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Old age doesn't come alone: a case study on the impact of the ageing population on a Scottish local authority's care at home service.

16th August 2013

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This paper is dedicated to the following people:

Alison – thank you for all your love and support x

“The Boys” – apply yourself now and reap the benefits later x

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Dr Ailsa Cook – for guidance, clarity of thought and focus.

Abstract

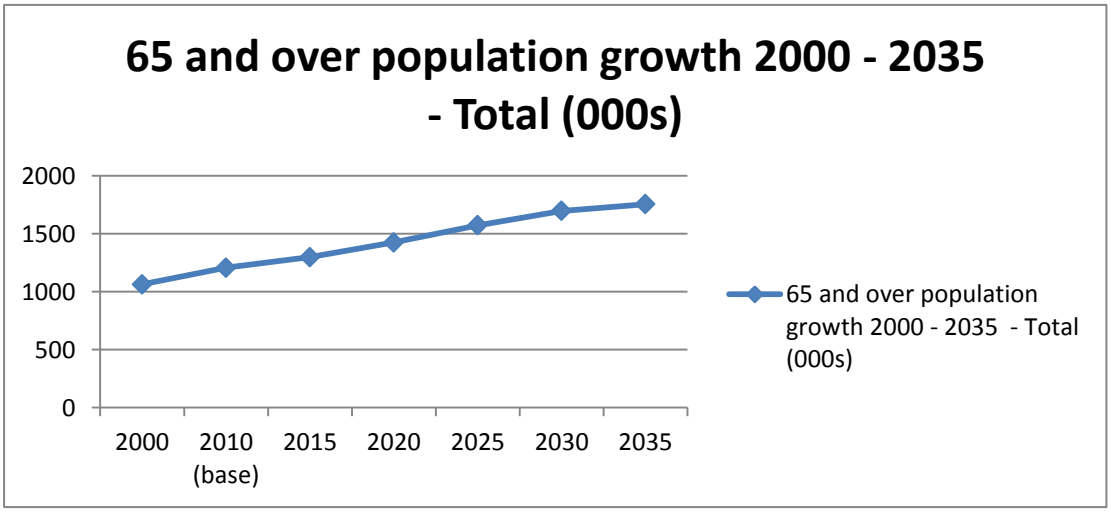
The ageing population is the predominant issue faced by the health and social care sector today. The increased numbers of people reaching their later years are now beginning to impact on organisation's abilities to meet obligations and fulfil policy objectives. However, the numbers alone only tell a part of the story and the adage that old age doesn't come alone is prevalent within this debate. Policies and initiatives have been introduced nationally and locally in an attempt to offset the anticipated demands in the years ahead and this research project has been designed to consider their impact. Using a case study approach a more detailed analysis has looked at one area of the care at home service's operation – the enablement service – to understand better the current trends of activity, but also to develop explanations for these trends.

The findings confirmed that the health and care sector is under increasing pressure to cope with the demand for services which is now not just based on increased numbers, but also from far greater complexity of need. This study recommends that: (i) therapy services are vital to the development of an enablement approach; (ii) there is a need to prioritise those that have the greatest enablement potential, and; (iii) time needs to be ring fenced for enablement services (and wider policy initiatives) to be fully effective. To achieve this there is a need to realign the additional monies provided by the Scottish Government to fund change.

1 Introduction

Scotland like many western European countries is faced with an ageing population that is likely to have major economic and social implications for policy-makers, service providers, and commercial organisations in the future (van Dalen et al, 2010). For example, in 1999 to 2009 there was a 12% increase in those in the 60-74 age group and the increase in the over 75s was higher still at 14%. According to Audit Scotland (2013) the number of people aged 75 and over will rise by 60% by 2031. There is a predicted rise of 38% in the number of people who will be over 85 in the population by 2016, and a 144% in the over 85s by 2031. Population ageing will continue for the next few decades as result of improving survival rates and the two post-World War baby booms of 1947 (Cohort 1) and the 1960s (Cohort 2) begin to impact (GROS, 2013). Figure 1 provides a detailed account of Scotland's ageing population as it has grown from 2000 and the projections through to 2035.

Figure 1: Scotland's ageing nation 2000 -2035



(Source: GROS)

Consequently, Scotland's social care services are likely to face significant challenges as the population ages and demand for front-line services increases (Davidson, Maclardie & Murray, 2007). For public sector organisations in Scotland, service change is inevitable as policy objectives develop innovative thinking around service provision that improves performance and reduces cost (Christie Commission, 2011). The current sense of urgency elevating social care up the national policy agenda is fuelled in part by what is often described as a demographic time bomb that will increase the need for and cost of social care (Razavi and Staab, 2010). In the current gloomy economic climate and faced with imminent cuts in public expenditure at both local and central government levels, the public funds available for social care are likely to be restricted (Unison, 2010). Consequently, policy initiatives driven by the Scottish Government have now challenged the public services to develop future innovative services that will: (i) consider how best to address the increase in demand (Reshaping Care, 2010), and (ii) provide services that will be sustainable in the future (Christie Commission, 2011). Prevention and early intervention are at the very heart of future care and support provision and it is argued that and the promotion of independence in older people through a strategic shift to maximise independence and regain skills (rather than being cared for in the traditional sense) have been shown to offer considerable benefits for many people (Pitts et al, 2011). At the centre of the redesign programme is the paradigmatic shift from traditional care provision based on task and time (where services have dedicated times allocated to frontline staff to carry out specific support) to one that adopts the principles of enablement[1] (where services are short-term and are designed to promote independence and optimise levels of functionality). By adopting an enablement approach, greater emphasis is placed on

[1] Enablement – also referred to as reablement or re-ablement throughout literature. For the purposes of this dissertation the researcher will use enablement throughout

supporting service users towards maximising independence and making them less reliant on services in the future. Consequently, the time savings that can be realised are then used to offset increased demand, effectively doing more with less. A recent report (Joint Improvement Team, 2013) on Scotland's thirty-two local authorities' approach to enablement confirmed that:

> "the enablement approach is shifting the focus of services from task and time approaches to a person centred outcome focus through dedicated and goal focussed assessment, which is well received by service users and carers".
>
> (Dr Margaret Whorisky, Joint Improvement Team, 2013 p4)

The report concluded that additional work is necessary to fully understand the impact of enablement in relation to cost and correlation to health activity upon discharge (JIT, 2013). This dissertation does not seek to address these issues specifically but considers more broadly the impact of a rapidly ageing population on a Scottish local authority (LA) and its attempt to shift the focus to a more contemporary service provision. The overall aim is to explore what factors are inhibiting the effectiveness of enablement. Using a case study approach this dissertation will explore whether: (i) enablement is wholly effective in addressing the increase in current service demands; (ii) the approach adopted by the local authority is undermined as services are now over extended and are attempting to address competing objectives, and; (iii) the paradigmatic change across the sector in the future will materialise if organisations cannot create the capacity and infrastructure to enable change to occur. These issues will be considered by investigating the following research questions. First, what is the demographic context in which social care services are being delivered today. Second, what is the approach taken to enablement in LA. Third, to what extent are enablement services offsetting and preventing increased service demands. Fourth, what are the

factors that are impacting (positively or negatively) on the LA's ability to deliver enablement services.

The remainder of this dissertation is structured as follows. Chapter 2 will consider the literature that has provided the evidence base and supported the introduction of enablement practice in Scotland. Chapter 3 will discuss the methodological approach that this researcher has adopted to gather data to answer the research questions. Chapter 4 will present findings from the data. Chapter 5 will conclude with a discussion and recommendations for the future

2 Literature Review

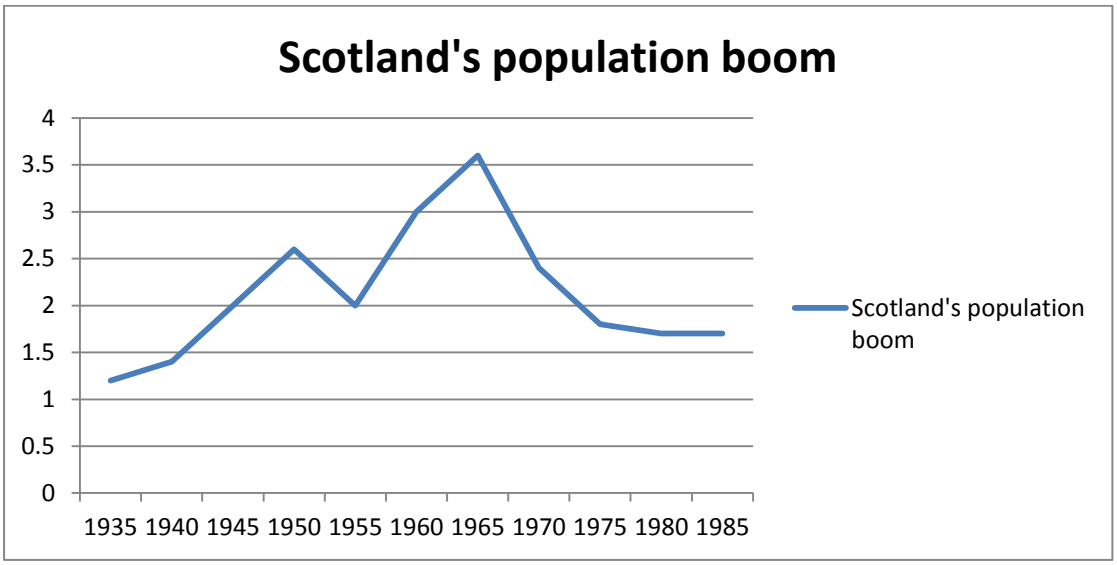
The ageing population is one of the key drivers for change in health and social care sector organisations (Christie Commission, 2011) and one that has been predicated to have significant impact in the developed world (Macunovich, 1999). Considerable statistical data has provided the basis for many organisations (World Health Organisation, International Monetary Fund, Help Age International, and United Nations) to write extensively about the resulting key social, political and economic consequences. The challenges faced by the health and social care sector today, however, are not simply based on increased demand. Although the ageing population remains a key factor in this debate, it cannot be considered solely in isolation and deliberation of a number of other associated matters are required to fully understand the issue. This chapter provides a context for the remainder of this dissertation by considering: (i) the reasons behind the ageing population through a historical lens; (ii) the current economic climate and the financial implications of an ageing population, and; (iii) the strategies and management of living longer.

2.1 The ageing population through a historical lens

Demographers and gerontologists have provided extensive analytical and statistical data from a historical perspective (Bond et al, 2001) and much of this literature focuses on the demographic phenomenon in the post Second World period. The significant population increase in the period 1946-1964 is often referred to as the baby boom years (Willets, 2010) and consists of two spikes of activity in birth rates, one in the immediate post war years from 1946 - 1948 and the second a prolonged period

extending from 1958 through to 1964. It is the first cohort of individuals who are now advancing into their 60s that are having an impact on the health and social care provision in society today (Audit Scotland, 2013). There is no consensus regarding the cause of the baby boom and many social scientists suggest a complex mixture of economic, social and psychological factors (Andersen, 1995). The vast majority of it appears to have occurred not through an increase in family size but rather through a sharp decline in the proportion of women choosing to remain childless (Raeside and Khan, 2007). For many older women these were births postponed during the Depression and World War II (Macunovich, 1999). Consequently many of these births are accounted for by the immediate 1946 - 48 spike in population and are associated with returning troops at the end of the War (Bean, 1983). This phenomenon has also been noted in other countries and internationally; there is a wide diversity in the patterns exhibited by the population increases in different countries. Macunovich (1999) provides a series of graphs that evidences how the baby boom has affected each country in the developed world. In Scotland, the graph (Figure 2) demonstrates a spike of activity in the immediately post War period, however it also demonstrates a more significant spike starting in the early 60s which reaches a second peak in 1965.

Figure 2 Scotland's population boom 1935 – 1985



Source: Adapted from Macunovich (1999)

Despite the ageing population being a triumph of the 20th century (Joseph Rowntree Foundation, 2011), the growth in the number and proportion of older people has been as a result of not just increased birth rates but also of lower mortality rates and the successful management of conditions that previously would have shortened life expectancy. The General Registers of Scotland record that in 1900 the average life expectancy was 40; in 2004 that had risen to 74 for a male and 79 for females. By 2010 this had risen again to 75.8 for a male and 80.4 for a female. There is agreement that the health status of individuals aged 65 and over is improving and the general health of the older population is good (Bell and Bowes, 2010; Jacobs et al, 2012). Healthy life expectancy[2] figures demonstrate that the areas with the longest life expectancy (usually also those with the highest numbers/proportions of older people) also have the longest healthy life expectancy and consequently those individuals have less need of health and care services (POST, 2006).

[2] the average number of years that a person can expect to live in "full health", excluding the years lived in less than full health due to disease and/or injury

The advancements in medical expertise and technology have also provided the opportunity for people to live longer with complex health conditions. Conditions such as coronary heart disease, stroke, diabetes, asthma are often long term and require on-going medical care, and limit what a person can do. In Scotland, it is estimated that 65% of the over 65 population has reported some form of long-term illness, health problem or disability with a 35% reporting two or more conditions (Scottish Government, 2013). In the over 75's these figures rise to 67% and 36% respectively (ISD, 2004). The Long Term Conditions Action Team (2004) reported that most people with long term medical conditions also have other complex needs leading to disabilities that require care from other sources such as social care. The Long Term Conditions Alliance (2010) recently published figures suggesting that two million people in Scotland were living with one or more long-term condition. Procter et al (2012) argues that the number of individuals living longer with chronic, long-term conditions will increase markedly in the forthcoming years and that this will also have an impact on the delivery of health and social care services. Consequently, one of the main reasons why an ageing population is a cause of concern is that it has increased the size of the cohort that is dependent on health and social care which also increases spending (Raeside and Khan, 2007).

The following section will now consider the wider economic implications of the ageing population.

2.2 The economic implications of an ageing population

It is argued that the ageing population has already had a financial impact in Scotland with local authority's needing to prioritise service provision, redesign services to maximise efficiencies or externalise work to obtain services at more competitive rates. However, many local authorities have failed to increase spending on social care in line with demand (ADSW, 2013). The challenge for the local authorities is to balance competing community priorities at times where the overall funding arrangements see little or no growth. Consequently, the introduction of initiatives designed to minimise increases in demand are now at the forefront of policy thinking (Christie Commission, 2011). Increases in expenditure are central to this debate and there is one argument that is consistently applied, as Lloyd suggests:

> "…linked with the rising numbers of older people and anxieties over containing the cost of care, the moral message of health ageing is sharpened so that even though the outcomes of a healthy life may be the enjoyment of a longer life, the *primary* purpose is to ensure that older people make minimum claims on the public purse."
>
> (Lloyd, 2012 p23).

The economic and financial implications of the ageing population are a well-researched field on an international, national and local scale. A report by the International Monetary Fund in 2008 stated that:

> "… the major threat to long-term fiscal solvency is still represented, at least in advanced countries, by unfavourable demographic trends."
>
> (IMF, 2008 p21)

From a Scottish perspective, much of the literature highlights the importance of this issue. The Office for Budget Responsibility in its fiscal sustainability report of 2011 stated that:

> "…demographic change is a key source of long-term pressure on the public finances and policymakers and would be policy makers should certainly think carefully about the long-term consequences of any policies they introduce or propose to introduce in the short-term"
>
> (Extract from Scottish Government Finance Committee, 2013, p1)

The Association of Directors of Social Work (ADSW) in response to the Scottish Government inquiry into the impact of demographic change and an ageing population (Scottish Government, 2013) provide a detailed cost analysis of the financial burden over the next twenty five years and reported that social care spending on older people would have to double between 2010 and 2035 based on current service models and rates of provision (ADSW, 2013). This figure is corroborated within the Christie Commission report (2010) which suggests that spend on social care currently at £4.4billion will need to increase by £1.1 billion by 2016 and £3.5 billion by 2031.

Audit Scotland (2013) reported that the Scottish Government funding settlement to local authorities for 2013/14 is £9.9 billion, representing a decrease of about 0.2 per cent in cash terms or 2.2 per cent in real terms. Consequently, the actual amount of money councils receive has been cut and the challenge then for local authorities is to balance their funding agreement against competing departmental pressures. ADSW (2013) report that despite this growing consensus that more investment is needed on a scale that will make an appreciable difference, the current budgets that the public sector bodies have are under so much pressure to meet existing levels of demand there is not the scope to develop initiatives further. The growing gap between needs and resources has led to a tighter rationing of care by local authorities, with 85% restricting publicly funded care to those with substantial and/or critical needs (ADSW, 2013). Consequently, social care resources are being directed towards high acuity and

relatively expensive services, despite promising evidence of earlier interventions securing better outcomes in the long run (Humphries and Curry 2011). The net result of these trends is that the publicly funded system is becoming more narrowly focused on those with the highest needs (Ham, 2013). Consequently, as a result of the increased demands resulting from demographic change and a decreasing funding settlement, local authorities and their partners are now required to consider different approaches to the management and delivery of health, care and well-being.

2.3 The management of living longer

Policy makers in the developed world have been challenged throughout the years to develop strategies that best meet their country's particular demands for health and social care provision based on their individual demographic patterns. Within a Scottish context, the substantive policy document (All Our Futures: Planning for a Scotland with an ageing population, 2007) sets out a framework that acknowledges the challenges, and seeks to develop an intergenerational, multi-agency approach to tackling the issues. The Communities Minister at the time stated that:

> "In the context of a changing world and an ageing population, we know that simply relying on our current actions and achievements will not be enough. As we look forward, we will need to ensure that our actions, our services and infrastructure fully reflect and are adapted to our changing demographic picture. Achieving our vision for future generations will not be the result of one strategy or action plan, or the actions of a limited number of people. Each and every one of us will have a role to play if we are to succeed and achieve our aspirations for Scotland's future."
>
> Rhona Brankin, MSP Minister for Communities, 2007 (p1)

The three primary commitments from this paper for the government of Scotland, and all other stakeholders, were to: (i) work together to develop a shared understanding of the wider implications of an ageing population; (ii) work together to carry through the culture change that Scotland needs, and; (iii) plan effectively for the years ahead (Scottish Government, 2007). In strategic terms, this paper provided the vision for an active ageing population that would continue to contribute to society. To achieve this aim, the Scottish Government set out to establish the opportunities for health, participation and security to enhance the quality of life as people age (World Health Organisation, 2002). Subsequent policy initiatives (Better Health, Better Care, 2007; Health Care Quality Strategy, 2009; Reshaping Care for Older People, 2010) have envisaged an ageing population that will benefit from enabling health and well-being in later life thereby leading to more fulfilling lives (Billiter, 2012). To achieve these outcomes, however, a paradigmatic shift in the way that services are delivered becomes the key factor.

Central to this debate is the role of rehabilitative services and the focus on restorative, recuperative and reconstructive therapies that allow individuals to regain a level of independent functioning (Bowman et al, 1999). Indeed, Foote and Stanners, (2002) describe rehabilitation as the very essence of older people's care. The Royal College of Nurses (2000) suggest that rehabilitation should focus on re-enablement, facilitating and trying to recapture motivation so as to help people adapt to changes in their life and circumstances. De Monteford University (2007) describe rehabilitation as services for people with poor physical or mental health to help them get better; they define enablement as services for people with poor physical or mental health that cannot help people to get better but helps them to accommodate their illness by

learning or re-learning skills necessary for daily living. Brophy (2008) describes rehabilitation as a continuum of intermediate care[3] operating across the health and social care spectrum. Figure 3 provides a schematic. What rehabilitation is and what it can achieve, therefore, proves challenging within the literature. Similarly, extensive debate ensues on the theoretical underpinnings of rehabilitative care. Philips (2005) argues that rehabilitation should remain centred on medical ethics and the doctrine of cure, whereas Young (1996) describes rehabilitation in a more holistic process that factors in the social aspects of community, the personal fulfilment of the individual as well as realisation of full potential. This latter statement is important as it begins to weave the elements (home or homely settings and personal outcomes) that are critical to the development of services that promote active ageing. In either case, however, the development of rehabilitative programmes has played a prominent role both in terms of cost-containment strategies (Office of Science and Technology, 1995), but also to address the changing needs of people as they live longer (World Health Organisation, 1981). In the Delivering Health, Enabling Health policy (2006), the opening remarks introduce the concept of enablement within the context of health professionals such as Nurses, Midwives and Allied Health Professionals (NMAHPs):

> "Enablement must be the overriding goal of all the services which NMAHPs, and particularly AHPs, offer to their patients…human beings instinctively want to be as self-sufficient and independent as possible and to maximise their physical potential. Patients are their own best carers; you are missing an obvious trick if you do not enable and encourage them to contribute their own ideas and insights and take ownership of their care plan."
>
> Olivia Giles, Meningitis Awareness Campaigner
> (Delivering Health, Enabling Health Introduction, 2006)

[3] Intermediate care is a range of services focussed on prevention, restorative or rehab activity designed to prevent admission to hospital and/or facilitate early discharge from hospital (JIT, 2012)

For social care in Scotland, the introduction of enablement is less clear cut. Over time as policy thinking has changed to address the changing demographic or socio-economic circumstances, social care services have evolved from the traditional home help service to introducing community care and delivering personal care services. The establishment of enablement into social care is a continuation of that evolutionary process, but it is one that now represents a crossover into services that have their theoretical underpinnings embedded within the rehabilitative spectrum.

This model suggests that the therapy services can act as the boundary spanner[4] between the elements of social care and rehabilitative care. In particular, occupational therapy skills are central to enablement (Social Care Institute of Excellence, 2011) either for the training and support of social care staff or as integral members of the team. The College of Occupational Therapists (COT) and Association of Directors of Social Services (ADSS) (1995) suggest:

> "Occupational therapists within social care services are in a unique position to respond to individual needs through rehabilitation programmes which focus on improving people's abilities."
>
> COT:ADSS p3 (1995)

Their importance is further recognised by the need to build effective systems and manage demand by ensuring that the necessary expertise and capacity is available at the point where the service user requires it. The Christie Report (2011) describes this as the need to address the issue of failure demand[5] within the public services. Seddon (2008) suggests that there is a need to ensure that the right professionals with the right skills are available at the right time to respond to demand. It is through this approach

[4] individuals within organisations who assume the responsibility of spanning operational boundaries and gaining the support of employees (Williams, 2008)

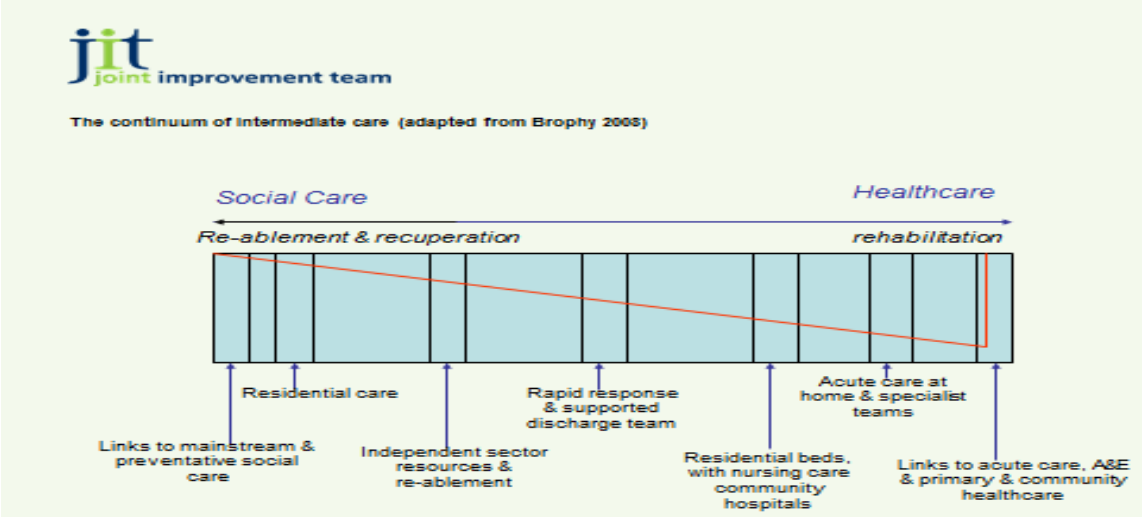
[5] Seddon (2007) describes failure demand as increased work caused by the failure to do something right first time for an individual

that the right expertise is on-hand to ensure that the work then flows cleanly through the system.

Consequently, it is argued that to embed the enablement ethos it is essential to develop a successful rehabilitative culture within the organisation that harnesses the skills of a range of different disciplines and professionals (Wade, 2004)[6]. This approach, therefore, considers a multi-disciplinary model that focuses on an individual's needs and the function of team members. This pooling of resources to achieve better outcomes was a central feature of the development of intermediate care services in England in the early 2000s. The concept of intermediate care was to enhance the independence of older people in an attempt to prevent the admission to hospital and reduce costs and promote better quality of life (DOH, 1997). Within this model, Brophy (2008) describes the various stages of rehabilitation and identifies the individuals who may assume responsibility for the delivery of the service. See Figure 3.

[6] The notable exceptions to this organisational ideology are where individuals present in the end stages of an illness/life or where there are significant cognitive challenges.

Figure 3 Brophy's Continuum of Intermediate Care



Source: Adapted from JIT

In Scotland, a delivery framework for adult rehabilitation (Scottish Government, 2007) was developed that focused on three key groups – older people, adults with long-term conditions and people returning from work absence and/or wishing to stay in employment – and it aimed to maximise individuals' participation in their communities and improving quality of life for them, their family and carers. Reports such as the Better Health, Better Care (2005) and Reshaping Care for Older People (2010) call for a significant shift in health and social care services in the community to support this overall policy by developing innovative health and social care services. The limited success of these policies and the development of joint initiatives lie in part to the organisational difficulties that extend across the health and social care sector (Griffiths, 1988). The introduction of the legislative programme to integrate health and social care will provide the legal framework for improved, collaborative working in the years ahead (Scottish Government, 2013).

Enablement is a preventative, restorative approach to the delivery of care at home services that has its focus on maximising independence for individuals and getting them to do for themselves rather than have done for them. The literature shows that when introduced properly there is time savings to be made for the providers of care. The important thing here is that the time saving can then be recycled and used with other service users thus allowing the service provider to do more with the same resource. The benefits for the service user are a general satisfaction with increased well-being, health and mood. The introduction of enablement services is viewed as one of the key government-led initiatives that will fulfil policy objectives, promote active ageing, deliver better outcomes for people and offset the increase demand for services in the years ahead. However, no formal policy document exists that establishes enablement within social care in Scotland, more simply an initiative from the Joint Improvement Team[7] (JIT) to follow the examples of good practice evidenced in England was promoted from which the organisations took their lead (NIHR 2010). JIT has played a central role in facilitating and supporting the introduction of enablement practice in Scotland assisting the local authorities to embed enablement practices and make the connection to relevant national strategy and policies (Intermediate Care Framework; National Dementia Strategy; Talking Points; Self Directed Support; Delayed Discharge; Reshaping Care). From a recent survey of all the Scottish local authorities, the JIT (2013) reported that 78% of the Scottish local authorities now have an enablement service with the remainder in the development stage of such services.

[7] Organisation established in 2004 to offer practical assistance and managerial capacity to health and social care partnerships.

The introduction of enablement as an approach to support individuals at home is a significant initiative and one that aims to address the increased demand for service in the forthcoming years (JIT, 2010). Further, the introduction of such services are seen as a key development in care at home services that can prevent or delay the need for more costly, intensive services but can promote the quality of life of older people by maximising independent living (Anchor, 1996). In 2011, the Institute of Research in Social Services (IRISS) described enablement within the policy context as a means of assisting individuals to lead full and independent lives whilst reducing the overall cost of provision.

At the centre of the redesign programme is the shift from traditional care provision based on *task and time*[8]to one that adopts the principles of enablement at its core. Thus, enablement is designed to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central, as is the active, functional assessment processes at the outset that determines capabilities and establishes what realistic outcomes can be achieved (Francis, et al 2011). By adopting such an approach, programmes of activity are designed to optimise an individual's level of functioning thus restoring their ability to perform usual activities and, consequently, improve their perceived quality of life. In practical terms, an enablement intervention lasts for a short period of time, usually for a six week period, where the individual and the enablement staff focus on the programme of activity and work towards achieving the personal goals and outcomes instead of simply meeting needs. Consequently, enablement teams need to have trained staff with the

[8] Task and time services refer to dedicated times allocated to frontline staff to carry out specific support tasks to service users.

appropriate skills and the mind-set to support individuals with their programme of activity. Records of achievement, goals attained and outcomes reached should be made at each contact and the programme of activity adjusted in accordance with changing circumstances (Francis et al, 2011). Above all, however, longer, more responsive and flexible visits are essential to allow the time required to work through a programme of activity and achieve satisfactory outcomes for the individual and the services.

Evaluations of the early adopters of home care enablement (Glendinning and Newbronner, 2008; Mcleod and Mair, 2009) report significant benefits to individuals and health and social care partners although more recent reports (Francis et al, 2011; JIT 2013) begin to raise concerns about the greater costs of enablement compared with conventional home care and the organisational implications of establishing and maintaining an enablement service. Indeed, Francis (2011) suggests that:

> "enablement requires substantial up-front investment, which is greater than the cost of providing conventional home care. A typical enablement intervention costs around £2000 compared with £1392 for conventional home care over a comparable period"
>
> SCIE, Research Briefing, 2011 No 36 p9

What becomes apparent from the literature is that the evidence base around the overall success of enablement services is inconclusive. There is significant writing in descriptive terms around what enablement interventions can potentially achieve and the processes that need to be followed to establish services (Care Services Efficiency Delivery, 2007; Pilkington, 2008; Rabiee, 2009) but less evidence has been produced which would allow policy-makers or researchers to draw definitive conclusions on its

overall effectiveness to achieve its outcomes (DEMOS, 2012; Whitehead et al 2013). Further, the majority of the analysis to date has been carried out on English local authorities and the only published work on Scotland relates to the City of Edinburgh (Mcleod, Mair and RPM Associates, 2009) and Glasgow City (Ghatorae, 2013)

Despite an extensive search of the literature, none could be found that considers the direct impact of the ageing population on social care services today using a case study methodology. Searches of the Health Management Online and the Social Services Knowledge Network databases only produced a small number of reports that were relevant. This dissertation, therefore, attempts to address this gap in literature through a mixed methods study carried out in one case study site that sought to answer the following research questions:

1. What is the demographic context in which social care services are being delivered today.
2. What is the approach taken to enablement in LA
3. To what extent are enablement services offsetting and preventing increased service demands.
4. What are the factors that are impacting (positively or negatively) on LA ability to deliver enablement services.
5. Finally, what are the recommendations for future policy and practice in the years ahead

3 Methodology

The previous chapter considered some of the relevant literature in relation to the ageing population, alongside other contributory factors that challenge the delivery of public services in Scotland today as well as identifying a gap. This chapter explains the research design that has been used to investigate the demographic context within which social care services are being delivered today and what factors are effecting their ability to deliver services designed to prevent increased demand from the ageing population with a Scottish local authority. The remainder of this chapter is structured as follows: (i) an explanation of the research design; (ii) a discussion of case study methodology; (iii) consideration of the philosophical assumptions that underpin this research; and (iv) the methods used to collect data.

3.1 Research Design

This study has sought to investigate the impact of the ageing population on a local authority's care at home service. The provision of service is a multi-faceted and requires many individuals, processes and procedures to plan, co-ordinate and deliver the care and support. Consequently, this is a large area of enquiry involving multiple factors. Therefore, this researcher has adopted a case study approach to look at one area of the care at home service's operation – the enablement service – to understand better the current trends of activity, but also to develop explanations for these trends.

The study adopted a mixed method approach to gathering and analysing data. The predominance of data gathered was quantitative through the collation and analysis of pre-existing data at national and local level. New datasets were also compiled using specifically designed measurement tools to obtain more precise information on service activity. The analysis of the quantitative data was contextualised by analysis

of qualitative data gathered from interviews carried out with Social Care Organisers (SCO) The interview data was pre-existing data that had been captured by the researcher as part of a service improvement programme early in 2013. The researcher sought retrospective permission to allow further data analysis for the purposes of this project.

3.2 Case study methodology.

Darke et al (1998) suggest that the use of the case study in research is useful in newer less well-developed research areas such as the current topic particularly where examination of the context and the dynamics of a situation are important. A case study methodology allows this by using multiple sources of data and evidence. By drawing from these various sources, the researcher has determined what the most important elements at play are and what their consequences (intended or otherwise) appear to be. This subject of the case study was chosen as a consequence of the researcher's local knowledge in this field thus offering reasoned lines of explanation based on knowledge of settings and circumstance (Fenno, 1986). As an integral member of the Local Authority's Home Care Service's (LAHCS) management team the researcher has been mindful of his position and throughout this research project has attempted to maintain a neutral viewpoint by focussing on the research methodology.

By adopting a case study approach a holistic analysis of the subject of inquiry has been possible which focusses on the impact of the ageing population on the operational demands of LAHCS.

The challenges facing the public sector organisations has been well documented over the past few years (Christie Commission, 2011), but little evidence has been produced on the day-to-day implications that are impacting on the delivery of front-line services. This case study approach assumes that examining the context and other complex conditions related to the case being studied are integral to understanding the case (Yin, 2012). It is argued that a single methodological approach would not have been able to penetrate the complexities that present within this research and may not have addressed the research questions. Consequently, a case study methodology is deemed appropriate as Hamilton (2011) concludes:

> "…it is an approach that is focussed on the idea of a bounded unit which is examined, observed and analysed in order to capture key components of the case."

3.3 Philosophical Assumptions

May (2011) suggests that central to the process of social research is an explicit account not just of the data produced but how that is understood and interpreted. Burrell and Morgan (1979) suggest that it is possible to classify philosophical assumptions underpinning different approaches to research into defined categories. First, ontological assumptions relate to whether the phenomenon under investigation is understood as being external to an individual or is a product of their consciousness (Burrell and Morgan, 1979). Second, an epistemological assumption is concerned with how the researcher understands the world and communicates that knowledge to others. Third, assumptions about human nature address the relationship between human beings and their environment and address whether human behaviour is a product of the environment or whether the environment is created by human

behaviour. The methodologies that are then developed by researchers are influenced by the different ontologies, epistemologies and models of human nature that occur (Burrell and Morgan, 1979). In essence, the philosophical assumptions are the *modus operandi* or paradigms that researchers use to gather, analyse and interpret data within their research. Walsham (1995) argues that it is important for a researcher to define their philosophical position clearly as a means of reflecting on the basis, conduct and reporting of their work. He further suggests that there is a need to adopt multiple perspectives but to reflect periodically on their philosophical position when writing up their work. Alvesson and Skoldberg (2000) suggest that researchers are required to operate on a least two levels paying attention to both the research material and how it is being interpreted by the researcher. Therefore, reflexive objectivity (Kvale and Brinkmann, 2009) is key in the production of knowledge to make judgements on the basis of our understanding (Gadamer, 1975).

Within this research project, the researcher has adopted a critical realism paradigm within which to interpret and analyse the data. Critical realism is a philosophy that believes there is a reality independent of our thinking about it. Consequently, there is an acknowledgement that all observations (or measurement) are fallible and our ability to know meaning with certainty is critically questioned:

> "Because all measurement is fallible, the critical realist emphasises the importance of multiple measures and observations, each of which may possess different types of error, and the need to use triangulation[9] across these multiple errorful sources to try to get the better bead on what's happing in reality"
>
> Social Research Methods (2013)

In summary, therefore, a critical realism approach provides a framework for discussing the direct impact of the ageing population on a Scottish local authority's

[9] Triangulation is the means of using different sources of information to validate findings

care at home service by explaining the causal mechanisms that have influenced the phenomenon (Danemark et al, 1997). Further, through the researcher's knowledge of the services and close working relationships with the staff group, the application of retroduction[10] has been important to establish the basic conditions for the existence of the phenomenon studied (Danemark, 1997)

In LA, data is held in a number of different places and in various formats thus making it difficult to interpret and analyse. In making decisions around current and future service commitments, it is important to recognise the importance of the information that is available. By adopting a quantitative approach emphasis is placed on the collection of data that can be measured. From these measurements, conclusions can then be drawn that provides the service with evidence that can support and inform decisions. Measures need to make sense within context and it is the context that gives meaning to the numbers. Consequently, a case study approach has been adapted as a methodological tool to investigate the impact of the ageing population phenomenon within a real-life context of delivering front-line social care services. A mixed method of quantitative and qualitative analysis has been used as an approach to gather the data for this research project thereby providing the basis for a thematic analysis (Bryman and Burgess, 2002). The quantitative analysis provides context for the subsequent interviews and the resulting rich data is then useful for understanding the operational challenges faced by LA

The formal evaluation consisted of two integral components: (i) the scrutiny of the quantitative data gathered, and; (ii) nine interviews with Social Care Organisers (SCOs).

10

3.4 Methods

This section will consider the methods used to collect the three sources of data. First, the quantitative data which is considered in two sub-sections: (i) pre-existing data, and (ii) new data. Second, the qualitative data gathered from the interviews.

3.5 Quantitative Analysis

3.5.1 Pre-existing data

The quantitative analysis in Chapter 4 addresses two of the research questions: (i) what is the demographic context in which social care services are being delivered in LA, and; (ii) what are the factors that are impacting (positively or negatively) on LA's ability to deliver enablement services. Analysis of the quantitative data which was drawn from pre-existing datasets that are in the public domain and from sources within LA, was conducted in May 2013. Specifically, the data on the population distribution was drawn from central sources (Office of National Statistics Office, Scottish Government, General Registers of Scotland) thereby ensuring there is a greater degree of consistency and validity. The analysis in Chapter 4 focuses on the national age demographic through a historical lens in the first instance thus providing a context to the changing profile of Scotland's population distribution with particular attention being paid to the population that is over 65 years old; the same consideration was given to the data as it presented for LA. The researcher then used the raw data to establish a framework to allow more detailed, analytical work to be carried out. Specifically, data has been gathered from the national datasets on the following: (i) UK population trends 2002 - 2035; (ii) Scotland population trends 2002 – 2035; (iii) Scotland age profile population 2002- 2035; (iii) local authority age profile population 2002 – 2035; (iv) Scotland Home Care activity (general) 2002 – 2012. This information was then input to an Excel spreadsheet thus allowing the researcher the

opportunity to produce a variety of graphs and tables to demonstrate national and local trends. For analytical purposes population projections have been used extensively to demonstrate the national and local variations as well as being used for comparison purposes. Population projections are trend related and are, therefore, based on a number of assumptions.[11] Consequently, the reliability of the data can be challenged as the assumptions about future migration, fertility and mortality is often limited by the inertia in population change (Scottish Government, 2013). As the process of change is cumulative, the reliability of projections decreases over time. However, the projections provide a common basis for use in planning and policy development of public services in geographic areas (Office for National Statistics, 2013)

There is significant data held around demography and many references are made to the over 75 and over 85 age group within datasets. However, the data required for the Home Care annual census[12] refers to that age group which is over 65 years. Consequently, this paper refers throughout to this age group in relation to the ageing population. To ensure consistency, and for comparison purposes, all figures drawn from the various sources have been aggregated by the researcher to provide the whole number of people over 65 years. Similarly, the ageing population increases are predicted to stabilise in the 2030s. Again, depending on the source, the intended year of stabilisation varies from publication to publication, but for the purposes of this

[11] Assumptions are made that all factors influencing population will remain a constant. Consequently, projections can only provide indicative predications about future trends (Population Reference Bureau, 2013)

[12] The census presents the latest national figures for home care services provided or purchased by local authorities in Scotland. All local authorities in Scotland provide Home Care services which give people the support, practical help and personal care that they need to live as independently as possible in the community. All figures relate to the last week in March.

paper the researcher suggests that the period for consideration extends from the present and concludes in 2035.

Data was added to the Excel spreadsheet in relation to care at home service provision from two sources. From the national datasets, the following data was drawn: (i) Scotland Home Care activity (age profile) 2002 – 2012; (ii) Scotland Home Care activity (intensive) 2002 – 2012; (iii) LA Home Care activity (age profile) 2002 – 2012; (iv) LA Home Care activity (intensive) 2002 – 2012, and; (v) Long Term Conditions data. There are no national datasets produced on enablement services. Consequently, additional data was provided from the local authority's internal data sources which provided the background information for the organisation in terms of its size, the activity, the nature of the work carried out and the measurable outcomes.

The Local Authority Home Care Service Enablement Team (LAHCSET) commenced December 2009 and data has been collected since mid-2010 through to present day. All of the local data has been collated onto separate, password-protected Excel spreadsheets that are held within a common drive of the LA's IT network. Information is either directly input to the spreadsheet by Social Care Organisers (SCOs), or is transferred in by administrative staff from: (i) a paper-based recording system completed by the SCOs, and/or; (ii) directly from service user databases. Presently, LAHCS has no centralised, electronic means of gathering this information[13]. It is with caution therefore that the local data is analysed as there have been a number of issues identified in the recording of and interpretation of the data requirements which calls its validity into question. In some cases monthly recording sheets have been altered to include additional data for some teams but not others. This

[13] The local authority is about to invest in a new scheduling tool that will have the facility to gather data and produce reports for performance management purposes

has required information to be transposed and merged to deliver standardised results. Despite these issues, however, the data collected represents what is going on at present within LAHCS. Specifically, data relating to 2010/11; 2011/12, and 2012/2013 has been gathered on the number of people progressing through the enablement teams in a year running from 1st April to 31st March.

By adopting an inductive logic approach[14], the researcher has accumulated and aggregated the data to produce generalisations about the patterns or connections between the variables and events. Data has been gathered on: (i) the number of hours committed; (ii) the mean average per individual service user; (iii) the outcomes for each individual (independent, hospital admission, long term care, deceased); (iv) the aggregated number of increased or decreased hours noted per individual exiting the enablement service but requiring on-going support, and; (v) those individuals whose service has remained unaltered. This data has afforded the researcher the opportunity to consider the LAHCET's current obligations and measureable outcomes.

3.5.2 New data

To determine the impact that the increased demand for service may have had, the researcher developed a tool that measured the capacity that exists within LAHCS. The measurement of productivity is important as it provides an indicator of the actual level of service delivery that can be delivered week-on-week. Often literature refers to staff in terms of whole time equivalent (wte) or as whole numbers employed. What these figures fail to acknowledge is that only a percentage of time is actually available for hands-on service delivery. Consequently, the development of the productivity tool seeks to address this issue by providing this analysis with a more specific account of

[14] Inductive logic is a form of reasoning that uses data or statements to draw a likely conclusion (Social Research Methods, 2013)

staff availability. To measure the productivity levels of the teams carrying out the front-line service provision, two weeks were chosen to provide a comparative analysis: (i) week beginning the 12th November 2012, and; (ii) week beginning 18th February 2013. Each Social Care Organiser (SCO) was then asked to input the data for the respective weeks into an Excel spreadsheet against the headings described in Appendix 1.

From this information the researcher was able to determine the actual productivity of the respective teams in the allotted weeks against the contractual commitments. To determine the figure the productivity figure was arrived at by totalling the figures in each field, aggregating the figures and then subtracting that from the monthly contractual commitments. To substantiate the figures, a third week was analysed in May 2013 and cross-referenced against the original data.

It is acknowledged that demands within the service can vary from week to week and to provide a more comprehensive analytical breakdown then figures detailed should be gathered over a longer timeframe (12-24 months) to more robustly validate the measurement tool. However, owing to time constraints, this has not been possible, but offers the opportunity for the researcher to develop this tool further in a separate research project.

3.6 Qualitative Data: Interviews

The interviews originally commenced as an exercise to inform the researcher of the existing systems in relation to a wider, departmental service improvement programme. As part of the researcher's substantive work, the engagement with staff across the LAHCS had been identified as an appropriate means of understanding and addressing the operational challenges and difficulties faced. However, following the initial analysis of the data gathered for the service improvement work, it became apparent that themes were emerging from the LAHCS data that required a more in-depth, specific analysis. The process described in the following section represents the analytical work carried out in relation to these emerging themes. In particular, many comments were made in relation to LAHCS losing focus and becoming so overwhelmed with service requests that it was failing to meet its founding principles and was no longer fulfilling operational commitments. Consequently, the interviews were used in relation to answering the following research questions: (i) what is the approach taken to enablement in LA; (ii) to what extent are the enablement services offsetting and preventing increase service demands, and (iii) what are the factors that are impacting (positively and negatively) on LA's ability to deliver enablement services.

Although full explanations of the researcher's activity had been detailed through a series of team meetings, no formal ethical approval was sought at this stage as the work carried out was an internal operational issue. As part of a service improvement programme, the researcher conducted a number of interviews with key personnel in LAHCS between January and February 2013. To ensure a broad understanding of the functioning within the service, and to ensure variability in sampling, the interviews were conducted with all the first-line managers in the service. Each participant was

required to describe their experiences from commencement of their employment through to the present day thus considering all aspects of the service's history and current operational practices. Prior to interviews taking place, all participants were advised of the nature of the work and informed that all comments raised would remain anonymous and would not be attributable to any individual. It was explained that notes taken throughout the interview would be organised in such a way that would allow a thematic analysis to be conducted. The emerging themes would then form the basis of a report for senior management on the findings. Further, it was advised that the information gathered would only be used for the stated purposes and retained by the researcher for a limited period thereafter being disposed of securely. Nine interviews were conducted each lasting for approximately 1 hour. The interviews were loosely structured (Gomm, et al 2000) around: (i) a historical perspective on how the LAHCS came into existence; (ii) the challenges that the service is faced with, and; (iii) to establish what the current operational issues were. The researcher adopted an informal approach to the interviews, thereby allowing latitude to follow-up unpredicted but interesting lines of enquiry. Field notes were taken in relation to responses given by the participants and summaries were then written up. From the summaries, the data gathered was transferred to a spreadsheet specifically designed for this purpose. The preliminary findings were discussed with senior management and a request was made to develop the analysis further and to incorporate the work into this research project. An application was made to the local authority's Learning and Development Section requesting approval and approval was granted in April 2013 on the proviso that a summary of the findings were made available to senior management. Ethics approval was also granted by Edinburgh University following submission of this dissertation proposal with the caveat that retrospective permission

be sought from the original participants to use the data collected to fulfil commitments to this research project. Therefore, each LAHCS participant was presented with an information sheet (Appendix 2) detailing the purpose of the research project along with a consent form that included a formal confidentiality agreement to preserve anonymity. Participants (and senior management) were advised that they would have access to the final report.

A phased approach[15] (Gaskell and Bauer, 2000) was used in the analysis of the qualitative data. First, time was taken to read all the interview summaries to become immersed in the data gathered. Preliminary findings emerged from this analysis, which formed the themes that allowed a further breakdown of data to conduct a more in-depth analysis. To simplify and categorise the data, a simple matrix was created using database management systems that produced a framework with interviewees on the x axis and the emergent themes along the y axis. From the summaries the researcher then colour coded words/comments that correlated with the emergent themes and placed them into the matrix. As this data was categorised, new themes began to emerge and a second iteration of the matrix evolved. A similar colour coding exercise took place that allowed the researcher to establish core themes. This process assisted the dependability of the analysis of the data set from which key findings emerged from the research project.

By adopting a case study approach a holistic analysis of the subject of enquiry has been possible bringing together data on demographics and service use with insights from first line managers. In so doing, the research has identified a number of key

[15] a stepped approach to managing, analysing and interpreting data in an iterative process.

findings which focuses on the impact of the ageing population on the operational demands of LAHCS.

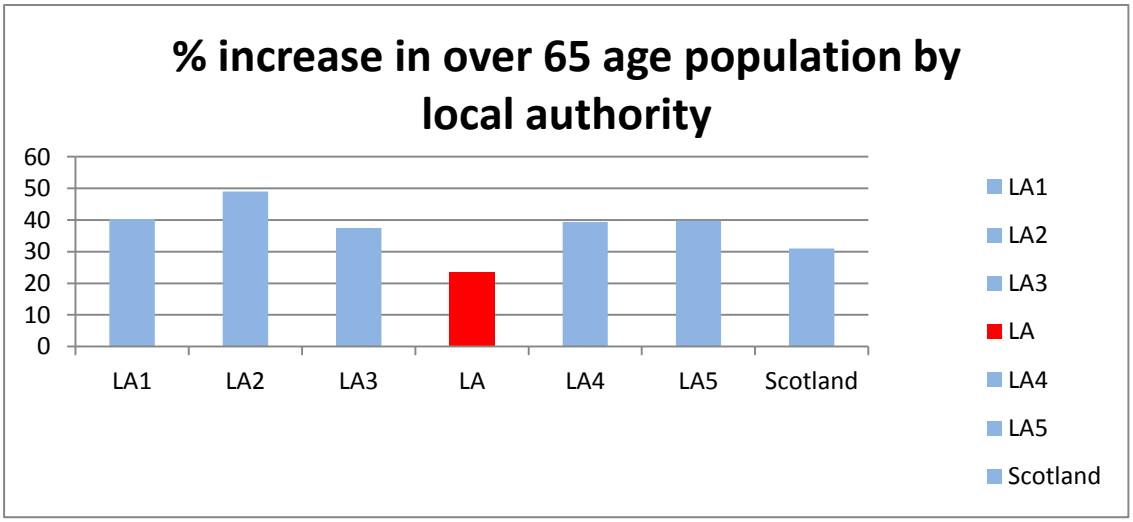
4 Findings

Two key findings were identified from the analysis that appear to have impacted on the day-to-day operation of LAHCS and include: (i) from a demographic perspective, that the organisation is attempting to cope with an increased demand for services that are not based solely on increased numbers, but also include individuals that have more complex needs than in previous years; and (ii) although enablement services appear to have offset and prevented some detrimental consequences of increased demand, there is a worrying trend that this may not continue in the future. The following sections will consider each of the findings in turn.

4.1 Demographic Context

Although LA is geographically the smallest local authority in Scotland, it is also one of the most densely populated. For example, it has a current population of approximately 144,000 residents and has some of Scotland's most deprived areas in terms of health, access and income (Scottish Index of Multiple Deprivation, 2012). Similar to its neighbouring authorities, LA has an ageing and increasingly dependent population. In accordance with the national trends, the number of people aged over 65 is expected to rise over the next 20 years. However, the projected percentage increase is one of the smallest of all Scotland's local authorities. Figure 4 compares the over 65 population of LA to its neighbouring authorities and the overall Scottish average figure.

Figure 4 Percentage increase in +65 populations (aggregated) by local authority (2010 – 2035).



Source: GROS, 2012

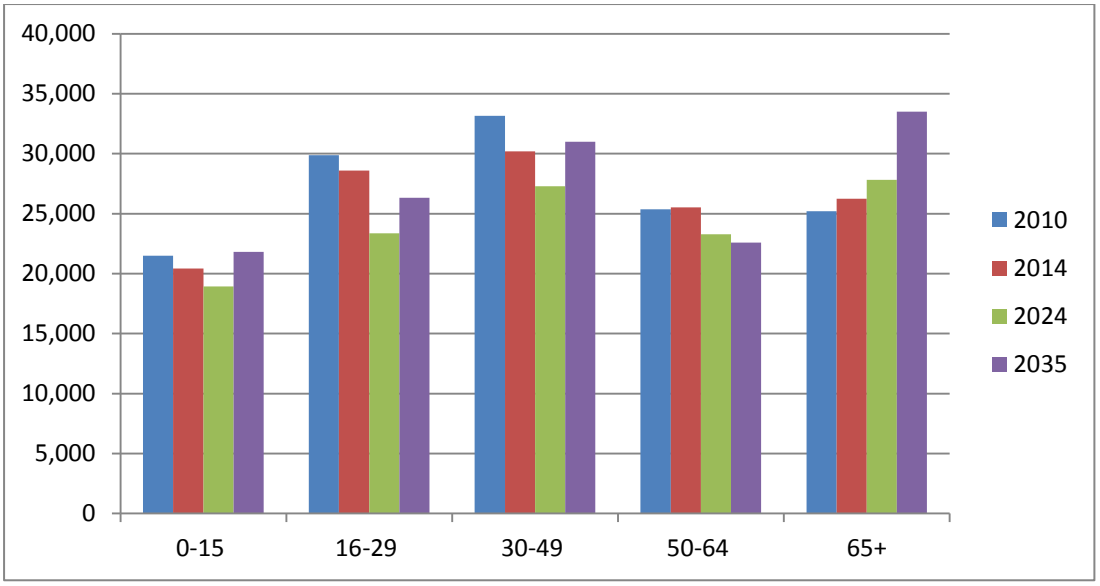
The reasons for this modest increase in the over 65 population are not immediately obvious, but further investigations produced two explanatory factors. First, the wider population distribution across LA is skewed by a disproportionate number of younger people who attend higher education establishments but then move away from the area upon completion of their studies. Second, LA's age corrected[16] death rate is 13.6% higher than the rest of Scotland meaning that people's life expectancy is further reduced in LA (GROS, 2013). Consequently, LA has a lower than average number of older people. On purely numerical terms, it can be concluded that the challenges presented by the ageing population will be less for LA than their neighbouring authorities. However, even though the increases present as relatively small by comparison, the impact of the ageing population will still be prevalent. LA has seen a 21.4% increase in hours of care allocated to older people since 2006 and those

[16] Age corrected rates is a way to make fairer comparisons between groups with different age distributions

requiring intensive support have increased by 44.8% (Community Care Datasets, 2012).

By 2035, the overall population of LA is projected to be 135,229, a reduction of 6 % compared to today's figure, however, in the same timeframe the age group that is projected to increase the most is the aggregated 65 and over age group that will increase by 23% (GROS, 2012). Figure 5 below evidences the trend by age group.

Figure 5 LA projected population change

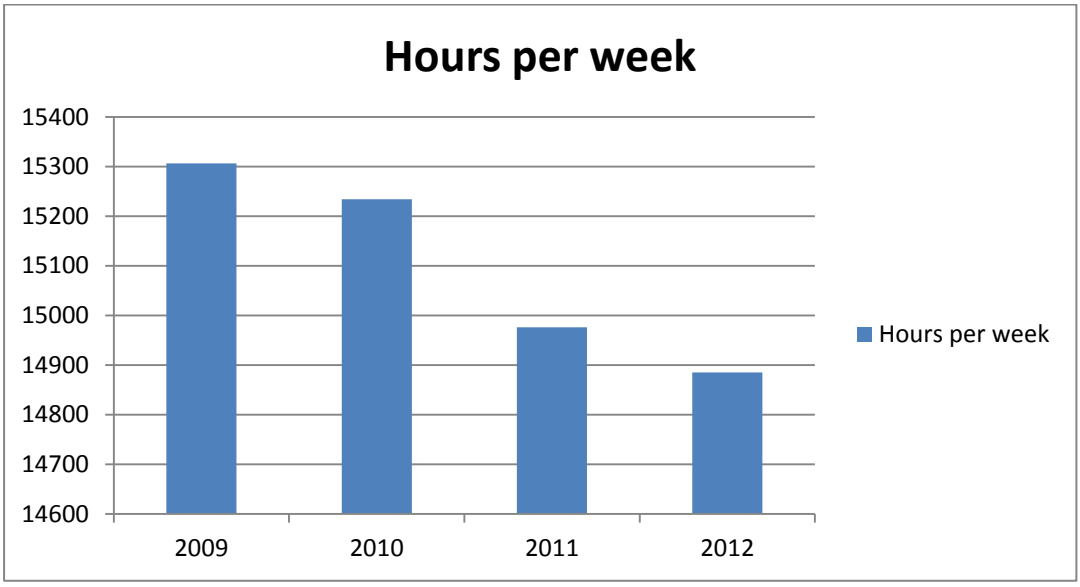


Source: GROS 2012

It is evident from the figure that the 65 and over age group demonstrates an exponential rise over the timeframe whereas the other age bands have different distribution trends. Consequently, this group will continue to influence LA's population structure in future years.

The immediate problem for LA is that it already has 1882[17] service users in the system currently who receive 14885 hours of care and support per week (Home Care Census, 2012) where the current in-house staff ratio is approximately 1 carer to 14 hours of service. This staffing ratio has remained a constant over the past four years (LAHCS, 2013) despite an externalisation of work that has seen a 25% reduction in the in-house staff levels (LAHCS, 2013). Notwithstanding this, the out sourcing provides additional capacity[18] (LAHCS, 2013), the demand for service has remained almost a constant (Community Care Statistics, 2013) in the timeframe. A small reduction in hours is noted but this will be discussed further in relation to enablement intervention. Figure 6 provides an account of the hours delivered since 2009

Figure 6 Hours delivered per week



Source: Community Care Datasets, 2012

[17] This figure represents services provided in-house and those commissioned externally(LAHCS)
[18] as a consequence of the external providers being able to provide more hours at a lower unit cost than the in-house service provision

4.1.1 Complex care needs

The increased demand for services due to the growing over 65 population is further complicated by the increased prevalence of long term conditions in Scotland. Around two million people, 40 per cent of the Scottish population, have at least one long term condition and one in four adults over 16 reports some form of long term illness, health problem or disability (Scottish Government, 2012). However, long term conditions become more prevalent with age and The Long Term Conditions Alliance (2010) report that by the age of 65 nearly two-thirds of people will have developed a long term condition. Also, older people are more likely to have more than one long term condition: 27 per cent of people aged 75-84 have two or more (LTCA, 2010)

Evidence would suggest, however, that there are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health (Scottish Government, 2012). This report suggests that people living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income. The Scottish Index of Multiple Deprivation (SIMD) measures such indicators and has recently reported that LA has 55 (30.7%) areas within its boundaries that are in the lowest quintile of Scotland's most deprived areas. Consequently, it could be argued that, because of, this LA already have a larger percentage of individuals with long term conditions being supported by the health and social care sector. Further, should there be no change in those social indicators, then LA may experience a larger percentage of people presenting with long term conditions in the future.

Table 1 provides a breakdown of prevalence of selected long term conditions (ltc) within LA 2011/12 and demonstrates that prevalence has increased in ten of the 17

long term conditions described by the QOF register. For the remainder, six have not changed at all and only one has reduced

Table 1 Long Term Conditions LA 2011/12

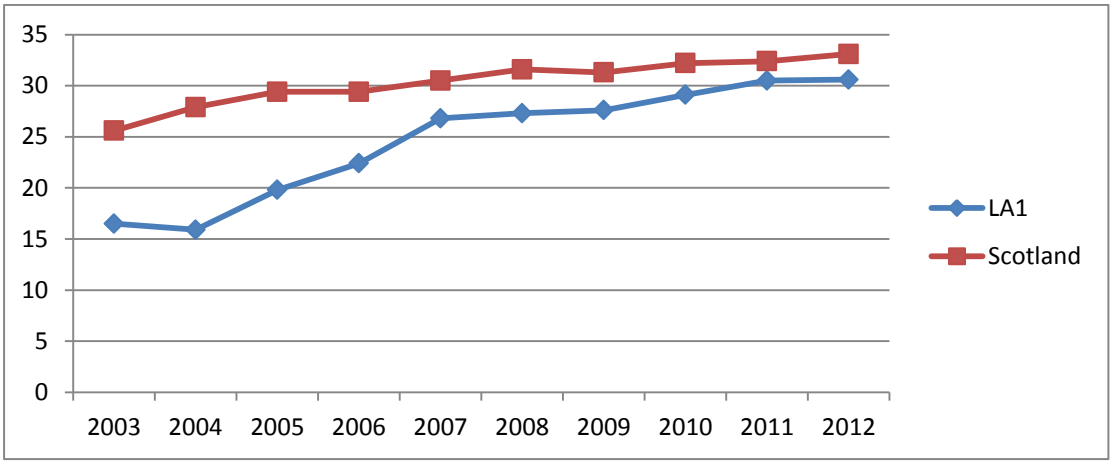
Long Term Conditions					
	2011/12		2010/11		
Conditions	**QOF register**	**LA1**	**QOF register**	**LA1**	**Variance**
Hypertension	23,467	13.8	23,363	13.8	Same
Obesity	16,439	9.7	16,265	9.6	Up
Asthma	10,159	6.0	9,909	5.8	Up
Hypothyroidism	8,652	5.1	8,449	5.0	Up
CHD (Coronary Heart Disease)	7,266	4.3	7,474	4.4	Down
Diabetes	8,028	4.7	7,721	4.6	Up
CKD (Chronic Kidney Disease)	6,572	3.9	6,243	3.7	Up
Depression 2 (of 2): new diagnosis of depression	12,413	7.3	11,690	6.9	Up
Stroke & Transient Ischaemic Attack (TIA)	3,955	2.3	3,913	2.3	Same
COPD (Chronic Obstructive Pulmonary Disease)	4,770	2.8	4,639	2.7	Up
Atrial Fibrillation	2,477	1.5	2,424	1.4	Up
Cancer	2,761	1.6	2,489	1.5	Up
Dementia	1,333	0.8	1,203	0.7	Up
Heart Failure	1,625	1.0	1,623	1.0	Same
Mental Health	1,847	1.1	1,817	1.1	Same
Epilepsy	1,389	0.8	1,378	0.8	Same
LVD (Left Ventricular Dysfunction)	1,213	0.7	1,214	0.7	Same

Source: Quality Outcome Framework (QOF), Analytical Services Division

Unfortunately, there is no data available that correlates long term conditions with social care use, although within this debate this is an important point as it demonstrates the amount of care and the complexity of needs of individuals supported within their own homes. Indeed, the number of people supported at home in receipt of an intensive package of care is one of the key measures in determining the shift in the balance of care from institutionalised settings to the community. Therefore, the figures not only represent the current position, but also demonstrate whether the overarching principles of community care as set out in the NHS and Community Care

Act, 1990 are being met. Using this as a measure, therefore, Figure 8 demonstrates the trend over the past 10 years thus confirming that has been a shift in the balance of care in Scotland. In LA, the percentage of people over 65 years in receipt of an intensive care package has increased significantly over the past ten years. Despite this, LA sits below the national average of Scottish local authorities delivering intensive personal care services. Figure 7 provides a comparison of percentage of 65 plus individuals against the national average. Currently the number of hours delivered to intensive packages of care for LA represents 31% (Community Care Datasets, 2013) of the overall commitment.

Figure 7 Percentage aged 65 plus receiving 10+ hrs of home care in LA1 2003 to 2012 against national figure



Source: Community Care Datasets, 2013

This shift to intensive packages of care appears to have been at the expense of those packages of care that deliver less than two hours per week. In the ten year period from 2002-12, there has been a 19% reduction in the number of individuals in LA receiving less than two hours of care per week. In the same timeframe, the intensive packages have increased by 19% (Community Care Datasets, 2013). Consequently, LA is now providing more hours of care per week but to less people.

LA has a proportionately smaller number of older people than its neighbouring local authorities but this has not lessened demand. What is unquestionable is that over the period from 2000 – 2009 there has been a significant rise in the number of hours of service provided by LA in meeting the increased demands. This increase levelled out in 2009 and there has been a reduction in actual hours committed since then. However, there has been a significant shift in the profile of LAHCS's work commitments with an increasing move away from services less than 2 hours to those that are intensive care packages. This substantiates the view taken by the ADSW in that the Scottish LAs are targeting resource at the high end, complex more expensive care packages (ADSW, 2013)

4.2 Enablement

4.2.1 Historical perspective

The following section discusses the second finding of the empirical analysis. Specifically, it considers enablement first from a historical perspective and then identifies how that has impacted on the arrangements that exist currently.

Analysis of LA committee papers and findings from the interviews confirm that in 2009/10, LA established an enablement service based on a model of operation prevalent throughout Scotland at that time. The teams were introduced to deliver the principles and expectations of enablement across the geographic boundaries and LA was able to establish dedicated enablement by restructured services and re-configuring a hospital discharge team and a crisis care team. As part of the original set up arrangements, therapy services were assigned to the team and played a critical role in determining goal and attainments for individuals. LA's Occupational Therapists

were involved in the establishment and delivery of training events for the social care staff transferring into the new service thereby ensuring that the ethos of enablement was firmly embedded. The close engagement with colleagues from the therapy services at that time was essential in the start-up phase, as well as providing the support and training for front line staff. As one SCO 2 commented in an interview:

> "Without the help from our colleagues (in the therapy services) we would have been struggling to get off the ground. It wasn't that we didn't know what we were doing but they were brilliant at keeping us right without being too overpowering. Their expertise was invaluable as we developed care plans around the service users' functioning. XX helped me initially to make sure that I was doing what I was supposed to do."

The interviews describe how an eligibility criteria was set against which individuals were selected or de-selected depending on their suitability for an enablement intervention. This criteria was developed to target specific individuals who would benefit from an intensive period of enablement thus leading to better outcomes.

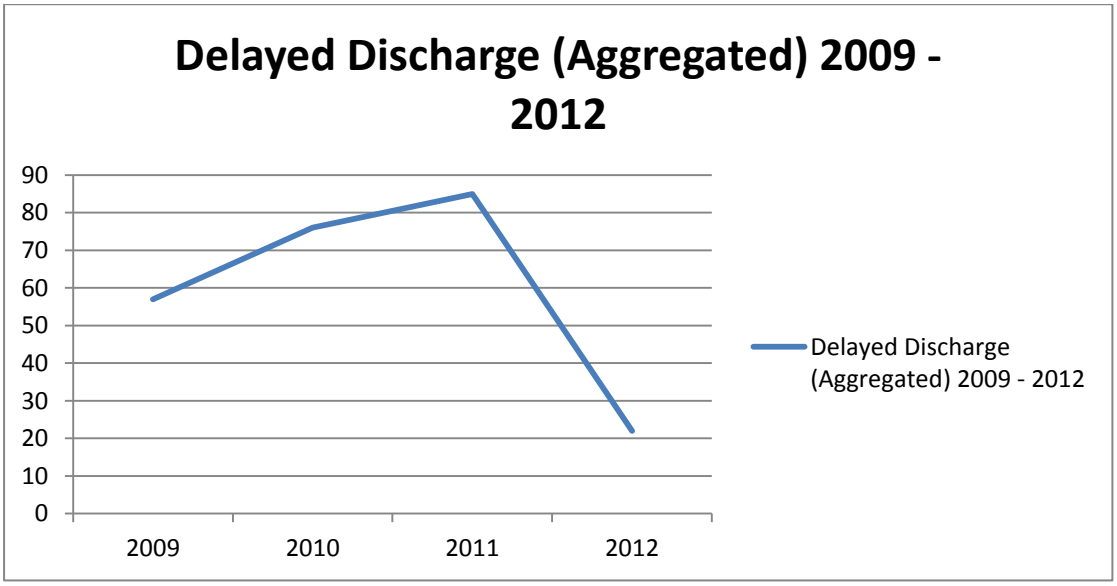
However, a change to the eligibility criteria was effected in 2011 and, as a result of that decision; the enablement service no longer operates on a target specific basis but operates as an initial intake team[19] for the home care service. Consequently, all individuals referred to the LA (except those in the end stages of an illness or with significant cognitive difficulties) are expected to have a period of enablement to optimise their level of functioning and independence. This approach is widely adopted across Scotland (JIT, 2013) on the premise that everyone can benefit from a period of enablement thereby maximising independence and lessening the dependence on services. The decision to switch to an intake model has not been universally welcomed and as one SCO 6 put it:

"the intake model creates difficulties"

[19] The intake approach suggests that all referrals should progress through the enablement team

The interviews suggested that the need to change the eligibility criteria was the result of pressures felt across the health and social care sector in 2010/11. At that time, it was reported that there were significant increases in delayed discharges from hospital for individuals in LA (ISD, 2013). From the interviews and from anecdotal information, the general perception was that the length of time taken to undertake an assessment, as part of the discharge protocol, was taking too long. Consequently, key targets measuring the performance of health services were not being met. Therefore, a decision was taken in 2011 to relax the eligibility criteria to the enablement service which had a resultant effect on the Delayed Discharges in LA hospitals. Figure 8 evidences the trend in delayed discharges from 2009 – 2012

Figure 8 Delayed Discharge (Aggregated) 2009 – 2012



Source: ISD Delayed Discharge

The figure clearly demonstrates that there are now fewer individuals who are delayed in hospitals in LA and that a peak was reached in 2011. By resolving this problem,

however, the failure to recognise the cause and effect[20] implications have simply shifted the problem across to another part of the system (in this case the enablement teams) but the consequences here are potentially far more reaching. The impact that these decisions have had on the current enablement service are described in the following section.

4.2.2 Current arrangements

Although the decision to decrease the delayed discharges from hospital increased the number of individuals requiring social care services in LA, no changes were implemented to the staffing levels or the management arrangements of the enablement service to accommodate the change in approach. Alternatively, team capacity that existed at that time was used to absorb the influx of service users. Operationally, the impact on the service has been quite marked and, in particular, the time set aside within the service to develop, implement and monitor enablement programmes of activity has been lost. As SCO 2 remarked:

> "We have become so inundated with service users who shouldn't be on our service, we no longer have the time or capacity to deal with enablement."

This was further emphasised by SCO4 who suggested that:

> "The enablement teams are simply chocked up with people…too many people. Previously, we wouldn't be dealing with many of these people as they would have been deselected."

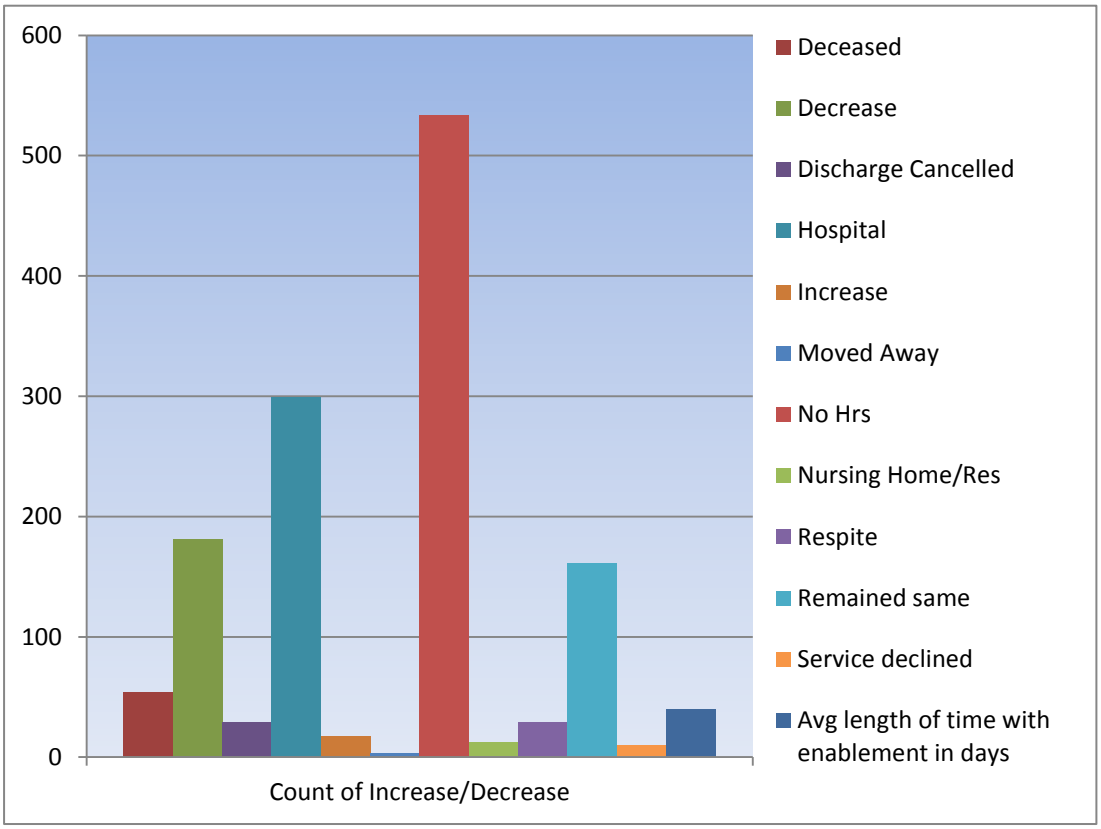
[20] The relation between an event and a second event where it is acknowledged that the first event has caused the second to occur.

Perhaps the most telling remark was from SCO6:

> "Enablement no longer works. I'm dealing with people who are in the end stages of their lives and the potential to enable does not exist. The staff has no time any longer to spend with people"

These comments in isolation tell part of the story. However, when they are added to the quantitative data, the full impact of the operational shift in approach becomes more apparent. Figure 9 provides a graph of the outcomes for individuals in LA in 2013 following a period of enablement intervention. This graph illustrates three emerging consequences: (i) the number of individuals needing no further (or decreased) service post enablement; (ii) the length of time spent with enablement, and; (iii) individuals returning to hospital during enablement. A further factor was identified by the interviewees in relation to the assessment of enablement users. These are discussed in more detail in the following pages.

Figure 9 Enablement Service Outcomes 2013

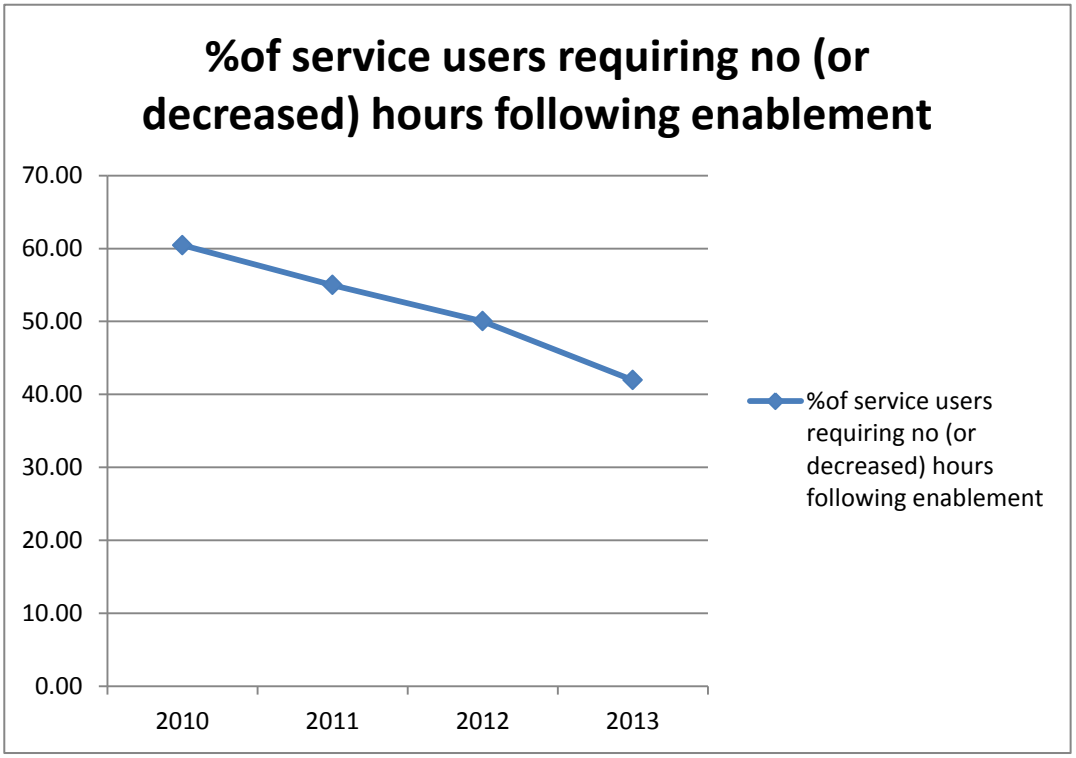


Source: LAHCS

(i) No services required post enablement

The largest peak in Figure 9 shows that over 500 individuals left the enablement service with no hours (or reduced hours) required; this may be considered a positive outcome. Indeed, when this outcome is considered against Figure 6 it could be argued that the small reduction (3%) in total hours committed by LA from 2009 – 2012 may be attributable to the enablement interventions starting to take effect. However, upon closer analysis there is a worrying trend emerging from the data.

Figure 10 % of service users requiring no (or decreased) hours following enablement

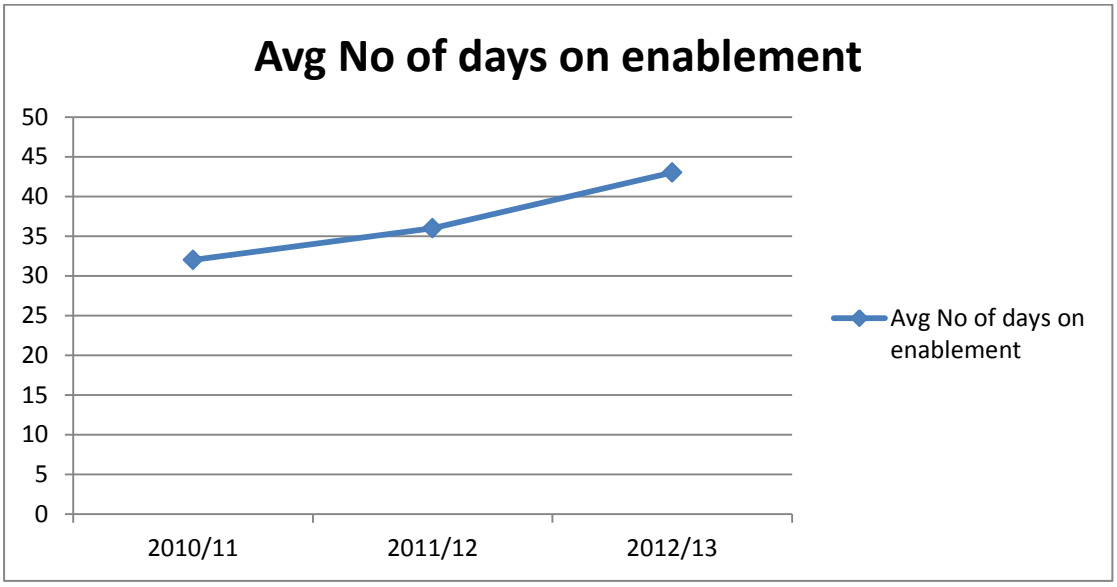


Source LAHCS

Figure 10 shows that in 2010 60% of service users exited the enablement team requiring no further (or decreased) service; by 2013 this had reduced to 42%. This decrease is quite marked and demonstrates a worrying trend because the aim for enablement is to increase the number of service users needing less care, consequently reducing the demand for services in the future. Figure 10 illustrates that there are now fewer individuals exiting the enablement service requiring little or no on-going support than at start-up. Consequently, it is argued that should that trend continue in the years ahead, enablement services will have failed to offset the increased demand and this will result in added pressure being applied to the health and social care sector. For the time being the 42% (2013) requiring no further service or decreased hours remains a positive outcome.

(ii) The length of time with enablement

Figure 11 Average number of days on enablement LA



Source: LAHCS

Figure 11 demonstrates that the average number of days that an individual spent on the enablement programme in LA increased from just over 30 days to just over 40 days. The implications of not being able to move an individual on from enablement then mean that there is a reduction in the capacity available within the team which results in fewer people being able to access enablement services. Referring back to the decision to relax criteria to speed up the discharge arrangements from hospital, it is concerning that the capacity needed within the enablement service is being reduced. Social Care Organiser 6 observes:

> "Six weeks no longer applies in enablement. People remain on the service for as long as needs be now, but it is not to do with the fact that they need further service from us it's just that there is no place for them to go"

The delay in moving an individual on to another part of the service (in-house or external) is commonly referred to as the cliff edge[21]. Consequently, outcomes for the individual remain uncertain because they don't know when or which service he/she may be moving on to. Similarly, for the staff charged with the responsibility of managing services or care arrangements, this is equally frustrating as explained:

> "part of my job is now dealing with frustrated families who are constantly wanting to know whether they can retain the carers that have now or when they are getting new ones."
>
> Social Care Organiser 3

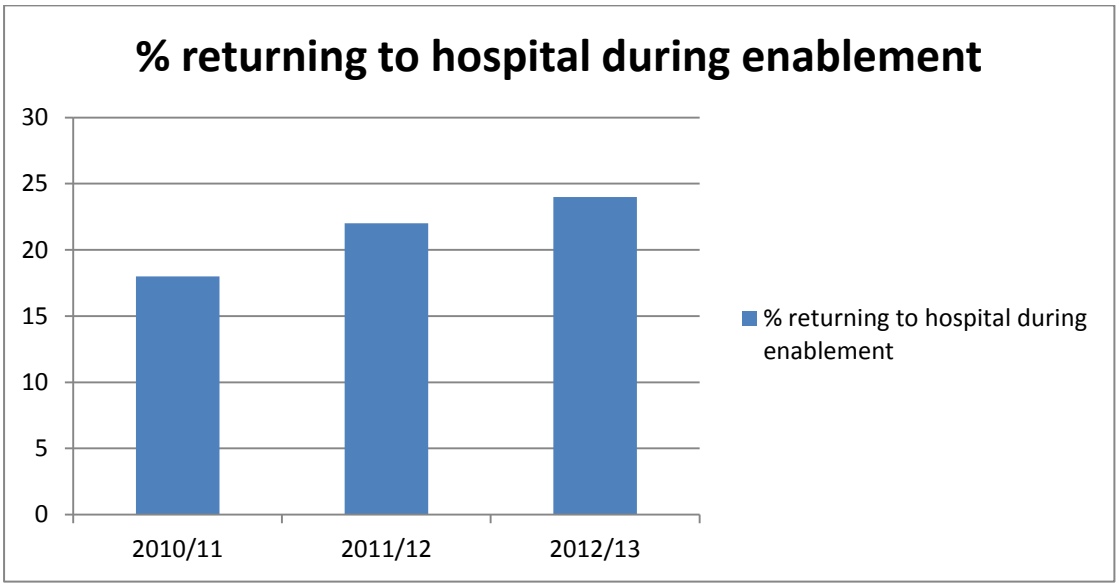
The interviews explained that the longer an individual remains with a provider, then the more dependent they become; when they do eventually move on, then they have to cope with the anxiety of introducing new staff and to familiarise them with individual's care needs.

(iii) Individuals returning to hospital

Finally, an analysis of the evidence also highlighted the increasing number of people who return to hospital following (or during) the period of enablement intervention as being the third factor that inhibits the efficiency of the enablement service. Figure 12 illustrates these increasing numbers over the three years that the enablement team have been operating in LA.

[21] Term used to describe the feeling of the unknown as people pass from service to service

Figure 12 % of individuals returning to hospital during enablement intervention



Source: LAHCS

Figure 12 demonstrates that in 2010/11 nearly 17% of people returned to hospital during an enablement period in LA; by 2012/13 this had increased to 24%. The increasing trend is not favourable and the interviews suggested that it places additional strain on the service. They identified two contributing factors: (i) the complex nature of needs that individuals are presenting with, and; (ii) the general frailty of individuals. As SCO 3 confirmed:

> "we are routinely dealing with people who are very aged. There capabilities are limited and I'm not sure that enablement is right for them."

Figures from LAHCS datasets confirm that the age of individuals who are accepted into the enablement teams ranged from 23 to 99 but that the median age was 83. The predominance of disabilities noted was physical. SCO2 confirmed that the number of

people who were presenting as being old-old and very-old[22] was increasing and that their ability to be enabled was severely compromised by their general frailty.

> " we had someone yesterday who is 99 years old and is pretty much confined to bed…there isn't much I can do with her other than have her transferred across to the long term services but I know they've not got the space so we'll just need to keep her here until a space is available."
>
> Social Care Organiser 2

(iv) Assessment for enablement services

In addition to the three key factors identified in the Figure 10, the interviews suggested that a further contributory factor to the reduced efficiency of enablement was in relation to the assessment for enablement.

Assessment for enablement services is carried out by Care Managers[23] (CM), either based in the hospitals as part of the hospital discharge service (71%), or as part of the first contact service that receives referrals that are community-based (29%). Several comments were raised in relation to the appropriateness of the assessment received. As SCO 4 claimed:

> "the assessments that we receive now are not focussed on enablement. Sometimes it seems like it is just a tool to get the person out of hospital."

[22] Young-old (65-74); old-old (75 – 84); very old (85+)
[23] Fully qualified social worker

This comment was supported by SCO 8 who suggested that:

> "the assessment is vital to us to allow us to understand what the person is able to or not do. There have been occasion where I have not known what that is and the person is already home. We've then had to rely on our staff going in blind so to speak to review the situation and work out what it is they should be doing."

To date, LA has continued to utilise an assessment framework that is centred on the procedural model[24] from which a judgement is made on service provision. It is argued that this approach can be a challenge because the emphasis is not on determining the best personal outcome for the individual, but more on whether the individual meets criteria pre-determined by the local authority. In taking forward an outcomes focussed approach – or exchange model[25] - it is vital that outcomes for individuals are the principle driver for activity (Cook and Miller, 2012). Indeed, Miller (2010) argues that implementing personal outcomes approaches such as Talking Points supports organisations to deliver on policy goals, including increased independence, personalisation, enablement, prevention, improved integration and a shift in the balance of care from hospital to the community. Without the proper assessment, then the starting point for a servicer is skewed. If the principles of enablement are not embedded from the outset then there will be operational difficulties experienced throughout the period of intervention. As SCO4 suggests:

[24] Procedural exists model where the professional gathers information to make a judgement about whether the service user fits the criteria for service provision. . (Harris & White, 2013)
[25] Worker acts as facilitator to generate discussion and assumes that the individual is the best person to understand their needs and outcomes. (Harris & White, 2013)

“assessment is the work book from which we can start the enablement process. If that is lacking in content then we are not able to commence the tasks that we need to start that will help enable the individual. It makes the whole enablement team better than useless.”

5. Discussion and Recommendations

Section 4 demonstrated the four main factors that have contributed that have hindered the development of enablement services in LA. This section reflects on these factors and shows how they help to answer the research questions posed in Chapter 2.

5.1 The demographic context in which social care services are being delivered today

Research question 1 addressed the demographic context in which social care services are being delivered today. Chapter 4 showed that the most obvious factor to effect this service is the volume of people requiring immediate support. Much is written within the literature about the demographic time bomb (Davidson et al, 2007; Razavi and Staab, 2010) and it considers potential policies that might be invoked (Christie Commission, 2011). What is not recognised, however, is that the situation is imminent and is here with us now. Despite demographers and gerontologists writing extensively over the past three decades (Bean 1983; Andersen, 1995; Macunovich, 1999; Bond et al 2001) to predict the demographic challenges, the steps required to offset the demands have failed to materialise. Indeed, if we consider the demographic data in relation to the over 65 population in ten year cycles, a 14% increase is noted between 2000 -2010[26]. This analysis sharpens focus around the baseline data. In terms of determining future service and budgetary provision, these marked increases should provide the focus and understanding to allow meaningful planning of anticipated

[26] The following two decades show slightly higher increases at 15% and 16% respectively.

commitments. The introduction of joint commissioning strategies[27] across the health and social care sector clearly makes provision for a population needs assessment and the analysis of any gaps that may arise in service provision. This analysis then becomes a pivotal factor in the determination of future planning and strategy. Indeed, it might be argued, that, had this level of planning taken place throughout the last 15-20 years, the current plight that the public sector organisations find themselves today may have been averted.

The second factor is perhaps less obvious but is equally important. The increased prevalence of individuals living longer with long term conditions is putting significant strain on the public sector resources. Raeside and Kahn (2007) argue that the increase in expenditure in health and social care is directly attributable to the size of the cohort that is dependent upon health and social care services today. The wider concern for LA is that the evidence would suggest (SIMD, 2013) that there is a higher prevalence of long term conditions in areas where there is higher levels of deprivation. LA currently has 55 data zones (out 179) that are in the lowest quintile in Scotland. This then becomes a wider issue for LA in how it begins to tackle the socio-economic problems that underpin the deprivation index. Interestingly, of the 55 data zones identified the one indicator that shows a sign of improvement is the health indicator (SIMD, 2013). In summary, when these two factors are taken together, they represent the very crux of the challenges posed by the ageing population today.

[27] A framework for the health and social care partners to assist the development and fund community services that will deliver the Government's agenda for better outcomes for older people

5.2 Approach taken to enablement in LA

The second research question considered the approach taken to enablement in LA. Like most other local authorities in Scotland, LA has taken its lead from the JIT in relation to the development and implementation of its enablement service. The model that was initially adopted sought to use the expertise of the therapy services and that would appear to have been justified in terms of start-up and training commitments. However, over time the provision of these services has diminished for a variety of reasons (funding streams, realignment of priorities) essentially leaving the enablement service as a stand-alone service with no direct engagement with therapy services. In this context, therefore, it is argued that there are two related issues that need to be considered within this question. First, the issue of enablement sitting within social care is a moot point because the definition of enablement is not clear within the literature (Becker, 1994; Young, 1996; Bowman, 1999, Brophy, 2008) and consequently it finds itself positioned between health and social care. What is clear, however, is the process that individuals are required to work through to achieve specific goals or outcomes through a short-term, focussed period of activity thus seeking to optimise levels of functionality that prevent further demand on service provision (Pilkington, 2008; Rabiee, 2009). To achieve this, however, two factors emerge that are critical: (i) Wade (2004) argues, good outcomes for individuals and organisations may be difficult to achieve unless there is a culture within the organisation that is focussed on an enablement ethos and utilises all of the skills of all of the players, and (ii) Francis et al (2011) suggest that for enablement to work effectively there is a need to ensure that the appropriate skillset, knowledge and expertise is available to fulfil objectives**.** As Seddon (2008) contends, the failure to

have the right person, doing the right job at the right point it is needed will, invariably, lead to demand failure thereby creating additional work.

It can be argued that neither of these factors has helped LA achieve their goals for the following reasons. First, the assessment for enablement continues to be based on a procedural model which, importantly, is tied to an eligibility criterion that only allows those with the highest needs to access the service. Consequently, those individuals progressing through the system following assessment are those at the upper end of the needs scale who potentially have the least potential to be enabled. Second, the demand to move people out of hospital and back to the community at the earliest opportunity places great pressure on those staff with the responsibility to assess need. As an intake team, LA's enablement team receives 71% of referrals from hospital settings. Within the hospital, however, there is an expectation that discharge will not be unnecessarily delayed (Scottish Government, 2012). Consequently, there is a need to keep the discharge rates at a level that maintain a level of throughput. The concern now is that the pressure exerted on the assessment services to maintain that expected level of throughput results in mechanistic assessments which are form-led and have a checklist approach (Francis et al, 2011) This is contrary to the ethos of enablement that is focussed on describing the outcomes and detailing the activity schedule to meet those objectives (Francis et al, 2011).

It might be argued that, if enablement is defined within the spectrum of rehabilitation, then the assessment for service needs that seeks to optimise independence through a restorative process requires the skillset to develop the goals and outcomes that will be beneficial to individuals. Consequently, the issue of assessment is critical within this

debate. The lead for preventative, restorative service should be with the services steeped in therapy and it should be the qualified professionals in this field who drive forward this agenda.

5.3 Enablement's ability to offset and prevent increased service demands.

The third research question sought to consider the extent that LA'S enablement service was offsetting and preventing increased demand for services. Section 4 shows that enablement services are meeting objectives and are delivering outcomes that are reducing the numbers of individuals requiring on-going, long term support. The emerging trend, however, confirms Humphries (2011) assertion that these early successes are being overlooked as resources are increasingly directed to maintain high level, complex care needs. This is borne out from the quantitative data on those individuals receiving intensive care arrangements for LA. The marked decline in the number of individuals needing no hours following enablement should be an alert to facilitate a review of current arrangements to determine underlying factors to ensure that the successes that have been achieved continue to be maintained.

The evidence suggests that although support must be delivered to those with the highest need, it is also necessary to prioritise those individuals where there is the greatest enablement potential thereby preventing increased demand in the future. Despite limited resources and growth potential failure to prioritise these individuals now will result in challenges in the years ahead. To do this now will be challenging when resources are limited and growth remains unlikely. The need to reconsider the eligibility criteria against this backdrop is essential.

5.4 Factors that are impacting (positively or negatively) on LA's ability to deliver enablement services.

In relation to the fourth research question, in addition to the demographics, the lack of engagement with therapy services and enablement's ability to prevent increased demands, the evidence suggests that two other issues impact on LA's ability to deliver. These relate: (i) to time and timing, and; (ii) policy implementation.

5.4.1 Time and timing

Time exists on an operational and strategic level. At the operational level the biggest challenge for the enablement service is that the time needed to properly construct and deliver an enablement package has diminished in comparison to previous years. As the demand for services has grown over the years and the pressures have been applied from elsewhere (delayed discharge pressure), the time described by Francis et al (2011) as being essential to satisfying outcomes has been compromised. There is a concern that the dedicated enablement teams are no longer specialist teams but are extensions to the mainstream services and that the focus on enablement has been lost because more individuals can be attended to using the time and task model. Consequently, it might be argued that the time allocated for enablement needs has to be ring-fenced to allow this activity to occur effectively. The intake model adopted by LA does not let that happen because its primary focus is to deal with volume to the detriment of enablement outcomes. This has clear implications for policy objectives if the principle, preventative model is not working as envisaged.

On a strategic level, the timing of the establishment of enablement services is vital in this debate. It is argued that in the case of LA the establishment of enablement teams

in 2009/10 was too late as there were already too many people in the system in receipt of traditional services. For these people, no change to their existing service commitments is expected. Therefore, they will continue to draw from existing resources for the foreseeable future. Despite enablement services being promoted as a principle measure in the management of demand it has been overwhelmed by the volume of people now in the system.

5.4.2 Policy implementation

Policies and initiatives are vital to develop the strategic position. Despite the policies being well intentioned, the length of time required to implement and reap the benefits can be prohibitive. Organisations that are rooted in management structures based on consensus management practices means that change takes time. Second, an expectation that a consultative process that seeks to engage with wide stakeholder groups through meaningful dialogue and discussion also means that a change process will take time to implement. Third, to change services that have been entrenched through time requires a shift in culture within communities and an acceptance that the statutory agencies cannot supply the level of services necessary in the future (Christie Commission, 2011). This coupled with the slow pace of change in the public sector would suggest that little or no impact will be evidenced from change proposals for some time to come (ADSW, 2013).

6 Conclusion

The implications of an ageing population are wide-ranging, but it is far more complex than a simple increase in numbers. The ageing population coupled with the high prevalence of long term conditions means that people will be increasingly dependent on health and care support to enable them to stay in their own homes for longer. Whilst it is acknowledged that work is progressing to develop the sustainable, modernised, appropriate public services in Scotland that are built around people and their communities the question remains whether it will be too little, too late to face up to today's scenario**.** The findings within this dissertation point to that conclusion as the initiatives and strategies introduced most recently, such as enablement, have now been subsumed in the increased numbers of ageing, dependent people seeking the essential care and support required to maintain them within their own homes. Consequently, it is this researcher's view that immediate, reactive measures are needed now to prevent the challenges escalating into a crisis situation that will only be addressed by greater investment. However, it is contended that these projects or initiatives will require time to become effective and that the results will not be immediate. Time is the one factor that cannot be controlled in this debate.

This researcher, therefore, concludes that there is a need create the environment over the next few years that will allow the initiatives the opportunity to bed in, but also to be better understood against measurable outcomes. To achieve this, the researcher suggests that there is a need to realign the additional monies provided by the Scottish Government through the Change Fund to "purchase" additional care and support to offset the increase demands. By doing so equilibrium can be maintained in the short

term but it will allow the policies to take full effect and realise the outcomes that will allow more people to be supported in the community in the years ahead.

The overall aim of this research project was to explore what factors that are impacting on the effectiveness of enablement. This researcher acknowledges that within a dissertation that is limited by a word count then it has not been possible to write about all the factors that are at play. However, based on the researcher's background in social care, and having drawn from the multiple sources of data and evidence available, then the most important factors and their consequences have been presented. This dissertation, therefore, only provides an overview of what is occurring within LA.

Had time permitted, a more detailed analysis of the cost implications of establishing and maintaining an enablement service would have been carried out to establish a cost benefit analysis for the LA. Similarly, there is a need to understand the differences in approach between targeted support and an intake model to determine the most effective approach. The findings from this research, however, would suggest that an intake approach is less effective at meeting stated enablement outcomes but is better placed to deal with the volume of referrals. However, a longitudinal, comparative study is required to fully understand the dynamics.

In terms of future research, there is a need to understand the national picture to allow policy makers the opportunity to align (or realign) priorities for the future. The development of a framework to consider what is actually happing within each local authority based on demography, finance and enablement outcomes would then allow the 32 local authorities to measure the success of the policies and initiatives that have been introduced.

Appendix 1

LAHCS Measurement Tool: Data Gathering Framework

(i) established posts;

(ii) staff in post;

(iii) contractual commitments;

(iv) vacancies;

(v) sickness absence;

(vi) annual leave absence;

(vii) unused flexi staff[28];

(viii) service users in hospital;

(ix) additional hours[29];

(x) travel time;

(xi) other[30]

(xii) spare hours[31].

This information was then input into a spreadsheet against the headings for each locality area[32]

The figures were aggregated and totalled for each area. By deducting the non-activity in columns (iv) to (xii) inclusive from the contractual commitments this then produced the activity data in each locali

[28] Staff who, as part of their weekly commitments, are engaged on a flexible basis and provide cover for day-to-day absences.
[29] Hours out with contracted commitments
[30] Includes training, paternity leave, secondments to office, lunch clubs, cancelled services
[31] Hours not committed to any activity.
[32] LAHCS operates over two geographic localities (East and West)

Appendix 2

13th June 2013

Dear

MSc Integrated Service Improvement (Health and Social Care)

Dissertation Proposal: *How effective is the enablement approach at addressing the age demographic challenges: a case study.*

I am writing to invite you to participate in my research project.
As a Team Manager with the Community Care (Older People) Home Care Service, I am seeking to evaluate the effectiveness of home care enablement as a resource to offset increased demand for services. I intend to frame my research within a dissertation that I will submit later this year to complete the MSc Integrated Service Improvement (Health and Social Care). My research will focus on whether the approach adopted is living up to (or will meet) policy expectations driven by the Scottish Government.
To help you decide whether to take part I have detailed below what the research will involve for you and how the information will be collected and used. If you have any queries at this time, please do not hesitate to contact me at stuart.fordyce@

What the study is about

The introduction of enablement practice in Scotland's social care sector has been widely adopted as an approach to care at home that maximises independence and lessens dependency on care support. Despite evidence continuing to describe enablement in positive terms, there are now a number of questions arising in respect of value for money and how effective the approach actually is.
My research, will seek to answer the following questions: (i) how is the ageing population in Dundee impacting on the local authority's ability to deliver social care services; (ii) is the approach adopted by Dundee City Council the most effective means of offsetting and preventing increased dependency on service provision, and (iii) what are the longer term implications for Dundee City Council's Enablement Service. The dissertation will form an independent, self-directed piece of research, but is very much based in the reality of day-to-day work. It is about looking at things afresh and creating new insights that have the potential to improve service provision in the future.

Why you have been asked to take part

As someone with the background and knowledge around the introduction, and on-going management of enablement services within Dundee City Council, the part of the study I am inviting you to take part in is the survey of first line managers directly involved in the organisation and delivery of enablement support.

What the study will involve

I will use the data gathered from the service improvement interviews held earlier this year. I may also need to get back to you for a brief meeting if I need to clarify points from the original interview.

Confidentiality

I will not use your name in any reports of this work and it will not be made known who took part. I will use quotes from interviews to illustrate general points emerging from the study, but I will ensure the identity of the participants cannot be traced. My dissertation will be shared with you ahead of submission on the 16th August 2013. All information will be held anonymously, using ID codes, and kept in secure systems. Hard copy records will be shredded at the end of the project and anonymous computer files held securely with password protection for 12 months post submission and then destroyed.

Risks and benefits

My hope is that the dissertation will feed into a wider consultation exercise around the challenges facing social care in the future and whether an enablement approach to care at home is the most effective means of fulfilling policy objectives. Taking part will help inform that debate and will help the organisation prepare for the challenges ahead. It presents a real opportunity to proactively consider the development of social care services for the future.

Complaints

If you have a concern about any aspect of this study, you should contact me directly and I will do my best to answer your questions (see contact telephone number/email below). If you remain concerned and/or unhappy and wish to complain formally, you can do this through my dissertation supervisor: Dr Ailsa Cook, Programme Director: Postgraduate Programme Integrated Service Improvement, School of Health in Social Sciences, Edinburgh University tel: 0131 650 4028/ailsa.cook@ed.ac.uk.or through the Social Work Complaints Procedure.

Next steps

If you decide to take part, please retain this information sheet, complete the attached consent form and return to me. You are still free to withdraw at any time and without giving a reason.
If you decide against taking part, I would ask that you return this information sheet to me and I would thank you for you for your consideration.

Yours sincerely,

Stuart Fordyce

enc

Interview Consent Form

Dissertaion proposal: *How effective is the enablement approach at addressing the age demographic challenges: a case study*

.

Name of Researcher: Stuart Fordyce

If you agree with the following statements, please provide your initials in the box and sign and date the agreement below.

1. I confirm that I have read and understand the information sheet dated: 13th June 2013 for the above study and have had the opportunity to ask questions. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3 I understand that the notes may be looked at by the researcher ☐

4 I give permission for anonymised data to be presented in research reports and/or publications ☐

I agree to take part in the above study.

_____	_____	_____
Participant	Date	Signature

Please return (Marked "Staffing – In Confidence") to:
Stuart Fordyce, Team Manager (Home Care), Community Care Services, Social Work Department,

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