
Evidence-informed Performance Improvement Series No 2

National Performance Indicator: increase the percentage of people aged 65 and over with high levels of care needs who are cared for at home

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Full Report

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Introduction

It is widely acknowledged that the majority of people wish to remain at home throughout their life rather than be admitted to institutional care (see for example Eckert et al, 2004). Government policy has actively supported the transition from institutional care to community care over a number of years. This review aims to bring together evidence from a number of sources that evaluate interventions that support older people with complex needs to remain at home, in line with the current national indicator in Scotland, that aims to:

Increase the percentage of people aged 65 and over with high levels of care needs who are cared for at home

The Scottish Government has suggested that this indicator is important as evidence suggests that remaining at home enables older people to remain independent for as long as possible. Indeed, evidence suggests that remaining at home can result in positive mental well-being. Cutchin and colleagues in 2009 suggested that a positive outlook on life can enhance mental and physical wellbeing. Elkan and colleagues (2001) have indicated that by emphasising health promotion and other preventative measures we might delay the onset of illness and dependency.

As the older population in Scotland increases, (e.g. between 2005 and 2008 those over 85 increased by 11%, SWIA, 2010) the Government has suggested that innovative approaches to providing support at home that make use of technology will become increasingly important. The pressure on local authorities and all other public sector bodies to “do more with less” is intense, and decisions made now and in the near future could have a significant impact on all public services. In addition the advent of the UK Coalition Government and the pending Scottish Government elections in 2011, all combine to create a challenging environment for the provision of care services. Councils are already working towards making unprecedented cuts in public services likely to impact for some time to come on the type of services provided. Furthermore the Scottish Civil Service has already commenced planning up to 25% reductions for the end of the Budget cycle, with 10% reductions to be achieved by April 2011 (MHO Newsletter, 2011). It has therefore never been more important to be able to evidence effectiveness in models of practice if they are to continue to be supported.

This review will provide an overview of the evidence available on the range of measures and services that currently support older adults with complex needs to remain in their own homes. It will present the best available research evidence to highlight “what works” in this area, providing examples of good practice and relevant research studies where appropriate.

A note on terminology

During the review it was recognised that there were significant challenges in defining “higher level needs”. It is further important to note that the relationship between needs and the provision of support is complex, oftentimes simple solutions can be provided for what are deemed complex needs and more complex interventions required for what may seem like a simple need. Therefore establishing a definition for higher level needs was important for the research.

Home care statistics for Scotland in 2010 (Scottish Government, 2010a) indicated that inputs of over 10 hours a week are seen as intensive packages of support. This level of support package has been increasing steadily since 1998 and is now aimed at 18.1 people per thousand population as of April 2010. This amounts to 30% of those receiving home care, an increase from 11% in 1998. However other measures of higher level needs would appear to indicate that it relates to those receiving more than 20 hours of home care each week. This proved to be challenging for the researchers in identifying literature appropriate only to this group of service users. A decision was taken to include literature that focused on those aged over 65 with needs identified as higher level, complex or intensive. If a study had as part of the core sample those over 65 with no indication of level of need this was excluded. As an indicator of higher level need, sample groups who received interventions from both health and social care were included.

Methodology

Literature Search

A combination of database, manual and citation searches was used to identify key studies and grey literature. The following databases were searched: ASSIA, Social Services Abstracts and Sociological Abstracts (all through CSA), COPAC and ISI Web of Knowledge. Search strategies were designed to be sensitive to the range of available literature and were refined on an iterative basis following examination of initial search results and feedback from key informant interviews and in discussion with the Research Advisory Group.

Further material, particularly grey literature, was not identified via this search strategy. We accessed the principal types of grey literature of relevance to the study including policy documents, expert opinion pieces and unpublished primary research via the Research Advisory Group members and individual interviews with key informants. In addition contact was made with home care managers across Scotland to try and identify unpublished locally commissioned work. Websites of key organisations that hold repositories of research including the Scottish Government, Department of Health, Social Care Institute for Excellence (SCIE) and relevant centres of excellence such as the Dementia Services Development Centre, Centre for the Older Person's Agenda and the Scottish Consortium for Learning Disability were also undertaken.

Inclusion criteria

1. Studies since 2000 that address the aims described above, undertaken in Scotland, or with clear applicability to a Scottish setting (e.g. recent non-Scottish UK studies with clear relevance to the National Indicators above).
2. Policy documents and expert opinion, since 2000, with clear relevance to the Scottish context.

International studies and studies completed prior to 2000 were excluded unless they were frequently cited in 1. and 2., and were therefore regarded as seminal.

All primary studies were further subject to quality appraisal in order to decide whether they merited inclusion. All other literature sources that were not primary studies were included on the basis of relevance to the National Indicators and the contemporary Scottish context.

Data Extraction and Synthesis

A data extraction template was developed and used to extract data from each selected source. The researchers met to discuss each study and the data extracted from it to ensure consistency and reliability (where practicable). Analysis of the material followed principles for robust qualitative research, to elicit a narrative review. In addition to the above during the course of the review, clarification was sought over a range of other issues following which additional exclusion and limitations were agreed as follows:

- Wellbeing in intermediate care settings: only where it focuses on older people with complex needs returning home.
- End of Life Care: Exclude
- Abuse: Exclude
- Getting people home from various locations rather than maintaining them at home: only where this is specific to older people with higher level needs and not where it focuses principally on process
- Costs of different models of care: only robust useful examples

Key informant interviews

Interviews were carried out with a number of key stakeholders representing the interests of the Scottish Government, ADSW and COSLA to test out the key themes emerging from the literature and to find unpublished locally commissioned work.

Policy Context

The care and support of older adults in Scotland, and across the UK as a whole, has been subject to myriad policy developments in recent years. Key policy drivers relate to further shifting the balance of care from institution to community and the promotion of independence. As a result the majority of recent developments are focused around anticipatory care and re-ablement.

What follows is an overview of key policy developments in Scotland, presented according to three major themes:

- Promotion of choice
- Shifting the balance of care
- Focusing on outcomes for older people

We focus primarily on Scotland but highlight policy developments across the rest of the UK where these are of particular relevance or thought to offer examples of the broader direction of travel.

Promoting Choice

A recurring theme across a range of policy documents in Scotland and elsewhere is an increased priority of promoting choice for people who use services, including the choice to remain at home and receive person centred services that promote independence (e.g, Changing Lives, 21st Century Review of Social Work; Scottish Government, 2007a; Scotland's Dementia Strategy Scottish Government, 2010b). This reflects the broader personalisation and self-directed support agendas that promote transferring the location of power, decision-making and expertise from the health and social care system to service users and their families (ADSW, 2009; Scottish Government 2009a).

Personalisation, Self-Directed Support and Individual Budgets

Self-directed support involves re-designing the social care system in order that people who require support can take much greater control. There have been significant developments across the UK in promoting this agenda as a way of underpinning the development of personalised services. Direct payments and individual budgets give people who use social care services, the opportunity to control the resources allocated to their support – essentially they are provided with cash for care. This care and the cash associated with it can be provided in different ways, e.g. using the in-control model, individual budgets and direct payments (SCIE, 2009a - <http://www.scie.org.uk/publications/briefings/briefing20/index.asp>). Recent figures from England indicate that one in four adult service users now use a personal budget (however described) to purchase and organise their care (Community Care, 5th November 2010), this is an increase of 68% from

March 2010, although progress varies across councils. Councils in England are expected to have 30% of eligible service users using personal budgets by April 2011¹.

Evaluation of similar initiatives in England, have found that older people with higher level needs require additional support to take advantage of the opportunities presented by the various models of self-directed support, (Glendinning et al, 2008). Further, the benefits of such initiatives do not appear to be enjoyed equally by all service user groups. Whilst there has been positive reporting of outcomes and views of service users to this approach to service delivery, there have been exceptions for older people, see for example the evaluation of the three phases of the work of In-control on <http://www.in-control.org.uk> and the work carried out to evaluate the individual budget pilots in England, (e.g. Manthorpe et al, 2008). However it has subsequently been posited that this may be because older people, particularly those with more complex needs require more time and support to get the most from individual budgets (SCIE, 2009).

A recent study by the Audit Commission in England (2010) found that personal budgets did not save money for local authorities but that they did produce better outcomes for service users and were consequently value for money. However it noted that more work on the financial cost of personal budgets was required on a medium to long-term basis and that resource allocation systems were needed to ensure personal budgets were sustainable. In addition the report noted that councils needed to develop more effective mechanisms for monitoring spend on personal budgets. The Scottish Government has commissioned a study to examine the financial benefits of self-directed support in more detail. This study will be undertaken during 2011/12.

Personalisation and people with dementia

Currently uptake of direct payments amongst people with dementia is very low. Research by Alzheimer's Scotland (2010) has identified a number of barriers that have limited the wider implementation of the personalisation agenda to include people with dementia.

In order to increase take up, they recommend:

- Increasing potential recipients' awareness
- Improving understanding within social work departments of the potential benefits of direct payments for people with dementia

¹ A strategy for delivering self-directed support across health and social care in Scotland was published for consultation early in 2010 (Scottish Government, 2010c) and analysis of the findings published in September 2010, (see <http://www.scotland.gov.uk/Publications/2010/09/24110530/2> for further information). One outcome of the consultation was a proposal for self-directed support legislation and a draft bill was circulated for consultation in early December 2010, See <http://www.scotland.gov.uk/Publications/2010/12/15105332/23> for further details.

- Streamlining systems with reduced bureaucracy and a quicker process
- Improving support and information and making reporting requirements more straight-forward
- Working with local authorities to ensure parity in the operation of direct payments
- Adapting legislation to allow an appropriate person to talk on the management of the direct payment on behalf of the person with dementia when the person lacks capacity and there is no one with Guardianship or Power of Attorney
- Introducing a straight-forward process for health money to be included in direct payments

Co-production

A SCIE research briefing (2009b) notes that the term 'co-production' is increasingly being applied to new types of public service delivery in the UK, including new approaches to adult social care. It refers to active input by the people who use supports to meet their needs as well as – or instead of – those who have traditionally provided them. So it contrasts with approaches that treat people as passive recipients of support designed and delivered by someone else. It emphasises that the people who use services have assets, which can help to improve those services, rather than simply needs which must be met. These assets include the skills, expertise and mutual support that service users can contribute to effective public services. Cummins and Miller (2007) note that, co-production is about how services 'work with rather than do unto users'. Many of the approaches taken to working with older people with complex needs now exhibit this philosophy for example, outcomes focused assessment, self-directed support and personalised services. Consequently co-production is used as a way of talking about participation and community involvement in social care services. This concept has implications for how services are designed, commissioned and managed in the future in a way which promotes the participation of service users and carers (HM Government, 2007)².

Shifting the balance of care

In Scotland, perhaps the most significant initiative in recent years to ensure older people and others remain at home for as long as possible is the Shifting the Balance of Care agenda. Shifting the Balance of Care (SBC) describes changes at different levels across health and social care systems – all of which are intended to bring about better health outcomes for people, provide services which reduce health inequalities; promote independence and are quicker, more personal and closer to home. The *Shifting the Balance of Care – Into the Spotlight* report (Scottish Government, 2008a) provided an update into the development of an improvement framework aimed at shifting the balance of care from institution to the community. It identified eight

² The full SCIE briefing can be accessed at: www.scie.org.uk/publications/briefings/briefing31/index.asp

improvement areas, which were key to the delivery of national and local outcomes and targets. To:

- maximise flexible and responsive care at home with support for carers
- integrate health and social care for people in need and at risk
- reduce avoidable unscheduled attendances and admissions to hospital
- improve capacity and flow management for scheduled care
- extend the range of services outside acute hospitals provided by non medical practitioners
- improve access to care for remote and rural populations
- improve palliative and end of life care
- improve joint use of resources (revenue and capital).

The Shifting the Balance of Care Improvement Framework is viewed as crucial to working with stakeholders with acute, primary, social care and housing interests and has been drawn both from existing policy initiatives and wide stakeholder discussions. It brings together key policy strands and collaborative processes into an overarching framework that aims to help health boards and their local authority partners to deliver HEAT targets and better community care outcomes. In considering the evidence base for shifting the balance of care an overview of the evidence was produced for the Scottish Government by Johnson et al (2008). The key elements of the evidence base for shifting the balance of care were considered at four levels, focus, location, responsibility and professional roles. Evidence was sought which could aid in:

- shifting the focus to prevention with quicker access to appropriate support which is closer to home as well as integrated continuous care rather than episodic care
- shifting the location of services, particularly from acute setting to community hospitals and other local facilities, to facilitate easier access for those requiring support.
- shifting the view of those who require supports as passive in the process to one which promotes partnership in the management of their needs. This will include providing access to support which promotes independence such as telehealth, telecare and reablement
- shifting the emphasis away from individual professionals to integrated care pathways.

The evidence identified included the following as interventions or models, which could assist in shifting the balance of care.

Shifting the Focus

- assessment and care management
- multi-disciplinary working
- integrated care for older people, particularly those with long term conditions

- disease management
- early supported discharge
- rehabilitation in the community

Shifting the location of care via

- housing adaptations and equipment
- support discharge, particularly for older people
- early supported discharge for older people
- care at home and hospital at home interventions
- community hospitals
- day hospitals.

Shifting responsibilities via

- telephone support services
- telephone consultation
- self-care support
- self-monitoring of long term conditions

The study also identified gaps in the knowledge base including, details of the potential of preventative and assessment-based interventions, the role appropriate housing could play and the impact on carers on shifting the balance of care³. The Shifting the Balance of Care Improvement Framework directly supports the delivery of HEAT targets and Community Care Outcomes, which inform Single Outcome Agreements and the Scottish Government National Performance Framework⁴.

Reshaping Care for Older People

The Scottish Government (2010d) suggests that the current demography and anticipated changes over the next 20 years mean that existing models of care and support for older people are simply not sustainable in the long term. Therefore, the Scottish Government, the NHS and COSLA have developed a programme of work streams to explore the most effective ways of providing support to an increasing number of older people. A range of key messages across the work streams have been identified including:

- by 2033 the number of people aged over 65 in Scotland will have increased by 64%

³ For further information on the evidence base for shifting the balance of care see the overview carried out by Johnson et al for the Scottish Government (2008) at the link below:
<http://www.scotland.gov.uk/Publications/2009/08/07143830/11>

⁴ Links between the improvement framework, community care outcomes and the HEAT targets can be found at:
<http://www.shiftingthebalance.scot.nhs.uk/improvement-framework/>.

- preliminary baseline costs projections to 2033 for care imply real increases of 158% for care homes; 107% for care at home; 88% for day care (with slight reductions in expenditure for those under 65 partly offsetting a higher rate of increase for those aged 65 and over)
- those requiring care are likely to have higher level health and social care needs
- long term review required to assess the type and size of workforce required to provide care to older people
- analysis required of existing educational opportunities for the social care workforce
- develop clear learning and career frameworks for those working with older people
- promote and develop volunteering in social care and the NHS
- specific developments required to develop the rural workforce
- provide support to those in the caring workforce who are also informal carers
- enable social care and health staff to remain in work longer by developing flexible working practices.
- professional qualifying courses need to reflect the requirements of working in the 21st century including integrated approaches, use of technology (telecare etc), developing a mutual partnership approach with informal carers and a focus on outcomes/ personalisation/ enablement⁵.

National Dementia Strategy, (Scottish Government, 2010)

Relating specifically to people with dementia, the Scottish Dementia Strategy (Scottish Government, 2010b) echoes many of the messages found within Shifting the Balance of Care. One of the key priorities is to ensure people receive appropriate care and treatment in all settings. Since 2007, local authorities have been developing innovative approaches to enable more people to live at home, with their families, for longer. In addition, the National Telecare development programme (Scottish Government, 2006) has been established and is having an impact on the lives of people with dementia.

The strategy has suggested that people with dementia who have other health problems are more likely to be inappropriately admitted to hospital and are more likely to remain in hospital for longer, to the detriment of their own wellbeing. They are also more likely to be discharged to a care home. The strategy has argued that inappropriate admissions can be addressed by increasing the availability of step up intermediate care services that offer a temporarily higher level of care for someone living at home to cope with a short-term need, instead of the person going into hospital.

⁵ For further information on the development of the Reshaping Care for Older People work streams please see link below:
<http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/>

Upon discharge from hospital, facilitating a return home should be the starting point, as it usually is for other patients. People with dementia in hospital are often further disabled and confused by the hospital environment and by their physical ill health and therefore may appear less able to cope at home than is the case. Step-down facilities, which offer rehabilitation following a hospital stay can increase the number of people who return to their own homes.

The Scottish Government believes that improved post-diagnostic services will increase capability, allow for planning and better management of the illness over time and therefore delay the point at which a person might need access to a care home or other intensive supports. The government aims to reduce unnecessary hospital admissions by providing a higher standard of care at home or at times though intensive support. This will reduce direct costs to the NHS and reduce the costs that fall on local government. This is because the temporary extra support will prevent or delay admission to a care home⁶.

Outcomes Focus

A focus on outcomes is also inherent across the policy agenda, which impacts on older people with high level care needs (e.g. Community Care Outcomes Framework – Scottish Government, 2008). Outcomes are understood as the impact of services or supports on people's lives. Defining user and carer outcomes is increasingly recognised as necessary in order to deliver effective, responsive public services (Glendinning et al, 2006). This includes a range of mechanisms for measuring outcomes, including the Talking Points initiative in Scotland, which focuses on outcomes-based assessment (see the JIT website for further information). Glendinning et al (2007), building on work reported in 2001 (Quereshi and Nicholas, 2001), in a survey of managers and practitioners in England and Wales, known to be interested in developing outcomes focused services defined outcomes in the following way:

Change outcomes:	relate to improvements in physical, mental or emotional functioning
Maintenance outcomes:	prevent or delay deterioration in health, well-being or quality of life
Process outcomes:	relate to the experience of seeking, obtaining and using services

The development of outcomes-focused services is increasingly important, as users of such supports have reported improvements in confidence and physical functioning. A major challenge relates to the long-term provision of maintenance outcomes. Staff working on re-ablement programmes, for example, were concerned that once significant change outcomes had been

⁶ The evidence base of the recommendations made in the dementia strategy is considered in more detail throughout this report

achieved there was limited scope for focusing on maintenance outcomes. Inflexible commissioning arrangements were highlighted as a significant barrier. It was found that national policy is necessary to facilitate an outcomes focused approach, coupled with local commitment and strong local leadership. Wider partnership working is also viewed as essential, although a number of difficulties relating to a lack of shared meaning and understanding by different professional groups have been identified (Glendinning et al, 2007).

Care Pathways

Bringing all of the above together is the concept of a “care pathway”. A care pathway is an intervention for the mutual decision-making and organisation of care processes for a particular group of patients during a defined period. Characteristics of care pathways include:

- (i) An explicit statement of the goals and key elements of care based on evidence, best practice, and patients’ expectations and their characteristics;
- (ii) the facilitation of communication among team members and with patients and families;
- (iii) the coordination of the care process by coordinating the roles and sequencing the activities of the multidisciplinary care team, patients and their relatives;
- (iv) the documentation, monitoring, and evaluation of variances and outcomes; and
- (v) (v) the identification of the appropriate resources.

‘The aim of a care pathway is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction and optimising the use of resources’ (Vanhaecht et al, 2007).

Evidence to date suggests that integrated care pathways have improved process indicators and there was some suggestion of improved length of stay with no apparent effect on outcome. Evidence has been found that integrated care pathways have made a difference for both patients and staff (see for example Kent and Chalmers 2006; Furley et al 2006), particularly in ensuring clarity of process.

Discussion

Clearly, the policy framework in relation to services for older people has changed substantially over the last ten years. There is increased recognition of the services required by older people with complex needs to enable them to remain at home for longer and there is a growing commitment to promoting choice for older people in relation to their support packages. Yet despite these policy drivers there is little evidence that older people are

consistently able to choose to remain at home. For example in 2009 older people in Scotland were twice as likely to live in care homes than to receive intensive home care and total home care hours fell. In addition, despite targets to reduce unplanned admissions to hospital for older people there was a 14% increase between 2004 and 2009 (SWIA 2010). It was further acknowledged that there was a wide variation between council areas and that this discrepancy required further exploration.

However perhaps the renewed commitment to shifting the balance of care exhibited by the Scottish Government through a range of initiatives, e.g. the focus on home care re-ablement signals an increase in choice for older people to remain at home regardless of their level of care needs. In addition, given the significant financial constraints being experienced by local authorities and indeed central government; innovative, cost effective ways of supporting people in the community are likely to be viewed positively.

Literature Review – Issues, Evidence and Good Practice

Practice Issue One: Assessment and Care Management

Single Shared Assessments/Integrated Assessments

Key messages:

- The evidence as to whether single shared assessment does in fact avoid duplication is mixed.
- Evidence on the impact of SSA in providing timely support to maintain older people at home is patchy and uneven.
- Training needs to target all staff to ensure consistency. This training must be underpinned by commitment at management level in the form of guidance and on-going support

Research findings:

Single Shared Assessment integrates assessment and service delivery across nursing, occupational therapy, physiotherapy, social work services and addiction services. It brings together what were previously separate processes for referral, assessment, planning for care and service delivery into one shared process. Professionals use an agreed set of shared paperwork.

The need for single shared assessments arose from concerns expressed by both service users and practitioners with regard to a number of key areas. In particular, multiple agency contacts requesting the same information from service users and carers, disagreements between professionals on the needs of individuals, fast access to the resources of other agencies and underreporting of unmet needs (Clarkson et al, 2009). A single shared or single assessment process was introduced to remove the barriers between organisational assessments (including shared recording systems) and to reduce duplication for service users. In Scotland the development of the single shared assessment built on work carried out in developing a single assessment process for people with dementia and older people (Carenap D and E Scottish Executive, 1998) and was generally promoted under the Joint Future agenda (Scottish Executive, 2000).

The evidence of the impact of SSA on the process of assessment, reduction in multiple contacts and timely delivery of services is patchy and uneven. For example, a study of the impact of the single assessment process in Manchester found that where single assessment procedures were applied, the probability of detecting need was higher than before (Clarkson et al, 2009). This was particularly evident where service users experienced depression and cognitive impairment. This suggests that early detection and application of

interventions could maintain older people at home for longer. Likewise Christianson and Roberts (2005) provide evidence that SSA avoids duplication and results in the faster provision of care. However work carried out in a large urban authority in Scotland by Eccles (2008) suggests that the implementation of SSA has been driven by process rather than outcomes and has to date not delivered on its stated aims for example in reducing duplication for either workers or service users and that the benefits were unclear. Likewise, McNamara (2006) found that while frontline workers were committed to the joint working agenda and the shared assessment process, further training was needed to explore differing professional cultures, roles and remits. A key message is that training needs to target all staff to ensure consistency. This training must be underpinned by commitment at management level in the form of guidance and on-going support. Seddon and her colleagues (2010) highlight the well known challenges relating to a lack of IT systems to support joint working as well as difficulties in identifying common documentation that is fit for purpose. In addition they identify the lack of engagement among GP's as a considerable challenge.

A recent review of the literature carried out by Miller and Cameron on behalf of the joint improvement team in Scotland in 2011, provided an overview of literature on shared assessment. They were able to identify a number of significant challenges relating to the provision of shared assessment as well as a number of benefits. Challenges included:

- Devising appropriate assessment documentation for shared assessment that met the needs of all professional groups. Particular challenges related to the scope and extent of free text boxes (associated with the social model) as opposed to tick boxes (associated with the medical model), a lack of standardisation and difficulties associated with different IT systems.
- Engaging with key stakeholders. Particular challenges related to engaging with GP's, clinicians and the acute sector more generally. Lack of GP engagement in England, Scotland and Wales led to duplication and limited potential to incorporate preventative work (see for example, Eccles, 2008).
- Identification of need and rationing. This represented a particular challenge for staff. Staff concerns about capacity to provide services were found to influence their interactions with service users. This was a particular challenge for social work and social care staff rather than health staff where rationing of services is less apparent.

A number of benefits of shared assessment were also identified in the literature. These included:

- An increased ability to identify and manage risk as a result of greater partnership working and sharing of information between agencies.

- Less duplication and faster access to services. When assessment and care management processes were led by one person, this resulted in improved co-ordination (Christianson and Roberts, 2005).
- Improved standards in relation to assessment and recording of information.
- Improvements in interagency communication and joint working.
- Greater involvement of services users in the form of improved communication between staff and service users.

Implications for Practice

- Assessment tools should be locally developed and flexible in order to reduce duplication and engage both health and social care staff.
- Engagement of key stakeholders including GPs important in developing preventative responses to assessment.
- Clarity about capacity to deliver services is essential to ensure staff do not become disengaged.

Further reading:

Details of shared assessment, links to national outcome frameworks, care planning and review as well as care management can be found at the link below:

<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/SSA>

Seddon D, Robinson C and Perry J (2010) Unified Assessment: Policy, Implementation and Practice. *British Journal of Social Work* 20(1): 207-225

Care Management

Key messages:

- There is no consistent agreement in practice of what constitutes care management despite extensive guidance from Central and Scottish government. While definitions and language can vary a number of key central tasks within care management can be found: case finding, screening, assessment, care planning, implementing care package, monitoring and review.
- The range of professionals undertaking the role and/or functions of care management remains limited
- The evidence suggests that there are very few examples of resources being put in the hands of care managers for the purpose of providing flexible care (Challis et al, 2001)
- Training needs to target all staff to ensure consistency. This training must be underpinned by commitment at management level in the form of guidance and on-going support

Research Findings:

Care management refers to the process of assessing need and co-ordinating services to enable people to continue to live at home (Challis et al 2001). For older people with complex needs this requires a multi-disciplinary assessment, the co-ordination of health and social care input as well as regular review and adaptation of provision to meet changing needs. Whilst early definitions of care management were relatively broad and provided for local interpretation with regard to form, content and target group, the evidence suggested that it was more effective when targeted on those with complex needs, particularly vulnerable older people with long term needs (see for example Scottish Government, 2007). For older people with more complex needs, care management could consequently be defined as intensive care management as in original UK policy documents, (e.g. DOH, 1994; Scottish Office, 1991). Despite the evidence for a specific model of care management, with devolved budgets, agreement on what constitutes care management and where it should be targeted has been difficult to achieve. Local and national variations across both Scotland and the UK more broadly ensure that there is a lack of consistency in how and when care management (and what type) should apply (Challis et al, 2001).

In Scotland, the most recent care management guidance (Scottish Executive, 2005) and its associated circular (Circular CCD8/2004) aimed to reinvigorate and refocus care management. In particular the circular refocused care management on those with complex and/or frequently changing needs. In a study undertaken by Stalker and Campbell (2002) it was found that care management had drifted from the original concept outlined in the guidance produced in 1991 (Social Work Services Group 1991a); that systems to support it effectively were not in place comprehensively; and policy had moved on significantly. In particular, early visions of care management held that control of resources would be placed in the hands of care managers, enabling them to draw on a range of services to provide flexible packages of care. However this particular feature of care management was never extensively developed.

Research has noted that a failure to delineate between co-ordinating types of care management and intensive care management has meant that care management has often been applied inappropriately (Challis, 2001). The terms case management and care management are often used interchangeably although care management is more likely to be used by social care staff and case management is more likely to be used by health staff. Essentially however they have at their core a similar set of tasks including, case finding, screening, assessment, care planning, monitoring and review (Gravelle et al, 2007).

Despite the central policy drive to achieve more effective and better-focused care management for older people the evidence base on care management is inconclusive. In addition there does not appear to be one care management intervention that is better than another (Reilly et al, 2010). Indeed, Sargent

et al (2007) suggests that a specific care management approach adopted in the Evercare pilots in England failed to achieve its aim of reducing bed days and hospital admissions by maintaining frail older people with long-term conditions at home.

Research example:

Challis et al, (2001) Intensive care management at home: an alternative to institutional care Age and Ageing 30: 409-413

This seminal research study published in 2001 contains a number of important messages with respect to care management that are still relevant today. Questionnaires were sent to two social service departments across England with the aim of determining whether intensive care management at home could be used as an alternative to institutional care. Completion rates of 85 per cent and 77 per cent were achieved. The research found that although there is a policy of diverting people from residential to home care, there was little evidence of intensive care management at home. Levels of care management were not always differentiated between or applied appropriately resulting in a failure to address in appropriate admissions.

Implications for Practice:

- Clarity of the model of care management across agencies is essential for successful implementation
- Multi-agency protocol on who should become the care manager, why and for how long should aid in increasing the range of professionals who undertake the role
- Resources should be made available to care managers from across agencies to increase the flexibility needed to achieve outcomes for service users.
- Intensive care management appears to be the most effective method of working with frail older people, this requires clear eligibility criteria and specialist dedicated staff with smaller caseloads (Challis, et al, 2001)

Further Reading:

Scottish Government (2010) Proactive, Planned and Co-ordinated: Care Management in Scotland.

<http://www.scotland.gov.uk/Publications/2010/04/13104221/3>

National Training Framework for Care Management: Resource Pack (web based) March 2006

<http://www.scotland.gov.uk/Publications/2006/05/24093431/0>

Practice Issue Two: Specialist services to maintain people at home, prevent admission to hospital or increase the speed of discharge

In order to provide some level of thematic analysis we have classified support for older people in terms of short term, specialist services alongside more long-term provision. We recognise that models such as home care reablement, rapid response and supported discharge programmes share many common features. Their goals include: enabling older people to remain at home or supporting them to return home sooner, they tend to be short term in nature and are provided by specialist workers. The main difference tends to be the entry point to the service. Inevitably there is some level of overlap in what follows, however we have attempted to draw out common themes across services, highlighting where there are particular implications for one service or another.

Homecare Re-ablement

Key messages:

- Home care re-ablement can reduce the amount of commissioned hours of home care for local authorities
- Home care re-ablement can produce efficiency savings for local authorities of between 28% and 41%.
- Home care re-ablement can offer sustained and significant benefits to service users by increasing their skills, confidence and ability to live independently.
- There is limited but detailed research evidence available on outcomes for individuals over time suggesting improved quality of life, social care outcomes and improved health related quality of life.

Homecare re-ablement can be defined as an input that aims to:

Maximise [service] users long-term independence, choice and quality of life, to appropriately minimise on-going support required and to consequently minimise the whole-life cost of care

(CSED, 2007)

The aim therefore is to increase service users confidence and skills with the eventual goal being a reduction or withdrawal of services required. As a model of care it is relatively new, however an evidence base is beginning to emerge (e.g. Glendinning and Newbrunner 2008, Scottish Government 2009b, DH 2010). In general, there are two models of re-ablement 'intake' and 'discharge support'. Intake services appear to take all service users assessed as requiring re-ablement, excluding only those who will not benefit.

Discharge process services can be more selective only accepting those most likely to benefit.

Research Findings:

Re-ablement includes services for people with poor physical and/or mental health; to help them accommodate their illness by learning or re-learning the skills necessary for daily living. It is important to note that home care re-ablement is not only used for older people with complex needs, however the majority of services developed to date appear to have focused on older people as a group therefore we have included studies where this is the case.

Since 2000, there have been a number of studies evaluating the effectiveness of home care re-ablement, (e.g. Pencheon 2002, CSED 2007, Scottish Government 2009b, PSSRU 2009) and notably a DH website devoted to re-ablement. In addition the Care Services Efficiency Delivery (CSED) programme established in 2004 by the DH in England to aid councils develop and deliver more efficient adult social care including home care re-ablement explored the evidence base for this emerging model of practice. Key elements of home care reablement are viewed as:

- Helping people 'to do' rather than 'doing to or for' people
- Outcome focused with defined maximum duration
- An acknowledgement that assessment for ongoing care packages cannot be defined by a one-off assessment but requires observation over a defined period.

Reducing long-term dependence on support services.

The evidence reviewed suggests that on average a reduction in commissioned hours can be achieved by those undergoing a phase of re-ablement compared to those who had not (see for example, DeMontfort 2000, Scottish Government 2009b). Re-ablement services have, further, been evidenced to reduce input to service users, by over 40% in some instances (Scottish Government 2009b), with 2/3 of recipients requiring no further input at the end of the re-ablement period. In addition re-ablement has been seen to maximise service users long term independence, choice and quality of life and consequently to minimise the whole-life cost of care.

However the evidence further suggests that whilst increased levels of independence had been achieved for individuals through home care re-ablement it was not known how long these could be expected to last. Therefore a prospective longitudinal study has been carried out by SPRU at the University of York and PSSRU at the University of Kent. The interim report (CSED, 2007) suggested that older people who have had home care re-ablement interventions have reduced packages of care following the intervention, including those in the 65+ and 85+ age group with higher level needs. By the end of the study however, comparisons with control groups

receiving traditional home care with no re-ablement element suggested that when taken together there was *no statistically significant difference* in the costs for health care for those in the re-ablement groups with those in the control groups (DH, 2010). Whilst there were savings in social care costs over the study period, £380 compared to the control group, this was also not viewed as statistically significant. In addition, the report concluded that re-ablement was most likely to be effective when targeted at those recovering from acute illness, falls or fractures rather than those with chronic, complex or progressive health problems.

Despite the largely positive evidence base for re-ablement, there has been criticism of the methodology used in some of the studies. Slasburg (2009), for example has suggested that in the DeMontfort study (2000) those allocated a package of re-ablement were those thought to be most likely to benefit. This suggests conversely that those allocated to the control group were less likely to benefit and so it is unsurprising that they required a greater number of homecare hours. He found that re-ablement was unlikely to reduce the number of admissions overall as despite having higher than average homecare provision this has not resulted in fewer admissions to residential care. He suggests that a change in focus from the provision of re-ablement services to the development of a re-ablement culture aimed at all service users is necessary. In addition, concerns about cultural and organisational barriers such as staff attitudes and entrenched traditional home care practice have also been seen to impact on the effectiveness of the re-ablement process (Glendinning and Newbronner, 2008)

Implications for practice:

- Assessment arrangements – importance of assessment being undertaken in service users own home as they are more likely to be able to maximise their functioning in this setting.
- Discharge and onward referral arrangements – in order to avoid delays the re-ablement team should be able to commission services as transferring to a care manager in another setting can cause delays. Ensuring any onward referral is to an appropriate home care agency, who will consolidate the achievements made through re-ablement rather than undermine and create dependence.
- Staff - those staff less embedded in traditional home care culture provide more effective re-ablement including promoting greater involvement of service users. However those with greater experience more clearly focused on improving physical access and safety.
- Skill mix – having rapid access to OT services is viewed as key in ensuring an effective re-ablement service as without this significant delays can be caused.

- Staff commitment and attitude – staff require to be committed to re-ablement approach and require skills to motivate and encourage service users to become independent.
- Benefits of re-ablement – compared to people receiving traditional home care support, those receiving re-ablement have been found to have: better social care outcomes, better perceived quality of life and a significant improvement in health-related quality of life over time.

(CSED, 2007; Petch, 2008; Scottish Government, 2009b; DH, 2010)

Research Example:

Department of Health (2010) Home care reablement: Prospective, Longitudinal Study

Research by the Social Policy Research Unit, University of York and the Personal Social Services Research Unit, University of Kent examined the immediate and longer-term impacts of home care re-ablement, the cost-effectiveness of the service, and the content and organisation of re-ablement services. People who received home care re-ablement were compared with a group receiving conventional home care services, both groups were followed for up to one year.

The study found that:

- * Re-ablement was associated with a significant decrease in subsequent costs of social care service use
- * Re-ablement had positive impacts on users' health-related quality of life and social care-related quality of life, in comparison with users of conventional home care services
- * Using the National Institute for Health and Clinical Excellence cost-effectiveness threshold, re-ablement was cost effective in terms of health and social care costs.
- * The reduction in social care costs was almost entirely offset by the initial cost of the re-ablement intervention. The average cost of a re-ablement episode was 2,088 pounds with a mean cost of 40 pounds per hour of service user contact time.

Practice Example:

City of Edinburgh Council: Home Care Re-ablement Service - from Community Care Works Edition No 73 (2009)

Mrs T – Case Study

Mrs T is an 80 year old lady who was discharged from hospital following admission with neck and shoulder pain. Mrs T was diagnosed with Brachial Neuritis. On discharge her condition was resolving, although she still had weakness in both arms, was short of breath and fatigued.

Her re-ablement package of care was based on a referral and proposed care package from the hospital Occupational Therapist. The package of care consisted of care and support seven days per week:

- Assisting with breakfast preparation; also assisting to set up and supervise personal hygiene tasks for washing and bathing.
- Main meal preparation; also to assist with household tasks and prepare snacks and drinks for later.
- Supporting client to independently manage bedtime snack/hot drink preparation, and assist to undress and prepare for bed if required.
- Assisting client to ensure safety with appliances and secure home for the evening.

Mrs T wanted to get back to the level of independence she had prior to going into hospital. In addition, Mrs T advised the home care re-ablement team of her own aspirations to be able to spend some time outside the home to build her confidence and independence and be able to walk to the local doctor and shops. Regular multi-disciplinary reviews took place to assess Mrs T's progress and this was recorded in Mrs T's home and supports reduced accordingly throughout the process.

Following re-ablement, Mrs T was able to dress and undress independently, manage her breakfast, was managing to prepare herself a light meal and apply her own eye drops independently and was making progress in being able to walk to the doctors and local shops.

This case study illustrates the use of goal setting, team working, a person centred approach, record keeping to show progress, planned reviews, choice and empowerment for the service user. As well as better outcomes for Mrs T, this case study indicates that home care were making the most effective use of the resources and had reduced the care hours required by Mrs T by 85% of the original care package.

Prevention of Admission/Supported Discharge Models

Key Messages:

- A whole systems approach is required to ensure the cycle of admission/re-admission, particularly for frail older people is broken.
- Planned discharge protocols should aim to ensure follow up care is provided.
- Effective joint working is at the heart of effective discharge and prevention of admission services.
- A clear process is required for effective working; identifying patients at risk, assessment carried out by appropriate specialist services, discharge planning and follow up interventions.

Research findings:

Delayed discharge continues to be a significant problem across the UK, although numbers have reduced over recent years. For example, NHS Scotland (Information and Statistics Division, 2010) reports that in July 2010 there were 62 patients delayed over six weeks compared to 2,162 patients in October 2001 when figures were at their highest. Particular groups are more likely to experience a delayed discharge including older people with higher level needs (see for example Hubbard et al, 2004). It has been suggested that this relates to the availability of support networks of friends and family, levels of affluence and availability of staff (e.g. Gilbert et al, 2010).

The Commission for Social Care Inspection published a review of major initiatives to speed up hospital discharge in 2004. They found that although the process of discharge was speeded up, if appropriate services were not in place the well being of service users suffered. Godfrey et al (2008) also found that there was a need to develop interim care measures to support those with higher level needs to prevent delayed discharge. Likewise, Aminzadeh and Daniel (2002) found that the dominant medical model of emergency care does not always respond well to the complex needs of older patients. Given their needs are often inter-related; medical, functional and social problems, it is clear why this might be the case. They argue that appropriate screening and intervention protocols are needed to ensure effective targeting of services. They suggest that a two-step process might be most effective:

Step one: involves identifying at risk patients

Step two: transfer to specialist service for further assessment, discharge planning and follow up interventions (Aminzadeh and Daniel, 2002)

Gilbert et al (2010) in an English study found that patients from more disadvantaged areas and areas that had a multi-racial demographic were more likely to be discharged home than those from an affluent mainly white area. They posit that the likely key factors in this finding are that affluent patients may demand or be able to pay for care and that less affluent patients may have better informal care networks and less access to care/nursing homes. They further found that those in isolated or rural areas were also more likely to be admitted to care and/or nursing homes, often as a purely pragmatic decision as no locally available home supports are provided. However, a Scottish study (Mitchell et al, 2010) found that in the area studied those from a more deprived background were more likely to be discharged from hospital to a care home. There can be issues of recruitment of staff to local authority services in rural areas (Graham and Stewart, 2005), or recruitment as personal assistants via personalised services or individualised budgets.

In England the Community Care (Delayed Discharges etc) Act 2003, provided legislative mechanisms for transferring costs between the local authorities and the NHS when delayed discharges occurred. For example, if a local authority could not provide a service that would allow an older person to return home once deemed medically fit to do so, they could be fined and the money given to the NHS to continue to provide care for the individual. In addition an extra £100 million was provided to encourage Local Authorities and the NHS to work together more effectively to prevent delayed discharge. However a study which directly compared this policy approach to the one taken in Scotland, Joint Action Planning, found that whilst policy solutions can aid in tackling delayed discharges that they were insufficient to address the wider system changes required to respond to the re-shaping of acute care (Godfrey et al, 2008)

The reasons for delayed discharge and the impact on patients, as well as the cost to the NHS are well documented (see for example, National Audit Office, 2003; Glasby et al, 2006; Krishantha et al, 2009). The Commission for Social Care Inspection published a review of major initiatives to speed up hospital discharge in 2004. They found that although the speed of discharge had increased, where services were inadequate to underwrite requirements for recovery, service users well-being could suffer.

There is further evidence that some models of admission prevention have failed to meet their main aim. For example Walker and Jamrosik (2005) in a study examining the impact of screening for risk of medical emergencies in the elderly (those over 75) in London found that no significant impact was made on admissions to hospital or indeed to visits to accident and emergency centres. This was despite the services ability to detect those most likely to require medical attention and additional health and social care services being provided. Wilson et al (2006) found that depression was common in older people discharged from acute medical care and was a major risk factor for

reduced duration of community survival and subsequent re-admission to hospital or other form of institutional care.

Conversely, Hyde et al, 2000 in a systematic review, confirm that supported discharge is associated with a reduction in future hospital admissions and that more people remained at home for up to a year after discharge. The key elements that appear to ensure success include the monitoring of patients following discharge with a clear discharge support plan in place. Significantly the national evaluation of the Partnership for Older Peoples Projects: conducted in England found that overall interventions to prevent or delay older people's need for high intensity or institutional care could reduce overnight stays in hospital by 47% and could improve their quality of life, particularly for those with complex needs (PSSRU, 2009). Further it has been found that discharge planning can reduce the length of hospital stays, increase patient satisfaction and reduce the number of patients experiencing a delay (Hubbard et al, 2004)

A recent Cochrane review (Shepherd et al, 2010) found that the available evidence suggests that a structured discharge plan tailored to the individual patient brings about small reductions in length of hospital stay and readmission rates for older people admitted to hospital with a medical condition. However the overall impact of mortality, health outcomes and costs remain uncertain.

Overall therefore, the evidence found suggests that the success of various models of admission prevention and supported discharge is mixed. Glasby and colleagues (2004) suggest that this disparity in the evidence can be accounted for by differences in outcomes being measured, populations being studied, definitions adopted and research methods used.

Practice Example:

Practice Example

Perth and Kinross: Transitional care at home service

This early supported discharge scheme aimed to ensure a co-ordinated and seamless transition for patients. It comprised a transitional care nurse and social care officers with an interest in dementia care. The team had links with a range of other professionals as well as the out of hours community alarm service, overnight community nursing and social work services. The six week duration of the programme was removed as it had resulted in few patients being accepted onto the service. The service resulted in a reduction in stay in hospital, a reduction in multiple emergency admissions, improved user and carer satisfaction and reduction in mainstream homecare packages on discharge. There were cost benefits for health and the local authority as a result of savings from the reduction in bed days, readmission and a reduction in care packages. Overall there was a reduction in costs of 55% (£4302.83) per patient although this did not include the additional costs

Implications for practice:

- Whole systems approach - Given the number of complex and inter-related factors which can cause a delayed discharge, a whole system approach should be developed. Specifically this needs to include: identifying the main causes for delay in the local system, developing services to tackle these causes, evaluate the impact of these services and monitor the statistics to ensure effectiveness.
- Planning - discharge planning needs to begin on admission to hospital, be transparent and communicated across disciplines and agencies via a coherent process. It should also be patient focused.
- Working with carers - For early supported discharge models to be effective they require clear commitment from carers in order to ensure an effective outcome for all involved.
- Local responses - Responses to delayed discharge require to be locally developed to reflect local circumstances – *one size will not fit all*. Benefits include being able to draw upon shared histories of effective joint working.

Intermediate care

Key messages:

- Definitions of intermediate care vary and this impacts on the robustness of the evidence-base. This is partly due to the wide range of models of intermediate care that exist. These can be broadly classed as hospital discharge teams and admission avoidance schemes (e.g. early supported discharge and rapid response teams).
- It is possible to identify a number of benefits. These include positive service user experiences and outcomes such as increased independence and confidence, retention of support networks and social activities, person centred, flexible and holistic approaches, the promotion of choice and interpersonal contact. In addition increased quality of life has been reported in evaluations of intermediate care.
- Challenges to the success of intermediate care include the recruitment and retention of staff, a lack of effective joint working, lack of a secure funding base. It also requires clear access to mainstream services. In addition, those with a broader range of needs may not be well served by intermediate care.

Main research findings:

There have been significant policy drivers that have resulted in the development of intermediate care for older people with complex needs. However the evidence base on the effectiveness of intermediate care remains patchy (see for example Pencheon, 2002; Barton, 2006; Mitchell, 2011). Part of the difficulty of establishing a clear evidence base for intermediate care is the range of services that are available under this umbrella term. Such services range from one weeks duration following a hospital discharge to six weeks at home, e.g. rapid response teams. Differences also relate to the types and location of input and disciplines involved and how the service is funded.

The National Service Framework for older people and associated DH guidance (2001) suggested that intermediate care post-discharge should comprise of:

- a structured programme of treatment/care to assist recovery with the ultimate aim of service users being able to live at home,
- a time limited (usually max 6 weeks) mix of health and/ or social care input as appropriate,
- provision on a residential or community basis and a
- single, multi-disciplinary assessment.

A number of different models of intermediate care were identified in the literature. A particularly helpful article by Katsaliaki and colleagues (2005) identified a number of different intermediate care services in Hampshire:

- Intermediate home social care team (rapid response home care team) – preventing admission to hospital and/or residential care. This service is provided seven days per week.
- Intermediate health care facilitators: supplies enhanced nursing care at home to ensure early discharge or to prevent admission. Provided on week days only, mainly in the service users own home but also in specialist beds in community hospitals.
- Step up and step down beds in hospitals where the patient has no one at home to look after them until they are fully functioning. Often used whilst patients wait for a care home placement.
- Rehabilitation beds within hospital settings where patients are no longer considered ill and requiring a hospital bed but where they still require rehabilitation to return to full functioning. This service is provided under the leadership of a consultant geriatrician and a multi-disciplinary team.

Parker et al (2000) in a systematic review of intermediate care found that evidence of effectiveness is, at best clinically equivalent to conventional in-patient care. The provision of intermediate care services has been shown to be ineffective, relative to the 'usual' health and social care at home services in terms of the amount of time that service users remain in their own home (Trappe-Lomax et al 2006). This may be because many intermediate care services are too small, inadequately targeted or insufficiently integrated to achieve a whole system change to the care of older people (Young and Stevenson, 2006).

On the other hand Griffiths and colleagues (2000) found that in nursing-led inpatient units, discharge to institutional care was reduced, functional status of older people was improved and there was a reduction in early readmission. It appears that a range of factors including definitions of intermediate care used, the range of models of support subsumed within this overarching term, characteristics of research participants and differences in outcomes being measured can explain such contradictory evidence.

Despite the conflicting evidence, our review of the evidence has enabled us to identify a number of benefits and challenges in relation to intermediate care. These findings are in line with those in the national evaluation of the costs and outcomes of intermediate care. (Barton et al, 2006). This Leicester/Birmingham evaluation of intermediate care was one of three projects commissioned by the DH and MRC as part of a national intermediate care research programme. The evaluation of intermediate care for older people undertaken by Leeds University (University of Leeds, 2005) found that

intermediate care should be viewed as a key element of the pathway of care for older people which faces both into the acute sector and out into the community. This study further noted that one of the difficulties in identifying whether or not intermediate care achieves effective outcomes for service users is the variation in what constitutes a good outcome from person to person.

Benefits identified relate primarily to service user experiences and outcomes, particularly in relation to independence and increased confidence. Enabling older people to retain support networks and social activities are viewed as essential to rehabilitation. Services that are responsive, patient-centred, flexible and holistic are particularly valued by service users and staff alike (Regen et al, 2008). Service users also value services that promote choice and inter-personal contact: "the elements of contact with a friend, provided by interaction with project workers were particularly valued by service users" (McLeod et al, 2008: 85). However six to eight weeks was generally viewed by service users as being too short a time for intensive input.

Challenges also relate to difficulties in the recruitment and retention of staff and a lack of effective joint working – with the usual barriers relating to separate budgets, different organisational visions, different employment policies and incompatible IT systems (Dickinson and Glasby 2008). Significantly, the short term, non-recurrent nature of some funding for intermediate care was seen as problematic for medium to longer-term service development (Barton et al, 2006; Regen et al, 2008). Intermediate care appears to be less successful in rural areas where there is a lack of home care services to complement intermediate care services. Likewise, older people with additional needs such as mental health problems would appear to be poorly served by intermediate care services (Regen et al, 2008).

Rapid Response Teams

Rapid Response Teams are one model under the intermediate care umbrella and they are often identified as a way of delivering patients to intermediate care services and often subsumed within that term when being described within research.

Although there is evidence to suggest that Rapid Response Teams assist in getting people home from hospital quicker and ensures that individuals can remain out of hospital (e.g. Beech et al, 2004), there are some concerns. In particular there is concern that early discharge can create additional stress for carers, and that such services can create additional dependence rather than independence. In spite of these concerns service users and their carers generally felt that RRT was better than remaining in hospital (Beech et al, 2004).

The evidence around the effectiveness of RRT's is generally positive although Young et al (2005) in a study involving 1600+ patients (800 in a control

group and 826 in a group receiving intervention from the RRT) identified that they could not establish any clinical difference for those receiving intermediate care services via the rapid response team. However, in another study involving 231 older people with an average age of 75.9 years with multiple conditions, only 5.7% of RRT patients were readmitted to acute care (Beech et al, 2004). This rate was similar to other studies, e.g. National Audit Office study (2003). Other discharge facilitation schemes research (see for example, Davies et al, 2000) which focused on the differences between hospital at home and acute care for a condition specific group of older people found that they are capable of maintaining health care outcomes for older people. However there are ongoing challenges for RRT and other forms of early discharge schemes. For example, although such schemes are popular among service users given their desire to get or stay at home, the evidence that they cost less over time than a hospital stay is variable.

Falls Prevention and intermediate care

Gilbert et al (2010) in a significant study involving a range of older people including frail older people with higher level needs found that those people (with similar characteristics) admitted to hospital after a fall are more likely to be discharged to a care or nursing home than those admitted to hospital for any other reason. In addition being older, female and having severe co-morbidities were also seen to increase an older person's likelihood of being discharged from hospital to a care or nursing home. This means that falls strategies are important in ensuring that older people with higher level needs remain at home.

A study exploring the key benefits of a fast access falls and syncope facility in Newcastle (Rose et al, 2002), found that a dedicated service reduced the need for emergency admissions, particularly amongst older people. The service saved an annual equivalent of 6616 bed days or 2400 consultant episodes.

A Cochrane review of interventions for preventing falls in older people in the community conducted by Gillespie and Handoll (2009) found that exercise routines and other interventions that reduce and prevent falls could reduce overall care costs by preventing admission to hospital. This study found that in the 111 RCTs they examined, 43 focused on exercise as an intervention. The exercise-based interventions such as strength and balance training were shown to reduce falls in older people and that Tai Chi and individually developed home-based exercise were also effective. Use of Vitamin D was not found to reduce falls except potentially in those who have a vitamin D deficiency. The study also explored the impact of certain medications such as the withdrawal of psychotropic medications and found that in some instances a gradual withdrawal and a comprehensive prescribing modification

programme for GPs could reduce falls. Surgical interventions for example cataract surgery could reduce falls⁷.

User and carer perspectives of intermediate care

Petch (2003) examined older people's experiences of intermediate care in relation to outcomes. A range of models was explored alongside older people's experiences of each of these models. The key areas identified from the perspective of service users included:

- effective monitoring of home care staff to promote confidence of older people,
- availability of step-down facilities to provide a social environment for recovery and
- services should be designed at a local level to reflect local need. The need to ensure the availability of local resources prior to discharge

Petch (2003) concluded that intermediate care may in fact inhibit rather than encourage a whole system approach due to a lack of clarity and consistency with regard to the different models of intermediate care. However, Glendinning et al 2008 reported that older people experienced significant benefits in relation to intermediate care. In particular they highlighted the ability of intermediate care to achieve service user defined outcomes. However, concern has been expressed about the lack of involvement of service users and their carers in intermediate care (SCIE, 2005)

The work of McLeod et al (2008) provides particularly helpful messages for practitioners. They found that social care workers supported older people's reintegration into a variety of networks including friendship, recreational and family groups, health care treatment programmes and locality based contacts and organisations. Material, interpersonal and health care resources were accessed which contributed to restoring and sustaining physical health and psychological wellbeing (McLeod et al, *ibid*). The process is also crucial in that service users' priorities must be reflected. In terms of good practice, McLeod and colleagues suggest that:

- A safe transition from hospital to home may be compromised if service users are discharged too early and therefore do not have the resources to cope at home
- Assistance with practical home care/ personal care and aids will restore service users' morale in times of social isolation. CSCI (2005) suggested that lower level preventative inputs need to be added to the acute service provision typified by intermediate care. It is argued that "a genuinely comprehensive preventative service needs to extend

⁷ A full copy of the above review can be found at:
http://onlinelibrary.wiley.com/doi/cochrane/clsystrev/articles/CD007146/pdf_fs.html

beyond the provision of intensive care to incorporate more simple, practical support for the wider community of older people with the aim of maintaining and enhancing well being and quality of life” (2005:6).

- Advocacy is necessary to assist service users to access to material and social resources
- Social care staff can be an educational assistance for example, supporting service users to learn how to use new aids or adaptations, helping confidence return in relation to previous tasks such as driving
- It is necessary to address psychological barriers to entry to social networks. This can be important in terms of promoting positive mental health
- It is necessary to offer older people support to access health care organisations and networks (McLeod et al, 2008)

Research Example:

Research Example

Barton et al, (2006) National evaluation of the costs and outcomes of intermediate care

The review aimed to map the development of intermediate care services across England and to assess its impact on the lives of service users. It involved a postal survey of intermediate care co-ordinators and case studies of intermediate care systems. The research found that services differed in size and function, however generally the six week time limit was viewed as too narrow in scope. Partnership working was viewed as the single most important driver to the success of intermediate care although barriers relating to long term funding and staff shortages were identified. Service users reported satisfaction with the multi-disciplinary aspect of intermediate care although overall satisfaction rated on a par with other surveys of health service provision. Overall, costs and outcomes vary depending on the clinical need of the service user and the model of service adopted with admission avoidance services costing less than supported discharge schemes, which results in an increase in costs overall.

Practice Example:

Intermediate Care Demonstrators

The Joint Improvement Team in Scotland have provided funding to five demonstrator sites that show where intermediate care services make a significant contribution to delivering against HEAT targets, community care outcomes and partnership objectives. Each site is focusing on a number of work strands including access to pharmacy, in-reach service to prevent unnecessary admissions, including extending hours of access to the service, and services to people with dementia. The five sites are Fife, Edinburgh, West Glasgow, Perth and Kinross and Scottish Borders. The following themes have been identified as key elements of success and common challenges:

Key elements for success:

- Joint governance framework

- Generic support workers able to work across agencies including access to finance
- Involvement of voluntary sector key to assisting in shifting the balance of care.
- Transport – getting people to and from locations efficiently and effectively
- Training for key staff in any intermediate care model

Challenges:

- Impermanent nature of the funding
- Assumption that this model of working is effective and appropriate – various elements being tested but not the model itself
- Service capacity including availability and retention of staff.
- Developing the interface between intermediate care and mainstream services
- Effective partnership working

Implications for practice:

- At a strategic level consideration must be given to where any intermediate care initiative sits in the care pathway of an individual service user and there must be explicit links with other appropriate mainstream services.
- The type of service developed including the detail of services provided and location should be determined by the specific needs of those service users in transition.
- Intermediate care services should be structured in such a way that enables flexibility and responsiveness to individual need.
- Effective partnership working is integral to the success of intermediate care schemes this should include clear transition procedures from one service to another as well as agreed procedures for case finding and eligibility.
- Access to and inclusion of specialist staff for those older people with additional needs, e.g. mental health.
- Consideration should be given to costs, quality of life and functional improvement when identifying the most appropriate model.

Further reading:

For a comprehensive reading list on intermediate care visit the Kings Fund website: www.kingsfund.org.uk

Of particular interest is the Scottish Patients At Risk of Readmission And Admission (SPARRA) data. This is a way of identifying those people at greatest risk of emergency admission to hospital. The tool was developed by the Information Services Division (ISD) at the NHS. It identifies people who have experienced a cycle of repeat admissions to hospital in the previous

three years and predicts their risk of future hospitalisation. The use of SPARRA data can support local teams to provide planned and co-ordinated care for people with complex or frequently changing needs. This tool can be used to support anticipatory care developments:

<http://www.scotland.gov.uk/Resource/Doc/309288/0097425.pdf>

Practice Issue Three: Long terms services to maintain people at home

Home Care

Key messages:

- The importance of recruiting and retaining a committed and well-trained workforce cannot be overstated.
- Empowering service users to be involved in decision-making can improve outcomes in relation to home care.
- The evidence suggests that home care works. It is less clear however, to which components success can be attributed. It is also less clear which populations are most likely to benefit.
- Incorporating a preventative element into traditional homecare services is crucial.

Main research findings:

Home care is increasingly targeted at those clients with the highest needs. Recent figures from the Scottish Government (November 2010) suggest that the number of older people (aged 65 and over) receiving an intensive service (more than 10 hours per week) was around 18.1 clients per 1000 population. It further notes that this has been steadily rising since 1998 when the rate was 9.0 clients per 1000 population. This represents an increase from 11% of all local authority provided home care clients in 1998 to 30% of all local authority provided home care clients in 2009.

In relation to homecare the focus has shifted increasingly towards time-limited re-ablement services that aim to reduce the number of hours of support that are provided. As a result, little research has been published on the effectiveness of traditional homecare since the early 2000s. The evidence that exists highlights the long term sustainability of homecare services as a particular issue. Governments in the four countries of the UK face challenges in funding home care for the growing older population. In response to this, Scourfield (2006) has argued that in-house provision should be expanded rather than residualised. He suggests that the quasi-marketisation of home care has not solved the problem of staff shortages and has brought a set of difficulties of its own, primarily related to achieving the necessary stability and continuity of provision. Other problems relating to the homecare workforce include cream-skimming and the blurring of accountability. Likewise, Leece (2003) has argued that the home care sector faces challenges relating to staff shortages. Issues relate to:

- low pay and status for workers
- financial constraints on local authorities

- poor working conditions
- competition with other employers
- lack of suitable candidates
- new requirements for higher standards of care and staff qualification

Despite these difficulties, home care staff have a crucial role in enabling older people to remain at home. Eloranta and colleagues (2008) in a study of home care clients suggested that if the client is involved in decision making, that will have the effect of strengthening “their faith in their own resources and the sense of control over their own lives” (p309).

Professionals can support and enhance older people’s resources by among other things, being present, having conversations with them and by listening to them (Eloranta et al, 2008). In order to do this, staff must have greater knowledge and understanding of their client’s wellbeing in order to identify those at risk. In addition they need training in order to follow up their interventions to ensure they have the desired effect:

for older people, independent living at home requires not only the existence of abilities and resources but also the ability to make good use of these strengths. In this, motivation and encouragement by professionals can help in the maintenance of people’s beliefs in their own resources. This helps to improve clients feeling of safety regarding home living.

(Eloranta et al, 2010: 852)

Evidence suggests that home visiting can be effective in enabling older people to remain at home. A meta-analysis of 15 studies showed that home visiting programmes were effective in reducing mortality and admission to long term institutional care although there was no reduction in admissions to hospital (Elkan et al, 2001). Likewise, a study in Denmark with over 4000 older people suggested that an educational intervention used with home visits had positive outcomes in terms of improved functional ability (Cutchin, 2009). Although there is evidence to suggest that home visiting works, what is less clear is exactly which elements make a difference. The challenge therefore is to tease out which components of the intervention are effective and which populations are most likely to benefit (Egger, 2001).

Some of the research evidence has focused on the role that preventative homecare can have in health promotion. Hallberg (2004) in a review of literature in this area found that very few interventions took a deliberate preventative approach. Markle-Reid et al (2005) meanwhile in a randomised control trial of older people aged 75 years and over found that proactively providing older people with nursing health promotion as part of their homecare package rather than providing nursing services on demand resulted in a number of positive outcomes. These included better mental health functioning, a reduction in depression and enhanced perceptions of services.

Practice example:

Integrated care co-ordination service

The integrated care coordination service is a holistic service for older people aged over 65 at risk of avoidable hospital admission, premature admission to institutional care or simply causing concern due to health and social care issues. The service has the following components:

- Assessment
- Coordinating range of interventions in response to identified needs
- Operating across health, social care and other organisational boundaries
- Preventative service – majority of clients needs have not reached the “critical and substantial stage”
- Assessment then services (may have been the same service anyway but not provided in the same timely way)
- 3 month follow up then transfer when appropriate services are in place

ICSS services are unlikely to improve health as such but may well impact on well-being and reduce for example the number of falls. The timing of intervention appears to be crucial to success:

When the conditions for referral are met cost effectiveness is more likely to be enhanced as compared with a referral that is either too early or too late.

(Mayhew, 2009: 283).

Home care and day care for people with dementia

Day services for people with dementia might include day care (including day centres) and home care. Such services have been shown to reduce the stress of family care-givers and can delay the onset of institutionalisation. Yet, despite the benefits, some research has suggested that older people with dementia can be reluctant to accept services as a result of believing that they did not need support and fears about losing their independence. A lack of tailored approaches is another potential explanation for refusal to accept services. In addition Durand et al (2009) suggested that those who consistently refused services may be experiencing undiagnosed depression.

Research Example:

Alzheimer’s Scotland (2010) Meeting our needs? The level and quality of dementia support services in Scotland

The research looked at the views of care managers, people with dementia and their carers in relation to support services. Home care, day care and respite care were identified as being of particular importance. The study

found difficulties with the availability and quality of services from the perspective of both service users and carers. Most local authorities had waiting lists for day care, yet specialist dementia day care was highly valued by people with dementia, carers and care managers. In addition, the majority of home care services were found to be task centred, suggesting that people with dementia are not being assisted to maintain their skills and a level of independence. Recommendations included:

- Increasing the provision of specialist day care
- Allocating more time to home care workers to enable a support oriented service
- Greater variety and choice of respite services
- Improved training in dementia care
- Clear, consistent council eligibility criteria for community care services
- Consistent standard of dementia specific data to be collected to enable accurate national statistics to be produced
- Increase in funding is required to meet current demands and should be increased in line with demographic changes

Implications for practice:

- Recruitment and retention of an appropriately trained workforce is essential.
- Provision should be outcome focused rather than task focused in order to promote service user independence.
- Services should consider adopting a preventative approach with the long term aim of reducing the level of input required.

Practice Issue Four: Innovations

Telecare

Key Messages:

- Evidence suggests that telecare can create efficiency savings by reducing bed days and the level of home care needed
- There is limited evidence that telecare can improve quality of life for older people with complex needs.
- The attitudes of older people towards telecare impact on its success
- The evidence base is largely based on pilot studies
- There is a lack of evidence on the ways in which older people, particularly those with complex needs use assistive technology

Main Research Findings:

Telecare is a term that covers a range of devices and services that harness developing technology to enable people to live with greater independence and safety in their own homes. In Scotland, the Joint Improvement Team has supported the development and enhancement of Telecare services in Scotland through a National Programme that was launched in August 2006. The programme made funds for Telecare developments available to health and social care partnerships across Scotland through a Development Fund. The Telecare Development Programme (TDP) is expected to provide the foundation for telecare systems to become an integral part of community care services across Scotland. A recent evaluation of the first two years of the TDP programme indicated that not only did telecare save money but that the introduction of telecare made a difference to the quality of life of service users and their carers (Scottish Government 2009c). The evaluation further reported that over 13,000 bed days were saved and that over 61,000 care home days were saved by the use of telecare. A similar picture appears across the rest of the UK⁸. Yeandle, in a review of the evidence, published in 2009 argues that telecare offers a practical solution to the difficulties associated with maintaining the increasing older population at home. The paper presents evidence to suggest that telecare can:

- Reduce risks
- Respond rapidly and appropriately when needed
- Assist in the management of specific conditions
- Delay the entry of people with some conditions to residential or nursing care

⁸ In England a whole system demonstrator evaluation is being undertaken in three sites, Cornwall, Newham and Kent. Results from these studies should be published late 2010/early 2011. For further information on this work please visit:

www.dh.gov.uk/en/healthcare/longtermconditions/wholesystemdemonstrators

- Enable more people to be discharged in a timely and safe way from hospital care
- Cut some unnecessary costs from the health and social care system

The evidence suggests that particular *types* of telecare intervention targeted at particular *groups* results in successful outcomes. Research published by CSIP in 2006 for example found evidence of effective outcomes for services users on a range of telecare interventions including vital signs monitoring and information, advice and support. However, there was almost no evidence that safety, security and monitoring telecare interventions aimed at a general population, such as frail older people was effective in reducing costs or in achieving improved outcomes. Similarly, Barlow et al (2007) in a systematic review found that the most effective telecare interventions appeared to be automated vital signs monitoring (for reducing health service use) and telephone follow-up by nurses (for improving clinical indicators and reducing health service use).

The cost-effectiveness of these interventions was less certain. There appeared to be insufficient evidence about the effects of home safety and security alert systems. Goodwin (2010: 5) sums this up by stating:

The cost-effectiveness of sensor-based monitoring...and its use in early-stage prevention programmes still needs independent evaluation to provide the evidence that convinces some of the skeptics

A number of factors have been identified that facilitate success. In particular the attitudes of older people towards telecare can influence its success. A study by McCreddie and Tinker in 2005 found, that the success of telecare interventions rested largely on older people's willingness to use it. However they further found that willingness to use the technology is based on a complex mix of factors including:

- Felt need for assistance (accepted or not)
- Access to and availability of assistive technology (information, delivery system, payment)
- Attributes of the assistive technology (efficiency, reliability, simplicity, safety and aesthetics)
- Acceptability

A review of the literature on telecare conducted by Damodaran and Olphert (2010) suggested that a majority of users and carers expressed positive views about telecare, whether actual or potential. There is some evidence to suggest that telecare was most welcomed by those who had existing concerns about their health and ability to cope independently and by those who lacked social support. Carers appear to welcome telecare in the form of monitoring services that were perceived to provide peace of mind (Damodaran and Olphert, 2010).

There is considerable research on the ethics of using assistive technology with older people (see for example Eccles, 2010). As with other new interventions assistive technology has great potential to be of benefit but also to be misused. Concerns relate particularly to the rights of service users and carers to privacy and the potential for telecare to create dependency or disempower people (Percival and Hanson, 2006; Wey, 2007; Damodaran and Olphert, 2010; Eccles, 2010). Particular concern relates to the potential for telecare to reduce human contact thus resulting in greater social exclusion. In order to overcome this, telecare must be viewed as complementary to services.

In order for telecare to work well, appropriate back up services need to be put in place (Percival and Hanson, 2006). Otherwise, there is concern that family carers could be put under additional strain. There is concern that large specialist call services, will emerge to keep costs low and further reduce contact between service users and key professionals, such as GPs, social workers and community nursing services.

Telecare and people with dementia

The Mental Welfare Commission for Scotland (2007) stated that:

We believe that technology can be a valuable tool which helps people to maintain their independence and enhance a person's freedom without unduly increasing any risks that he or she may face and this is to be welcomed

For 60% of people with dementia walking about can become a problem (At Dementia, 2010). Although good practice suggests that it is important to try to identify the cause of the problem, a property exit sensor can be a useful tool in terms of preventing people from coming to harm by leaving their home inappropriately and often for long periods of time.

The MWC suggest that "wandering technology" should be used in accordance with the principles of the Adults with Incapacity (Scotland) Act 2000. For example, one must consider the benefit of such technology to the individual. When used appropriately it can increase someone's dignity, independence and sense of freedom. It may reduce the need for sedative medication and may reduce the need for obtrusive levels of observation. However, they emphasise that technology should never be used to reduce costs of staffing. Wandering technology should be used as a last resort only and the importance of appropriate levels of stimulation and exercise should also be considered.

The MWC have provided a good practice checklist. This includes:

- Consider the causes of behaviour
- Assess the risk

- Consider alternatives to wandering technology
- Identify whether wandering technology is available and appropriate
- Ascertain the views of individual, relatives, care team and so on
- Consider ethical implications, the benefits and disadvantages of the system
- Consider the legal implications for the individual concerned, particularly in relation to possible use of Adults with Incapacity (Scotland) Act
- Formulate individual care plan
- Ensure all staff and involved relatives understand the care plan
- Monitor implementation of the care plan
- Review care plan frequently

Practice Examples:

Home Safety Service – West Lothian

West Lothian Council's Home Safety Service aims to help maximise a person's potential independence by increasing their personal and environmental safety enabling them to remain living in their own home for as long as possible. People at risk can have unobtrusive and easy to use equipment installed in their own home that is linked to specially trained advisers who will respond to alarm calls for help. The equipment ensures that access to help is there when most needed. The council may also offer this service as part of a larger package of support which may including a regular personal care worker. The home Safety Service is available to all householders in West Lothian where an assessment has identified needs/risks that can be addressed by technology.

Smart Flats and Smart Ideas Handbook – Dumfries and Galloway

This initiative aims to increase public and professional awareness of the range, uses and availability of 'Telecare' and other aids and equipment, in order to promote independent living for older people and for people with disabilities. The service provides people with information which enables them to access aids and equipment. The initiative has involved a range of partner agencies and disciplines including the NHS, local authority, social work staff and occupational therapists.

Two flats, one in the west and one in the east of the region have been set up with a range of Tunstall Telecare equipment and other aids and equipment for people with physical disabilities, sensory impairment and memory difficulties. The telecare equipment is linked in to the council's community alarm response centre. Trained staff from both agencies, are available during the week to provide demonstrations to staff and service users. A handbook called 'SMART IDEAS' has been produced as a link to the flats, which provides information on where and how the equipment can be purchased. The handbook is free and to date 550 copies have been distributed. Over 250 people have attended demonstrations of the equipment.

Implications for Practice:

- Packages need to be person-centred
- Should be provided as part of a broader community care package rather than as a stand-alone service to prevent social isolation
- Effective back up services need to be available in order that additional pressures are not put on carers
- Service users should be able to pilot equipment to ensure it meets their needs.

Further Reading:

Eccles, A. (2010) Ethical Considerations Around the Implementation of Telecare Technologies. *Journal of Technology in Human Services*, 28:44-59

Langenseipen C, Lotfi A and Higgins S (2010) Use of gesture recognition to control household devices for older people. *Journal of Assistive Technologies* 4(4): 4-10

Practice Issue Five: The implications of maintaining older people at home

Costs

Key messages

- It is predicted that demand for long term care for older people will peak in 2040.
- Community care is chronically under-funded. Investment is needed particularly in relation to home care, which is most highly demanded, and relatively cheap.
- While the principle of free personal care is sound on ethical grounds, there have been major problems in relation to predicting demand and costs. There are major doubts around the continued feasibility of the scheme.

With the growing number of older people, particularly those with complex needs living in the UK, and in the current financial climate, funding and cost considerations have never been more significant. It is predicted that demand for long-term care will continue to grow, reaching a peak around 2040 (Karlsson et al, 2006). This is coupled with long standing concerns that community care generally is under-funded. The Health and Community Care Committee in Scotland argued that:

Fundamental problems exist in the funding of community care in Scotland...real spending on community care is currently set at an inappropriately low level, presenting an insurmountable barrier in raising service ambitions

(Scottish Parliament, 2000: 4)

The Joseph Rowntree Foundation (2006) has suggested that the UK as a whole has an inadequate system for paying for long term care. Problems relate to overall funding levels, with unmet need suggesting that these are already falling short. In addition multiple funding streams create complexity and confusion in relation to paying for services. There are also issues of equity:

Means testing causes widespread resentment by taking away most of people's assets and income before they can get state help

(Joseph Rowntree Foundation, 2006:2)

In Scotland the policy commitment to free personal care has raised questions as to whether the current situation is sustainable in the long term. The drive to increase the numbers of older people living in their own homes must be considered in financial terms but the evidence base around the efficiency savings of a range of models of care is mixed. The Joseph Rowntree Foundation (2006) argues that reform is necessary to create a sustainable system, however this will involve an increase in resources, which seems unimaginable in the current financial climate. Hirsch (2005) has suggested that creating a fairer system will result in people being willing to pay for it.

Research findings

Predicting the costs of long term care

Predicting the cost of long term care is notoriously difficult as a result of the different variables involved. The Personal Social Services Research Unit developed a model based on the number of daily activities such as cooking that were "failed" by an individual (see research summary). Their calculations predicted that services will have to expand by 61 per cent between 1995 and 2031. Home care will have to increase by around 60 per cent by 2040 (although this is relatively cheap in comparison to other services). In terms of costs, Karlsson et al (2006) predicted that the cost of long term care will rise from £11billion (across the UK in 2006) to around £15billion in 2040. This figures look even more alarming when considered in real terms with costs estimated to quadruple from £12.9billion in 2000 to £53.9billion in 2051 (Joseph Rowntree Foundation, 2007). Further if current funding policies continue much of this increase would fall on the individual

Free personal care

The Sutherland committee was established in 1997 to look at the long and short term options available for funding long term care for older people. The committee made a number of recommendations around rehabilitation (reablement), direct payments (personalisation) and free personal care. The Westminster government accepted the majority of the committee's recommendations but rejected the notion of free personal care. In England, *Nursing* care was made available free of charge however, residents had to continue to pay for accommodation costs and personal care. In Scotland, the decision was made to implement the recommendation of free personal care and this became the Scottish Executive's flagship policy (Dickenson et al, 2007). Initial concerns about the policy related to the fact that free personal care simply changes who pays for care rather than changing the level of resources invested in services for older people.

The policy was implemented as part of the 2002 Community Care and Health (Scotland) Act. In practice, its implementation is more complex than it might appear. Those in receipt of free personal care were, in some cases, no longer eligible for attendance allowance for example, which may result in service

users having to make a contribution to the cost of some elements of their care. For those living at home, eligibility for free personal care is subject to a needs assessment by the Local Authority and non-personal care services continue to be subject to discretionary charges by the council (Dickenson et al, 2007).

According to Dickenson and colleagues (2007) there is limited data available on the cost implications of free personal care for those older people living at home. However, the Care Development Group, established by the Scottish Executive in 2000 highlighted a gap of £63 million across Local Authorities (Dickenson et al, 2007). Difficulties in predicting costs relate also to difficulties in predicting variables such as levels of unmet need and the impact that free personal care has on unpaid carers.

The Audit Commission, in 2005, suggested that the cost implications of free personal care had been calculated inaccurately. Within the first nine months of implementation for example, costs outstripped predictions by £19million (Audit Scotland, 2005). Bell and Bowes (2006) in a study funded by the Joseph Rowntree Foundation the following year also confirmed that expenditure had been greater than expected but highlighted that free personal care added only 10 per cent to expenditure on older people's services.

Figures from the Scottish Government (2010e), suggested that the number of people receiving free personal care at home increased by 34.5% per cent between 2004 and 2008/9 and that expenditure on personal care for home care clients increased from £128million in 2003-04 to £273 million in 2008/9, an increase of more than 112%. Long-term modeling on the affordability of long-term free personal care varies according to changes in patterns of home ownership, costs and the economy as a whole although various "policy levers" (such as eligibility criteria) can be used to control costs (Dickenson et al, 2007).

Major concerns about the financial viability of free personal care remain and the policy as a whole has major implications for the future delivery of community care services. The Scottish Parliament Health Committee Inquiry into care legislation identified a number of difficulties with funding (Bell and Bowes, 2006). One possible, unintended outcome could be that free personal care, rather than helping to support the policy goal of enabling more older people with complex needs to remain at home, might result in a greater number of older people being moved to a care home. This might be cheaper than providing a complex package of care at home. On the other hand, the use of free personal care might result in earlier intervention, thus enabling older people to remain at home for longer.

Implications for practice

- Cost containment remains a central priority at National and Local government level hence anticipatory care is more important than ever before.
- Managers and front-line practitioners are under pressure to make efficiency savings and to “do more for less”.

Further reading

Bell, D and Bowes, A (2006) *Financial care models in Scotland and the UK*, York: Joseph Rowntree Foundation

Wittenberg, R, Pickard, L, Comas-Herrera, A, Davies, B and Darton, R (2003) *Future demand for long term care 2001-2031. Projections of demand for long term care for older people in England. PSSRU Discussion Paper 1980*

Carers

Key messages

- Our reliance on unpaid carers to support older people with complex needs to remain at home will continue to increase, peaking around 2050
- A range of research evidence exists that highlights the experience of caring, focusing particularly on carer burden and stress.
- It is difficult to measure the impact that various interventions have on carers wellbeing however such interventions have not always been successful.
- Consideration must be given to the availability of support networks, coping styles and number of hours spent caring when deciding on an intervention

Unpaid or informal carers can be said to be the cornerstone of community care. As the number of older people increases, their contribution is more essential than ever. A wealth of research has been conducted in relation to the experience of carers. This section provides an overview of this evidence.

Research findings

Karlsson et al (2006) predict that the number of older recipients of informal (unpaid) care will increase from 2.2million (in 2006) to 3million in 2050. Interestingly, they also argue that if female care-giving patterns were to converge to those of males, there would be a shortage of between 10 and 20 million hours of care each week.

Impact of caring

There is a substantial evidence base that highlights the impact of caring on the unpaid carer's general well-being. Carers of people with dementia in particular experience higher levels of burden and depression when compared to other groups of carers (Schoenmakers et al, 2010). Interestingly, Schoenmakers et al, 2010 found that although carers report a high level of satisfaction and gratefulness with professional support they are not less depressed or burdened. They suggest that caregivers who feel well supported and feel confident in the adequacy of both professional and informal networks had better outcomes in terms of wellbeing.

Carer stress or well-being is difficult to predict and measure (Charlesworth, 2010). Pearlin (cited in Charlesworth, 2010) developed the "stress process model of caring". The model suggests that carer outcomes such as physical and psychological wellbeing are influenced by contextual factors (such as age, ethnicity and socio-economic status) as well as stressors (such as "problem" behaviour exhibited by the person with dementia and their need for assistance with tasks of daily living), intra-psychic and interpersonal strains

(such as divided loyalty between caring and employment) and resources (including coping and social support). The model predicts that the carer copes better when strains and stressors are minimised and resources are maximised.

Evidence suggests that interventions to support unpaid carers have not been overwhelmingly successful. Schoenmaker and colleagues 2010, highlight the importance of not assuming that one type of intervention will suit all care-givers. A number of factors such as background, social networks, relationships with the cared for person and the number of hours spent carrying all have to be considered. Differences in coping styles and problem awareness mean that different interventions will benefit different care-givers. Generally speaking however, interventions to enhance psychosocial resources are likely to be significant and include:

- Carer education
- Behaviour management techniques
- Problem solving training
- Personal counseling for emotional distress

Carers Assessment

Evidence suggests that practitioners continue to have concerns and anxieties about undertaking carers assessments (Miller, 2007). These concerns relate particularly to resource implications. Yet a number of studies have confirmed that requests from carers for support tend to be fairly modest (Miller, 2007; Seddon, 2006). Seddon et al (2007) in a study of the use of carers assessment in Wales found that most carers assessment protocols were narrow in focus and particularly task-oriented. Carers emotional needs are not well served by such assessments. This is a particular concern given the need for support services to meet these needs as outlined above.

Outcomes for carers

SPRU undertook a programme of work to identify the particular outcomes that were important to carers. They identified four categories of outcomes that related to quality of life for the cared for person, quality of life for the carer, and managing the carer role. The final strand related to a range of process outcomes such as being valued and respected (SPRU,2007).

Research example

Askham et al (2007) Care at home for people with dementia: as in a total institution *Ageing and Society* 27: 3-24

Askham and her colleagues (2007) carried out in-depth interviews with twenty people with dementia and their carers in and around the London area. They also carried out non-participant observation by spending several hours

in the home observing the interactions between the cared for person and their carer. Participants included five husbands with dementia being cared for by their wives, four wives being cared for by their husbands, four mothers and their non-resident carer daughters, three mothers and their resident carer daughters and four women being cared for by someone else including a friend, neighbour or other relative.

The researchers' drew on Goffman's concept of the total institution to theorise the relationship of carers and cared for people. Goffman suggested that "custodial care" involved three key elements – routinisation, surveillance and "mortification of the self". The researchers found all three elements present in the relationships that they observed. For example, those with dementia were particularly distressed by the loss of their former identities such as car driver, or homemaker, and were often treated like children by their carer.

The researchers found that all of the caring partnerships found ways of balancing custodial care, intimate relationships and a home life. This included combining routines with other activities, evading surveillance or carrying it out by discrete means and attempting to maintain some semblance of former identities.

Practice example

East Lothian Community Health and Care Partnership

Health and social work staff in the community health and care partnership undertook training in relation to outcomes and also with respect to carers assessment. This training emphasised outcomes focused carers assessment and provided opportunities to improve communication with service users and carers and was perceived to improve decision making and result in more relevant interventions. The work was evaluated by Cook and her colleagues in 2007. Staff and carers participated in focus groups to discuss the impact of the pilot. Practitioners who had initially been sceptical about carers assessments became more positive and carers noted the positive impact of undergoing an assessment that focused on their needs. Digital stories involving carers and staff were created at the end of the pilot and are now shared as examples of good practice.

Further reading

Cavaye, J (2006) *Hidden carers*, Edinburgh: Dunedin Academic Press

Miller, E (2007) *Identifying the outcomes important to unpaid carers*, Edinburgh: Scottish Government Joint Improvement Team

Workforce

Key messages:

- Gathering accurate data on the social care workforce is essential if demand is to be met appropriately.
- Providing appropriate training to the workforce to meet the increasing demands for personalised services will develop capacity.
- Raising the status of social care work will enhance the workforce
- Enhancing the regulatory framework and qualifications systems will encourage recruitment.

Research findings:

Background

As can be noted from the policy context described earlier there have been significant changes, over a relatively short space of time, in the care environment relating to the delivery of services for older people with higher level care needs.

- First, there is a commitment to a more person centred style of care service with a greater level of choice for the service user.
- Second, demographic and social changes have led to an increased demand for care services thereby requiring an expansion in the social care workforce. Third, there has been a decline in the supply source for this traditionally low skilled work.
- Fourth, in response to policy requirements, there have been changes in the arrangements for the delivery of social care which mean that a significant number of social care staff are now employed outside the statutory sector. Finally changes in practice brought about by policy drivers such as personalisation have changed both the role and remit of the social care workforce and the relationship between the workforce and those who require support.

(Chester et al 2009)

The impact of these changes will be considerable and research has already established that local variations in types of personalisation and individual budget use may affect the workforce capacity to tailor support and to sustain developments (see for example Manthorpe and Stevens, 2010). Much of the research evidence reviewed focused on the challenge of recruiting and retaining a social care workforce as well as evaluating the use of migrants within the workforce (e.g. Hussein and Manthorpe, 2005; Hussein et al, 2010). However, it is difficult to assess the contemporary implications of this evidence in the current economic climate with unemployment rising and funding of social care services reducing significantly across the U.K. The focus

perhaps therefore should be on identifying and enhancing the current workforce taking account of the impact of the existing policy framework on the changing role and skill set required.

Workforce planning

Comprehensive workforce planning is crucial yet challenging, particularly as it is heavily dependent upon information gathered from employers. There is a view that existing data collection is not coherent or comprehensive (Ripfa 2010), partly due to the fact that non-registered organisations such as community projects do not regularly return data on their workforce. In addition data on new types of posts emerging from initiatives such as self-directed support is limited. In addition some employees work across organisations and therefore may be double counted. The Care Commission annual returns in Scotland as well as the Scottish Local Authority Social Work Services (SLASWS) survey and the annual business inquiry (ABI) provide the basis for what we currently know about the social care workforce in Scotland. The latest data snapshot provided by the Scottish Social Services Council (2011), based on figures from 2008 and 2009, provides an overview of the current workforce with the majority of social care workers providing support in care homes for adults and housing support/care at home.

Status

Improving the status of social care work has been seen as an aid to increasing recruitment of staff (Ripfa 2010), with the lack of detailed regulatory or qualification requirements being seen as a barrier to this improved status. Potential ways to improve status includes the development of an agreed qualifications framework across the workforce. In Scotland however there is a clear commitment to the extension of both regulation and qualifications across the social care workforce.

Research example

Manthorpe and Stevens (2010) Increasing Care Options in the Countryside: Developing an Understanding of the Potential Impact of Personalisation for Social Work with Rural Older People. In the

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This research examined the possible impact of personalisation of social care services in England on older people living in rural areas and those people supporting them in both formal and informal roles. Interviews were conducted with 33 participants. Findings were that the potential flexibility arising from choice and control might be much appreciated by some older people, however there were concerns that local variations would affect the capacity to tailor support and to sustain developments and that the long term effects of personalisation required to be monitored and assessed to ensure

equitable outcomes in rural areas.

Implications for Practice:

- In order to enhance recruitment and retention a clear qualifications and career framework should be developed.
- Accurate data should be recorded across sectors at a local level to ensure a balanced workforce and effective workforce planning.
- Monitoring the emergence of new roles within a Self-Directed Support framework should allow for more effective recruitment

Further reading:

Bernard J and Statham D (2010) Dartington Review of the future of adult social care: The future adult social care workforce. Ripfa: Dartington

Conclusion

The evidence presented in this review suggests that policy drivers and interventions to support older people with higher level needs at home are focused on the promotion of service user involvement, choice and empowerment. In addition new methods of planning, commissioning and purchasing services are evolving with an emphasis on putting decision-making and money in the hands of older people themselves. Whilst there is much positive evidence to support these moves towards co-production within clear care pathways, mechanisms to ensure that choice, services and support are available to all, particular those with the most complex needs are perhaps less well developed.

A range of methods of intervention to support older people to remain at home regardless of their level of needs are considered within this review and implications for practice have been highlighted. While, in many areas, much of the evidence base is inconclusive and often still emerging, the clear policy drivers identified indicate this direction of travel will remain in force for some considerable time to come. This raises questions around the extent to which policy is based on the best available research evidence.

A consistent theme throughout much of this evidence review was the need for effective partnership working and integrated service provision that takes a whole systems approach. This is likely to remain problematic as the evidence base for effective partnership working is patchy with many of the challenges appearing difficult to resolve (see for example Glasby and Dickinson, 2008). However, Currie (2010) indicates that there is now sufficient evidence of integrated working meeting the needs of older people with higher level needs at home and that there is a need to look more closely at options for functional and structural integration in order to deliver better and more cost effective care for older people.

In addition spiralling costs of care at a time of decreasing resources, including the availability of appropriately skilled and trained staff, mean that the provision of services that can effectively meet the needs of older people with higher level care needs will continue to be a challenge. The evidence reviewed herein therefore provides guidance on where the focus of interventions should be to achieve effective outcomes for older people.

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