

Introduction

Welcome to the 7th edition of the PSSRU at Manchester Research Focus. In this edition we have highlighted three studies from our work in the NIHR School for Social Care Research (NIHR SSCR). The first of the studies examines the work patterns and responsibilities of Occupational Therapists in Social Care and links to a toolkit which can be employed in agencies. The second study looks at Resource Allocation to individual service users in the context of personal budgets. It

examines some of the risks and inefficiencies of using unproven tools in complex care. The third considers the emergence of Care Coordination for Older People in the non-statutory sector, a role developing in a number of localities. Each of these studies is very relevant to the implementation of the 2014 Care Act, the changing responsibilities of the social care workforce, changing role of providers and making best use of scarce resources.



The Changing Role of Occupational Therapy Services in Social Care

A new policy and practice landscape has emerged in England. Successive reforms have expanded community care and reduced residential home placements to promote independent living at home. In addition to the evolution of specialist assessments and equipment and a growing emphasis on cross-professional themes, occupational therapists now play a key role in integrated care. Despite the fundamental impact that such changes may have on the occupational therapy role, surprisingly little is known about the breadth of their activity.

The lack of standardised instruments available to measure the role of occupational therapy services in social care is a hindrance to research, evaluation and evidence-based practice. Diary tools have been repeatedly used with practitioners in adult social care, community mental health services, hospital-based social work, continuing healthcare and intermediate care settings which – when linked with other data – provide a means for exploring a wide range of research questions. The PSSRU, funded by the NIHR SSCR and in association with the Staffordshire and Stoke-on-Trent Partnership (SSOTP) NHS Trust, developed a new diary tool to determine how qualified and assistant-grade practitioners invested their time, and to investigate any association between time use, service setting and qualification status.

The self-report paper-based diary tool comprised an anonymised daily grid divided into 30-minute intervals, with a list of 37 activity codes for practitioners to complete each day during a reference week. The activities were organised into four sections: direct care, indirect care, team/service work, and other tasks.

One hundred and fifty-one schedules from the 244 SSOTP Trust practitioners undertaking

an occupational therapy role were subject to a narrative and pragmatic evaluation: (1) an evaluation of the standard of schedule completion, (2) a group interview with three participants to explore their experiences using the schedule, and (3) a presentation of preliminary findings from the pilot to operational and strategic managers to review the face validity of the findings and to explore the utility of the diary schedule in reviewing performance.

Almost 5000 hours of practitioner activity were recorded. It was found that less than 10 per cent of the average working week was spent on 'therapeutic activities': one of the roles expected to be a central component of an occupational therapist's duties. For the average working week, 39 per cent was spent in direct care with clients, whilst 31 per cent was undertaking indirect casework and a further 22 per cent in service development activities. Data also suggested that respondents spent over twice the time undertaking wider assessment activities as they did on occupational therapy specific assessment.

These findings possibly reflect the breadth of skills possessed by occupational therapists and the multi-disciplinary nature of their work. The appropriate balance between direct and indirect care has been a topic of some debate, due to concerns that health and social care reforms have proceduralised service delivery at the expense of service user/carer contact. These findings are similar to a 2000 study of a health visiting practice, in which respondents spent on average 41 per cent of their time in direct client contact and 27 per cent on 'client-related' activity, with the remainder on travel, administration and so on (Crofts et al., 2000).

The data provide some evidence that qualified staff spent more time undertaking

occupational therapy specific activities than assistant grade counterparts, particularly in primary care services. Qualified practitioners spent more time than assistant grade respondents on multi-disciplinary working, whilst spending less time on office-based administration. Assistant grade practitioners spent significantly more time on therapeutic activities than their qualified counterparts, whilst the reverse was true for time spent on care planning, monitoring and reviewing.

These results raise questions about whether occupational therapists have moved too far away from rehabilitative forms of support and too far towards the delivery of compensatory approaches. Given the current emphasis towards prevention and self-care (NHS England, 2014), and the College of Occupational Therapists' previous statement that the majority of casework should be focused on special occupational therapy interventions (Pettican and Bryant, 2007), the findings here hint at a cause for concern.

For further information, visit:

<http://research.bmh.manchester.ac.uk/pssru/nihrsscr/projects/occupationaltherapy>

Other References

Crofts, D., Bowns, I., Williams, T., Rigby, A., Haining, R., and Hall, D. (2000). **Hitting the target: The equitable distribution of health visitor caseloads.** *Journal of Public Health Medicine*, 22(3), 295-301.

NHS England. (2014). **Five Year Forward View.** London: NHS England.

Pettican, A., and Bryant, W. (2007). **Sustaining a focus on occupation in community mental health practice.** *British Journal of Occupational Therapy*, 72(8), 366-370.

Resource Allocation at the Micro Level in Adult Social Care: Determinants, Methods and Guidance

How can social care costs be accurately predicted from individual needs and characteristics? Local authorities are required to offer 'personal budgets' tailored to personal goals and circumstances. One element of this personalised approach has been the attempt to develop resource allocation systems that provide a consistent method for estimating the appropriate amount to meet identified needs.

The challenge has been to develop a credible resource allocation system in which the needs of individuals can be related clearly to the resources expended. Resource allocation mechanisms must be clear, fair, defensible, workable and delivered within budget. The criteria which underpin them must be both valid (with resources allocated accurately according to level of need) and reliable (where the methods used with similar groups of people produce broadly similar findings). However, the feasibility and utility of such systems has been queried, suggesting that the relationship between needs and costs cannot be modelled with sufficient accuracy to provide a useful guide to individual allocation (Series and Clements, 2013; Clifford, Saunders and Gibbon, 2013).

This research was commissioned by the NIHR SSCR and undertaken by the PSSRU in partnership with FACE Recording and Measurement Systems Limited. The research aimed to promote a greater understanding of resource allocation processes in adult social care. The financial guidance in the Care Act 2014 increases the salience of this work.

The study used information from a variety of sources:

- i. A scoping review of the literature relating to resource allocation processes within adult social care.
- ii. Analysis of tools used by local authorities.
- iii. Empirical analysis of routinely collected assessment and resource allocation data in 20 local authorities.
- iv. Consultation with older people and adults with a learning disability.
- v. Consultation with Directors of Adult Social Care.
- vi. Perspectives of Directors, older people, adults with a learning disability, and actual expenditure were compared.

The literature review found a lack of high quality empirical evidence on resource allocation, much of it descriptive. Some papers and most reports lacked methodological rigour,

and necessary information was not easily accessed. There were variations in the quality of the work included, and underlying concerns about the adequacy, accuracy and validity of the resource allocation systems given the lack of psychometric evaluation. The studies failed to address the relative needs weights for different user groups and the contribution of carers.

Several approaches to the allocation of resources were identified, including points-based approaches. The extent to which key domains of need were included in the resource allocation tools varied considerably. Moreover, there was a lack of empirical evidence underpinning the content and operation of these resource allocation processes at the individual level.

Analysis of data from local authorities on characteristics and costs of care identified eight needs-related outcomes which determine resource allocation: activities of daily living (ADL), instrumental activities of daily living (IADL), social relationships, active citizen, care for others, safety, carer burden, and psychological well-being. For older people, ADL and IADL were the most important determinants of resource allocation, and for people with learning disabilities, carer burden and ADL were most important. The amount of resources allocated to both older people and adults with a learning disability was inversely proportional to the amount of care undertaken by informal carers, i.e. those who reported a higher level of reliance on their carers were expected to be allocated fewer resources.

The views of 436 older citizens, twelve citizens with a learning disability and 34 per cent of Directors of Adult Social Care within England were collected and compared. Participants were asked to identify the three most important of the eight needs-related outcomes.

For older people, citizen participants (4/5 aged 70 and above) prioritised ADL and IADL. Outcomes relating to carers, well-being and social relationships were identified as the least important. Directors prioritised ADL and personal safety. Interestingly, psychological well-being was ranked much higher in this consultation than in actual resource allocation.

For people with learning disabilities, the outcomes of psychological well-being, active citizen and safety were identified as the

most important by citizen representatives. Again, directors prioritised the need outcomes relating to ADL and to personal safety. Participants with learning disabilities prioritised needs-related outcomes relating to themselves rather than those relating to their carers or their caring responsibilities.

The processes that underscore the allocation of a personal budget are complex. A critical issue is whether the relationship between need and cost can be modelled with sufficient accuracy to provide a guide to individual allocation – a question of broad relevance to social policy. Resource allocation to individuals with complex, multiple and varying needs is perhaps too complicated to be left to over simple solutions. There remains the challenge to accommodate different perspectives about need; a concern over the employment of unproven techniques in determining resource allocation; the general lack of psychometric evaluation of resource allocation tools; and the potential insensitivity of these to complex and multiple needs. Alternative approaches, such as more traditional resource allocation processes like assessment, could be more suitable to certain user groups to ensure that the personal budget is appropriate to meet needs.

For further information, visit:

<http://research.bmh.manchester.ac.uk/pssru/nihrsscr/projects/resourceallocation>

Other References

Davies, S., Clarkson, P., Hughes, J., Stewart, K., Xie, C., Saunder, R., and Challis, D. (2013). **Resource allocation priorities in social care for adults with a learning disability: an analysis and comparison of different stakeholder perspectives.** *Tizard Learning Disability Review*, 20(4), 199-206.

Series, L., and Clements, L. (2013). **Putting the cart before the horse: resource allocation systems and community care.** *Journal of Social Welfare and Family Law*, 35 (2), 207-226.

Clifford, P., Saunders, R., and Gibbon, L. (2013). **Modelling the relationship between needs and costs: how accurate resource allocation can deliver personal budgets and personalisation.** *Research, Policy and Planning*, 30(2), 107-120.



Care Coordination: Exploring and Informing the Emerging Role of the Non-Statutory Sector in Long-Term Aged Care in England

Guidance and legislation introduced over the last 20 years has encouraged partnerships between the government, non-statutory sector and service users. It has transformed the provision of care coordination by increasing capacity within the social care market and encouraged more personalised care for service users. The Care Act (2014) confirmed this trend permitting delegation of some local authority functions to the private or non-statutory sector, thus allowing greater flexibility and efficiency in the delivery of care coordination services.

Estimates put the numbers of non-statutory health and social care organisations in England between 26,000 and 35,000, although there is diversity in their size and scope. However, little research exists exploring the role of non-statutory organisations in the provision of social care services. Furthermore, there is limited systematic research into the delivery of care coordination for older people or guidance to inform the conduct of organisations within this sector. The NIHR SSCR commissioned the PSSRU, in partnership with staff at two non-statutory organisations (Age UK Trafford and LMCP Care Link, formerly the Longsight/Moss Side Community Project), to undertake this research. The purpose was to inform future practice by exploring and articulating the care coordination arrangements for older people in the non-statutory sector.

A ten-stage mixed methods approach was adopted (Table 1).

Findings were subjected to a structured analysis to identify strengths, weaknesses, opportunities and threats associated with developing care coordination services in the non-statutory sector.

Strengths

Strengths of the non-statutory sector included its unique selling points in the local care economy. For example, organisations were able to recruit staff based on 'the right attitude' as opposed to professional qualifications, although this then required a bespoke training and development programme. A further strength was that organisations maximised the contribution of volunteers in service delivery.

Non-statutory organisations contributed to a wider spectrum of care by providing services which complemented statutory provision. Additionally, service users and carers valued the organisations' independent status and the informal approach to service delivery. Such customer feedback may directly inform service improvements and quality assurance.

Weaknesses

Most weaknesses related to the working practices of non-statutory sector organisations. Some were small in size potentially limiting their scope. This posed a particular problem for care coordination in long-term aged care, where immediate availability and continuity of care in the longer term were recognised by practitioners and services users as important.

Integrated care may be further limited by underdeveloped links with the statutory sector. Volunteers were an essential component of many non-statutory organisations. However, their long-term commitment to the service was not always matched by investment in their recruitment or training. Finally, an excessive focus on performance data, to meet both organisational and contractual requirements, may be detrimental to the overall operation of many organisations.

Opportunities

Historically, non-statutory organisations have played an important role in developing innovative services in response to unmet need. They also acted as service providers to people with specialist needs thereby filling the gaps in care provision and complementing statutory provision.

Partnership working, which facilitated information sharing between organisations within the non-statutory sector, improved the service user experience. More generally, the promotion of organisations in local areas meant those in need were aware and could access services. There were two main methods to achieve this. First, publicity and marketing in public places (such as GP surgeries) and the internet. Second, through direct contact with professionals (nurses and social workers).

Threats

The small size of many non-statutory organisations limited their potential to both complement and substitute for statutory provision. Short-term funding can make it hard to recruit and retain staff and may contribute to uncertainty within the work environment. Of more relevance to service users and carers, particularly older adults, this threatens continuity of care and long-term support.

Therefore, commissioning, contracting and monitoring must be proportionate to the non-statutory organisation, reflecting the scale and nature of the services. Measures of performance for contract monitoring should not be the sole determinants of service quality nor appraisal associated with contract renewal.

Conclusions

These findings suggest that care coordination arrangements for older people are attainable by the non-statutory sector, however there are factors affecting the feasibility and longevity of this. The strengths of the sector are derived from their independence from the state and flexible approach to staffing. Their weaknesses relate to their relatively small scale and sometimes limited range of available care coordination tasks. Nevertheless, opportunities exist for non-statutory organisations to provide specialist services for older people and to work in partnership with other local agencies. Threats to their longevity are associated with fixed-term funding and the uncertainties consequent on commissioning processes.

For further information, visit:

<http://research.bmh.manchester.ac.uk/pssru/nihrsscr/projects/carecoordination>

Table 1. Ten-stage mixed method approach

i	A scoping review of the literature comprising 23 papers to explore what is known about the role of the non-statutory sector in care coordination for older people
ii	Analysis of 20 existing documents describing standards to inform the practice and management of care coordination from agencies in both the UK and further afield
iii	Consultations with 34 people with experience of or familiar with receipt of services to ask their opinions about priorities for inclusion in standards of care coordination in the non-statutory sector
iv	A structured internet search of non-statutory organisations which identified 294 services providing care coordination to older people and working age adults
v	A national postal survey of non-statutory organisations to examine the key determinants of service provision based on 122 responses
vi	Interviews with managers of 17 services in the non-statutory sector to explore operational arrangements and identify emerging themes
vii	Consultations with 19 people with experience of or familiar with receipt of services to determine which attributes of a good quality care coordination service they found most important
viii	A Discrete Choice Experiment questionnaire undertaken with 120 practitioners to elicit their views through ranking and choosing between the most important attributes of a good quality care coordination service for older people
ix	Interviews with practitioners in 17 services in the non-statutory sector to explore the focus and content of care coordination activities undertaken
x	Costs per care episode were calculated from the analysis of activities completed in conjunction with the interviews with practitioners in all services

Recent Publications

Social workers as members of community mental health teams for older people: what is the added value?

Abendstern, M., Tucker, S., Wilberforce, M., Jasper, R., Brand, C., and Challis, D. (2014). *The British Journal of Social Work*, 46(1), 63-80.

Social workers have worked with older people with mental ill health in hospital settings from the 1950s; it was the closure of mental hospitals in the 1960s and the need to provide care and support in the community that precipitated the development of a new type of service in which the social worker was crucial. Articulating the social work role, however, is challenging.

Qualitative data from semi-structured staff interviews were drawn from a multiple case study of community mental health teams (CMHTs) for older people, some with and others without social worker members. Interviews included questions about team roles and the impact of the presence or absence of social workers on team functioning. A grounded theory approach was adopted to analyse the data, enabling issues of importance to interviewees to emerge.

Non-social work CMHT staff were found to place a high value on social worker team membership due to their specific skills, knowledge and values, and with regard to communication pathways. Social workers and other team members' views were found to differ regarding whether social workers within CMHTs should operate as generalists or specialists. The findings suggested the need for formal structures extending beyond the co-location of multidisciplinary staff; appropriate and sufficient supervision for social work team members; and the development of more workable and direct referral systems between CMHTs and social services adult social work teams.

An examination of factors influencing delayed discharge of older people from hospital.

Challis, D., Hughes, J., Xie, C., and Jolley, D. (2014). *International Journal of Geriatric Psychiatry*, 29(2), 160-168.

Improving outcomes for older people during their stay in hospital and on discharge is an international concern. Excessive length of stay (LOS) for older people in acute hospital settings is one facet of this, but little is known about the nature or scope of the problem.

A four-stage sequential framework was developed to investigate the factors associated with the delayed discharge of older people from hospital and their LOS. It was found that cognitive impairment and dependency were significantly associated with delay. Patients admitted to trauma and orthopaedics were significantly more likely to be delayed. Respiratory illness was negatively associated with delay. Care-related factors associated with delayed discharge were not being in the responsible consultant's bed for part of their stay, two or more moves between specialties, and receipt of rehabilitation services. Admission to a care home or receipt of domiciliary care were associated with delay. In the multivariate analysis, dependence and cognitive impairment impacted differently on delay and LOS. Hospital variables were the most important predictors of LOS and social care variables in respect of delayed discharge.

Patient characteristics and especially the organisation of care in hospital and the provision of services on discharge are related to the likelihood of delayed discharge and LOS. Improved services and structures are required to systematically assess and treat patient needs in hospital, together with timely post-discharge services tailored to individual circumstances.

Perceptions of self-defined Memory Problems vary in South Asian Minority Older People who consult a GP and those who do not: a mixed-method pilot study.

Giebel, C., Challis, D., Worden, A., Jolley, D., Bhui, K., Lambat, A., and Purandare, N. (2016). *International Journal of Geriatric Psychiatry*, 31(4), 375-383.

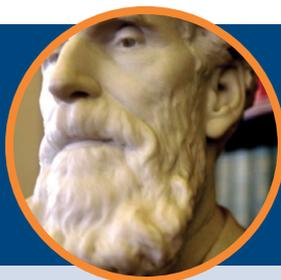
Different communities are reported to have different understandings of dementia therefore factors influencing service access for minority ethnic groups must be addressed. South Asian older adults access services for mental health problems and dementia less than other older people in the UK, unlike for physical health problems. This pilot study investigated how South Asians with self-defined memory problems, with and without a GP consultation about the memory problems, construe the symptoms, causes, consequences and treatment of the condition.

The newly developed Barts Explanatory Model Inventory for Dementia was administered to South Asians aged 65 or above with memory problems. Cognition, executive function and depression were also assessed.

A greater proportion of older adults without a consultation considered memory problems to be given by God, saw acceptance of fate as an alternative treatment and did not identify medical support as appropriate. Forgetfulness and loss of social meaning were identified as symptoms of dementia more by those with a consultation. Higher levels of diabetes, heart disease and depression were found in those without a consultation. Differences in perceptions may influence the decision about consulting a GP. This pilot study suggests the need to explore the impact of perceptions on rates of GP consultation, to improve timely diagnosis and access to services.

Acknowledgement

The three projects in this issue present independent research funded by the NIHR School for Social Care Research. The views expressed in these articles are those of the authors and not necessarily those of the NIHR School for Social Care Research or the Department of Health, NIHR, or NHS.



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