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Person-Centred Integrated Care (PCIC) As Experienced by Older People and Carers: Findings, Insights and Recommendations From a Qualitative Multi-Case Study in the Context of a National Integrated Care Programme

RESEARCH & THEORY

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ABSTRACT

Introduction: Knowledge gaps exist regarding the successful application of person-centredness in integrated care contexts and older people's experiences.

Methods: This study applied qualitative multi-case study methodology to explore PCIC experiences in the context of an Irish national integrated care programme for older people (NICPOP) and three multidisciplinary staff teams implementing diverse models of integrated care. Methods included consultations with NICPOP management and staff; care summaries regarding interventions; and 23 semi-structured interviews with 22 older people and 10 carers. The Person-centred Practice Framework was applied to conceptualise findings regarding person-centredness.

Results: Five themes were identified regarding older people's and carers' PCIC experiences: coordination and management continuity of care; being cared for holistically, relational care and relational continuity, being supported to live well independently; and involvement in and enjoyment of care.

Discussion: Insights concerned PCIC's capacity to optimise care experiences. PCIC experiences were mixed and varied according to care context. This study identified enablers of and barriers to successful implementation of PCIC at organisational and systems levels.

Conclusion: This study confirmed PCIC as especially suitable for older people with complex needs and carers and identified components of their positive PCIC experiences, addressing knowledge gaps. This study makes recommendations for policy, service and practice development to optimise PCIC experiences.

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INTRODUCTION

Ireland's population, like many populations internationally, is ageing rapidly, with the cohort of adults over 65 years increasing at a faster rate than most other EU countries [1]. For many, increased life expectancy has come with a corresponding decrease in disability-free life expectancy and increased years of chronic illness and multimorbidity, negatively impacting on their quality of life and capacity to continue living independently [2]. Significant inequality exists in life expectancy, experiences of ageing and healthcare needs, influenced by socioeconomic factors [3]. Due to older people's increased complexity of needs and subsequent increased health and social care consumption, they are considered a 'high need, high cost' patient group [4] who experience increased care fragmentation and poorer care outcomes [5].

Increases in life expectancy and levels of chronic illness and multimorbidity exert pressure on healthcare systems and related resources. New frameworks and models of integrated care increasingly promote interdisciplinary integrated approaches to service delivery and design at multiple levels. These models represent a fundamental paradigm shift regarding how care for older people with chronic illness is delivered. They entail a move from acute episodic care to longer-term continuous management at primary level through community-based integrated multidisciplinary teams providing care for older people that is accessible, timely and cost-effective [6–9].

Sláintecare, a 10-year governmental reform strategy for the Irish healthcare service, focused specifically on integrated care and established NICPOP in 2016 [10]. NICPOP aimed to avoid care fragmentation for older people with multiple complex health and social care needs through integrated services provided by Integrated Care Programme for Older Persons Community Specialist Teams for Older Persons (ICPOP CST-OPs) and to support them remaining in their homes. As provision of integrated care for older people is multi-faceted and complex, the formulation of a standardised national model was not considered to be viable. Instead, NICPOP is based on a 10-Step Integrated Care Framework for Older Persons, grounded in established best practice and presented in Figure 1 [5, 11]. There are currently over 30 ICPOP CST-OPs nationally.

Integrated care and person-centred care both aim to improve quality of care, care experiences and outcomes and are each ideally conceptualised as involving the other [12]. A focus on the person is central to most integrated care definitions, which reference person-centred values and goals [12–16]. The term PCIC recently emerged in literature, policy and practice [17]. Like integrated care, PCIC is characterised by a lack of consensus regarding definition and composite components and considered to be 'awash with overlapping and conflicting concepts and terminology' [18, p. 2], which can hamper evaluation. This terminology includes 'person-centred coordinated care' [19] and 'people-centred integrated care', often focused on population-based strategies [7, 13]. Definitions encompass the addition of a focus on the person and their care experience to integrated care strategy and delivery and the drive to ensure that care is integrated from the person's perspective and not only from professional, organisational and systems perspectives [18, 20]. However, there is a lack of research on effects of integrated care and its person-centred outcomes on service users [21], including older people. There is also a knowledge gap regarding experiences of PCIC, with few qualitative research studies focusing on older people's lived experiences of PCIC and related

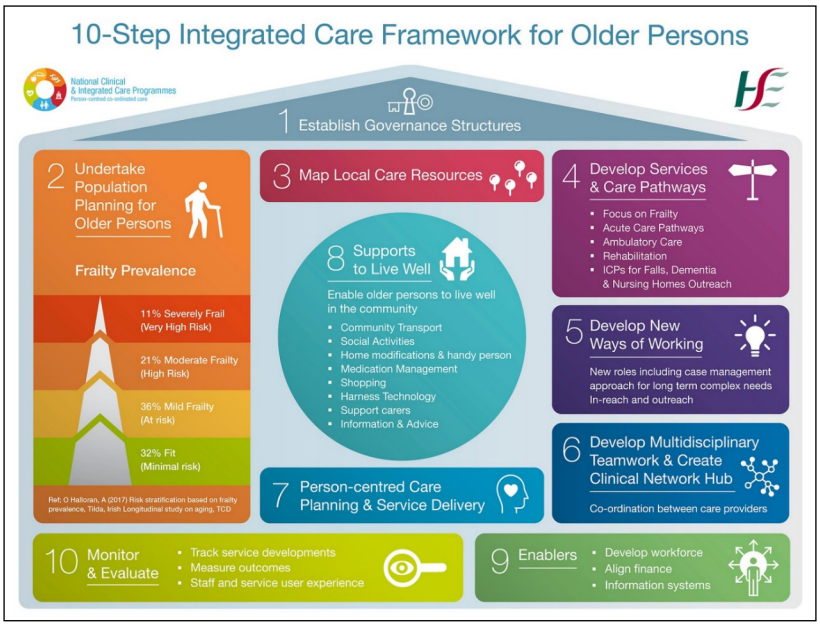


Figure 1 NICPOP 10-Step Integrated Care Framework for Older Persons.
Source: NICPOP, 2023.

preferences. PCIC evaluations are often service-centred, rather than person-centred [18, 20, 22].

The aim of this study was to explore older people's experiences of PCIC in the context of NICPOP. Its four research objectives were to: i) to explore the nature of relationships experienced within PCIC; ii) to explore the integration of personhood within integrated care experiences; iii) to ascertain the enablers of and barriers to the delivery of PCIC; and iv) to identify the person-centred outcomes of integrated care.

METHODS

This study applied qualitative case study methodology, recognised as especially suitable for contextual exploration of complex healthcare phenomena and experiences [23]. It applied qualitative, embedded, exploratory, instrumental multi-case study methodology, focusing on older people's and carers' PCIC experiences across three NICPOP sites nationally, which implemented three distinct models of care. Its data collection methods were multi-perspectival, including four consultation and planning meetings, with the National NICPOP team and with staff on each of the three multidisciplinary CST-OPs; care summaries provided by staff regarding interventions; and 23 semi-structured interviews with 22 older people and 10 carers. In line with ethical considerations, older people were offered the opportunity to be accompanied by their carers who communicated their wish to also participate in interviews, with the consent of the older person where possible. An additional six member reflection interviews with seven older people and carers were conducted as part of ensuring rigour, trustworthiness and gaining participants' insights regarding preliminary findings and recommendations. Two expert interviews were also conducted.

Cases were selected to ensure maximum heterogeneity and sufficient length of establishment as they had been among the initial programme pilot sites. Models implemented at each case varied in terms of care location, including home and hub or clinic-based care, duration of care and specific interventions and organisation of care, including case management. Case 1 was predominantly home-based and provided long-term ongoing engagement with older people, in response to its population needs; Case 2 was clinic-based with rural outreach home care and operated a dormancy model where older people were discharged from interventions but could re-engage as needs required; and Case 3 applied a hybrid model of home and hub-based care with condition-specific care pathways and consisted of a finite 4–8 week intervention. The cases included, as is typical of ICPOP CST-OPs, nursing and medical geriatrician-led input; occupational therapy; physiotherapy; speech and language therapy; and social work. Case 2 also included clinical psychology.

Sampling techniques included critical case sampling and non-randomised purposive demographic sampling to maximise heterogeneity of participants, recognising the diversity within the cohort of older people, regarding age; gender; rural/ urban geographical location; living alone/ with family and carers; and health status, nature of chronic condition(s), and ICPOP care pathway, where appropriate. The recruitment of potential participants at each site was supported by ICPOP-CST staff and participants were not known to the research team. Five older people declined to participate, citing ill health. The sample for this study is summarised in Table 1.

Ethical approval was awarded by Atlantic Technological University's (ATU) Research Ethics Committee and the three participating hospitals' Research Ethics Committees, and appropriate safeguards were put in place, including optional referral to a support and advocacy service. All participants gave informed consent and participant information materials emphasised in accessible language that the research was independent and confidential and would not impact on the care they were receiving. A Topic Guide relating to the research aim and objectives focused on older people's and carers' perspectives on and experiences of their care, the nature of relationships and the aspects of care they most valued. This was piloted and used with additional image cards to guide some interviews due to some older people's acute hearing and literacy issues. Carers were asked about their role as carer in the context of the ICPOP-CST-OP episode and their experiences. While carers were not explicitly asked about their age or health issues, this information was often shared as part of interviews.

Nine interviews were joint interviews, five consisted of clients with their carer spouse; three of clients with their carer adult children; and one of two clients who were a married couple. Most interviews were in-person, except for two online interviews with carers. All in-

CASE	NO. INTERVIEWS	NO. PARTICIPANTS		GENDER OF PARTICIPANTS	
		CLIENTS	CARERS	CLIENT	CARER
Case 1	6	6	4	4 male; 2 female	1 male; 3 female
Case 2	7	5	4	4 male; 1 female	1 male; 3 female
Case 3	10	11	2	2 male; 9 female	1 male; 1 female

Table 1 Summary of sample.

person interviews took place at participants' own homes, except two at care locations at participants' requests. The average length of interviews was 54 minutes, with the longest lasting 1 hour and 37 minutes. In line with the Reflexive Thematic Analysis (RTA) method selected [24], reflexive field notes were taken during and after interviews and during analysis, as well as continuous reflection on researchers' positionality as active participants in the research. Interviews were transcribed for thematic analysis, anonymised and stored according to best practice in data protection and confidentiality. Data from all sources, including interviews, consultation meetings and care summaries received from staff, were incorporated as part of data triangulation.

The six stages of RTA were conducted: familiarisation with the data; coding; generating initial themes; developing and reviewing themes; refining, defining and naming themes; and writing up. Each case was firstly intrinsically analysed followed by cross-case comparison. Manual coding and NVivo software were used for all cases. Coding was conducted by the lead researcher with collaboration from the other authors on refining, defining and naming themes. All researchers had extensive experience in qualitative research.

This study applied the Person-centred Practice Framework (PCPF) [25] as its overarching theoretical framework following RTA, to situate findings regarding person-centredness, as recently applied to PCIC experiences [17], while also ensuring that themes were data-driven.

RESULTS

Older people who participated were aged between 61–93 years, with an average age of 78 years. Their profiles were complex and varied across cases, with most acute social isolation and complexity of needs evident at Case 1. Complex psychosocial contexts, characterised by significant heterogeneity regarding socioeconomic circumstances, impacted on older people's and carers' lives and care experiences across cases. Complexity evidenced concerned experiences of ageing, multiple chronic illnesses and deterioration of health and functionality, and subsequent multiple care needs. Many participants had suffered from ill health for many years or been a carer for many years, and often both. They had extensive experience with different care services and systems. Participants lived with a range of health conditions, including diagnoses of COPD, dementia, arthritis, cancer, MS, Parkinson's disease, and other rare neurological conditions. They also lived with conditions which were sometimes less understood and for which they struggled to get any treatment. These included incontinence, poor balance, swollen legs, disorientation and unexplained black-outs, nausea and chronic pain. These significantly impacted on their quality of life and inhibited them leaving their homes for long, particularly chronic pain and incontinence. Many described the past year as the worst of their lives due to deteriorating physical and mental health. Many lived with depression and anxiety, and some also experienced suicidal ideation. A greater number of carers participated than anticipated. More detailed characteristics of cases and participants are included in Supplementary File 1.

Five themes were identified which articulate the experiential dimension of PCIC, shown in Figure 2 and summarised in Table 2. Each theme was evident in distinct ways across the three cases, due to the heterogeneity of clients and carers engaging with NICPOP and the different models of care applied.

1. EXPERIENCING COORDINATION AND MANAGEMENT CONTINUITY OF CARE

Coordination was experienced by older people and carers as feeling '*under an umbrella*':

> *It's all under one umbrella…once you get under… that umbrella, you'll get help.* (Carer)

> *You feel that you're in a combined piece.* (Carer)

This experience of being protected by coordinated multifaceted wraparound care featured strongly, experienced by clients and carers as having their needs addressed in coordinated, holistic ways, resulting in feelings of reassurance and security. This entailed comprehensive seamless multidisciplinary care and supports, which facilitated timely access to care, involving both internal coordination within ICPOP CST-OPs and external coordination between these teams and other services and agencies. Staff acted in bridging and liaising roles to facilitate signposting and fast-track referral. Carers, as primary coordinators of care, reported benefiting from these coordinating supports, often delivered by case managers. Case managers coordinated supports within and outside of ICPOP, vouching for need so that carers did not have to explain situations to several health providers. Case managers opened previously locked doors to access care, taking pressure off carers, and lessening their sense of being alone or up against an unresponsive system. Carers described this relationship as a saviour, the supports as life-saving and that they would not have been able to manage without them.

Management continuity of care was experienced by older people and carers as being able to '*trust the system over time*':

> *If something went…wrong…that the team would click back in quickly…I'd like that.* (Older person)

> *We're known to them…the option to re-engage is really important…knowing I can get back into the system…it's…security.* (Carer)



Figure 2 Five Themes.

NO.	THEME	DESCRIPTION	ILLUSTRATIVE QUOTATION
1	**Experiencing coordination and management continuity**	Feeling under an umbrella	*"It's all under one umbrella"* (Carer)
			"You feel that you're in a combined piece" (Carer)
		Being able to trust the system over time	*"Knowing that…we're known to them…[option to re-engage] really important…I can get (back) into the system…it's… security"*. (Carer)
2	**Being cared for holistically**	Holistic care needs of the whole person	*"The whole person is looked after in [ICPOP]"* (Older person)
		Being seen and known in my own home	*"They could come in and see what was needed… It's absolutely fantastic…being in your own environment…more relaxed"* (Older person)
		Support for carers	*"They were there for me too, they could see me. They knew I needed a break before I did"*. (Carer)
3	**Relational care and relational continuity**	Knowing that someone has my back	*"You feel that someone has your back…we've someone we can ask…you'll get help"* (Carer)
		Social and emotional support, same staff over time	*"They got to know me, and I got to know them, they'd have a cup of tea and a chat"* (Older person)
			"It was the same staff, that was really helpful" (Carer)
4	**Being supported to live well independently**	Physical health improvements, mobility, practical supports, home adaptation and social connection	*"Independence is so important to me, to have my own mind… to remain at home…to not be a burden"*. (Older person)
5	**Feeling involved in and enjoying my care**	Being listened to, responsive communication and accessible language	*"I felt like someone listened to me for once…they're not talking in them words I can't understand. They treat you like a person"* (Older person)
		Knowing what to expect from integrated care	*"To have the big picture, the team, where it fit in"* (Older person)
		Enjoying care, including in the context of social isolation.	*"I get enjoyment out of it…they're lovely people…we love to see them coming"* (Older person)
			"It (care) broke the silence" (Older person).

Table 2 Summary of five themes concerning the experiential dimension of PCIC.

Management continuity fostered feelings of security, safety and satisfaction with care and led to more effective use of resources. Service user experiences of management continuity and discontinuity were linked with the care context, the specific model applied and ICPOP intervention delivered, its duration and whether it facilitated potential re-engagement. Clients and carers at Cases 1 and 2, which delivered ongoing engagement or dormancy models, reported accessing continuous care and feeling known within a service; experiencing effectively managed care transitions; and being able to re-engage with the intervention or system. Management discontinuity, in the form of unexpected and unplanned discharge to healthcare staff unknown to them, resulted in feelings of uncertainty and insecurity at Case 3, operating a finite model. This led to fear, concerns regarding future care, worries they would '*fall out of the system*', and a sense of personal responsibility to source care and navigate a fragmented health system where accessing care was challenging:

> *I'm just wondering…where I can expect to go…how I get back into the [system]…I'll…have to chase it [care]*. (Older person)

> *When ICPOP…ends…do you fall out of the system?* (Older person)

> *It's up to me now [to access care]*. (Older person)

Participants called for check-ins post-discharge to monitor emerging needs and the opportunity to re-engage with the programme where required.

> *It's devastating to know they'll never come again…I wouldn't expect them to call as often as they [did]…but…every [few] months…would be nice, to see how are we getting on*. (Older person)

2. BEING CARED FOR HOLISTICALLY

Older people and carers across cases valued individualised holistic care as part of ICPOP care, leading to '*feeling seen and known*' by staff and described as being cared for as a whole person, as situated in their lived experience, sociocultural worlds and psychosocial contexts:

> *The whole person is looked after in [ICPOP]*. (Carer)

Contexts were vastly diverse and informed individuals' care needs and preferences. Contextual understanding and incorporating their needs, preferences and wider values into care resulted in participants feeling known by staff. Holistic ICPOP care was contrasted with previous experiences of non-holistic or atomistic care, especially in acute settings, in which providers had treated symptoms in isolation. Being cared for holistically included addressing multiple clinical needs, together with social and practical needs, including provision of aids and appliances and other supportive equipment; carers' needs; supporting clients and liaising with local authorities regarding home adaptations; social care and supports; and administrative supports relating to finances or entitlements. Holistic care featured less where condition-specific pathway models of care were applied which lacked holistic assessment processes.

This study found that home care facilitated positive holistic PCIC experiences, identifying health and social care needs which would have been less visible in clinic or hub-based consultations:

> *They could come in and see what was needed… It's absolutely fantastic…being in your own environment…more relaxed*. (Carer).

For most, home-based care was a new experience and was positively received by clients and carers, experienced as enabling enhanced understanding of their complex needs and facilitating the provision of holistic PCIC. Staff could better understand clients', carers' and families' personhood and psychosocial contexts and provide more holistic, relevant and preventative care, better identifying required supports. This theme illustrated the value of the home-based integrated care model and related service user experience. Preferences for home-based or hub-based care were influenced by levels of need. Home-based care was considered especially important for people living with complex degenerative conditions and multimorbidity. Experiences depended on the various models implemented and the extent of home-based care provided.

3. RELATIONAL CARE AND RELATIONAL CONTINUITY

This theme was experienced as '*knowing that someone has my back*', entailing a key trusted continuous therapeutic relationship with staff, and related relational continuity and emotional support, reliability and responsiveness of care. This relationship was experienced as enabling the provision of holistic PCIC through establishing trust; knowing the person and understanding vulnerabilities, care needs and priorities; and facilitating effective communication about care and preferences. Clients and carers reported interpersonal connection and receiving emotional support, often from a case manager or other ICPOP staff with whom they had a central trusted relationship, including during situations of acute personal crisis.

> *We were like old friends*. (Older person)

> *It's easier if you know somebody*. (Older person)

> *[Older person] made a great bond [with staff]*. (Carer)

Relationships were valued highly by all participants across cases and considered by many as the most important elements in their integrated care experiences. The formation and maintenance of this trusted relationship were facilitated by case management models of care; continuous and longer-term interventions; staff ethos and disposition and their interpersonal and communication skills; and sufficient time to form relationships. Participants were aware of scarce healthcare resources and stated that longer appointments were not always necessary once staff were present '*in the room*'. Carers reported the importance of relational care and related emotional support:

> *You feel that someone has your back…we've someone we can ask.* (Carer)

> *They were there for me too; they could see me. They knew I needed a break before I did and they came with the cavalry.* (Carer).

> *The best care experience is that you feel that the person is…with you, in the room.* (Carer)

Participants noted staff '*going above and beyond*' to provide comprehensive integrated supports. The formation and maintenance of relationships was impacted by the duration of the ICPOP intervention and whether it enabled continuity or not. Discontinuity and lack of sufficient time were barriers in forming and sustaining this relationship and led to feelings of insecurity and unsafety.

4. BEING SUPPORTED TO LIVE WELL INDEPENDENTLY

Older people across cases reported valuing their independence and their fears of becoming a burden:

> *Independence is so important to me, to have my own mind…to remain at home…to not be a burden.* (Older person).

Older people reported being supported to live well independently, as a result of the ICPOP intervention. The importance of independence, participants' desire to remain independently living at home and the associated pride and sense of identity was strongly evidenced. Being supported to live well independently through ICPOP care entailed improvements in clients' physical functionality, including reported increased mobility, balance and physical strength, which subsequently increased their levels of confidence and feelings of security and reduced stress. It also included holistic supports outlined above under theme 1; coordinating home and garden repair and community-based meals services; social supports, including referral to befriending services and social prescribing to community resources and opportunities; supporting clients to become more socially connected through practical supports, including hearing aids and mobile phones; and new knowledge to further enhance their capacity for self-care.

> *I have more confidence in myself…it was great, am back driving now*. (Older person)

Carers also reported acquiring new knowledge which supported and sustained them in their roles, essential to enabling older people to continue living independently. ICPOP practical and social supports enhanced social connectedness and related expansion of clients' and carers' social worlds. However, some older people expressed frustration that practical supports they required, including cleaning, shopping and having their fires lit, were not provided by ICPOP or other care.

5. FEELING INVOLVED IN AND ENJOYING MY CARE

This theme included understanding integrated care and knowing what to expect from it, feeling involved in and enjoying care. Knowing what to expect from care consisted of clients and carers knowing about the ICPOP intervention and related multidisciplinary team offering, and what it could provide. Clients at one case, Case 3, reported a lack of sufficient information about the ICPOP intervention and CST-OP which negatively impacted their capacity to know what to expect and to '*get the most out of*' the care episode. Participants requested that a client information leaflet be given to all clients as standard:

> *To have the big picture, the team, where it fit into the system*. (Older person)

A lack of knowledge about ICPOP among members of the public and health professionals across the health system was also reported at Cases 2 and 3, which had the effect of hampering and delaying referral to the programme. Further promotion of ICPOP to external service providers was suggested to remedy this.

Feeling involved in care included clients and carers feeling that their preferences and values for care were ascertained, listened to and incorporated into care planning; that they were involved in shared decision-making (SDM) about care; and that they were effectively communicated with and informed about care options to facilitate meaningful involvement. This theme also entailed relational care and was enabled by trusted relationships with staff. Staff taking sufficient time for communication and using accessible language, which avoided jargon, particularly in the context of cognition issues or communication difficulties, further enabled clients and carers feeling involved in care:

> *I felt like someone listened to me for once…they're not talking in them words I can't understand. They treat you like a person.* (Older person)

> *They're all so lovely…they listened…[to] how we felt about it.* (Older person)

> *[ICPOP] staff listening to me…if you don't have other people to talk to…I found that that was very helpful.* (Older person)

> *I loved to see them coming…it broke the silence.* (Older person)

Feeling involved in care also included the right to refuse care and support. Experiences of being involved in ICPOP care were favourably contrasted with previous non-ICPOP care experiences where participants had felt silenced, dismissed or alienated from care and related processes and decisions. Clients and carers across cases reported enjoying ICPOP care and related increased wellbeing; a novel and welcome experience. Many had lived for years with chronic illness and received care which they did not enjoy from a range of healthcare professionals in varied settings. Enjoyment of care consisted of the social component of care and the 'chat', through unrushed, positive, respectful and friendly interactions. Clients and carers valued ICPOP staff taking sufficient time to engage socially with them:

> *I get enjoyment out of it…they're lovely people… the best I ever had…I love going up [to ICPOP hub]…once a doctor's nice to me, that makes a big difference.* (Older person)

> *[ICPOP staff] stay…[to] have a chat…a laugh.* (Older person)

This was especially important in contexts of acute loneliness and social isolation, exacerbated by COVID-19 and experienced by clients and carers across cases, increasing needs for social and emotional support:

A lack of time for care interactions had a negative impact, leading to unenjoyable experiences and perceived dehumanised impersonal care. Clients across cases reported more time in ICPOP appointments than other non-ICPOP care consultations and more meaningful interactions.

DISCUSSION

This study's six key insights relate to the PCIC experiences of older people and carers, and the capacity of care service design, delivery and systems to optimise these from micro levels of patient interactions to macro policy levels. These resonate closely with the PCPF domains, as detailed in Figure 3, aligning with and adding to a recent review of older people's PCIC experiences [17].

Firstly, this study identified the importance of holistic PCIC approaches informed by lived experience and psychosocial context to address the heterogeneity of lived experiences of ageing, chronic illness and multimorbidity. Older people are often mistakenly seen as a homogenous cohort to a far greater degree than adults in other age groups [26]. This heterogeneity of older people's lived experiences and their carers, wider families and households, was characterised by varying levels of complexity, impacting on health and psychosocial contexts and resulting health and social care needs,

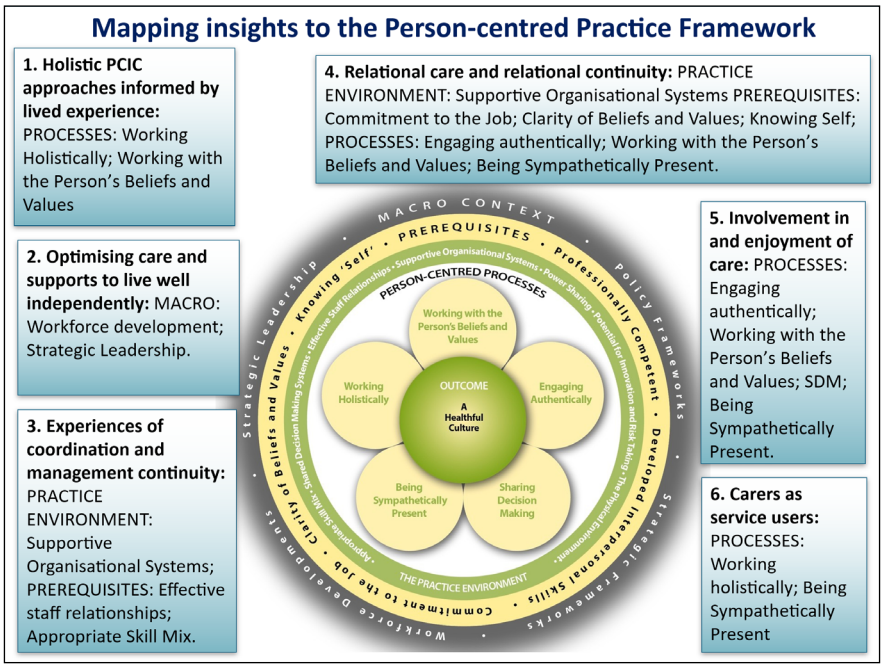


Figure 3 Mapping insights to the Person-centred Practice Framework.

preferences and goals echoing other research [18, 27]. Findings illustrated that holistic PCIC was hugely valued by older people and carers and was necessary to address changing needs, consistent with global best practice and policy frameworks [15]. This also corroborated literature viewing integrated care as a 'one-stop shop' and previous research reporting older people's preferences for this [28, 29]. It further aligned with studies emphasising practical and community-based supports to support older people remaining at home [27, 30].

Holistic care provision was impacted by the care model, most notably limited by pathway models and a related lack of holistic assessment aligning with previous studies [27, 28]. This understanding and honouring of personhood through holistic approaches resonated with the PCPF's process of 'working with the person's beliefs and values' and 'working holistically' [25]. This further echoed literature underlining the importance of dynamic, proactive holistic integrated care [31]. This study's findings evidenced vulnerability and complexity as embedded in and often exacerbated by individuals' psychosocial contexts. Therefore, definition of needs and related service responses must reflect a biopsychosocial holistic approach to understanding vulnerability and complexity. Social conceptualisations of frailty that go beyond clinical definitions to encompass older people's psychosocial and situated care needs are essential. This reflected increasing evidence of the importance of community-based supports, social connectedness and community resilience as part of integrated care and public health policy and initiatives [32]. The three cases met individuals' holistic needs to various degrees through a focus on case management, supported discharge, and preventative early intervention. Aspects of all these models should ideally be combined to provide holistic care that adapts and responds to the diverse and changing needs of older people. ICPOP CST-OP multidisciplinary supports must be dynamic and responsive to service users' lived realities.

Secondly, this study identified PCIC as optimising older people's care experiences and supporting them to live well independently. Findings confirmed PCIC as especially suited to and important for older people living with chronic illness and multimorbidity, due to its capacity to provide person-centred coordinated care to meet multiple complex needs and prevent care fragmentation. This corroborates literature evidencing increased complexity as increasing risks of care fragmentation and necessitating a coordinated and person-centred approach [5, 15, 33]. It confirms research indicating integrated care's particular suitability for older people with multiple care needs, at increased risk of care fragmentation [34, 35]. This insight was also consistent with literature identifying integrated care as leading to more efficient and responsive care [36] and better care experiences for older people in integrated initiatives compared with non-integrated [29, 36, 37]. This further aligned with integrated care literature identifying older people as especially vulnerable to fears and experiences of losing functionality, independence, social connection and ultimately control over their lives [31, 37, 38].

Findings evidenced independence as hugely valued by older people and the programme's viability and success in supporting older people to live well independently in their own homes and communities. The role of the macro context was evident in enabling this, resonating with the PCPF's macro domain, which highlights the importance of policy and strategic frameworks, strategic leadership and workforce development. This also confirmed research identifying the macro context as driving the success of PCIC and its impact on service users, through coherent and shared vision, policy direction and strategic leadership, and supportive workforce development, encompassing PCIC capabilities and competencies [39, 40].

Thirdly, experiences of coordination and management continuity were found to be essential for positive PCIC experiences and to result in more coherent care and system efficiencies, including more effective use of resources and reduced duplication, consistent with previous studies [30]. Intrinsic capacity can change over time and, as evidenced by findings, where participants are more vulnerable, more intense care coordination is required. Coordinating processes were necessary within the ICPOP CST-OP, as well as cross-team communication and information sharing between ICPOP and other systems and services, including specialist geriatric services. The social component of ICPOP MDT supports, including social and emotional care, counselling and psychological care, varied across cases. While this is currently not present as part of all ICPOP CST-OPs, this was found to be essential to address social vulnerabilities present [27].

Experiences of coordination and continuity were impacted by model and intervention type and were particularly associated with an intensive case management approach and longer-term engagement, consistent with literature [41]. Conversely, finite interventions were associated with experiences of relational and management discontinuity and care fragmentation. Discharge was experienced as particularly distressing when unexpected and unplanned for, practices unsupportive and transitions to unknown contact points in other systems, echoing similar findings [38]. Pathway models of care led to care fragmentation, a lack of holistic assessment and were associated with a lack of coordination and informational continuity between ICPOP and other systems. Follow-up check-ins, suggested by participants, could address this discontinuity. While short-term initiatives may be adequate for older people with less complex needs, longer-term and intensive support were needed for individuals with more complex and multiple chronic health and social care needs.

This insight resonated with the PCPF's macro and practice environment domains, specifically 'supportive organisational systems', 'effective staff relationships' and 'appropriate skill mix' [25]. Supportive organisational systems were found to be vital to enable communication and information sharing across systems to facilitate more coordinated care and appropriate referral. This insight also closely resonated with literature asserting coordination and continuity as central tenets within integrated care and PCIC [15, 40–42] and as key experiential outcomes of successful PCIC for older people [15, 17, 34, 35].

Fourthly, this study evidenced the significance of relational care and a continuous relationship between ICPOP staff and the client and carer, and related trust, relational continuity, and social and emotional support as a key element of PCIC experiences. This relationship facilitated other PCIC processes and outcomes, including coordination, continuity, involvement and enjoyment of care, resulting in feelings of reassurance and psychological safety. Because of this relationship, older people and carers trusted the wider system of care. Findings showed the importance of the care model and environment supporting the formation and maintenance of this relationship. Enablers included relational care processes and relational continuity; case management models of care; staff interpersonal skills, ethos and disposition; and sufficient time afforded as part of care consultations. This was consistent with previous research findings [31, 38, 42].

Sufficient time within consultations to invest in these relationships was vital. Longer appointments were not critical, however, provided there was an empathetic, friendly interpersonal atmosphere that engendered trust and respect. This resonated with the PCPF processes of 'engaging authentically', 'being sympathetically present' and 'working with the person's beliefs and values'. The importance of staff disposition and drive to provide comprehensive integrated supports for older people and carers to '*have their back*' indicated a necessary commitment to and understanding of their role. This resonated with the PCPF prerequisites of 'commitment to the job', 'clarity of beliefs and values' and 'knowing self', and 'supportive organisational systems', which afforded staff time during consultations and follow-up communications to form and maintain relationships [25]. This insight confirmed literature evidencing older people's preferences for relational care and interpersonal social connection [31, 28, 41]. It corroborated research findings regarding the capacity of relational care in integrated contexts to alleviate fears regarding ageing and ill health and support navigation and access to care [27, 37]. This also aligned with older people's identified preference to feel seen, heard and known within PCIC experiences [17, 20, 28].

Fifthly, feeling involved in care and enjoying care were identified as central outcomes of PCIC experiences. Care interactions are constructed by and through power relations and related norms or rules. Integrated care, and especially PCIC, require a redrawing of these rules, heralding significant redistribution of power towards collaborative professional practices and more equal power dynamics among providers, patients and carers [39, 40]. Feeling involved in care and respecting individuals' personhood and agency in their care was evidenced as especially important in the context of ageing, chronic illness and declining independence resulting in a potential loss of power and increased social isolation. It was also particularly valued given previous experiences of inaccessible, fragmented and often paternalistic health systems where older people and carers experienced poor or unreliable communication, felt ignored, excluded, and even discriminated against.

This resonated with the PCPF component 'power-sharing' and 'shared decision-making' in its practice environment and process domains. The rights of older people and carers to refuse care or support evidenced by this study's findings further connect with the PCPF practice environment component of the 'potential for innovation and risk-taking'. This finding confirmed the importance of PCPF communicative and relational care processes, 'being sympathetically present'; 'working with the beliefs and values of the person'; and 'engaging authentically' [25]. Again, care environments often determined the extent to which individuals felt involved in care and meaningful power sharing was realised. Care environments enabling this involvement consisted of trusted relationships between older people, carers and staff, staff communication skills and the use of accessible inclusive language, and sufficient time in consultations. This insight also confirmed literature identifying involvement and collaboration in care as central to integrated [13] and PCIC approaches [17, 18, 20] and older people's preferences for involvement in integrated care [29].

Finally, this study's findings evidenced the extent of care work carried out by carers and that, in addition to coordinators of care, carers should be recognised as service users with distinct PCIC needs. The workload of caring became a burden when carried out in isolating circumstances with very limited support, resulting in or exacerbating carers' physical and mental health and social care needs. Before engagement with ICPOP, carers, often older adults themselves and performing multiple caring roles, were largely managing their loved one's very complex care alone, with their own needs going unmet. Carers benefited from ICPOP supports for their loved one, such as coordinating care and advocacy, including respite care and providing personal care. ICPOP-CSTs, to varying degrees across cases, were also shown to be providing supports for carers directly as service users. These supports were experienced by carers as life-changing and included

IMPLICATIONS FOR PRACTICE, POLICY AND RESEARCH

This study informed practice development through its recommendations to optimise PCIC experiences within the NICPOP programme:

1. Consider the holistic psychosocial needs of older people and carers which directly impact on their health and wellbeing.
2. Continue the incorporation of longer-term home-based models of care, especially for more vulnerable and complex presentations.
3. Establish dynamic and adaptive approaches to longer-term engagement and incorporation of the potential to re-engage with the ICPOP CST-OP in response to emerging needs to ensure management continuity of care.
4. Ensure that the range of multidisciplinary ICPOP CST-OP offerings responds to older people's and carers' identified needs.
5. Further incorporate service users' subjective assessments of their health and social care needs, preferences, priorities and goals in person-centred care planning and delivery.
6. Prioritise and further develop case management models of care to facilitate the formation and maintenance of interpersonal relationships between ICPOP staff, older people and carers and enhance coordination and relational continuity of care.
7. Provide standardised information materials to older people, carers and families at the beginning of the ICPOP intervention, detailing the role and nature of the intervention and discharge planning.
8. Continue to enhance integration between ICPOP and wider health and social care systems, including increased awareness-raising, information sharing and coordination among health professionals caring for older people and their families.
9. Further develop service user involvement in regular evaluation of NICPOP care and service design to ensure meaningful Public and Patient Involvement (PPI) approaches to involve people with lived experience of chronic illness and multimorbidity.

This study informed future PCIC research, identifying scope for exploration of longer-term impact of integrated care interventions; carer PCIC experiences and needs; and enhanced involvement of older people and carers in service and evaluation design.

social and emotional supports and having someone to speak with about their lives and caring roles; increased knowledge about their loved one's conditions; referral to carers' courses and peer support groups, mitigating isolation and facilitating social connection with other carers; and mediation and support for relationship issues. Again, the extent to which interventions deliberately supported carers depended on the model applied. Not all ICPOP CST-OPs were deliberately or systematically providing supports to carers as service users. This should become a more standardised part of the intervention to provide holistic PCIC as is best practice [28, 38]. This insight further emphasised the importance of encompassing the wider needs of carers and households as part of holistic PCIC, resonating with PCPF processes 'being sympathetically present' and 'working holistically' [25].

LIMITATIONS

This case study explored PCIC in Irish contexts which may impact on transferability. Due to data protection and ethical requirements, participants included those currently engaged with NICPOP CST-OPs who had cognitive capacity to give informed consent, preventing inclusion of retrospective perspectives and experiences of those with cognition issues. Participation was determined by the availability and willingness of participants to share their experiences. While many participants were living with significant ill health and disability, it is possible that some participants experiencing health emergencies may have been excluded. It was not possible to access programme data for the three sites as these systems had not yet been developed. While recruitment was successful, numbers of willing participants may have been reduced by the context of the COVID-19 pandemic.

CONCLUSION

This study identified components of positive PCIC experiences, addressing knowledge gaps regarding effects of integrated care and PCIC on older people and carers [18–22]. It prioritised the service user voice through its qualitative multi-site case study design, appropriate to contextual, multi-perspectival exploration of complex healthcare phenomena, and its robust theoretical framework. It found PCIC optimised care experiences, integrating individuals' personhood and prioritising relationships in care; led to experiences of coordination, continuity, trusting the system, feeling involved in and enjoyment of care; and resulted in self-reported improvements in traditionally measured clinical indicators. PCIC enhanced older people's capacity to live

well independently in their homes and communities, confirming the merits of PCIC approaches and their suitability for older people. This study evidenced that it is possible to deliver PCIC in the Irish system given the right blend of enabling factors and supportive contexts at organisational and systems levels, including staff capabilities and competencies. Findings indicated that PCIC can lead to system efficiencies, more effective use of resources and reduced duplication.

This study identified limitations of pathway models in integrated settings and related risks relating to professional silos resulting in experiences of fragmented non-holistic care. Systems should ideally function in coordinated and collaborative ways to address the person's holistic needs rather than to facilitate separate specialist services. This study confirmed the desire of older people to remain at home and the policy imperative to ensure this and identified the importance of longer-term, home-based models for the most complex needs. Creativity will be essential to realise positive PCIC experiences within constrained resources. Failures to respond to older people's expressed and significant needs occurred mostly despite the commitment of staff and were often due to a lack of holistic assessment. This highlighted the value of involving older people and carers in design, planning and evaluation of services.

ADDITIONAL FILE

The additional file for this article can be found as follows:

- **Supplementary File 1.** Case and Participant Characteristics. DOI: https://doi.org/10.5334/ijic.11007.s1

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The authors have no competing interests to declare.

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