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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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1. Introduction

The aim of this review is to provide an overview of the best available evidence in relation to 'what works' in increasing the percentage of people aged 65 and over with high level care needs who are cared for at home. This is the aim of one of the Scottish Government's 45 indicators of success in achieving national outcomes identified in the National Performance Framework. Government policy changes rapidly and in the current financial climate it has never been more important to ensure that such changes are informed by good quality research evidence. Determining 'what works' is complex and is often contested. How it is determined depends on which particular outcome one is attempting to measure. This review attempts to highlight 'what works' from the perspectives of all the key stakeholders involved in the process. It will also highlight where there is a lack of high quality research evidence.

Terminology

There were significant challenges in defining higher level needs. In 2010 the Scottish Government indicated that homecare inputs of over ten hours each week were regarded as intensive packages. Other measures would suggest that receiving more than 20 hours of homecare each week indicates higher level needs. For the purposes of the review only studies that defined their sample group as having 'higher level, complex or intensive needs' or those with dementia were included. In addition sample groups of people over 65 who received interventions from both health and social care were included.

2. Methodology

A literature search was undertaken using a range of methods, including accessing key academic databases. 'Grey' literature of relevance to the study including policy documents and unpublished primary research was also accessed, with advice from a Research Advisory Group and interviews with key informants. In addition, contact was made with homecare managers to identify unpublished, locally commissioned work. Each source was analysed with the assistance of a Data Extraction Form that assisted the researchers to assess the quality of the research methodology adopted in each study and its relevance to the topic.

3. Policy Context

The provision of support to older adults has been subject to myriad policy developments in recent years. It is widely acknowledged that the majority of people wish to remain at home throughout their life (eg Eckert et al, 2004). Evidence suggests that this can result in positive mental well-being (Cutchin et al, 2009) and can delay the onset of illness and dependency (Elkan et al, 2001).

It has also been assumed that supporting people to remain at home will reduce the cost of care for older people (Dickinson et al, 2010). Given the predicted increase in the older population in Scotland this is an important consideration. In order to produce efficiency savings the Government has suggested that innovative approaches to providing support at home that make use of technology will become increasingly important.

The review of policy developments across the UK revealed a number of trends. The first related to the promotion of choice via the personalisation agenda. Research suggests that older people with higher level needs and people with dementia need additional support to take advantage of self-directed support (Glendinning et al, 2008; Alzheimer's Scotland, 2010). A study by the Audit Commission in England (2010) found that personal budgets did not necessarily save money for local authorities but that they did produce better outcomes for service users and carers.

The second key area relates to the promotion of independence for older people, part of the Shifting the Balance of Care agenda (Scottish Government, 2008). This identified a number of areas for improvement around maximising care at home, reducing inappropriate admissions and improving joint working. A key message was around the development of anticipatory care in order to meet the needs of older people before they reach crisis point. Likewise, the National Dementia Strategy (2010) highlighted the need for early diagnosis. It also emphasised the need to provide appropriate support to people with dementia and their carers at home.

A focus on outcomes is also inherent within the policy agenda, with outcomes-focused assessment and provision being recognised as increasingly important. The evidence base suggests that service users in receipt of such services have reported improvements in confidence and physical functioning (Glendinning et al, 2007; Manthorpe et al, 2007).

4. Practice Issues

1. PRACTICE ISSUE ONE: Assessment and Care Management

The concepts of single shared assessment (SSA) and care management are not particularly new but challenges remain in relation to their implementation. The goal is to ensure timely assessment and the provision of appropriate services while at the same time avoiding duplication. Effective collaborative working is essential to ensure that care is being provided by and managed by the most appropriate professional(s) and reviewed as appropriate. The evidence base around the effectiveness of SSA on maintaining older people with higher level needs at home is inconclusive. Clarkson and colleagues (2009) found that when single assessment procedures were applied, the probability of detecting need was higher than before, thus allowing earlier intervention that might enable older people to remain at home for longer. In addition Miller and Cameron (2011) noted that, whilst the evidence of benefits was fairly limited, improved communication, service user and carer involvement and improved partnership working could be attributed to the process of SSA. However, Eccles (2008) argued that SSA has not delivered on its stated aims and the benefits are unclear.

Care management, as a process, should be targeted at those with higher level or frequently changing needs. However research suggests that it has drifted from this original vision and has often been applied inappropriately (Challis, 2001; Stalker and Campbell, 2002). Again, the evidence base is inconclusive with no one model of care management being identified as most effective (Reilly et al, 2010). It is further unclear whether care management as a process can reduce bed days or prevent hospital admissions (Sargent et al, 2007).

Research example

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 homecare, 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 inappropriate admissions.

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

Implications for practice

SSA

For SSA to be effective:

- 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 is important in developing preventative responses to assessment
- Clarity about capacity to deliver services is essential to ensure staff do not become disengaged.

Care management

For care management to be effective:

- The core elements of care management require to be adhered to – assessment, care planning, implementation and review
- It needs to be targeted at those with higher level or frequently changing needs and caseloads require to be contained
- The process of care-management requires to be consistently applied and transparent across disciplines.

2. PRACTICE ISSUE TWO: Specialist services to shift the balance of care

Homecare reablement

Homecare reablement 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 minimize 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. To date, the research findings have been largely positive. An evaluation undertaken by De Montfort University (2000) provided evidence of a reduction in commissioned hours for those undergoing a period of reablement when compared with a control group. A more recent evaluation in Edinburgh found a considerable reduction in hours required, with two thirds of service users requiring no further service at the end of the reablement period (McLeod and Mair, 2009). Similarly, positive results were reported by Ryburn and her colleagues (2009) in their literature review of reablement in the UK and the USA.

A study published by the Department of Health (2010) added a longitudinal element to the research. Their findings were mixed. While they found that older people with higher level needs had reduced packages of care after a period of reablement, their comparison with control groups suggested that when taken together there was no statistically significant difference in the costs for health and social care.

Slasberg (2009) has questioned the methodology of such studies. In relation to the Leicester study for example, he highlighted that those allocated a package of reablement 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 reablement 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 reablement services to the development of a reablement culture aimed at all service users is necessary.

Research example

Four case study sites were selected that offered reablement services (two as part of the homecare service and two as part of the hospital discharge process). A range of data was routinely gathered on those who received homecare reablement and services subsequently used and interviews were carried out with service managers. The study found substantial reductions in homecare packages two years after receiving a reablement service. One of the key messages emerging from the study was the need to promote the reablement approach across all of adult social care to ensure long term outcomes. This requires a more flexible approach than perhaps the standard six week package allows. It also requires a shift in attitudes amongst staff, service users and carers. Staff training is required.

Social Policy Research Unit (2007) Home care reablement: Retrospective, Longitudinal Study

Implications for practice

For homecare reablement to be effective:

- a clearly agreed assessment process is essential
- person-centred flexible support ensures greatest success for service users
- inclusion of an OT in a team can promote faster access to equipment and adaptations
- staff should have a pro reablement attitude and be supported via appropriate training, eg SVQ level 2
- referral systems to follow-on services should be transparent to avoid delays
- there should be acknowledgement of the importance of working with carers on the reablement journey.

Prevention of admission/supported discharge models

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. This relates to the availability of support networks of friends and family, levels of affluence and availability of staff (eg Gilbert et al, 2010). The Commission for Social Care Inspection published a review in 2004 of major initiatives to speed up hospital discharge. 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. Hubbard 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.

The available evidence on the success of various models of admission prevention and supported discharge is mixed. Walker and Jamrozik (2005) found that screening for medical emergencies made no significant impact on admissions among the over 75s. Wilson and colleagues (2006) found that depression was common among those being discharged from hospital and that it was a major risk to their long term survival in the community. On the other hand Hyde et al (2000) in a systematic review did confirm that supported discharge is associated with a reduction in future hospital admissions. Significantly the national evaluation of the Partnership for Older Peoples Projects 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) The disparity in the evidence can be accounted for by differences in outcomes being measured, populations being studied, definitions adopted and research methods used (Glasby et al, 2004).

What is clear is that the evidence suggests that inter-related medical, functional and social problems need to be taken into account via appropriate assessment and screening. Shepperd et al (2010) found that a structured discharge plan tailored to the individual's needs results in a small reduction in length of hospital stay and a reduction in readmission rates for older people. However, the impact of discharge planning on mortality, health outcomes and costs remains uncertain.

Practice example

The 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% (£4,303) per patient although this did not include the additional costs involved in running the service.

Perth and Kinross: Transitional care at home service

Delayed discharge and people with dementia

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. 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. Step-down facilities, which offer rehabilitation following a hospital stay, can increase the number of people who return to their own homes.

Implications for practice

For delayed discharge models to be effective:

- requires a whole system approach which includes identifying the main causes for delay in the local system, developing services to tackle these causes, evaluating impact and monitoring the statistics
- discharge planning needs to begin on admission to hospital
- early supported discharge models can be effective: however they require clear commitment from carers in order to ensure an effective outcome for all involved.

Intermediate care

It has been difficult to establish a reliable evidence base on the effectiveness of intermediate care as there is such a wide range of services available under this umbrella term. It appears that intermediate care is clinically equivalent to traditional in-patient services and makes little difference to the length of time that service users are able to stay in their own homes (Parker et al, 2000; Trappe-Lomax et al, 2006). It is thought that services have been too small, inadequately targeted or insufficiently integrated to achieve a whole system change to the care of older people (Young and Stevenson, 2006). The National Evaluation of the costs and outcomes of intermediate care (Barton et al, 2006) identified a number of benefits relating primarily to service user experiences and outcomes, particularly in relation to independence, quality of life and increased confidence (Regen et al, 2008). The research evidence highlights the importance of patient-centred, flexible and holistic services. One of the most important functions of intermediate care from the perspective of service users and carers was to support their reintegration into social networks (McLeod, et al, 2008).

Challenges in delivering intermediate care relate to difficulties in the recruitment and retention of staff and a lack of effective joint working. (Barton et al, 2006; Regen et al, 2008). In addition, it is recommended that models of intermediate care adopt a holistic approach, providing practical support to maintain and enhance quality of life, provide an educational function, for example in terms of learning to use new technology as well as addressing psychological barriers that might exist in terms of returning to previous social networks.

Research example

The review aimed to map the development of intermediate care 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. 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.

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

Rapid Response Teams

There is evidence to suggest that Rapid Response Teams assist in getting people home from hospital quicker and ensure that individuals can remain out of hospital (Beech et al, 2004). The evidence around the effectiveness of Rapid Response Teams is generally positive. Beech and colleagues found that 5.7 per cent of rapid response team patients were readmitted to acute hospital care. This is similar to other studies such as the National Audit Office study in 2003. On the other hand, a study by Young and Stevenson (2006) could not identify any clinical difference between those receiving intermediate care from the Rapid Response Team and a control group.

Implications for practice

For intermediate care services to be effective:

- Strict time limits can be unhelpful and require to be flexible without being endless
- Effective partnership working with multi-disciplinary teams is most important element in success
- Home-like settings provide key benefits
- Stable funding with appropriate levels of staff is essential
- Ensuring awareness of role of service across agencies and disciplines
- A whole systems approach is required to ensure a clear care pathway.

Falls Prevention and Intermediate Care

Gilbert and colleagues (2010) found that older people admitted to hospital after a fall are more likely to be discharged to a care home than those (with similar characteristics) who are admitted to hospital for any other reason. Falls strategies are important in ensuring older people with higher level needs remain at home. Research into the effectiveness of such services found that a dedicated service reduced the need for emergency admissions (Rose et al, 2002).

A Cochrane Review of interventions preventing falls in older people in the community (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. Exercise-based interventions such as strength and balance training were effective in reducing falls as was Tai Chi and individually developed home-based exercise programmes. A gradual withdrawal of some psychotropic medications and a comprehensive prescribing modification programme for GPs were also found to reduce falls.

Implications for practice

For falls prevention work to be effective:

- A clear falls prevention strategy needs to be in place and part of the care pathway
- Multi-factorial programmes are seen to be most effective including person-centred exercise programmes
- Withdrawal of sedative or hypnotic medications can also increase success
- Surgical interventions, eg cataract operations, can produce effective outcomes.

3. PRACTICE ISSUE THREE: Long term services to maintain people at home

Homecare

Homecare has traditionally been associated with cost savings in comparison to residential care. This is only likely to be true when the level of care needed is low (Mottram, 2007). Homecare is increasingly targeted at those clients with the highest needs and the number of older people (aged over 65) receiving an intensive service of over ten hours per week has increased from 9.0 clients per 1000 population in 1998 to 18.1 clients per 1000 population as at March 2010 (Scottish Government, 2010).

The evidence suggests that homecare staff have a crucial role in enabling older people to remain at home. A meta-analysis of 15 studies showed that homecare programmes were effective in reducing mortality and admission to residential care although there was no reduction in admissions to hospital (Elkan et al, 2001). Eloranta and colleagues (2008) argue that the social aspect of homecare is crucial in terms of empowering older adults. It also has a significant role to play in identifying risk factors that might become a threat to older adults remaining at home.

Implications for practice

For homecare to be effective:

- It needs to be targeted at those with the most complex needs
- 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 homecare
- Staff need awareness and understanding of wellbeing to promote service user outcomes.

Homecare and daycare for people with dementia

Services for people with dementia have been shown to reduce the stress faced by family care-givers and can delay the onset of institutionalisation. Older people with dementia are often reluctant to accept services as a result of believing they do not need support and fears about losing services. Lack of tailored services is another explanation for refusal of services as is undiagnosed depression (Durand et al, 2009).

Implications for practice

For homecare with people with dementia to be effective:

- It needs to be task-centred to ensure independence is promoted
- Workers need to understand dementia and have appropriate training
- It will require more time than traditional day care with those who do not have dementia.

4. PRACTICE ISSUE FOUR: Innovations

Telecare

The Joint Improvement Team in Scotland funded a national development programme for Telecare that was launched in August 2006. An evaluation of the first two years of the programme found that not only did telecare save money, but it improved the quality of life of service users and their carers (Scottish Government, 2009). Over 13,000 bed days and 61,000 care home days were saved.

A growing body of literature has emerged in relation to the ethics of telecare (Eccles, 2010). While telecare has the potential to be of considerable benefit, a number of concerns have emerged. These relate to the privacy and freedom of the individual and the potential that telecare has to reduce human contact, resulting in greater social isolation.

The attitudes of older people towards technology are crucial to its success or otherwise (McCreadie and Tinker, 2005). Willingness to use technology is based on a complex mix of factors including felt need, access to technology, attributes of the technology such as efficiency, and reliability and acceptability. The felt need for support was found to be more important than chronological age in terms of accepting the technology.

An overview of the evidence base for the successful implementation of telecare was published by CSIP in 2006. The study found some evidence of effective outcomes for service users in relation to vital signs monitoring equipment and information, advice and support, but almost no evidence that safety, security and monitoring equipment was effective in reducing costs or in achieving improved outcomes.

Research example

This systematic review of home Telecare for frail older people and other patients with chronic conditions searched 17 databases and found 68 randomised control trials and 30 observational studies of interest. The review found that the most effective telecare interventions appear 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 the interventions was less certain. There appeared to be insufficient evidence about the effects of home safety and security alert systems.

Barlow J et al (2007) A systematic review of the benefits of home telecare for frail elderly people and those with long term conditions *Journal of Telemedicine and Telecare* 13 (4): 172-179

Practice example

The service aims to maximise independence by increasing personal and environmental safety, enabling the recipient to live in their own home for as long as possible. Equipment is linked to trained advisors who respond to calls for help. The equipment ensures access to help when it is most needed. The service can be offered as part of larger packages of support.

West Lothian Home Safety Service

For telecare to be effective:

- 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.

5. PRACTICE ISSUE FIVE: The implications of maintaining older people at home

Costs

It is predicted that demand for long-term care will continue to grow, reaching a peak around 2040 (Karlsson et al, 2006). The Personal Social Services Research Unit developed a model to predict the future costs of long-term care. They have predicted that services will have to expand by 61 per cent between 1995 and 2031. Homecare will have to increase by around 60 per cent by 2040 (PSSRU, 2007).

In Scotland, the policy commitment to free personal care has raised questions as to whether the current situation is sustainable in the long term. Bowes and Bell (2006) 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.

Carers

Karlsson et al (2010) predict that the number of older people in receipt of unpaid (informal) care will increase from 2.2 million in 2006 to 3 million in 2050. The impact of caring on health and well-being has been well documented. Looking specifically at carers of people with dementia, Schoenmakers and her colleagues (2010) have shown that they are more likely to experience higher levels of burden and depression compared to other groups of carers.

Carer stress and wellbeing is difficult to predict and measure. Contextual factors such as age and ethnicity as well as stressors and strains and resources such as coping and social support must be considered. Interventions to support unpaid carers have not always been successful. Schoenmakers et al (2010) highlight the importance of not assuming that one type of intervention will suit all carers. Interventions to enhance psychosocial resources are likely to be significant and include carer education, behaviour management techniques, problem solving training and personal counseling for emotional distress.

The importance of carers' assessments cannot be underestimated. However practitioners continue to have concerns and anxieties about undertaking such assessments (Miller, 2007). These anxieties relate particularly to resource implications. Yet, a number of studies have confirmed that requests from carers tend to be fairly modest (Seddon et al, 2007; Miller, 2007).

Workforce

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).

Conclusion

A consistent theme throughout much of this evidence review was the need for effective partnership working and integrated service provision, which takes a whole systems approach. This is a significant challenge as the evidence base for effective partnership working in a range of services/processes which support older people with higher level needs at home is patchy, with many of the challenges appearing difficult to resolve (see for example Glasby and Dickinson, 2008).

In addition spiraling costs of care with decreasing resources, including the availability of appropriately skilled and trained staff, mean that the provision of services which can effectively meet the needs of older people with higher level care needs will continue to be a challenge. However the evidence reviewed here does provide guidance on where the focus of interventions should be to achieve effective outcomes.

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Full report available at www.iriss.org.uk

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