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**An Extra Care community's perceived priorities for 'whole system' relationships: A Q-methodological study**

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### **Abstract**

Health and social care settings world-wide need to sustainably improve the quality of relationships across communities or 'whole systems'. This research informs the development of a relational framework based on stakeholder perspectives. It is grounded in an action research project with practitioners, and draws on a previous literature review, to present the underpinning elements of quality relationships as statements, organised under the headings of integrity, respect, fairness, compassion and trust. Using Q methodology, 27 participants, comprising a range of stakeholders (staff, residents, family and service providers), rank-ordered 48 statements based on perceptions of the importance of differing aspects of relationships. By-person factor analysis was used to create five factors or viewpoints by comparing and contrasting using the composite rankings alongside interview data collected for each participant. The first view 'Altogether now' prioritises compassionate engagement. Secondly, 'Respect is a two way street' emphasises the need for reciprocal respect and recognition of history. The factor labelled 'Free spirits' posits the dominant view of freedom. The fourth view 'Families... strengths and challenges' focusses on the necessary and complex involvement of families and finally, 'Helping hands' emphasises the role of relationships in increasing previously low expectations of social integration for previously isolated residents. The different views that exist on the composition of quality relationships can be used to help extra-care communities to understand and utilise relationships as a powerful and effective resource.

**Keywords:** Relationships, Q-Methodology, Action Research, Extra Care Housing, Health and Social Care, Ageing

#### **What is known about this topic?**

- There are increasing global challenges in relation to the socio-economics of ageing populations and the humane care of older people
- Positive human relationships and attributes that underpin them are a vital system-wide component of humane care for older people
- Extra-Care housing provides opportunities to draw upon community wide relationships to improve conditions across stakeholders

#### **What this paper adds**

- A 'system-wide' framework examines subjective views on developing high-quality relationships in an Extra-Care facility
- Five distinct factors were derived from the Q sort indicating the range of differing perspectives on developing the relational environment
- The work outlines how a relational framework combining the highlighted statement set and resulting factors can be used to monitor relational quality

## Introduction

Across the world, people are living longer, creating a shift in the socio-economic balance between older and younger generations (United Nations, 2013). This change is accompanied in many OECD countries with; welfare spending cuts and cost rises (Robertson et al., 2014), increasingly complex patient and user needs and a growing emphasis on the integration of services provided by differing models of public and private sector engagement (Humphries and Curry, 2011; NHS, 2014; English Health Service Ombudsman, 2011). Such pressures on health and social care systems are compounding to create a burgeoning delivery gap in older people's housing, care and support. However, a range of evidence now exists, which indicates that the improvement of stakeholder relationships, both within and between communities, holds significant potential for improving health and social care delivery.

The social determinants of individual health are well established (World Health Organisation, 2010) and reflected in the international evidence of health buffering effects available through social connectivity and activity, contributing to an increase in available resources and a decrease in social isolation (Derose & Varda, 2009). These networks of relations have a direct influence on community health through reciprocity, inter-dependence and family support (Antonucci et al., 1990; Smith & Christakis, 2008; Chen et al, 2014). For older adults, research indicates the influence of social support on improved physical and mental health and longer living across cultures (Fiori et al., 2008).

Alongside health benefits, the underlying quality of relationships is fundamental to management and delivery of health and social care across systems (Gilson, 2003/2006; Calnan & Rowe, 2006/2008; McCabe & Sambrook, 2014; Pattison & Kline, 2015), yet management often focus on considering only discrete parts of a system and not inter-relations between stakeholders (Plsek & Wilson, 2001; Peters, 2014). The beneficial potential of considering relationships within and between health and social care communities can be seen through both positive and negative outcomes.

Powell et al (2014) indicates how positive organisational relationships, underpinned by elements such as fairness and shared decision making, can have an important role in care outcomes. However, relational breakdown amongst stakeholders can have the reverse influence. For example, at the institutional level it is well established that a lack of trust in relationships between healthcare providers and communities negatively influences health seeking behaviour (Mechanic, 1996; Mohseni & Lindstrom, 2007). In the UK, Francis (2013) highlighted how a lack of consideration of the impact of organisational restructuring on the strategic relations between different bodies led to a serious deterioration of care delivery. In the housing care sector, a breakdown in relations

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3 between users and providers has been directly related to institutional abuse (Care Quality  
4 Commission Review, 2014) and relational failings between different agencies, families and external  
5 stakeholders has led to neglect (Corkhill, 2014).  
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### 8 **Frameworks and tools for measuring relationships**

9  
10 Whole-system approaches to help provide seamless provision of health and social care are  
11 increasing (Kodner, 2006) and frameworks that help gather relationship-focussed data across  
12 systems of stakeholders groups are needed to assist leaders and commissioners in making better  
13 strategic decisions based on relationships and connectivity (Turnbull, 2011).  
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17 Relational Coordination (Gittel & Douglass, 2012) is an example of a management tool developed to  
18 enable systemic measurement of relationships, with extensive use in healthcare (Gittel et al.,  
19 2000/2008/2013). Relational Coordination emphasises the positive elements of social integration  
20 expressed through co-ordination between different teams and disciplines by focusing on perceived  
21 levels of respect, problem solving, and the nature and frequency of communication between  
22 different roles. Emerging from the US context the approach provides some indication of the quality  
23 of underlying relationships but is primarily based on tasks and the roles of staff and does not directly  
24 account for all stakeholders within the system.  
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### 31 **Relationships in extra-care**

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33 Extra-Care housing (ECH) emerged in the UK as an approach to housing, care and support founded  
34 on principles of choice and control (Department for Communities and Local Government, 2008), and  
35 aimed at reducing the burgeoning cost of care whilst simultaneously managing the diverse needs of  
36 an ageing population (Riseborough et al., 2015). Distinctive features include; housing separate from  
37 care, secure and purpose built units that promote independence and 'progressive privacy', secure  
38 tenancy rights, controls over access, available office space for management and the wider  
39 community, communal space and facilities, 24 hour care, and use of assistive technology  
40 (Riseborough et al., 2015:4). People moving into extra-care facilities tend to be younger and suffer  
41 from less physical and cognitive impairment (Darton et al., 2012).  
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48 The potential for ECH to improve social well-being of residents has been widely discussed (Evans and  
49 Vallely, 2007; Callaghan, 2008; Callaghan, Netten & Darton, 2009; Orrell et al., 2013). In a whole  
50 system view (Lewin, 1946) stakeholder relationships will have a significant role to play in leveraging  
51 any social well-being impact of the increased independence associated with ECH.  
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### **The research project**

The work was undertaken in collaboration with an industry partner, specialising in strategic whole systems analysis. An action learning approach was adopted and provided two advantages. Firstly, it is congruent with conceptualising communities of stakeholders as whole systems in that 'to understand or to predict behaviour, the person and his environment have to be considered as one constellation of interdependent factors' (Lewin, 1946:338). Secondly, it promotes the acceptance of knowledge from all areas of the research context e.g. practice, research and policy are treated equally in shaping findings (Meyer, 2000).

The two objectives of the paper are; (a) to build a set of 'system-wide' relational statements for Q method subjective analysis, across extra-care stakeholders and (b) to develop perspectives (factors) from this work that when combined with the derived statement set can be used as a framework to sustainably and humanely consider system-level relational quality across extra-care communities.

### **Methods**

This study follows a Q Methodology (Stephenson, 1953) design that seeks to operationalize subjective views around a shared topic of interest (Brown, 1980). Q method extracts patterns of meaning from multiple responses to a given set of statements (known as the concourse). The two basic components of Q methodology are the Q sort procedure and the by-person factor analysis.

Q methodology has particular utility in health and social care due to; its appropriateness in complex social situations where professional and user perspectives differ, and where evidence is drawn from a wide base (Stainton Rogers, 1991), where there is a need to include the marginalized (Brown, 2006), and a robust qualitative technique is required (Cross, 2005). Divergent areas of H&SC research using Q methodology include: pain (Eccleston et al., 1997); mental health and housing (McCauley et al., 2015); health lifestyles (van Exel et al., 2006); quality of life (Stenner et al., 2003); economics of health choices (Baker, 2006); team working (Buljac-Samardzic et al., 2011); risk training (McKeown et al., 1999) and nursing practice (Clarke & Holt, 2015) .

The work was conducted through the four recognised stages of statement development - selection of a sample of respondents, statement ranking, analysis, and interpretation (Buljac-Samardzic et al., 2011). Full ethical approval for this work was sought and awarded by the University of Leeds Research Ethics committee (SHREC/RP/519) and support provided by the local Clinical Commissioning Group overseeing the new ECH development.

### Development and selection of statements – Q Set

To develop the statements this research drew on both extant journal literature, akin to Brown (2006), and practitioner perspectives, to identify underlying behaviours, practices and processes that might support 'quality' community wide relationships within an extra-care setting identified in a scoping literature review (Grimshaw et al., 2016). This material was used by researchers and practitioners (n=5) to derive and organise statements into five themes of *integrity, respect, fairness, compassion and trust*. For example, it is understood that inclusive decision making is a key component of a fair process both organisationally (Cohen-Charash & Spector, 2001, Colquitt et al., 2001) and within care settings for residents (Knight et al., 2010) hence the inclusion of the statement *Residents know why decisions that affect them are made*, placed under the fairness theme (statement No. 34 in Table 2). Finally, to complete the initial framework and to ensure the 48 statements were spread across the 'whole system' of the organisation, statements were also positioned under four socio-technical (Davis et al., 2014) headings of *culture, people, process, and infrastructure* (inc. physical and technology space). Mapping the statements in this way enables further analysis of the emergent factors.

### Justification of sample size & selection of participants – P set

Q methodology studies do not require formal power calculations to determine the number of participants. However, Kline (1994) suggests a ratio of 2:1 (statements to participants). A pilot study was conducted with 3 elderly participants to check for face validity of the statements and also to ensure the process was suitable for elderly participants in terms of timing, scale and topic. A total of 6 statements were changed and/or removed due to overlapping or repetitive elements.

### Recruitment for the study

The research included a range of stakeholders connected to the extra-care facility. We labelled these three groups as *residents (n7)*, people officially resident at the care home (the extra-care unit completed its own formal assessment of new residents and this informed the choice of residential participants); *staff (n5)*, anyone employed specifically by the care home, and *stakeholders (n15)*, people who have a relationship with the care home but are not employed directly e.g. family members or additional service providers e.g. facilities staff, social workers. The aim was to ensure the widest possible range of participants from across the system, the rationale being that the level of contact and differing role and mode of connection with the care community may colour the views of the different groups. The age range of participants was between 26-90 with 74% female. The selection of residential participants was conducted by random sampling of names and subsequent

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3 clarification discussions with the housing coordinator. Information sheets were included in all new  
4 residents' introductory packs for the care home. Posters were placed in the unit and staff and  
5 stakeholder participants were approached via researcher introduction at management meetings and  
6 introductory emails direct to all staff.  
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### 10 **Procedure - Ranking of the statements**

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12 Firstly, participants were asked to complete an informed consent form and then presented with a  
13 pack of shuffled cards (n48) with statements (Q set) printed on them and asked to arrange these  
14 cards on a pre-defined grid pattern. The statements were placed in response to a single over-arching  
15 question *"In order to have the best possible relationships within an extra-care housing community it*  
16 *is important that..."*. Statements were arranged on the basis that each person subjectively believes  
17 each statement is more or less important to them (See Figure 1). The statements were ranked on a  
18 dimension of +5 to -5 depending on subjective view of importance. The completed pattern  
19 represents an individual Q sort (n27).  
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### 26 **Interviews**

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28 Interviews with participants are an important but under used component of the q sort method  
29 (Brown, 1980:200). They are useful for integrating participant perceptions into the theory and  
30 thematic development and enhance "interpretation of the factor array to be based on the  
31 participants' perceptions and attitudes to the phenomenon under study" (Gallagher and Porock,  
32 2010: 296). This work follows the example of Stenner et al (2003) by integrating comments to  
33 support the presentation of each factor.  
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39 Interviews were conducted before and after statement ranking in order to capture (a) anything that  
40 is missing that people would have liked to have seen added, (b) more detail on items at the extreme  
41 points of the sort or the transition points from positive to negative, and (c) any items of confusion or  
42 needing further clarification. Interviews were 40-90 minutes in length and took place on-site at the  
43 extra-care housing facility less than six weeks from the time of opening, and were conducted over an  
44 eight week period between August and October 2015. All interviews were captured on a voice  
45 recorder and transcribed verbatim.  
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### 50 **Findings: Q-Analysis**

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52 The mode of analysis in Q Methodology is to attempt to explain the overall configurations and the  
53 common patterning and arrangement between respondents Q sorts by factor analysis. 27 Q sorts  
54 were entered into PQ Method (Schmolck, 2002) for analysis. The first stage of Q-analysis is the  
55 calculation of correlations between all the item scores for each Q sort. Factor analysis is then applied  
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3 to the data matrix. The centroid analysis method ( Brown (1993)) was used to derive the factors, and  
4 varimax rotation was used to reveal the different groups loading on each of the extracted factors.  
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6 The choice of how many factors can be chosen for rotation was based on balancing three aspects: (a)  
7 an explanation that accounts for the maximal amount of variance explained by the extracted factors  
8 (Watts and Stenner 2005), (b) had a minimum of 2 Q sorts loading on each of the factors alone  
9 (Brown 1980) (see Table 1), (c) results that provided the most useful theoretical explanation by  
10 reference to the 'whole' response set. The optimal number in this case based on the above  
11 conditions was a 5 factor explanation. Eigen values were all above the 1% minimum required for all  
12 factors with a total of 12.13. The 5 factors had 26 participants loading significantly with 52%  
13 variance (24, 8, 8, 6, 6 % percentage variance respectively). Scores of between 35-40 are viewed as a  
14 sound result (Kline, 1994), thus enabling further analysis. There was one non-significant QSort (See  
15 Table 1).  
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25 **INSERT TABLE 1 & 2 here**

### 26 27 28 **Interpretation of factors**

29 The analysis revealed 5 relevant factors. These 5 factors are presented in turn using factor scores  
30 differentiating statements, combined with qualitative quotes from the participants. Interpretation of  
31 the factors is assisted by examining those statements that are distinguished by position at points of  
32 most and least agreement between the factors and those factors that are statistically significant in  
33 distinguishing each factor from the others. The factors are arranged in order of variance *Brackets ()*  
34 *indicate statement number and [] participant.*  
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#### 42 **Factor 1 Unity: 'Altogether now'**

43 The majority of participants loaded on this factor and prioritised compassion statements, expressing  
44 a need to focus on the whole person (28) as the basis of the relational environment between staff  
45 and residents [P5] " if someone is in a wheelchair...they have got other things too and they can do  
46 activities, they can still feed themselves..hold a conversation...lead an activity, you're not just seeing  
47 them in a wheelchair...you've got to see that they've had a life, what they've done...". Empathy  
48 within relationships between staff members, focussing on understanding the pressures of fellow  
49 professionals, was seen as important in order to reach workable compromises around providing the  
50 best possible environment for residents.  
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3 Compassion in relations was also strongly connected with fairness and being treated as equals (33)  
4 [P5] “nobody’s any different in here, whether they’re in a wheelchair, they’re bed bound, they’re up  
5 and walking around, they’re still the same person”. People loading on this factor viewed residents  
6 seeing the same staff everyday (8) as an important mechanism for expressing compassion [P28] “We  
7 do need continuity of staff that’s coming in. We have the service users getting used to one person,  
8 then they’ll take them off... send somebody else in who’s got to learn all about that person again and  
9 it unsettles people, it unnerves them” and this continuity of relation was directly connected to trust  
10 building [P17] “[before moving in] it was different carers coming in all the time, so my mam didn’t  
11 trust them, she’s spitting tablets out, and this is part to do with the dementia”. Compassion and  
12 empathy statements were viewed as central within this factor to unlocking successful relationships.  
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### 19 Factor 2 **Reciprocal relationships: ‘Respect as a two-way street’**

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22 People loading on this factor were predominantly external stakeholders, and expressed the need for  
23 reciprocation moderated through respect for the individual as a key component for establishing a  
24 healthy relational environment. ‘Seeing the current and past potential of residents as important life  
25 achievements recognised by others’ (45), and ‘an opportunity to contribute skills and knowledge’  
26 (46) were important. ‘Age is respected’ (44) was also placed higher than in the other factors which  
27 largely negated age as an issue and a barrier to fairness. Here it was viewed as important not just  
28 from the position of elders naturally deserving respect, but also that younger people in the  
29 community may have different needs that need to be respected. The external stakeholders that  
30 loaded on this factor proposed respect for the individual in general as a guiding perspective [P26]  
31 “working in the industry for so long, you know, it’s always been....to treat the person with respect  
32 and as an individual”.  
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### 40 Factor 3 **Free spirits: “I’m free”**

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43 The statement suggesting a need to have regular access to the internet or phone (42) was viewed as  
44 most important when related in part to the need to connect more meaningfully with the boundaries  
45 beyond the unit and not be constrained by personal or institutional boundaries. This was  
46 exemplified by one resident who was highly involved with developing ideas with communities  
47 outside the facility to introduce activities or events for other residents. [P27] “I’ve phoned [x] today  
48 ...to organise our day out and that, you know, and we had a meeting this morning so I said, “we’ll do  
49 raffles and that [to] put the money towards like an outing for the residents”. Free expression of  
50 emotions was a relatively higher (37) loading on this factor. Staff saw this as connected heavily to  
51 relationship development ‘this is their environment, they should be able to say, [P19] “Oh well  
52 actually something’s not right. I don’t feel right” or, “I’m not happy with this member of staff,” or  
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3 something like that....and if they can't express their emotions, then I don't think that that's a good  
4 relationship'. Relatively low scoring of 'staff and residents having shared expectations of the future'  
5 (22) may also be suggestive of a need for freedom over cohesion. The statement 'People are  
6 prepared to give and take when they disagree' (20) is associated here with compassion but viewed  
7 differently through this factor, as a possible restriction on free expression [P27] "Yeah, that's me, if  
8 you've got [anything] to say, say it to the face and that's it, and it's always been my motto... and that  
9 would be the end of it".  
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#### 14 Factor 4 **Connecting communities: "Families...strengths and challenges"**

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17 For staff loading on this factor, family members prioritised family influence through contact with  
18 staff, suggesting it is important that family get on well with staff (2) and that family continuity is an  
19 important part of relational development. For residents this was related to the nature of family in  
20 providing a strong secondary support role [P8] "I think it's important that my daughters can hold  
21 discussions with the people that care for me, or visit, I think it's very important". For staff, family  
22 involvement represented an instrumental need for a good relationship directly connected to helping  
23 new residents to make the transition and settle in (32) and this was seen as a vital time for  
24 establishing trust as the role of the family changes [P2] "families are giving up the full-time role of  
25 caring and this can make it a difficult time for them to adjust". Families were viewed by staff as  
26 crucial in this process but also potentially putting a lot of pressure on the system through multiple  
27 and divergent demands. For example, dealing with multiple family members makes the need for  
28 good relationships more important and challenging [P28] "different family members deal with it  
29 [process of care] differently and they look for different support within you. So in a way it's a real  
30 emotional drain because you're trying to take pressure off the family, off friends".  
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#### 40 Factor 5 **Enabling independence: 'helping hands'**

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43 People loading on this factor see that the facility infrastructure and processes should be designed to  
44 enable relationships that focus on developing the autonomy of the residents. They rated  
45 infrastructure statements that support autonomy higher than those more obviously relating to  
46 compassion or respect. For example, they rated more highly the need for residents to have a say  
47 over the local environment (21) and that they should be directly involved in the decisions that affect  
48 them (36) [P13] "somebody in my position I'm more independent so I wouldn't want people to make  
49 decisions for me that I don't know about" and how things get done around the unit (38). This was  
50 the case even when people may lack capacity to be fully engaged in the process [P19] "Especially  
51 with some people that are not, maybe not all there in their mind, but you've still got to treat them as  
52 if they [are] .....trying explaining to them, maybe, things in a different way, and don't lie to them".  
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3 Direct involvement was viewed as more important than involving family and friends in decision  
4 making (31). [P9] "I can make me own decisions properly now, a rational decision whereas before I  
5 couldn't make a rational decision" [in previous environment]. In this factor, family can be seen here  
6 as an obstacle to independence; [P 26] "they [families] do take a lot of the independence off a  
7 person,.... they think they have good reason to, risk they might fall, they might harm themselves and,  
8 you know, we do disable the elderly" and [P 26] "Why are you letting my dad go out, he's not safe?"  
9 "Well, if he wants to go out, it's his choice" Respect for privacy (47) was also more important to this  
10 group, either seen as a fundamental principle "people respect each other's privacy....?...well...duh"  
11 [P26] [i.e. that's obvious] or as a reaction to a previous poor residential situation [P14] "before it was  
12 one constant worry about.... have you locked your door? [in previous accommodation]. We had  
13 notes literally stuck on the [front] door saying, do not open this door" [family member]. The relative  
14 negative emphasis on constantly helping people to feel at home (29) reinforced the view of the need  
15 for an autonomy based environment.  
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### 24 Discussion

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27 The twin objectives of this study were the exploration amongst system-wide stakeholders of pre-  
28 defined statements reflecting a healthy relational environment in extra-care, and using the  
29 responses to inform a relational framework for use by health and social care leadership. The first  
30 objective was met by capturing the subjective views of 48 relational statements across an extra-care  
31 community to reveal patterns of meaning. The second objective was met by establishing factors that  
32 can be used to inform the pre-defined framework of statements (Table 2). Analysis of the sorted  
33 statements revealed five distinct perspectives emerging from across the stakeholder groups. Factor  
34 1 'All together now' was the most loaded factor and occurred across all groups with a traditional  
35 emphasis on empathy, a key element underpinning compassion, as a driver for quality relationships  
36 within the community. Factor 2 'Respect as a two-way street' focussed on the need for recognition  
37 and achievement and was a view expressed predominantly from external stakeholders who had less  
38 contact with residents.  
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47 The third factor 'Free spirits' comprised predominantly younger and more outward facing residents  
48 who suggested they desired greater contact with the external community. People loading on Factor  
49 4 'Families...strengths and challenges' were senior permanent staff and professional external  
50 stakeholders with decision making responsibilities. It could be noted these people have a strong  
51 sense of establishing cohesion across the whole system and may be more alive to the influence of  
52 others on the core relationships between staff and residents. The fifth factor, 'Helping hands'  
53 emerged predominantly from family members who had relatives that had arrived at the housing unit  
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3 often from highly insecure and stressful environments. This factor also included a younger resident  
4 with a newly established desire for outward facing activity in the light of successful transition.  
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7 There were no clear consensus statements (statements with the same positioning across all factors)  
8 but the two in most agreement were 'Different people can take the lead when things go wrong' (1)  
9 which was viewed neutrally across all factors (i.e. placed centrally within the concourse) and the  
10 statement 'When something goes wrong someone is found to blame' (12) which was mostly  
11 considered as relatively less important across all factors. This low positioning of blaming is reflected  
12 in wider older adult research where the inverse of blame, forgiveness, is viewed as having important  
13 potential for acting as a social lubricant (Girard & Mullet, 1997).  
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18 Risk was also largely viewed as of lesser importance by participants, including most staff, in respect  
19 of relationships. The extent that people will take positive risk (1) has capacity as an important  
20 component of building stronger inclusive communities (Morgan, 2013). For one participant this  
21 could only occur when assessed needs were fully met and then 'risks can be stretched without  
22 compromising [safety]' [P15]. However, on the whole people tended to interpret statement (1) in an  
23 almost wholly negative light and something that should be avoided. This reinforces the difficulty in  
24 overcoming entrenched and important perspectives e.g. all risk is bad, to support a more relationally  
25 focussed community, where managed risk can be constructive. The statement 'Peoples culture and  
26 traditions are respected' (48) was not viewed as relatively important in any of the five factors. This  
27 was reflected in interviews where people viewed the community to be homogenous (White/British).  
28 This statement may be viewed differently in other older care communities where black or minority  
29 ethnic groups are increasingly represented (Mold et al., 2005) and where culturally inappropriate  
30 care maybe a barrier to some ethnic communities service uptake (Jewson et al., 2003).  
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35 An additional contribution of this work was the highlighting of the impact on relationships of the  
36 evolving notion of extra-care, and the nature, limits and balance between independence and  
37 benevolent care. Ambiguities around the meaning of extra-care are well- known (Baker, 2006), and  
38 we observed how this influenced decision making amongst staff and stakeholders, specifically about  
39 when and how to intervene with residents. For example, one participant [1] saw these ambiguities  
40 as a barrier to trust forming, as clear routines were taking time to emerge that would then enable  
41 people to move beyond rigid rule following. Developing common perspectives of the extra-care  
42 concept on the ground becomes even more important in facilities with mixed communities where  
43 the needs of specific groups such as dementia sufferers may be neglected (O'Malley & Croucher,  
44 2005).  
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### Research limitations

The study was conducted with a variety of stakeholders from a single extra-care community in order to provide a framework which does not delineate between different communities e.g. residents and providers but seeks to find common ground. Caution must be used in generalising from results as the emphasis of Q methodology is on establishing a population of viewpoints and not participants (Watts & Stenner, 2005). The emerging social context in a new extra-care facility was chosen as a transition point when immersion into a new environment would make the nature of relationships, old and new, salient to everyone. A potential limitation of this approach was that there was an inevitable settling in period for new residents and staff. This emerged as of specific importance for those residents arriving from relatively impoverished or insecure environments. However, a survey for a larger and more robust framework can now be informed by the viewpoints expressed and captured in the factors based on a whole system perspective of key indicators that could be more readily compared across contexts.

The behaviours, processes and practices that underpin the statements come from a wide range of literature and have been co-created with the academic/practitioner group. However, what constitutes a quality relationship is complex so it is possible that relevant characteristics in relation to Extra-Care were omitted although the statements were cross checked with participants during the Q sort procedure, and there were no additional attributes suggested that were not covered within the present statement set. People responded well to the process of sorting the statements, commenting that the process had helped them to think about relationships from the community perspective. Management of the facility also organised information sharing events for different stakeholders based on key findings.

### Implications for practice

Management tools that can be usefully deployed to build, maintain, and enhance community level relations are rare (Collins, 2014), hence results here may be of interest to other care settings where a whole system view of relationships needs to be considered such as palliative care settings where strong and resilient relationships between providers and patients, families and work colleagues are at the core of the provision of service (Walshe & Luker, 2010).

The five emergent factors, used in conjunction with the predefined statement framework (Table 2), may help management to consider strategies for managing community wide relationships. For example, a community that had a dominant 'free spirit' perspective amongst the community may neglect some of the more compassionate elements required to consider the needs of more

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3 disadvantaged groups. This could influence the recruitment of staff. For example, management  
4 might seek to consider the relational perspectives, based on the framework, before employing new  
5 staff as this may have an impact on care approaches across the system as a whole. For residents and  
6 families it might prove useful to consider the impact they have on the running of the facility through  
7 the way they seek to conduct their relationships and their preferences and expectations for  
8 relational behaviour as constituted under the five factors. For example, those requiring a preference  
9 for 'free-spirited' supporting relations could be assisted by staff who develop a less interventionist  
10 approach and employ managed risk strategies.  
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For Peer Review



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Table 1 Factor matrix with an \* indicating a 'defining sort'

	QSORT PP	F1	F2	F3	F4	F5
1	2FCSLM	0.0247	0.209	-0.0505	0.3780*	0.3459
2	5FASHS	0.5919*	-0.0137	0.1747	0.1281	0.3652
3	6FCSHM	0.4687*	-0.1066	0.4354*	0.5138*	0.1173
4	7FF1LD	0.1663	0.386*	-0.0674	0.0393	-0.088
5	8FD1LD	0.1601	0.1939	0.2863	0.4530*	-0.3274
6	9ME2LS	0.0592	0.4460*	0.5905*	0.163	0.1981
7	10MG1LM	0.5404*	-0.0212	0.3346	0.0198	0.2705
8	11FG1LM	0.4862*	0.1643	0.3671	-0.0477	-0.0038
9	13MD2LS	0.0772	0.0712	-0.1132	-0.1485	0.5549*
10	14FCFLM	0.6559*	0.1437	0.1439	0.2142	0.0972
11	15MCTH	-0.0245	0.0577	0.1	0.4870*	-0.0716
12	17FDFLM	0.4660*	-0.1111	0.0447	0.4525*	-0.1397
13	18FDFLM	0.378	-0.0043	0.4768*	0.1573	0.1236
14	19FAPLS	0.4993*	0.2341	0.4259*	0.1402	0.4183*
15	20MBSLM	0.5479*	0.2883	0.0365	0.2067	0.2851
16	21FCSLM	0.3962*	0.2507	-0.1939	0.1365	-0.0261
17	22FCTH	-0.0922	-0.0537	0.1994	0.0304	0.5558*
18	23FCTH	0.3845*	0.2936	0.0084	0.2076	0.2064
19	24MDPHM	-0.1124	0.6769*	-0.0244	0.3722	0.1599
20	25FAPLS	0.4669*	0.0304	0.4743*	-0.142	0.103
21	26FCTH	0.2616	0.6751*	0.2364	-0.0352	-0.1206
22	27FF2HW	-0.0152	0.0264	0.4903*	0.1389	-0.0984
23	28FBPH	0.3825*	0.1384	0.0431	0.4304*	0.2915
24	29FBPM	0.5301*	0.0146	-0.0421	0.0002	-0.1227
25	30FBSL	0.6154*	0.1861	0.1287	0.0639	-0.0359
26	31FEFLM	0.7717*	0.1265	0.098	-0.1009	-0.1878
27	32FDTH	0.09	0.5914*	0.2674	-0.0828	0.2684
	<b>Eigenvalues</b>	6.4348	1.7571	1.3508	1.3383	1.2575

Significant loadings ( $p < 0.01$ ) are indicated with \*

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Table 2 Relational statement matrix (including organising relational themes and socio-technical categories) showing Q sort statement descriptions and Factor Scores(1-5)

Q Sort No.	Relational statement matrix		Q Sort Statement	Factor1	Factor 2	Factor 3	Factor 4	Factor 5
	Socio-Technical	Relational themes						
1	Culture	Trust	People will sometimes take risks to help each other	-5	0	-2	-5	0
2	People	Trust	Families or carers get on well with staff	3	1	1	5*	-3*
3	Process	Respect	There are opportunities to begin activities with others inside the unit	-1	1	1	0	1
4	Infrastructure	Trust	There are opportunities to begin activities with others outside the unit	-2	0	1	-1	2
5	Culture	Compassion	Everyone works together to get things done	0	2	2	2	-2
6	Culture	Trust	Everyone has an opportunity to help others	-1	-4*	0	-1	2
7	Culture	Compassion	Everyone is generally open and honest	2	0	1	-1	0
8	People	Integrity	Residents see the same staff everyday	4*	-3	-1	0	1
9	People	Fairness	There are others around who share the same background	-3	0	-3	0	1
10	People	Trust	Different people can take the lead when things go wrong	-2	0	0	-2	0
11	Process	Trust	When things go wrong people feel there is always someone tell	4	-1	3	3	1
12	Culture	Trust	When something goes wrong someone is found to blame	-4	-5	-5	-5	-5
13	People	Trust	The people around the unit have each other's best interests in mind	2	2	0	-3	-4
14	Process	Integrity	There are lots of questions and discussions about how to improve things	0	-1	-1	1	0
15	People	Fairness	People will challenge each other if they think something is wrong	-4	-1	-3	0	-3
16	Process	Compassion	When arguments or fall outs happen there is a clear way of sorting things out	0	-3	0	2	-1
17	Culture	Integrity	Staff share the same idea of 'how things should work around here	-1	-4	-2	-4	1
18	Culture	Integrity	If others say they will do something they generally do	-1	0	-1	-3	2*
19	Process	Integrity	Residents only have to tell staff things once	-3*	-2	-1	-2	-1
20	People	Compassion	People are prepared to give and take when they disagree	-2	-3	-4*	-2	-1
21	Infrastructure	Respect	Residents have a lot of say over their personal environment	1	1	0	1	5*
22	Process	Trust	Residents expectation of their future is shared by the staff	-2	1	-4	-3	-3
23	Infrastructure	Integrity	There are a number of different areas where everyone can go and mix with others	0	-2	3	2	4
24	People	Integrity	There is the right mix of skills amongst the staff	2	-2	0	3	1
25	Infrastructure	Integrity	Residents can contact family and friends when they like	4	1	4	3	2

26	Process	Integrity	Everyday activities are carefully planned	0	-4	-2	0	-2
27	Culture	Compassion	People have the time to talk and listen and share stories	0	0	-1	4*	-1
28	People	Compassion	Everyone is treated as a whole person	5	2	1	3	4
29	Process	Compassion	A constant effort is made by others to help residents to feel at home	3	0	4	4	-3*
30	Infrastructure	Compassion	People get pleasure from being with other residents and staff	2	-1	2	4	0
31	Culture	Fairness	Families friends or carers are able to contribute to decisions that affect the residents	3	1	2	2	-4*
32	Process	Compassion	When someone is new a lot of effort is made to help them to settle in	2	4	5	5	-1*
33	Culture	Fairness	Everyone is treated as equals	5	3	4	2	3
34	Process	Fairness	People are involved in all decisions that affect them	1	4	3	1	3
35	Process	Fairness	Everyone could change the rules if they really tried	-5	-2	-5	-4	-2
36	Process	Fairness	Residents know why decisions that affect them are made	0	-1	-1	0	5*
37	People	Trust	People should feel they can freely express their emotions	1	3	5	0	-2
38	Process	Fairness	Residents understand how things get done around the unit	-2	-3	-2	-3	2*
39	Culture	Respect	Residents are addressed in an appropriate way e.g. Mr/Mrs	1	2	-2	-4	0
40	People	Respect	Others recognise the things people want to achieve in the future	-3	-1	-4	1*	-2
41	Culture	Respect	Peoples culture and traditions are respected	0	3	2	-1	0
42	Infrastructure	Fairness	Residents have regular access to the telephone or internet	-3	-2	3*	-1	0
43	Process	Integrity	The organisation has very strong rules and procedures	1	-5	-3	0	-5
44	Culture	Respect	Everyone's age is respected	1	5*	1	-2	-1
45	People	Respect	Residents previous life achievements are recognised by others	-4	4*	-3	1*	-4
46	People	Respect	Everyone has the opportunity to contribute their skills or knowledge	-1	5	0	-1	3
47	Infrastructure	Respect	People respect each other's privacy	3	2	2	-2*	4
48	Infrastructure	Fairness	Residents have easy access to the local community	-1	3	0	1	3

Significant loadings (p<0.01) are indicated with asterisk (\*)

Table to shows the comparative rankings given to each item (statement) within each of the 5 extracted factors. For example, Factor 1 ranks statement 1 at -5 and statement 2 and +3. Each row indicates how the statement was ranked across all 5 extracted factors.

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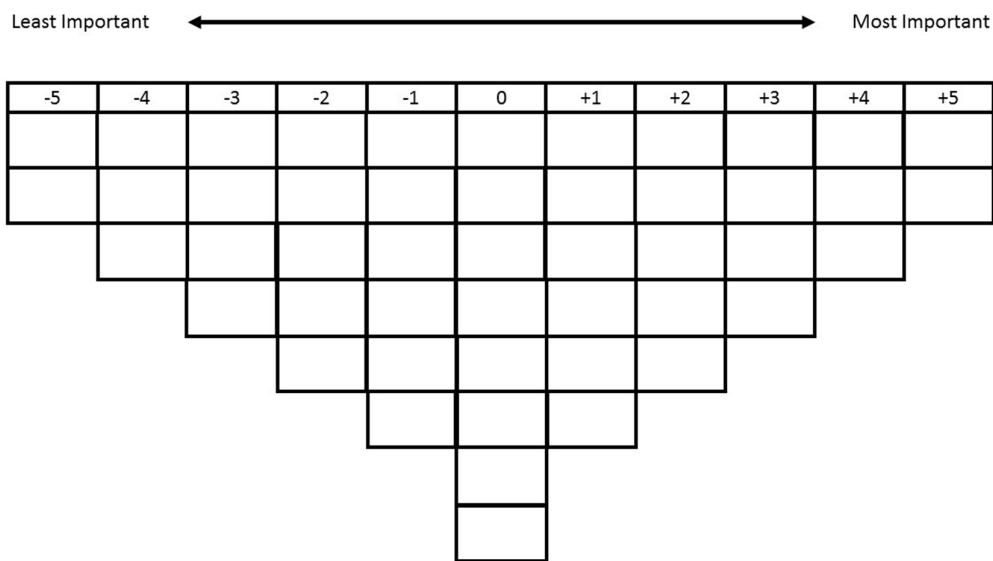


Figure 1 Q sort grid pattern for placement of individual statement cards

Peer Review