. This could contribute to a reminder of deficits in health for older people.

The aim of this research was to generate new knowledge about the experiences of care for older people to understand the nature of coproduced care, if it occurred, between older people and district nurses and to understand how care can be enhanced. In answering the research questions this study has explored the broader cultures of care for older people and district nurses and examined how these influenced the experiences of care at home. This research also offers some explanation in understanding how power, choice and control were experienced within the care interactions at home between older people and district nurses. The original contribution to knowledge will now be presented. Key insights gained from the conceptual framework of mindful coproduction and contributions to existing theory will be discussed.

7.8 Contribution to knowledge

The findings of this study contribute to older people's care. Through a focussed ethnography, drawing on the theoretical perspective of an ethic of care, this research has provided thick rich data that can contribute to shaping care at home for older people when working together with district nurses. The findings of this study are constituted as a concept of a mindful coproduction of care when older people and district nurses work together. It

is envisaged that this research can inform a wider strategic level of care, for policy makers, service providers and third sector agencies.

This study has highlighted that coproduction is a nuanced concept with which to consider care for older people at home with district nurses. The coproduction of care places older people as an expert, with equitable strategic power sharing and the blurring of roles between the person and the clinician. It mobilises the skills and capacity of people and nurses so that care can be coproduced. Coproduction is an asset based approach to care in which multiple voices and perspectives are brought together, each with equal value and power. Thus, coproduction builds on social capital with a collective responsibility for care and offers a new way in which district nursing services could be transformed for more egalitarian approaches to care. This has not yet been explored in district nursing service provision and this study offers insights into the value of coproduction in the context of home-based care for older people.

Tronto's (1993) theory of an ethic of care and contribution to the political theory of care suggests that a responsibility based ethic of care can offer a very different set of social arrangements in the complexities of caring policy. Tronto (1993) suggests that this can be achieved through a focus on caring relationships and the relationships between power and caring practices. Boyle and Harris (2010) contend that coproduction embraces a collective and social responsibility for care, reflective of the core values of care ethics. Drawing coproduction and care ethics together offers a framework of the mindful coproduction of care and a nuanced contribution to sustainable care for older people at home. The conceptual framework that has emerged within this study adds to understandings of an ethic of care as it aims to reduce power imbalances in care through mindful coproduction in which the older person is valued as an equal and as an expert.

The original and wider contributions this study has made to existing knowledge will now be presented.

7.8.1 Original contribution to knowledge

This study has brought together coproduction, care, care ethics and district nursing in the context of care at home for older people, which has not been explored elsewhere, offering an original contribution to knowledge. The coproduction of care between older people and district nurses when home is the place has not been considered elsewhere in extant literature.

The findings of this study have illuminated that when care is coproduced between older people and district nurses at home, it is mindful. Mindfully coproduced care was embodied for older people and could be the feeling of being safe, of having a friend or the experience of having a laugh. When care was mindfully coproduced between older people and district nurses, it was meaningful for older people and valued by them.

The findings of this study illustrate that mindfully coproduced care happened in tiny fleeting moments. Broader cultures of care, and social, political, and philosophical influences shaped and informed the practices and processes of care and competing demands disrupted opportunities for coproduction. The moments of coproduced care were so small that they could go unnoticed. However, tiny moments of coproduced care accumulated, and these mattered to older people.

This study illustrates how older people and district nurses work to craft the caring relationships in which the coproduction of care can occur. Crafting the caring relationship was a practice and process of district nursing in the home with older people. Older people crafted connections with district nurses with a sense of friendship and through coproducing their care. The coproduction of care by older people was evident in the work that was undertaken to prepare and contribute to the care interaction and the activities that older people took to participate in their health. Older people put aside their routines and rituals in preference to those of the district nurses so that their bodies could be attended to, together. However, it was evident that some district nurses did not recognise the work that older people undertook in their care as coproduction.

The relationships that were crafted between older people and district nurses formed part of the care for older people. When there was no relationship crafted with the district nurse the opportunity for the coproduction of care became limited and older people could experience poor care. This could result in feelings of being bullied or as being an object, in which older people became dehumanised.

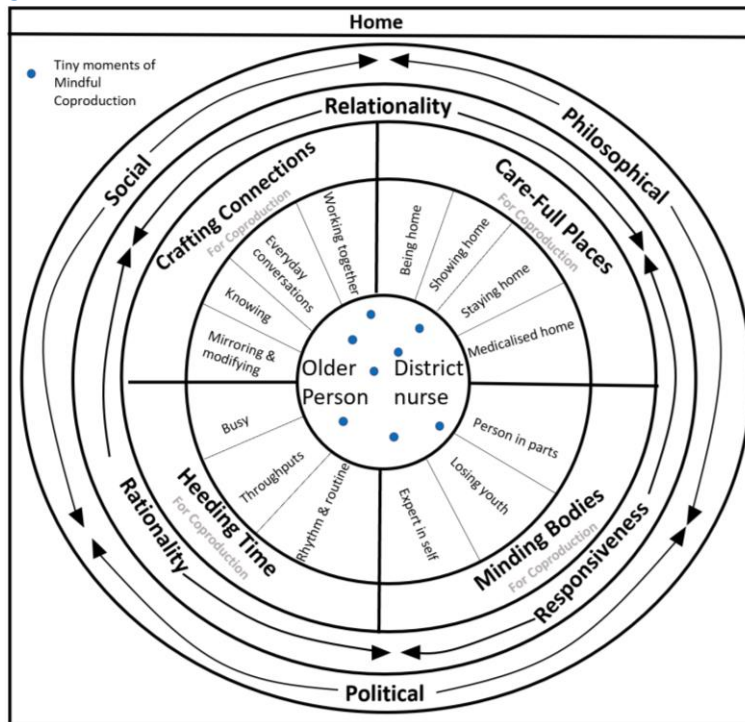
Older people in this study accommodated what was considered an intrusion of people and things into their homes, so that relationships could be crafted with district nurses. The findings from the research showed that some older people could feel coaxed into accepting equipment and technologies for nursing into the home. This study has illustrated that the nature of coproduced care for older people was intrinsically linked to the relational importance older people had with their homes, and the things and people in the home. When the home and the socio-material components of home were mindfully considered, care could be coproduced, and the experience of home continued for older people when it became the place of care. This study highlights that when feeling of home was disrupted for some older people this could have an adverse consequence for their experience of care.

The terminology of coproduction, person centred care, shared decision making, and collaboration can be used in practice interchangeably (Harding et al. 2015, Ahmad et al. 2014). This study has illustrated how coproduction is different and useful in the context of care at home for older people with district nurses. The exploration of the differences and similarities of coproduction, person centredness, shared decision making and collaboration in the context of care for older people at home has not been articulated elsewhere in the literature and is an original contribution to knowledge.

The liminal position of the researcher as a district nurse when exploring the nature of coproduced care at home with older people has not been explored elsewhere. Thus, my liminal position in the research has provided a novel lens with which to undertake, interpret and synthesise the findings of this study.

This study has presented an original conceptual framework of a mindful coproduction of care.

FIGURE 7.3 THE CONCEPTUAL FRAMEWORK OF THE MINDFUL COPRODUCTION OF CARE



The conceptual framework of the mindful coproduction of care contributes to existing theories of care, care ethics, nursing and specifically district nursing. The conceptual framework illustrates the complex components that influence the nature of coproduced care for older people at home with district nurses. It illustrates the intricate and significant interconnection of factors that have been found in this study which could influence and shape opportunities for the mindful coproduction of care.

7.8.2 Key insights from the conceptual framework

Two key insights have been drawn from the conceptual framework of the mindful coproduction. These are:

When care is mindfully coproduced between older people and district nurses this enables the place of care to remain the place of home. The embodied environment influences the experience of care. When home is the caring space for older people a sense of home can be lost, and the experience of home disrupted. A mindful coproduction of care ensures that the relationality older people have with their homes and the things in it

remains focal when care is required. The space of care is recognised and valued as the safe space of home and as important to older people. The clinical requirements of care are shaped to ensure the sense and experience of home are maintained for older people.

Coproduction offers an alternative participatory model of care in which systems, services and organisational practices have the potential to adapt to the person.

When care is coproduced, there is an opportunity for older people and district nurses to work together to find ways in which the care systems, services and organisational practices can be shaped to fit with the needs and preferences of older people, when home is the place of care. The mindful coproduction of care offers an alternative approach in which the development of social equality and social capital are possible. This is a prominent feature of coproduction. Predominately participatory models of care work to ensure older people can fit in the systems available and coproduction offers a different politics and philosophy. This study recognises that coproduction is not a perfect solution to the complexities and demands of contemporary healthcare. However, a mindful coproduction of care offers a conceptual framework for care practices at home between older people and district nurses in which meaningful, mindful care can be experienced.

7.9 Summary

This chapter has discussed the findings of the research study in the context of underpinning theoretical perspectives and extant literature and theory. New understandings and original contributions to knowledge have been presented. The conceptual framework presents a developing theoretical model for the mindful coproduction of care at home between older people and district nurses. Key insights from the conceptual framework have been highlighted.

The next chapter will present the implications and recommendations of this research and its strengths and limitations will now be considered. Reflexivity is considered throughout. The thesis will then close with concluding remarks.

Chapter 8 Implications, strengths and limitations, reflexivity and concluding remarks

8.1 Introduction

This final chapter will present the implications and recommendations for future practice, policy, research, and education that have arisen from this research. The strengths and limitations of the work will be discussed, and reflexivity will be considered in relation to the challenges faced throughout this study and the efforts taken to mitigate them. The thesis will then conclude with a short summary of closing remarks, bringing together the overview and summary of this research and its contributions.

8.2 Implications and recommendations

The research undertaken was centred on care for older people at home with district nurses. The implications for older people's care will be presented, followed by the implications and recommendations for district nursing practice, education, and policy. Areas for further research will then be considered.

8.2.1 Older people

As this study has focussed on the nature of care for older people it has raised several implications and recommendations for care. Outcomes in care are currently largely measured on process based objectives and not outcomes that are of benefit or meaningful to older people (Boyle and Harris 2010). Contemporary political agendas promote participation and engagement with health and care services by older people (Carey 2019). However, this has not extended to older people being included in the designing outcome measures in care (Brown 2013). There is a missed opportunity for older people to coproduce outcome measures in care that extend beyond satisfaction surveys which would contribute to a quality agenda that mitigates the risk of omitting outcomes that are important to people who use services (Cribb et al. 2020, BGS 2015, Brown 2013). As Boyle and Harris (2010) suggest, when quality is based on experience and

not on cost this can produce outcomes for mutual benefit, such as meaningful care.

However, a major challenge in coproducing on a service design and delivery level for older people who are in receipt of district nursing care is that by the nature of being housebound, accessing opportunities for coproduction activities is limited (QNI 2022, Boyle and Harris 2010). This results in older housebound people becoming disparate and marginalised with a lack of voice in coproduction, when foundational to coproduction is the concept that it is inclusive of everyone who participates, not only people who are accessible, able, and articulate (Boyle and Harris 2010). Furthermore, the language of coproduction is not familiar to older people potentially due to its emerging presence in healthcare policy, making coproduction more inaccessible to older people (Baim-Lance et al. 2018).

Older people's networks could have a key role in disseminating information about coproduction and liaising with service providers in coproducing opportunities for service design, delivery, and outcome measures (Blair and Minkler 2009). However, health and social care services remain fragmented with policy directives to improve integration (Shepherd 2016). Therefore, coproductive work with tertiary and charitable sectors, and older people's networks may not be a feasible reality when commissioned services within the same organisation face challenges in effectively coordinating and producing integrated collaborative service pathways (Joo 2023, Leyshon et al. 2019).

As previously considered by Barnes (2012), this study has highlighted the importance of home for older people, and the tensions that home-based care can bring to the experience of home. Policy on care closer to home implies a need to advocate for a more prominent attention to the complexities and experience of care at home (Barnes 2012, Keift et al. 2014, Monitor 2015, Maybin et al. 2016). This highlights another opportunity for integrated working or coproducing between older people's networks, district nursing and care providing organisations. However, as this thesis has shown, the broader

cultures of care can influence the priorities of care with the urgent over taking the important, particularly as fiscal resources and financial crisis prevail (Morris 2017).

The mindful coproduction of care occurred for the older people in this study in tiny moments. Should there be a more consistent practice of this care ethically based coproduction in practice there is the implication of transformational change in the experience of care for older people (Tronto 1993, Baim-Lance et al. 2018). Such transformational change could be in the experience of power, autonomy and self-determinism in care and care decision making (Boyle and Harris 2010). Essentially these values relate to human rights, like privacy, as seen in this study this is not a consistent reality for older people in the receipt of district nursing care, as this can be impeded by healthcare delivery cultures and systems (McCormack and McCance 2017, Seedhouse 2017). Human rights begin at home, and they mean the world to the individual person (Roosevelt 1958 cited in SCIE 2017). There have been many fundamental changes in how care is provided to safeguard human rights such as autonomy, this work must continue (SCIE 2017).

The conceptual framework of mindfully coproduced care illustrates the potential for a radical change in care for older people. It suggests that rather than being system led, where an older person may be supported to fit within care delivery systems (NHS England 2014), that alternatively services, practices and processes of care could adapt for older people (Abdi et al. 2019). As McCormack et al. (2010) argue, healthcare service delivery does not exist in utopia, and changes to care would take vision, time, and resources. Coproduction is an effective facilitator of change on multiple levels (NHS England 2019). However, a persistent barrier to affecting systemic change in service delivery for older people is the focus on quick wins and immediate efficiencies rather than working towards long term goals, despite the perceived benefits (Ham et al. 2018, Boyle and Harris 2010). As this study has highlighted, the opportunity for a starting point for improved and enhanced care for older people at home is through coproduction. Mindful care interactions with district nurses in the processes and practices of care

can contribute to meaningful care for older people. Advocating for change within district nursing practice is therefore fundamental.

8.2.2 District nursing practice

This research has identified that care can become secondary to task when there is a culture of busyness and throughput in district nursing practice, which is shaped by the broader cultures of care and socio-political influences. The significance of an ethic of care urgently requires reinstating in the everyday culture of district nursing. The erosion of the philosophy of care and caring in nursing practice contributes to it becoming the bottom of all agendas as competing demands take over. However, until care for older people is valued then opportunities and possibilities to improve it remain limited (Juujarvi et al. 2019, Barnes 2012).

Reflecting on care interactions and when things have not gone well in a supportive and safe context allows for new understandings in the practice of care and in working together with older people for mindful coproduction to be crafted (Koshy et al. 2017). Challenging the unconsciousness of ritualistic practice will illuminate what is important and valued by older people in care interactions with district nurses (Morris 2017). Arguably, a conceptual framework of a mindful coproduction of care can bring care and the older person back centre stage and embed a philosophy of care ethics in nursing practice. Highlighting the importance of the embodied nature of home for older people provides a lens for district nursing practice. However, nuanced and developing nursing theory for contemporary nursing practice could further contribute to this agenda.

District nursing is underpinned by nursing theory to guide practice, research, and education (Stolley 2000). As McCance et al. (2003) suggest, some nursing theory can be confusing in its language and lack application to contemporary practice. McCormack and McCance's (2017) person centred practice theory can further inform district nursing practice as this reflects equality and equity in caring relationships, increases autonomy and self-determinism in managing risk and places the person at the centre of care

delivery. New and evolving theory can further shape district nursing practice for older people's care which is framed within an ethic of care, with emphasis on the person as an expert in their own health and care and centred on the complexities of nursing care at home. Such theoretical underpinnings for district nursing practice would benefit from being coproduced with older people, who receive care and not only nurses who consider it.

Furthermore, theory that shifts from humanism alone and considers the embodied nature of home and the people and things in it could contribute to new understandings and guide practice when home becomes the place of care for older people. However, as discussed in this thesis, the practice environment and organisational culture can determine the conditions and circumstances in which theoretical knowledge is applied, and nurses can become more concerned with the processes and practice of nursing (Saifan et al. 2021). This can risk a nursing and care philosophy being lost in the consciousness of practice as broader cultures and competing demands take precedence in services which are stretched beyond capacity (Oldman 2014, Seedhouse 2017, Morris 2017).

8.2.3 Education

The significance of self-determining risk and for the shared understanding of independence for older people has been discussed; however, it is important to consider here in the context of nursing education. This research has shown that moments of ageist coercive practices of care could occur for older people at home, despite policy and processes to safeguard against such instances (Department of Health 2001, UK Parliament 2022). This highlights that there is an ongoing and urgent need to ensure care in acts of nursing for older people, illuminated by failings in care (Francis 2013, Kirkup 2015). This is particularly important due to consistent staff shortages and challenges in recruitment to nursing posts (Morris 2017, House of Lords 2022).

The risk of replacing of coercion with coaxing as a new way to convince would be of value of highlighting in pre and post- registration nursing and

district nursing education. Raising a consciousness of such practices and allowing these to be explored in a safe learning environment may help to reduce these experiences for older people. Coproducing teaching and learning with older people in the classroom and in practice, using real life expertise and experiences of care may offer a strategy to bring care and care ethics back centre stage in nursing education (Price et al. 2021, Barnes 2012). However, the unfamiliarity in concepts of coproduction and its value in education and care may limit engagement (Holland-Hart et al. 2018).

New NMC (2022) standards for district nursing have been published to inform and shape the context of district nursing education. These standards offer the opportunity for the reintroduction of the specialism of nursing in the home. However, the standards offer a generic application across a range of specialist roles. Encouragingly coproduction is considered within the standards to support the design and delivery process of education programmes for specialist practice (NMC 2022). District nurse educators are well placed to support district nurses in articulating their worth in the discipline of nursing (HEE 2015, PCWC 2015, Maybin et al. 2016, Demiris et al. 2020). However, it remains the education team's responsibility to ensure that coproduction is considered in the context of care for older people, and to encourage district nurses to work more flexibly when managing risk (Price et al. 2021, Boyle and Harris 2010).

8.2.4 Policy

This study has considered that the language of coproduction, although emerging and becoming more commonplace in policy, lacks definition and transferable meaning to practice (SCIE 2022). This is particularly so in the context of care with older people at home with district nurses. A clear, shared, and applicable definition for the coproduction of care in policy for use in care dyads at home would benefit coproduction and allow it to grow (Yuan et al. 2018). Macro and micro policy makers could benefit from using research and practice based examples of the coproduction of care to help embed this concept (Minghella and Kinsky 2018, Boyle and Harris 2010). Drawing on examples of coproduction, in the coproduction of policy with

older people as experts in care, and frontline health professionals could facilitate a useful and flexible approach to care policy development with shared understandings of coproduction (Filipe et al. 2017, Brown 2013).

District nursing is commissioned through achieving targets that improve productivity whilst reducing or stabilising healthcare costs for care closer to home whilst maintaining and improving high quality care (NHS England 2015). Commissioning processes would benefit from change as the culture of target driven pay by results can limit innovation such as coproduction and prevents front line staff from changing working practices (Boyle and Harris 2010). Commissioning in district nursing shapes how services are designed, delivered, and measured (NHS England 2015). Rather than paid by activity which is rationed in units of time based on the intervention required (Boyle and Harris 2010, QNI 2022), policy could refocus the commissioning strategy to embed an ethic of care and pay by person and the coproduced understanding of care need. Barriers to this persist due to the short term nature of policy, measurement centred on targets and not outcomes, and pressures in district nursing practice. However, a long term strategy of care ethics and coproduction in policy could see the commissioning of district nursing work to save time and resources as well as improve meaningful measurable coproduced outcomes.

This and other work have highlighted the complex nature of care relationships between district nurses and older people when home is the place of care (McGarry 2009, Barnes 2012). Acknowledging the boundaries in care relationships required for the safeguarding of older people and nurses (NMC 2018), consideration of the intricate nexus of relationships in care could be considered more specifically by governing bodies and policy makers. This may allow space in policy that consider connections that enable an embodied nature of care for older people (Aranda 2018, Barnes 2012). Similarly, a nuanced understanding of independence in care policy that reflects autonomy and not physical ability may facilitate a culture of care that is more conducive to the meaning of independence for older people (Barnes 2012, Ward 2015, Seedhouse 2017).

There is opportunity for local service providers to reconsider policies that may appear coercive in expectations of older people's participation in care. This could include developing shared understandings through coproduction with older people and district nurses on care need and what participation in care at home may look like (Baim-Lance et al. 2018). The coproduction of policy may reduce assumptions of ageing and dependency that can further marginalise housebound older people. The process of coproduction of policy may work towards facilitating mindfully coproduced care experiences in which older people are valued as equal, unique individuals with needs and preferences (Boyle and Harris 2010, Barnes 2012, Brown 2013).

This section has considered the implications and recommendations that have arisen from this study. Areas for further research will now be considered.

8.3 Further research

This research has identified a conceptual framework for the mindful coproduction of care at home and the pre-requisites and contributions required. The next stage of this work will be to develop and trial a model of this conceptual framework as an emerging theory for practice. I suggest that this could be a useful reflective tool for district nurses to evaluate care interactions with older people at home, reflecting on the coproduction of care in practice, the broader cultures of care and nursing and care philosophy. There is opportunity to coproduce with older people, district nurses, and district nursing students in the development of a model, learning resources and materials for practice.

Further research identified includes:

- The nature of the caring relationships and connections held when care occurs at home, to explore the concept of friendships between older people and district nurses in the coproduction of care.
- The work older people undertake in contributing the coproduction of care.
- Investigating how district nurses actively push against passivity in care when working with older people.

- To understand the influence and significance of the socio-material aspects of home on the experience of coproduced care through a post-human lens.
- How older people retain a sense of home when it becomes care-full
- An exploration into the gendered nature of the experience of home when it becomes the place of care and the nature and experience of coproduced care at home for black and ethnic minorities and LGBTQ older people.
- Investigation of how nurses use their professional experience and knowledge to craft connections and how this process informs the experience of nursing care.
- Further exploration of coaxing in care when home is the place of care.
- Investigation into how nursing actions enable or limit control and autonomy for older people at home in the coproduction.
- Explore how and why district nurses improvise to manage restrictions to the service.
- The meaning of independence for frail older people at home would be of value is shaping policy.
- More research in older peoples' experiences with frailty specialist services at home may offer further insights into the meaning and understanding of frailty for older people.
- Further research exploring concepts of busyness and throughput in care models for older people.
- Further research that explores risk management for older people receiving care at home.
- Further research in the concept of mindful coproduction in other care settings with other health and social care professionals.
- Consideration of service design and delivery models for district nursing practice.

8.4 Strengths and limitations

The design process of this study has highlighted some strengths and weakness in the approach taken, these will now be discussed with critique, reflections, and reflexivity.

A strength of this research is the qualitative approach which enabled exploration of the participants experiences, perceptions, and behaviours (Tenny et al. 2022). A focussed ethnography using the methods of observation and semi structured interviews allowed for an immersive, comprehensive account of the social phenomena of care that occurred, through a lens of the people that experienced it (Mason 2002). O'Rourke and Beresford's (2022) scoping review of homecare for older people suggest that care at home for older people remains under-researched. This research study enabled me to gain the perspectives of older people and district nurses, thus accessing two participant groups and data that can be challenging to obtain in the community setting, and more so within the homes of older people (Maybin et al. 2016, O'Rourke and Beresford 2022).

The study design was a three phased focussed ethnography. This design allowed for the collection of data over time which facilitated a deeper insight to the natural setting of care at home and provided a link between the everyday interactions of care and the wider cultural, social, and political influences (Higginbottom et al. 2013). Other methodologies were considered for this study but as it was particularly concerned with the cultures and nature of care from the perspectives of older people, using a focussed ethnography adds strength as it aligns with the research paradigm, aims and objectives of the study (Mason 2002, Green and Thorogood 2018).

The methodology of a focussed ethnography lends itself to a specific area of study in which I am familiar, experienced, and knowledgeable about the context of research (Taylor et al. 2015). However, familiarity with the context of research can introduce preconceptions and assumptions into analytical thinking (James 2013). However, the epistemological position held of social constructionism recognises the researcher as intrinsic to the process and that previous knowledge and experience will influence the construction of new knowledge through social interactions (Ritchie and Lewis 2005). Relativism allows me to consider multiple realities and (Silverman 2011). Reflexivity enabled my position in the research to be considered addressing

issues of preconception and enhancing credibility and transparency in the research (James 2013).

Older people and district nurses were invited to participate in the design of research materials which were used for the study through accessing older people's networks and district nursing services and forming consultation groups (BGS 2018). However, the research could have been further strengthened by using a coproductive design with older people and district nurses, as coproduction was a key concept to the study (Beran 2021). However, the focus of this study was coproduced care as opposed to research design and methodology, and the two differing applications may have been easily confused in practice (Hallam-Bowles et al. 2022). As there appears to be a paucity of evidence that considers a coproduction approach to research design in the coproduction of care with older people at home, this would be an exciting area to explore in the future.

The data collection of interviews and observations took place over a maximum of a three-week period for each older person and district nurse pairing. This study is limited in that only one care intervention was observed for each older person and district nurse pairing. A deeper perspective would have been gained from more time spent in the field (Hammersley 2006). Rashid et al. (2015) consider ethnography as a methodology in health research and suggest that health researchers spend less time than others in the field, as this is considered less important. I considered that the observations were significant and fundamental to this study and provided a plethora of rich data that would have not been captured using interviews alone as a research method (Morse 2002).

If I were to repeat the study, I would consider increasing the number observations as part of the methods taken and of observing different district nurses working with the older people participants to provide a wider view of the cultures, practices and processes that occur in care at home (McGarry 2009). This may have increased the number of participants and have increased the data for the study. Mason (2002) suggests that eight

participants and four data sets is a robust sample size in qualitative work, this is supported by O'Reilly (2009) and Green and Thorogood (2018) for the methodology of a focussed ethnography. However, this study is limited as one participant, Dot, was unable to participate in her second interview, leaving one data set short of one element of data collection.

Although a larger participant group may have added depth to the data and findings, time and data management were key considerations of this study (Green and Thorogood 2018). This was in part due to the nature of part time doctoral study and full time employment, but also a consideration in being able to access participants for the study, and participants who would be able to continue to participate for the duration of a longer study (Zweben et al. 2009). Furthermore, due to the pressures in district nursing practice accessing the field for further iterations may have been challenging (QNI 2022, Green and Thorogood 2018). In hindsight I was fortunate to be able to access the field and the participants and collect all data before the outbreak of the pandemic and social lockdown in the UK in March 2020 (Institute for Government 2022).

The duration of the study and data collection also enabled me to build relationships with the participants as a researcher. Fetterman (2010) contends that ethnography is defined by the researcher's relationship with the setting and the participants, in which the emic and etic perspective is considered and multiple realities acknowledged. As a new or novice researcher I was studying the context of care that I am well familiar with, having practised as a district nurse and now as a district nurse educator. This experience provided me with a liminal position as a researcher (Daniel 2006). This position provided me with a unique place with which to undertake this study and was of benefit as discussed in chapter 3. However, I initially experienced some challenges in shifting my position from that of nurse and educator to navigating the position of researcher due to my liminality.

Having met and gained consent from one man to participate in the study, I called at his house at the arranged appointment but was unable to gain an

answer at the door or by telephone. The door was unlocked but I could not enter as I was in my role as a researcher and not as his district nurse. I had to adjust to not practising as a clinician (Sheilds and LaRue 2010). I found this challenging as I was concerned for the wellbeing of this participant. Following the risk management protocol that had been constructed as part of the ethical application for this study, I contacted the district nurse team responsible for this man's care and advised of my concerns. I telephoned the man later that evening to rearrange the appointment and he advised me he had heard me outside, but I was unable to hear his call for help. He had fallen at the side of his bed and was unable to get up. Despite my phone call to the district nurses, he had been there all day until his son got home from work. He was later admitted to hospital and unable to continue his participation in the study.

I was upset that I had not been able to assist this man when he needed help and care, as I would have as a district nurse (NMC 2018). However, my liminal position with a cross disciplinary lens enabled me to recognise the boundaries of my role as a researcher, and to identify strategies with which to manage the situation and to mitigate risk for the man and myself (Hamilton 2015, Rutherford and Pickup 2015). This was a learning experience for me in the research process as it enabled me to shift my thinking from nurse to researcher, and I was able to position myself more clearly in the research process (Rutherford and Pickup 2015). This scenario also highlighted the importance and value in predetermining risk management strategies when researching in the home with older people (Keiner and Joshi 2021). However, it also illuminates that risk management protocols are not infallible (Risk Management Authority (RMA) 2016). Following this incident and a reflexive discussion with my supervisory team, I revisited the risk management process with the district nurses in the recruitment processes to emphasise the importance of the strategy and to ensure contingency measures were in place to safeguard the older people who participated in this study (RMA 2016, NMC 2018).

A limitation of this study is the recruitment process that was undertaken. I had considered that accessing participants for this study would be challenging due to the nature of the research. However, in practice recruiting participants was less challenging than I had initially perceived (Hall et al. 2009). As I have worked in practice and in education in the local area for several years, accessing district nurse participants with whom I had no connection I perceived was going to be a further challenge. The district nurses who participated had been known to me previously, although I had not worked with them in any capacity, this potentially introduces the potential of bias (Smith and Noble 2014). On reflection I could have waited and worked to recruit other district nurses with whom I had not had a connection through education or had used a research site outside of my local area (Ross and Zaidi 2019). However, time limitations prevailed and access to sites further away would have led to other challenges in undertaking part time study (Green and Thorogood 2018).

A further potential limitation of this study is that the district nurses recruited the older people themselves. This could influence the findings of this study, as older people may have felt compelled to participate due to their working relationship with the nurses. Informed consent process and that I was able to meet with older people without the district nurses present sought to mitigate this potential shortcoming in the research (Smith and Noble 2014). Reflectively, I could have worked with to older people's networks and carers networks to access older people to participate in this study, however, this may not have elicited the older person and district nurse pairings that I aimed to recruit, as understanding the relationship was important for this work (Ross and Zaidi 2019). It is through transparency and reflexivity that this limitation is addressed in this research (Galdas et al. 2017). Reflecting on how this potential bias and limitations can be mitigated has provided valuable learning for the future as my research profile develops (Ross and Zaidi 2019).

However, as the older people and district nurses were known to each other and had developed caring and trusting relationships over time, this provided

a unique opportunity and strength with which to explore the coproduction of care and provided rich ethnographic data. The relationships that existed allowed for a lens with which to explore the dynamic nature of care at home and to gain insight into the practices, processes, and powers at play in care (Barnes 2012).

This research is somewhat limited in that it considers coproduced care with frail older people, but that the older people who participated in this study did not identify as frail (BGS 2015). Providing a clear understanding of frailty and the differences in the adjective to that of a clinical state adds strength to this study, as it highlights that the term frailty has been used to describe what someone lives with, not what they are (Cluely et al.2019, Age UK 2014). The experiences of the coproduction of care may well be different for older people living with differing health needs, such as cancer or those at the end of life. For older people living in differing care environments with care interactions with nurses from other specialities or disciplines may be different and could be explored in further research (Olusson et al. 2013).

The demographic population of the area in which the study was taken is predominately white British and Eurocentric (ONS 2020a). The participants all identified as white British and therefore there is no representation of black and ethnic minority experiences of care for older people with district nurses. This was not a deliberate omission or exclusion as the participants were recruited on a first come basis to ensure that an adequate sample size was achieved. However, this omission would potentially limit any generalisation of this findings of this study (Shea et al. 2022). However, this study does not aim to generalise the findings but suggests that the findings may be transferable to other ethnic minority groups (Redwood and Gill 2013). However, it is recognised that the experiences of black and ethnic minority older people and district nurses may be different in the coproduction of care, due to historical racial marginalisation of black and ethnic minority communities within English culture and more specifically in healthcare (Robinson et al. 2022). Similarly, there was no inclusion of participants from

the LGBTQ community which may have provided a different perspective of the experience of care at home. This is worth exploring in future work.

The participants were all female except for Bill. This may be explained by the demographics of the local area in which older people are predominately women (Office for Health Improvement and Disparities 2022). Inclusion of more male older people participants may have altered the data and results due to the gendered nature of care (Philips 2007). The district nurses who participated all identified as female, male nurses were not deliberately omitted from the study. The gender gap in this study may be explained by the gendered nature of caring and the predominance of female nurses nationally in the UK (Tronto 1993, RCN 2018). However, June specifically mentioned in an interview that in her experience she felt she received better care and attention from male nurses. The inclusion of a wider gender, cultural and social groups in the coproduction of care at home would be of value to further explore to add strength to the findings of this research and for transferability (Ross and Zaidi 2019, Robinson et al. 2022).

This study provides a clear and repeatable audit trail of the research processes undertaken which adds to the trustworthiness of this study (Nowell 2017). Trustworthiness and rigour are further enhanced by the use of a structured data analysis process (Noble and Smith 2015). However, there was a switch from Ritchie and Lewis's (2005) framework analysis to Braun and Clarke's (2006) thematic analysis during the data analysis process. In quantitative research changing the analytical approach may alter results and conclusions (Thabane et al. 2013). However, in this qualitative study, I continued to use a thematic analysis in a different structure and continued to draw themes and patterns from the data (Green and Thorogood 2018). The transparency of the approach taken and the authenticity in the presentation of the findings adds credibility and dependability to the research (Smith and Noble 2014).

Data analysis is not a neutral process (Holloway and Wheeler 2002). Interpretation and understanding of data were shaped by the geographical,

gender, professional, ethnic and class similarities I have, and the cultural commonalities I shared with the participants (Mauther and Doucet 2003). While I cannot move away from any of these factors, an awareness allowed for a cultural sensitivity in data analysis. Furthermore, reflexivity in social research allows for me to provide an explanation of how I may have potentially influenced the products of the research and the processes in undertaking the research through the choices made (Davies 2009).

Choices were made throughout the research processes which were in part influenced by emotional, social, intellectual, and professional responses to reading the data, are arguably sources of knowledge that influenced my reading and interpretation of the data (Hammersley and Atkinson 2017). For example, I have not yet experienced being an older person, and my reading of the data was influenced by what I have read and my professional knowledge of the care of older people (Abdi et al. 2019). These constructed knowledges have led me to understand older people as socially and culturally marginalised and devalued (Centre for Ageing Better 2022, Barnes 2012). I tended to privilege the voice of older people in the data analysis, to give a voice to marginalised groups (Halpern 2019). Reflexive practice led me to go beyond a literal reading of the words and consider and understand the social, cultural, and political significance and implications for care and the coproduction of care for older people (Mauther and Doucet 2003).

As a district nurse my reading of the data was culturally influenced and initially accepting of social norms and practices that were present (Mauther and Doucet 2003). I perceived that people were autonomous in care practices and in choices about care. I understood people as independent or dependent, or somewhere in between (Barnes 2012). However, when I was introduced to a care ethics perspective, I was able to understand the political, cultural, and social influences of care and care practices, and how these were informing care experiences within the data. I was able to look at the data through a different lens. Concepts of a relational nature of care and of interdependency in care ethics provided a more balanced understanding (Barnes, 2012, Tronto 1993, Mauther and Doucet 2003).

The data analysis and interpretation of data was shaped by drawing on the work of my supervisors and their expertise. Literature that I had read and that resonated with me personally, professionally, and philosophically shaped my interpretation and analysis of data, as new understandings formed a lens with which to look at the data differently (Mauther and Doucet 2003). When examiners were identified, their work further influenced the lens which informed analysis (Wisker 2008).

In presenting the findings I was presenting the experiences and words of district nurses and older people. This highlights potential power in the researcher/ researched relationship, for the researcher to emphasise their account and perspective (Mason 2002). While this study presents my interpretation of the data, reflexivity aims to ensure that the voices of the participants are visible and central to the study, and that there is a veracity in the findings and conclusions made (Burr 2015). I have been able to do this by returning to the data continually and ensuring that the language used by the participants is reflected in my interpretation (Braun and Clarke 2006). I was unable, due to the constraints of the study, to include my participants in the analysis of data, which could have improved veracity however, this may not have redressed power relations (Green and Thorogood 2018, Burr 2015). In co-constructing this new knowledge with the participants, I am aware that my representations of their experiences are not neutral, and these are infused with my epistemology, ontology, the theoretical perspectives in which I have placed them, and my assumptions and knowledge (Mauther and Doucet 2003).

Writing has helped me in the process of making sense of the data and in considering perspectives and meanings. Writing drafts of the thesis has helped me transform ideas in an analytic process of explaining, justifying, and developing ideas (Silverman 2011). This has been particularly helpful to me in the process of data analysis. I found the process of data analysis challenging and it took a great deal of time. This is in part due to the break in time from data collection to data analysis which was enforced by the Covid 19 pandemic but also due to the high volume of data this study produced and

the unwieldy nature of qualitative data (Mason 2002). Moving from descriptive to explanatory accounts was a difficult process, despite following a framework approach to analysis (Ritchie and Lewis 2005) and the Braun and Clarke's (2006) thematic analysis. Initially I found it very difficult to think creatively about what the data was showing me in terms of the themes.

I have learnt through this reflexive process that I hold cognitive barriers from childhood with concepts of creativity and confidence (Finlay and Gough 2003). From being told I do not possess these traits I have always understood that I do not have them (Scope 2023). When advised to be creative by my supervisory team I was fearful that I would be unable to do this, and I could not understand what this meant. I could not assimilate creativity with a structured science-based research project (van Aken 2016). I have since learnt that creativity takes many forms, and that I do have the ability to be creative in the research process. Creativity occurs for me through curiosity. Reading, writing, and talking with others enables me to think about things differently has helped me develop creativity and formulate concrete ideas in the data analysis process (van Aken 2016). Confidence remains an issue for me, but this is developing as I become more immersed in the world of research. I have confidence in the findings of this study, through a robust design and a rigorous and transparent data analysis process (Smith and Noble 2014). The findings remain reflective of the words of the participants, and I feel this work has important messages for older people's care from the voices of the participants.

Some of the practices that were described and that I observed happening, I could remember doing myself as a district nurse. I questioned my practice, for example in contributing to the medicalisation of the homes of older people, without considering the implications this had for them or their experiences of home and of care (Hoffman 2013). I do not think this necessarily indicates that I was an awful nurse, or that my practice was poor or dangerous. However, I reflect that perhaps my practice was not always as mindful as it could have been. I now consider that as a district nurse I was caught up in the demands of practice. I was focussed on ensuring that

patients were safe and that all were attended to, with nursing needs met. I managed a growing caseload, prioritising care on a biomedical model, whilst supporting a team (Harper-McDonald and Bagueley 2018). Coproduction was limited to an understanding of shared decision-making that ensured consent and limited choices (Batalden et al. 2016, Ahmad et al. 2014). Reflectively I consider that my practice was professionally focussed. I brought professional skills, knowledge, and experience to the role (Gordon 2005). I practiced in the understanding that as a nurse, I knew best. I do not think this was personal to me, rather the culture in which I was practising (McCormack and McCance 2017). A concept of mindful coproduction was not known or considered important. I did not consider care as a process that was coproduced with older people. Care was the task that needed to be done, it was managing risk and making sure basic or fundamental needs were met. My practice then was not always mindful to the embodied nature of care (Tronto 1993, Barnes 2012).

I was not as conscious as I am now of the significance of how the relationships I had with older people, informed their care. I was not always co-present with the person (Barnes 2012, McCormack and McCance 2017). I remember thinking in terms of visits, not in terms of older people, arguably this is reflective of how the service I worked in was commissioned (NHS England 2015). However, this saddens me now. I remember managing risk, moving furniture around and installing aids for daily living, telling older people it was not safe for them to be at home without taking my advice with little understanding or appreciation of individual or diverse needs or preferences (Centre for Ageing Better 2021). There was not an equal sharing of power in the decision-making for coproduction (Boyle and Harris 2010). Care was not mindfully coproduced together with older people; it occurred in a nurse led way when it was convenient to the service and to me and although I worked with caring intent, my practice and service delivery did not come from an ethic of care (Barnes 2012).

I hope that this was not always the case, and when I worked in an advanced practice role, I consider that my practice may have been more mindful and

care with older people perhaps would have been more person-centred, now that I appreciate and understand that being person centred is more than being with an older person in a professional context (McCormack and McCance 2017). I reflect that I was more mindful as an advanced nurse practitioner in district nursing, and that care was perhaps coproduced with older people, in tiny moments. I reflect this is because time was managed and experienced differently (Tronto 2003). Throughput was not the model of delivery, there was an understanding of the long-term nature of care and frailty (Carrier 2009). I was able to better manage the complexity of risk with older people as I was able to craft meaningful connections with older people and we worked together to coproduce care that was important in that moment in time.

I remain somewhat incredulous that I had no conscious awareness of the theory of care ethics before undertaking this experience. I am also reflective of how far I and district nursing have moved away from nursing theory as my career has developed, and how evidence-based practice became the focus, perhaps distracting me from my personal philosophy of care and nursing at times (Stolley 2000). I am more mindful of my theoretical perspectives and philosophical position and intentionally and consciously apply these to my daily practices now within education and as a researcher (Crawford 2019).

I have learnt a great deal about my philosophical understandings of social constructionism (Burr 2015). Previously I was not as questioning of the social structures, discourses, and norms that I took for granted and accepted in culture and in healthcare and nursing practice. Prior to this work, I did not have a critical questioning of my understanding of how I perceived the world, and I am now more cautious of my assumptions (Burr 2015). For example, I was unquestioning of the busyness of district nursing, which I can now understand has differing perspectives and cultural constructions (Nagington et al. 2013).

Another learning experience for me is the deeper awareness I have gained in considering ageing and ageism (Centre for Ageing Better 2022). Throughout

my career I have considered myself to be a champion for older people's care and have worked hard to ensure the respect and dignity of older people in the delivery of care at home, and latterly in educational processes (Stevens et al. 2021). I had used a photograph in my advertising material, of an older 'wrinkly' hand, to signify that of an older person. Although of course unintentional and naïve, I realise now through immersion in literature for older people's care and from interacting with older people, that this could be perceived as offensive, discriminatory, and rude, to older people (Centre for Ageing Better 2022). This situation highlights the power differentials between researcher and the participants of the study (Mason 2002). Using this image in this way produced an inequity that could have influenced the willingness or openness of older people to participate in the study or share information (Kim 2021). However, this situation does highlight my learning and increasing awareness as a researcher (Green and Thorogood 2018). To ensure any unintentional bias or ageism does not influence my practice is a continual process on which I will continue to be aware and reflexive of (Finlay and Gouch 2003).

In sharing experiences and reflections, there is opportunity to coproduce learning with students. Dale and Armitage (2011) describe the coproduction of knowledge as a pooling of a multiplicity of knowledge types and sources to answer a question or to build a shared understanding. Undertaking this work has illustrated to me how coproduction also has relevance in education and learning (O'Connor et al. 2021). However, as O'Connor et al. (2021) suggest, coproduction may improve and enhance learning, but it is complex in its delivery and further research in this area will support the growing evidence base of its value in education. This would be a valuable area to explore in the context of care in nursing education in the future, with older people and students in the classroom coproducing learning together (Dale and Armitage 2011, Burger et al. 2018).

I will remain grateful to the older people who shared their experiences of care with me, and the district nurses who shared their practice, so that I could learn so much from them. This experience of what is essentially an academic

research process has fundamentally changed my perspective professionally and personally.

8.5 Concluding remarks

This study is a focussed ethnography that explored the nature of coproduced care between older people and district nurses, when home is the place of care. It has presented a conceptual framework that illuminates that the nature of coproduced care at home for older people is mindful. An accumulation of tiny moments of coproduced care are meaningful to older people, as this is the care that matters to them. Mindfully coproduced care for older people at home is embodied through the relationality of care. How home was experienced shaped care for older people.

It emerged through this study and the conceptual framework presented that the cultures of rationality, relationality, and responsiveness shaped practices of care at home for older people, and these cultures could limit the opportunities for mindfully coproduced care. This work has illustrated how political and social constructions and a philosophy of care inform the cultures and practices of care for older people. This study has also identified how ageist practices in care can occur when care is unmindful. Care ethics and coproduction underpinned mindful practices in care, but these were not realised or given attention in the busyness of the everyday care interactions.

Coproduction and care ethics provide the foundations for a conceptual framework of mindful coproduction, which can lead to transformational care for older people at home with district nurses. A rebalancing of power to realise equity and equality in care relationships can place older people as a resource and experts in care. With recognition and value of the contributions older people make to their care which extend beyond the physical participation in caring for their bodies but acknowledge how older people experience home results in a different set of social arrangements for care. When older people living with frailty and district nurses work together in the mindful coproduction of care at home, the place of care remains the place of home for older people.

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Appendices

Appendix 1

Worked example of observation protocol

	Person J	Nurse A
Activity <ul style="list-style-type: none"> • Actions • Task • Limitations to • Individualised • People • Environment 	<p>Sat in chair surrounded by stuff. She is perched on the edge. Loads of stuff. Folds up paper and moves stuff around, getting ready, turns the TV off. Doesn't move out of chair. J says she doesn't move from this room. A says she needs to move. J likes a leg wash she says.</p>	<p>A is accompanied by a student nurse. There is all this stuff in the house and no one can find the tape, they are looking everywhere for the tape. They walk in and say hello and get straight to work. They walk around the house, getting bowls of water, towels etc. chatting to J all the time, asking questions. They know their way around, and where stuff is, they don't ask permission, J doesn't seem to mind. She says she doesn't want 'people' going upstairs though.</p>
Behaviour <ul style="list-style-type: none"> • values • beliefs • attitudes • risks/ preferences • self-care • experiences • asset based • reciprocity • transformation 	<p>J is a bit cross, she says she has been snubbed by her surgery as they haven't phoned back. 'don't talk to me about the bed' She is assertively polite.</p> <p>J says she won't go in the bed no matter what. J is pleased to see the student, lots of questions for him.</p> <p>A asks J about the carers, J has cancelled them on a Saturday, says she doesn't need them, A is not so sure, seems a bit miffed. Reminds J what happened with the tablets when the carers didn't come. J mentions the cost, says they don't do anything and reassures A she is ok and can manages, mentions a friend she can call on if needed.</p> <p>J seems to be directing the show from her chair, she is telling the student where to find things, watching what they are doing, telling A what her leg has been like, what she wants in terms of creams, dressings.</p>	<p>Happy and personable. Explains to me she comes to see J as she is 'one of hers', as J has been so ill.</p> <p>It all seems very brisk and business like, here to do a job, but at the same time, it did not appear that A was rushing, just getting on.</p> <p>A asks to check J's bum. She refuses. A does a lot of checking, is this ok, is that ok, do you need this, are you still getting headaches (the pills that went wrong), checks the water, is this ok?</p>
Language <ul style="list-style-type: none"> • lay • professional • understanding • summarising • facilitative • <u>checking</u> 	<p>Jovial and laughing</p> <p>J says it wasn't clear, she has too many tablets and stuff just arrives she can't get the cream she wants. J moans about her carer and the mess. Doesn't want the bed. Emphatically does not want the bed! Don't bully me she says. They are very friendly though between them. They use lay language, sores.</p>	<p>Gentle and reassuring. Trying to convince to have a bed. She keeps on! She is checking the tablets. Asks what she has been taking. She is happy they add up, she tells me that too many were taken as J got muddled. A and J try to find</p>

		the empty cream amongst all the stuff. They can't find it. A talks about moving furniture around.
Interaction <ul style="list-style-type: none"> • social • non verbal • coaching • asset based • power • facilitative 	<p>J is cold</p> <p>Chatty, she is talking a lot, saying what has been happening, talking about TV. J is keen to tell me what the nurses have done for her.</p>	<p>There is a radiator, they can't work out how to turn it on. A is worried J doesn't know how to work it, what has she been doing for heat. I turn the heater on.</p> <p>A kneels on the floor. It is wet and covered in talc. Her trousers get covered but she is not bothered. They talk about the catheter leaking</p>
Knowledge <ul style="list-style-type: none"> • expertise • coaching • access to • acknowledgement of • evidence based • experiential • intuition 	<p>J knows what she wants- or doesn't want!</p> <p>J says she knows she should go to bed, but comfy in her chair. She has been here for ages and she is ok so something must be right.</p>	<p>A seems quite confident in her knowledge and what she is doing. She chats while she works, asking about food, toileting, etc. checks for problems. There is eye contact and nothing seems rushed, they are there for over an hour. A does a lot of checking</p>
Choice <ul style="list-style-type: none"> • shared decision making • isolation • access • team based • community links 	<p>None of the catheter options seem to be what J wants.</p> <p>J says she doesn't want any more junk in her house. She wants her dining room back, she wants the bed taken away. J says she will only sleep in the front room in the chair. Wants a dining room to have people round and feels she can't. There is things to see in this room, she likes it. She can look out on the street, see her neighbours. J is indignant when A suggests the bed goes in this room. J says she has nowhere to put anything.</p> <p>J seems exasperated and exhausted about the bed.</p>	<p>They talk about catheter bits, J doesn't want it poking out of her trousers. There is a list of options A offers= none are right. J says she might try a hook for her trolley to put the bag on.</p> <p>A explains she won't take the bed away in case J needs it.</p>
Relationship <ul style="list-style-type: none"> • power • partnership • mutualism • therapeutic • participation • active • length • equality • reciprocal • collaboration • centeredness • empowerment 	<p>They seem to get along well. J is pleased to see A. Talks about some of the other nurses who were late and didn't wash her leg.</p> <p>J says A is her friend. They have known each other for years, J says they have been coming for years, her leg got better then worse again. J says she could not do without them.</p> <p>They laugh about the bed- A asks if J puts her feet up in the chair and J says no, A says about the bed, half-jokingly and they laugh.</p> <p>They talk about J's dad.</p>	<p>A says she knows J is lonely, they talk about her mood and if she would like counselling</p>
Experience <ul style="list-style-type: none"> • preference • risk • expertise 	<p>Wants to get her legs healed, wants to go out. Wants a dog and to drive the car again. Talks about going upstairs and a stair lift = all she wants is her husband.</p> <p>J has had sores before, but she doesn't want the bed, says she is alright in the chair, she has a cushion (which is not on the chair) and her sores healed before, so she knows she doesn't need to go to bed.</p>	<p>A tries to explain the benefits of the bed.</p> <p>Talks about raising her legs, and her heart.</p> <p>Nursing know-how and instructions are broken up with chit chat, about J's dog, her friends, the doctor, the phone, but A keeps coming back to the bed.</p>

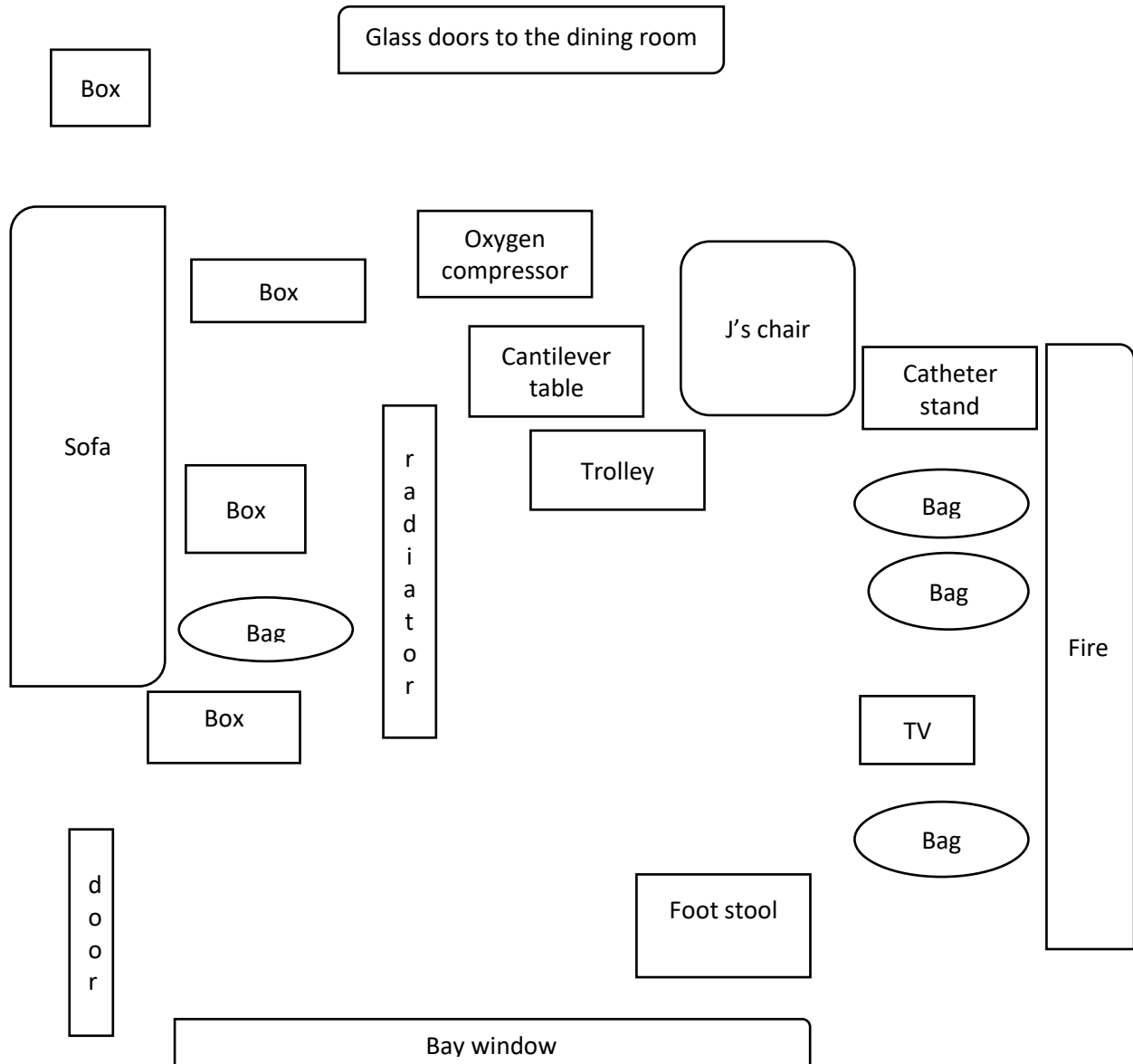
J is in a semidetached house, in a well-kept street. There is a driveway with a car on it. The car is black and looks new, it is only four years old. A tells me it is J's car; her gardener takes her out in it sometimes. The house looks well-presented, and the front garden is tidy. There is a key safe by the front door, but the door is unlocked, and we walk into a small porch, then into a hallway. To the right is a door which A opens, and we go in to a 'front room' which has a bay window with net curtains that overlooks the front garden and the street. The curtains are open, and it is quite a light room, east facing and it is morning. The room is painted a pale-yellow colour and the ceiling is white. In the window there is a large foot stool, where I sit to observe. It is just left of and behind the TV. J is opposite the TV, in the middle of the room, she is perched on the edge of a faded red recliner chair, and the leg rest is down. To her left is a wall length fire surround which is like one of the stone brick ones, but there is no fire, just bags in the fireplace. The hearth is covered in folded up newspapers, papers, carrier bags from the pharmacy, some books. The mantelpiece has photos and knickknacks all along it. There are pictures of some dogs and her husband. There is one picture on the wall above the sofa, a pink arty thing and wall lights. Next to J is a cantilever table, covered with papers, magazines, cosmetics, her phone, cups and plates, next to this is a mobility trolley, also covered with cosmetics, creams, papers, cups, air freshener, pens, and a meal on wheels meal container. The other side of these is an oxygen compressor, there is tubing trailing around the floor and the nasal specs are hung over the back of the recliner chair. There is a plug-in radiator, boxes and boxes of dressings are on the floor. There is a sofa against the wall, it is covered in boxes of incontinence pads. There are more carrier bags and boxes scattered around. Behind J is double glass doors that lead to a dining room and kitchen. Only A and the student go out there, for access to the tap. J is wearing a night gown. She has got bandages on both her legs, from toe to knee. They are a pink colour and are wrinkled and look like they are falling down. Her legs are sort of stuck out in front of her, she does not look comfortable, but no one asks. There is a catheter bag strapped on to her left lower leg, over the bandage. The floor is carpeted but it is worn in places. J says there is a wet patch as the carer did not do the valve on the bag up properly. There is talcum powder all over the floor. It seems to be everywhere. It smells like lily of the valley and there is a little odour of stale urine. It is a bit chilly in the house. There does not appear to be central heating.

June wears a hospital style nightgown, the type that is open at the back, although it is daytime, and her carers have already been to assist her with washing and dressing. June's catheter leg bag is wrapped around the bandage to her left leg, and there is another bandage to her right leg. There is a slight smell of stale urine mixed with the scent of lily of the valley. When Amy kneels to attend to June's legs, despite her plastic apron, her black trousers become covered in wet talcum powder that June has sprinkled on the floor, she says to cover up a leak from her catheter bag when the carer didn't close the tap off. Amy is rummaging through the various boxes and bags looking for what she needs for June's care. Despite the volume of equipment and supplies in the house Amy can't find what she needs and goes out to her car to get some tape and other bits. June is waving her arms around to emphasise the disruption and amount of stuff in the room as she tells me the other rooms are full of stuff too.

Amy tells June she is going to get a bowl of water to wash her legs and disappears out into the kitchen. She comes back with a washing up bowl of warm water and a towel. She kneels on the floor in front of June and removes the bandages and puts June's feet in the bowl to soak. Amy gently washes June's right leg before changing the water and doing the same to the left. They chat about things, June's gardener, Amy's dogs, some cream that hasn't arrived.

Amy is standing in front of June who is sitting in her chair, her legs have just been redressed. Amy gently approaches June, asking her how she would feel about going upstairs to sleep on a hospital bed. June rolls her eyes and laughs. June emphatically and firmly tells Amy no, but seemingly makes a joke out of it. June's lips tighten and her eyes and voice has hardened as she says no and does not appear to be amused. There is a distinct feeling of an underlying tension in the room, and Amy responds with lightness in her voice and gently says that she understands, but must ask about this, as she thinks this will be best for her. June abruptly changes the subject begins to brightly explain to us the problems she has been experiencing with her telephone and turns the conversation. Amy does not push the subject further, and asks June questions about her medicines, picking a packet of blister packs which are taped up in a carrier bag, on the mobility trolley.

Before we leave Amy disappears to the kitchen again, she comes back with a cup of coffee. She hasn't asked, it seems this is the usual routine. Amy places it on the trolley, next to the half-eaten lunch still in its metal food trays. It must be cold; we have been with June for nearly two hours.



Appendix 2

Demographic information

Demographic information: older people

- How old are you?
- How would you describe your marital status?
- Do you have any children?
- How would you describe your ethnicity?
- Do you have any health problems? If so, how would you describe these?
 - How do you feel about this?
- Would you describe yourself as frail? Can you explain why that is?
 - How does this make you feel?
- Would you describe yourself as having a disability?
 - How do you feel about that?
- Can you tell me about your education?
 - Where did you go to school?
 - When did you leave?
 - Did you go to college/ university?
 - Did you go straight out to work?
- Can you tell me about your working life?
- What age did you stop working?
- Do you feel that what you did for a job influences your health now?
- Do you receive any help from friends, family or carers?
 - Can you tell me about that?
- Do you mind telling me if you are in receipt of any benefits to help with your care?
 - Do you find this is helpful?
- Can you describe your housing situation for me?
 - How long have you lived here?
 - Where did you live before?
 - How do you feel about that?
 - How do you feel about living here?

Demographic information: district nurses

- Confirm gender
- How old are you?
- How would you describe your ethnicity?
- Can you tell me about your educational background?
 - What is your highest academic achievement?
 - Are you currently studying? If so what for? How do you feel about this?
- What is your work history?
 - Have you always been a nurse?
- How long have you been district nursing?
- Can you tell me about your current role?
 - Tell me about your job, what is your role and responsibilities

Appendix 3

Interview A schedules

Older person

- We have previously spoken about your life; can we talk about what is happening for you now?
- How are you today?
- How have you been recently/ since I last saw you?
- How long have the district nurses been visiting you at home?
 - How do you feel about that?
 - Do you see a regular person?
- Can you describe a typical visit from your district nurse?
- How do you find the visits from your district nurse?

- Do you enjoy them or would you rather not have them?
 - Can you tell me more about that?
- How would you describe your relationship with your district nurse?
 - Do you feel able to discuss what you need?
 - Do you feel involved in your care?
- Can you describe for me the problems you experience in your health and wellbeing?
- Can you describe for me how it feels to live with your health problems?
- Can you describe for me what limits your health problems have on your life?
- Do you feel that you have enough help in managing your needs?
- Are you able to identify any help that you feel you need but are not getting?
 - Can you give an example?
 - Do you feel there are the services available in the community to meet your needs?
 - Can you describe what you think prevents you from getting the help you need?
- Can you give me an example of how you manage your health / healthcare related problems?
- Can you describe any support that you have in managing your health/ healthcare needs?
 - Who helps you?
 - Can you describe how they help you?
- Can you describe for me what life is like for you on a typical day?
 - Talk me through your day.
 - What happens, what do you do, who do you see, who do you talk to?
 - How do you feel about this?
- Can you describe for me what your biggest challenges are in living at home?
- Do you feel that your age has an impact on your health and wellbeing?
 - Can you give me an example of how this is so?
- Do you feel the district nurse helps you in managing to stay at home?
 - Can you give me an example of this?
- Do you feel able to discuss any needs you might have with your district nurse?
 - Can you give me an example of this?
- Do you feel that the district nurse is able to help you get what you need?
 - Can you describe an example of when this has happened?
- Do you feel that you are able to work together with your district nurse to get the care you need?
 - Can you give me an example of how this might/ might not happen?
- Can you describe anything that you would like different in your relationship with the district nurse?
 - Can you describe how this would be better for you?
- Can you describe anything that you would like different in the care from your district nurse?
 - Can you give an example of what this might look like for you?

District nurse

- Can you tell me about a typical day at work?
 - What is your daily work routine like?
 - What do you like about this?
 - Is there anything about this that you would like to change?
- What types of patients do you have on your caseload?
 - How do you feel about this?
 - Do you feel yours is a typical district nurse case load?
 - Changes in the type of patients you care for now as opposed to previously?
- How do you organise your workload?
 - How do you organise your day?
 - How do you feel about this? Is it important?
- Can you describe to me what you find the most challenging about your role as a district nurse?
 - How do you feel about this?
 - What do you do to overcome challenges and manage things that might be stressful at work?

- What is your favourite part of the role?
- Have there been any significant events/ challenges at work for you lately?
- Can you tell me what district nursing means to you?
 - Can you tell me about nursing in the home?
- Why do you choose to work in district nursing?
- Can you give me an example of a typical visit as a district nurse?
- Can you describe/ tell me about the relationships you form with older people as a district nurse?
 - How do you feel about the caring relationships you have with older people?
- Can you tell me about any challenges you face in terms of caring relationships with older people?
 - Can you give me an example of this?
- Can you describe what is rewarding about the relationships you have with patients as a district nurse?
 - Can you give me an example of this?
- Can you describe for me from your perspective, as a district nurse, how your patients manage living with old age, at home?
 - Can you give me an example of this?
- Can you describe for me how you perceive the district nurse role to be in supporting independent living and self care for your older patients?
 - Can you give me an example from your practice?
- Can you tell me if, in your experience, you feel older people want to be involved in decisions about the care they receive from district nurses?
 - Are you able to give an example from your practice?
- Can you tell me if you feel that, as a district nurse you are able to give older people choice in their care?
 - Can you describe an example of how feel you are able/ unable to do this?
 - What knowledge do you feel is needed in order to do this?
 - Do you feel there are the resources in the community to do this?
- Who do you feel makes the decisions in the district nurse/ patient relationship with older patients?
 - Can you give an example of this?
- In your experience, do you feel that older people are able to contribute to their own care?
 - Can you provide an example?
- Can you tell me if you feel that you are able to give the care that you would like to as a district nurse? How do you feel about that?
- What are the challenges you face in giving care?
 - Can you give me an example of when you feel you have been able to give the care that you wanted to?
 - Can you describe what made this possible?
 - Were there any challenges you had to overcome?
 - How do you feel being able to do this impacted on your relationship with your patient?
 - Is there anything you need as a district nurse to give care that you feel you are not getting?

Appendix 4

Interview B schedules

Older person

I would like to talk about the visit I accompanied _____ on to you.

With reference to the visit, can you tell me how you felt about.../What did you think when.../You mentioned.../What did it mean to you when.../Can you describe what you experienced when...

Was this a typical visit from your district nurse? How?

Can you tell me how you felt about it?

Did it go well? Was it as usual in your experience from this nurse?

Can you describe your relationship with _____?

Can you describe the care you received?

Did you feel that all your needs were met?
 Can you describe for me how it is you feel / felt cared for?
 Do you feel you are encouraged or expected to self-manage?
 How does your nurse support you in this?
 Can you describe if you felt included in the decision making on the visit and with our care in general?
 Do you feel able to participate in the decision making?
 Do you feel you have an equal say in what happens about your care?
 Do you feel you have in the community the resources you need for your care? Do you feel you have access to these?

District nurse

I would like to talk about the visit I accompanied you on, to _____
 With reference to the visit, can you tell me how you felt about...
 What did you think when.../You mentioned../ What did it mean to you when.../Can you describe what you experienced when...
 Was this a typical district nursing visit? How?
 Can you tell me how you felt about it? Did it go well? Was it as usual in your experience, for this person?
 Can you describe your relationship with this person?
 Can you describe the care you gave?
 How did you know what care was needed?
 How do you feel about self care for this person?
 Can you explain how you made the decisions you did on the visit?
 Do you feel the person was able to participate in the decision making?
 What resources do you need in the community to provide this care? Do you feel you have these?

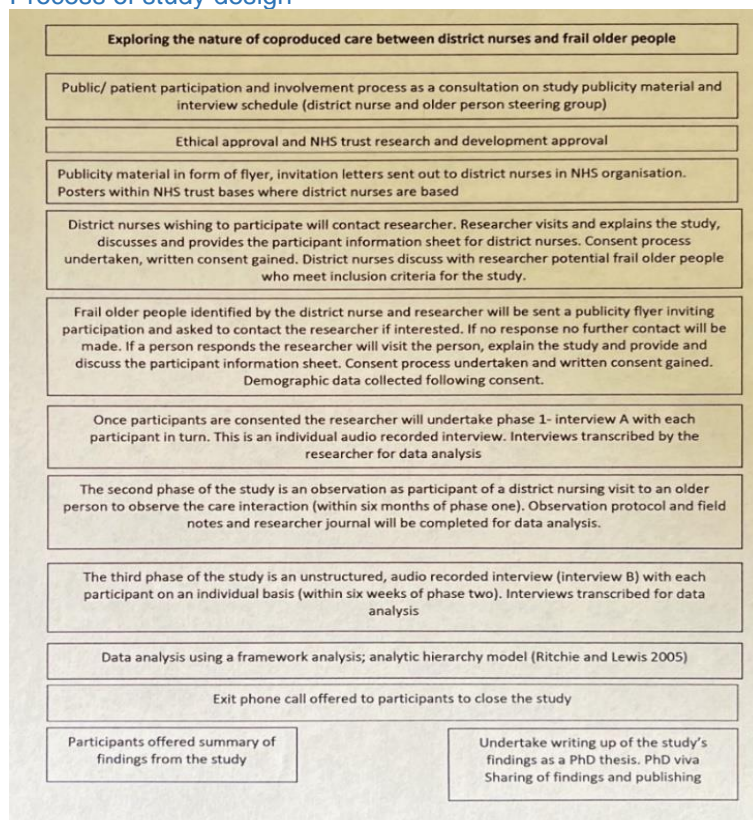
Appendix 5

Data sets of older people and district nurse pairings

Data set 1	Data set 2	Data set 3	Data set 4
Demographic information district nurse/ older person	Demographic information district nurse/ older person	Demographic information district nurse/ older person	Demographic information district nurse/ older person
Interview A district nurse 1	Interview A district nurse 2	Interview A district nurse 3	Interview A district nurse 4
Interview A older person 1	Interview A older person 2	Interview A older person 3	Interview A older person 4
One observed care interaction	One observed care interaction	One observed care interaction	One observed care interaction
Interview B district nurse 1	Interview B district nurse 2	Interview B district nurse 3	Interview B district nurse 4
Interview not completed as older person 1 became unwell	Interview B older person 2	Interview B older person 3	Interview B older person 4

Appendix 6

Process of study design



Appendix 7

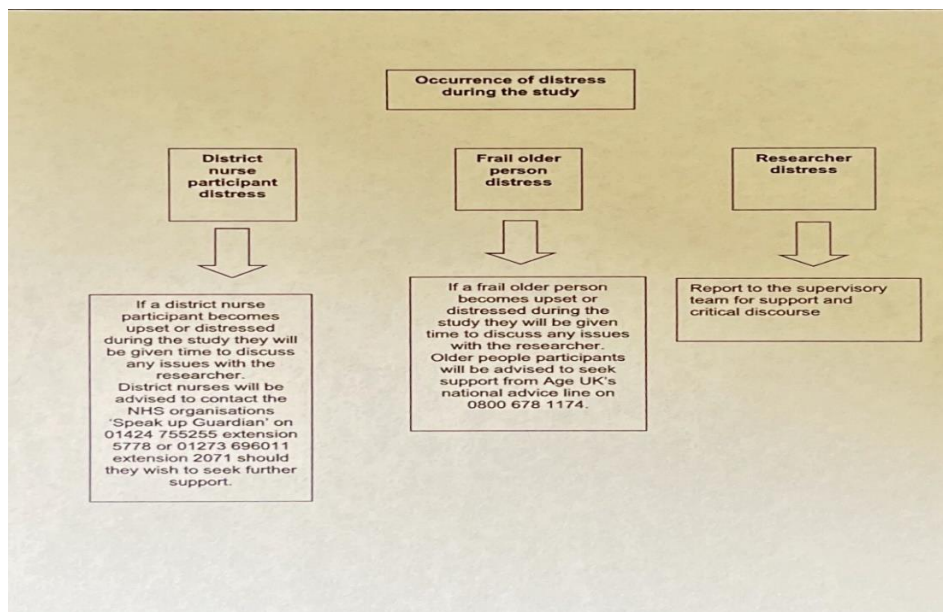
List of risks

Safeguards and monitoring processes/ procedures

- Risk will be assessed, and management of risk undertaken in concordance with the university's policy on research ethics and safety.
- This study will include lone working, including visiting people in their own home with consent in order to conduct interviews and a period of participant observation. This risk is mitigated by NHS governance patient participants will have previously been risk assessed by the employing organisation as safe for district nurses to visit, with risk assessments in place where appropriate.
- Researcher location and contact details will be available to the supervision team and the researcher will report the safe return to base following any lone working period.
- The researcher will be working with community health organisations and will adhere to the lone working policies of the practice environment.
- Lone working risk assessments will be completed, and policy followed
- Risky situations will be avoided but if experienced will be managed ethically, within the professional code and university policy.
- Confidentiality will be maintained for ethical research and nursing practice (Austin 2016, NMC 2015). No personal health records will be included as data for analysis.

Appendix 8

Distress protocol



Appendix 9

Consent form for older people

✳

University of Brighton

Participant Consent Form (*Older person version 2*)

Research project: Exploring the nature of care coproduced between district nurses and frail older people

Researcher: Hannah Morris H.Morris3@brighton.ac.uk 01273 644027

Lead Supervisor: Dr Kay Aranda k.f.aranda@brighton.ac.uk 01273 644168

Please
initial or
tick box

I agree to take part in this research which is to explore the nature of care that is produced and experienced between district nurses and frail older people.

The researcher has explained to my satisfaction the purpose, principles and procedures of the study and the possible risks involved.

I have read the information sheet and I understand the principles, procedures and possible risks involved.

I am aware that I will be required to answer questions and that the interviews will take place in my home. I am aware I can have a friend or relative present.

I agree to the researcher carrying out an observational visit to my home with a district nurse

I agree to the researcher taking notes and making an audio recording during the project.

I am aware I can stop the recording at any time (with no implications for me).

I understand how the data collected will be stored and used, and that all information disclosed will be kept confidential. This will only be seen by the researcher and her supervisors.

I consent to anonymised extracts of my discussion with the researcher being used in the writing up of the study.

I understand that I am free to withdraw from the study at any time without giving a reason and there will be no implications for me in doing so.

I agree that should I withdraw from the study, or become too unwell to continue in the study, the data collected up to that point may be used by the researcher for the purposes described in the information sheet.

Name (please print)

.....

Signed

Date.....

Appendix 10

Consent form for district nurses



University of Brighton

Research project: Exploring the nature of care coproduced between district nurses and frail older people

Researcher: Hannah Morris H.Morris3@brighton.ac.uk

01273 644027

Lead Supervisor: Dr Kay Aranda

k.f.aranda@brighton.ac.uk 01273 644168

Please
initial or
tick box

I agree to take part in this research which is to explore the nature of care that is produced and experienced between district nurses and frail older people.

The researcher has explained to my satisfaction the purpose, principles and procedures of the study and the possible risks involved.

I have read the information sheet and I understand the principles, procedures and possible risks involved

I am aware that I will be required to answer questions in interviews that will take place in an NHS base.

I agree to the researcher accompanying me to carry out an observational visit to a patient's home (with their consent)

I agree to the researcher taking notes, and making an audio recording during the project.

I am aware that I can stop the recording at any time (with no implications for me).

I understand how the data collected will be stored and used, and that all information disclosed will be kept confidential. This will only be seen by the researcher and her supervisors.

I consent to anonymised excerpts of my discussion with the researcher being used in the writing up of the study.

I understand that I am free to withdraw from the study at any time without giving a reason and without incurring consequences from doing so.

I agree that should I withdraw from the study, the data collected up to that point may be used by the researcher for the purposes described in the information sheet.

Name (please print)
Signed Date

Appendix 11

Participant information sheet for older people



University of Brighton

Participant Information Sheet

Older People

'Exploring the nature of coproduced care between district nurses and frail older people'

I would like to invite you to take part in my research study. Before you decide I would like to explain why the research is being done and what it would involve for you. I will go through the information with you and answer any questions you may have. This should only take about 30 minutes. Taking part in the research is voluntary. It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part I will ask you to sign a consent form. I will then ask you to tell me about yourself. You are free to withdraw from the study at any time, without giving a reason. This will not have any implications for your care.

Purpose of the research

This research study aims to look how you work together with your district nurse to meet your care needs. The purpose of this study is to better understand how care is produced in partnership between older people and district nurses. In turn it is hoped that this will inform practice, so that care, services and experiences may be improved.

Participants:

I would like to recruit four older people to participate in this study who have regularly received care from a district nurse for at least six months. For this study as an older person participant you will be over 70 years' old and experiencing long term chronic health problems. I am hoping to include people to participate that experience long term chronic health problems, as your experience is valuable to the research study.

What is involved?

This study will take place over the duration of a year. During this time I will ask to meet with you in your home three to four times for no longer than an hour and a half each time. If you are interested in taking part in this study I will meet with you and discuss and explain what is involved more fully. If you wish to participate you will be asked to sign a consent form. The research study consists of three parts, which are two individual interviews at your home and I will accompany your district nurse to a routine visit to you. The interviews will be confidential and audio recorded. The recording is to help me remember what happens and it can be stopped at any time. You can also withdraw from the study at any time without giving a reason. This will have no implications for you. You may ask a friend or relative to be present during your interview.

Before participating you should consider that we will be discussing your experiences, feelings, thoughts, values and beliefs during this study. Should you wish to discuss anything further or talk to someone for support following the interviews you can contact an advice line through Age UK on 0800 678 1174.

Anonymity/ confidentiality

During the interviews and visits to you I will be making extensive notes. All documentation will be anonymised and I will not identify you, your nurse or your place of residence. My thesis (research study findings) and any publications that may follow on from it will be anonymised. All notes and recordings and transcripts will be kept confidential, and stored in a locked cabinet in a secure room. Only my PhD supervisors and I will have access to this. Your nurse will not be told what we discussed in our private interviews.

I am bound by the Nursing and Midwifery Council code for professional conduct and the University's code of ethical research practice. Should there be any risk to you or staff identified during this process as a nurse and researcher I would have to report this to the appropriate person.

What will happen to the findings?

The findings will be written as part of the assessment process for my PhD, a copy of which will be submitted to the University of Brighton. A copy of this may be retained by the University of Brighton library. Findings from the study will also be submitted for publication to academic journals, as journal articles. Findings may also be presented at professional conferences as papers or posters. All written documentation from the study will be anonymised.

Any further information

I am happy to answer any questions or discuss any issues you may have about this study. Please contact me on 01273 644027 or email H.Morris3@brighton.ac.uk

If there is a problem

All research in the NHS is looked at by an independent group of people, called a Research ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by _____ Research Ethics Committee.

If you have a concern about any aspect of this study, please speak to me and I will do my best to answer your questions (01273 644027). If you remain unhappy and wish to speak to someone else you can do this by contacting Dr Susan Sandeman, Director of Postgraduate Studies, Doctoral College, Mayfield House, University of Brighton, Falmer, Brighton, BN1 9PH. By telephone on 01273 641635 or by email on s.sandeman@brighton.ac.uk

Appendix 12

Participant information sheet for district nurses



University of Brighton

Participant Information Sheet

District nurses

Exploring the nature of coproduced care between district nurses and frail older people

I would like to invite you to take part in my research study. Before you decide I would like to explain why the research is being done and what it would involve for you. I will go through the information with you and answer any questions you may have. This should only take about 30 minutes. Taking part in the research is voluntary. It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part I will ask you to sign a consent form at the end of our discussion. Following this I will ask you about your demographic information. You are free to withdraw from the study at any time, without giving a reason. This will not have any implications for you.

Purpose of the research

This is a qualitative research study that aims to look at how care is coproduced between district nurses and frail older people. The study will explore the nature and types of care produced between district nurses and frail older people, looking at the culture of care, of working together and the intricacy of care relationships. This study will aim to capture the complexity of care in the community healthcare setting through the experiences of care from the district nurse and older person perspective.

Participants:

I would like to recruit four district nurses within [area] NHS Trust. District nurse participants will have the Community Specialist Practice (district nursing) qualification (DN SPQ), and have held this for at least a six month period. Following recruitment to the study the district nurse participants will be asked to identify older people on their caseload who are living with frailty and or long term chronic health needs, and who receive care from a district nurse on a regular basis, and provide eligible people with an information pack

What is involved?

The study will take place over a year. During this time I will ask to meet with you three to four times for an hour and a half at the most, at your place of work. This will involve two audio taped interviews regarding your work and experiences of providing care. This is to help me remember and you will be able to request that the recording to be stopped at any time. I will personally transcribe all the interviews. I would also like to accompany you on a home visit to a patient. You will be offered an exit phone call/ visit on completion of the data collection, this is to draw the study to a close for you and is not central to the study's findings. This is not compulsory and will have no implications for you if you do not wish to undertake this.

Before participating you should consider that we will be discussing your experiences, feelings, thoughts, values and beliefs during this study. This can be emotive, and you may feel upset in doing this. You may wish to talk to someone after the study about this or seek support from your trust. Your trust offers support here through the 'Speak Up' Programme. The 'Speak Up Guardian' can be contacted on 01424 755255 extension 5778 or 01273 696011 extension 2701. The information you disclose for the study will be kept confidential and anonymous, you have the right to withdraw from the study at anytime, without giving a reason and this will have no implications for you.

Anonymity/ confidentiality

During the interviews and visits to your patients I will be making extensive notes. All documentation will be anonymised, and I will not identify you, your patients or your place of work. My thesis (research study findings) and any publications that may follow on from it will be anonymised. All notes and recordings and transcripts will be kept confidential and stored in a locked cabinet in a secure room. Only my PhD supervisors and I will have access to this.

I am bound by the Nursing and Midwifery Code and the University's code for ethical research practice. Should there be any risk to patients identified during this process as a nurse and researcher I would have to report this to the appropriate person.

What will happen to the findings?

The findings will be written as my PhD thesis, a copy of which will be submitted to the University of Brighton. A copy of this may be retained by the University of Brighton library. Findings from the study will also be submitted for publication to academic journals, as journal articles. Findings may also be presented at professional conferences as papers or posters. All findings will be anonymised.

Any further information

I am happy to answer any questions or discuss any issues you may have about this study. Please contact me on 01273 644027 or email H.Morris3@brighton.ac.uk

If there is a problem

All research in the NHS is looked at by an independent group of people, called a Research ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by _____ Research Ethics Committee.

If you have a concern about any aspect of this study, please speak to me and I will do my best to answer your questions (01273 644027). If you remain unhappy and wish to speak to someone else you can do this by contacting Dr Susan Sandeman, Director of Postgraduate Studies, Doctoral College, Mayfield House, University of Brighton, Falmer, Brighton, BN1 9PH. By telephone on 01273 641635 or by email on s.sandeman@brighton.ac.uk

Appendix 13

Advertisement flyer district nurse

211575 Version 2 1/1/18

Are you a district nurse caring for frail older people at home?

Would you like to participate in a research study?

I am looking to recruit district nurses who are caring for frail older people at home who would like to participate in a research study that aims to capture and explore the complexities of care.

This study aims to better understand how district nurses work in partnership with frail older people when producing care.



District Nurses

- To participate in this study you will need to be working as a district nurse within an NHS Trust organisation.
- You will have held the Community Specialist Practice Qualification for district nursing for at least six months.
- You must be willing to participate and share your experiences of working with older people
- You must be working with frail older people



The study

This is a qualitative research study that aims to look at how care is coproduced between district nurses and frail older people. The study will explore the nature and types of care produced between district nurses and frail older people, looking at the culture of care, of working together and the intricacy of care relationships. This study will aim to capture the complexity of care in the community health care setting through the experiences of care from the district nurse and older person perspective.

The study will explore how district nurses and frail older people work together and explore the intricacy of these unique care relationships.

It will aim to capture the complexity of care in the community, of nursing in the home through the experiences of care from a district nurse and frail older person perspective

- During the interviews and visits to you I will be making extensive notes. All documentation will be anonymised and I will not identify you, your patient or your place of work.
- The information you disclose will be kept confidential and anonymous. You can withdraw from the study at any time without giving a reason and this will have no implications for you

What's involved?

If you participate in this study you will be asked to undertake a confidential initial interview where you will be asked about yourself and your working life

The next phase of the study is for the researcher to accompany you on a nursing visit to an older person as an observer

The last phase of the study is another confidential interview where you will be asked about your experiences of district nursing, care and your relationships with your patients

You will need to participate in all phases of the study, but can withdraw at any time without giving a reason. This will have no implications for you. Both interviews will be audio recorded and the contents kept confidential

The study will be over the duration of a year

The researcher

- My name is Hannah Morris and I am a part time PhD student at the University of Brighton.
- My background is as a district nurse and then as an advanced nurse practitioner within district nursing services
- I currently work at the University of Brighton as a senior lecturer in community nursing

If you would like to know more...

If you would like more information or are interested in participating **please contact me**

Hannah Morris
Room 214 Westlain House
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University of Brighton
Falmer, Brighton
BN1 9PH
01273 644027
H.Morris3@brighton.ac.uk

 University of Brighton

Appendix 14

Briefing note



University of Brighton

Briefing note- Script for district nurses

This is some information on a research study that I am taking part in.

The researcher and I have identified a number of people who might like to participate and would like to invite you to join in the study. The people we have identified to participate in the study receive care from district nurses.

Please do not feel obliged to say yes, it is not compulsory. Whatever you decide to do, it will have no implications or impact on your care, or your relationship with me as your district nurse.

This leaflet will tell you more about the study and who to contact should you decide, you would like any further information, or to participate. I will leave it with you to consider.

Appendix 15

Advertisement flyer older people

Are you aged 70 years or over and receiving care from a district nurse?

211575 Version 2 1/1/18

Would you like to participate in a research study?

I am a PhD student looking to recruit people aged 70 years or over who are receiving care from a district nurse and who would like to participate in a research study that aims to explore how older people and district nurses work together in the care relationship.

This study aims to better understand how you and your district nurse can work together, which in turn aims to improve experiences in care



To participate you will:

- Have been in receipt of district nursing services for at least 6 months
- Be willing to participate and share your experiences of care from district nurses
- Be able to provide informed consent (written or verbal)
- Be able to communicate in English
- Be aged 70 years or over



The study

- This research study aims to look how you work together with your district nurse to meet your care needs.
- I would like to explore how it is for you to live at home with a district nurse visiting you. This study will aim to capture your experiences as well as those of your nurse
- I would like to recruit four older people to participate in this study who have regularly received care from a district nurse for at least six months. For this study as an older person participant you will be over 70 years old and experiencing long term chronic health problems or frailty
- During the interviews and visits to you I will be making extensive notes. All documentation will be anonymised and I will not identify you, your nurse or your place of residence.
- The information you disclose will be kept confidential and anonymous. You can withdraw from the study at any time without giving a reason and this will have no implications on your care.

What's involved?

- Giving your consent to participate once you feel fully informed about the study
- A sequence of two confidential initial interviews where you will be asked about yourself and your health
- The researcher to visit you at home with your district nurse as an observer to your care.
- Ideally you would be able to participate in all phases of the study, but can withdraw at any time without giving a reason. This will have no implications for your care. Both interviews will be audio recorded and the contents kept confidential.
- The study will be over the duration of a year

The researcher

- My name is Hannah Morris
- I am a PhD student at the University of Brighton.
- My background is as a district nurse and then as an advanced nurse practitioner within district nursing services
- I currently work at the University of Brighton as a senior lecturer in community nursing

If you would like to know more...

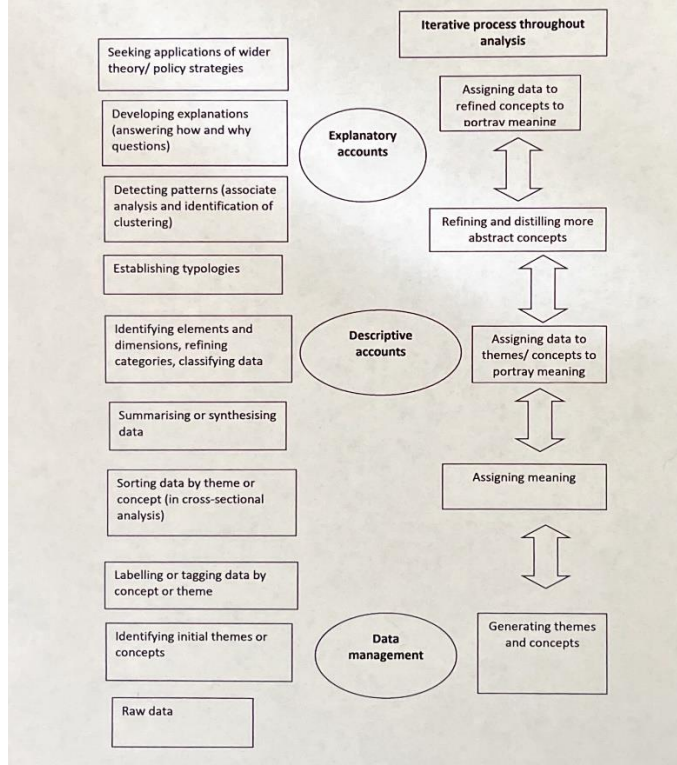
If you would like more information or are interested in participating please contact me

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 01273 644027
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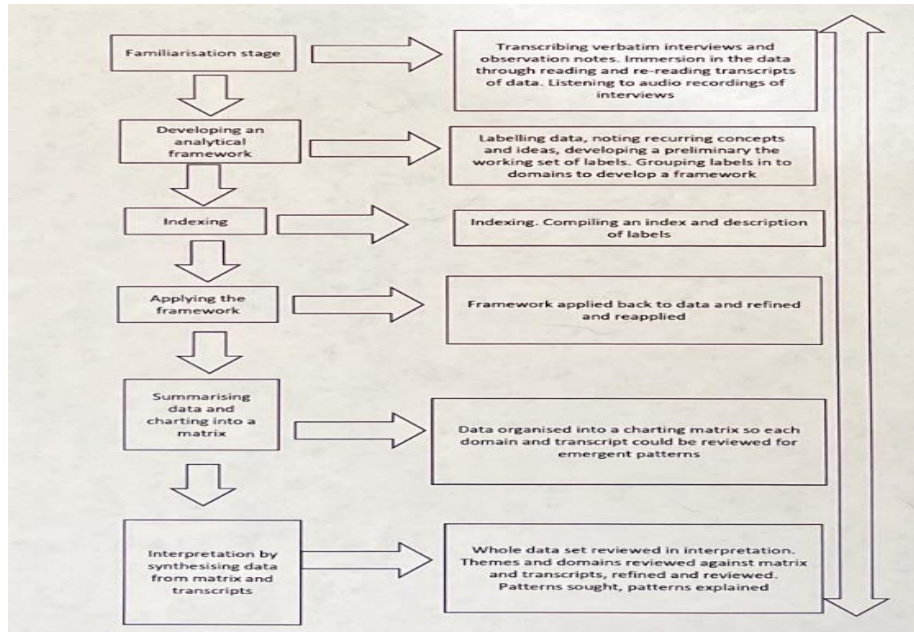
Appendix 16

Analytic hierarchy model of framework analysis (Ritchie and Lewis 2005)



Appendix 17

Worked example of using Analytic hierarchy model of framework analysis (Ritchie and Lewis 2005)



Appendix 18

Data analysis photographs of audit trail

Other
8:1
LOSS
animals 8:2

Reservas
11:1 time
12: money
13: knowledge
14: Skill
15: experience
16: waste
17: material
18: equip

Practices
1-1: liaison
1-2: delegation/allocating
1-3: asking/creating/tracking sue
1-4: (leg) case/treatment
1-5: ethics
1-6: advocacy - 1st social
1-7: explain
1-8: planning/organisation
1-9: getting things in place
1-10: coordination
1-11: problem solving
1-12: maintenance
1-13: occupation/entire

Relationships
1-1: trust
1-2: talking
1-3: friend
1-4: knowing
1-5: understanding
1-6: listening
1-7: responsibility
1-8: being ok
1-9: rewards/results
1-10: gratitude
1-11: kindness/love

Core
1-1: people
1-2: busy
1-3: good/bad
1-4: neglect
1-5: object
1-6: body

Core
6-1: compromise
6-2: agency
6-3: problem solving
6-4: du abax vs - self core
6-5: negotiation
6-6: engagement
6-7: autonomy
6-8: motivation
6-9: latent/persuasion/convince
6-10: saying no
6-11: resignation
6-12: complicity
6-13: experiences

Attitudes/beliefs
7-1: social/nursing
7-2: objectification/disease/body
7-3: lack of recognition
7-4: difficultness
7-5: riding
7-6: business

spaces
4-1: home
4-2: office
4-3: best space
4-4: alone/lonely
4-5: garden-aside
4-6: bandaid
4-7: distance
4-8: garden-aside
4-9: personal

MIND & TIME
... (handwritten notes on time and mind) ...

KATE + BILL
... (handwritten notes on Kate and Bill) ...

Appendix 19

Constituents of the broader cultures of care

Broader cultures of care for older people living with frailty when home is the place of care		
Responsiveness	Relationality	Rationality
Responsibility	Social norms	Commodity
Moral sensitivity	Power dynamics	Throughput
Morality	Relationships	Busyness
Vulnerability	Dominance	Task
Reciprocity	Resistance context	Choices
Identity recognition	Communication	Resources
Autonomy	Attention	Autonomy
Independence	Listening	Justice
Motivations	Receiving care	Agency
Capabilities	Emotions	Private/public
Conscious approach	Dependence	Self-care
Voice	Embodiment	Rhetoric
Cooperation	Equality	
Fixing	Equity	
Physicality		