Oxfordshire County Council's research into preventing care home admissions and subsequent service redesign

Rachel Taylor[1], Liz Cairncross[2] and Sara Livadeas[1]

[1] Oxfordshire County Council
[2] Institute of Public Care

Abstract

Oxfordshire County Council worked in partnership with the Institute of Public Care on a study of the pathways of older people who had entered a care home in 2008-2009. The aim of the research was to identify the critical characteristics, circumstances and events which led to a care home admission in order to provide appropriate services to prevent or delay such an admission. The project combined a literature review with a quantitative and qualitative approach. An analysis of 115 admissions of people admitted in 2008-9 was carried out to identify common characteristics. This was followed up with interviews of people who had entered a care home, their carers and care managers, to explore more fully the circumstances and experiences prior to entering a home. The study found that certain conditions and experiences were particularly prevalent - these included incontinence, dementia, falls and depression. Most people had been receiving social care support prior to entering the care home as well as informal care. However, despite common features, individual situations were both varied and complex. In response to the research, Oxfordshire County Council is working with the PCT to develop a co-ordinated continence service. In addition, 'Turnaround' is being piloted in Oxfordshire County Council, a holistic, targeted, outcomes-based service which aims to support people to become more independent and reverse a potentially inevitable course towards more costly and intensive care.

Keywords: care home admissions, elderly people, care home avoidance, prevention, promoting independence

Introduction

This paper presents Oxfordshire County Council's (OCC) research into issues surrounding care home admission and subsequent service redesign. The main part of this paper reports on methods and results of the research. A future paper will be written on the service pilots being developed as a result of the research.

Background and literature review

As part of its Promoting Independence and Prevention Programme, Oxfordshire's Social and Community Services (SCS) undertook research which aimed to identify the critical characteristics, circumstances and events which lead to a care home admission. The overall aim was to be better informed about what is needed to prevent or delay such admissions and which services are most beneficial. The research was undertaken by SCS and the Institute of Public Care (IPC) and overseen by a Steering Group which included service user representation, the PCT, operational and strategic staff. The research design and resulting commissioning decisions evolved in a participatory manner through regular Steering Group meetings.

Similar research had been undertaken by Northamptonshire County Council (Woolham *et al.*, 2009) and is currently being completed by Kent County Council. Meetings with both these councils were held during the design phase of the study. Each

council's project involved an analysis of case file data but Oxfordshire's research had the additional aspect of interviews with older people, carers and care managers.

IPC undertook a review of the broad prevention literature as well as honing in on particular key areas as they arose during the course of the research. These specific areas of foci included continence, falls, stroke, and carers of people with dementia. Two of these areas, falls and continence, are discussed briefly here by way of background literature. A fuller review of the literature will be available at www.oxfordshire.gov.uk. This includes research on targeting interventions because early on in the project it became clear that the most useful study outcome would be a more finely grained understanding of how to target those people on a potential route into residential care, with a view to preventing or delaying that admission. Key messages from our review are outlined below.

Current social care policy in England (Department of Health, 2009) emphasises the role of prevention and early intervention and the need for joint working across local government and with health services. Such an approach is also consistent with recent health and housing policy statements (Department of Health, 2008). However, the term "prevention" is not clearly defined and there is no agreement as to what is included in "preventive services". Therefore, for the purposes of this paper preventive services are defined by us as those that:

> *prevent or delay the need for more costly intensive services, or, proactively promote the independence of older people and engagement with the community.*

Even using the above definition, it is not always easy to determine where and how to focus preventative interventions. This is underpinned by recognition that,

particularly in the current economic climate, there are scarce resources that need to be allocated in the most appropriate way.

Research indicates that key explanatory variables for care home admission include, for example, age, sex, ethnicity, deprivation, morbidity, health service use, drugs prescribed, as well as patterns of social care needs and usage (Barton *et al.*, 2006). Lewis (2007) indicates that most studies on factors statistically predictive of institutionalisation have considered age, dementia/cognitive impairment, activities of daily living (ADL) restriction, number of family members, and use of day services. People living alone are at greater risk of institutionalisation and of worsening mental health. However, older people who have never married are much more likely to be in residential care than those who are still living with their partners (Wenger, 2000) and, in particular, older men without partners are more likely to live in residential care, despite lower levels of disability than lone older women (Arber & Ginn, 1995; Tinker, 1997). The importance of these factors was highlighted in our audit of a sample of over 100 files of those admitted in Oxfordshire in 2008-2009.

All of these factors are potentially open to 'upstream', preventive intervention. However, it is still unclear, how, when or where best to invest. Research has been undertaken, particularly in health, to predict health risks with a view to intervening and reducing risk and therefore cost. One approach is predictive modelling which seeks to establish relationships between sets of variables in order to predict future outcomes, for example, Patients at Risk of Readmission (PARR). This model usually incorporates formulae to allow interpretation of historical data and make predictions about the future, map associations and statistical relationships to a specific target. Evidence indicates that predictive models are superior to both threshold models and clinician knowledge in identifying patients at risk of future

admission. It appears that diagnoses and prior utilisation are key predictive variables when combined with demographic data (Curry *et al.*, 2005).

Curry *et al.* (2005) suggest interviewing the first 50 patients (and their providers) flagged by the PARR system to determine the needs of these patients and the factors that contributed to any preventable/ avoidable admission. This information could then be incorporated into efforts to design interventions, whether the services are ultimately "made" or "bought" by the PCT/SHA. A similar approach, taking a sample of recent admissions to residential care, or delayed discharges and looking at the factors that contributed to preventable or avoidable admission could be adapted and developed as part of the Oxfordshire prevention project.

A review of the literature on falls found that a third of people aged over 65 and nearly half of people over 80 fall each year without effective intervention. Falls are the main cause of disability and the leading cause of mortality due to injury in people aged 65 and over in the UK. A hip fracture is the most common serious fall-related injury, resulting in a cost to the NHS of £1.7 billion each year. Mortality after hip fracture is high; over 10% within 30 days of the fracture (National Centre for Health Outcomes Development Clinical and Health Outcomes Knowledge Base, 2010) and around 30% at one year (Scottish Intercollegiate Guidelines Network, 2002)

Our review of literature surrounding incontinence revealed that it affects 25% of the older population, 24% experience urinary incontinence whilst faecal incontinence affects 1-4%. In care homes these figures are considerably higher being 30-60% and 25% for urinary and faecal incontinence respectively. The difference in these figures may be due to underreporting in the community (Edwards & Jones, 2001; Tan, 2003). Furthermore, incontinence may

contribute to premature referral for care home admission, as the older person or their carers reach the point whereby they can no longer manage the situation. Thom (1997, p.367) demonstrated that urinary incontinence was a significant factor in increasing the likelihood of care home admissions in the United States. His work concluded that urinary incontinence 'increases the risk of hospitalisation and substantially increases the risk of admission to a nursing home independent of age, gender and the presence of other disease conditions'.

Evidence shows that many causes of incontinence are amenable to treatment and that continence in older people can be restored in most cases (Shaw *et al*., 2007) Though conservative treatment is frequently possible (Teunissen *et al.*, 2004), management of the problem seems to be the dominant approach to helping people cope with incontinence. Containment (e.g. limiting activities, wearing pads) rather than cure is expensive from a health, financial and personal perspective.

Methods

Our project combined a quantitative and qualitative approach. Ethical approval was obtained through Oxfordshire County Council's Research Governance Group. Social and Community Services research staff carried out an audit of a random sample of 115 care home admissions (2008-9) across the county, approximately a quarter of all admissions over the last year The data for each case was held on two separate electronic files both of which were examined. It should be noted that the information held on file will typically reflect what staff thought relevant to record, for example the severity of an older person's situation may be strongly emphasised in order to ensure that they are considered eligible for admission to a care home. Health data was not obtained due to data protection and consent issues. Therefore, as

is often the case in this type of research, only part of the whole picture was obtained.

This bias was redressed to some extent by the second phase of the study which focused on interviewing an opportunity sample of the older people, their informal carers where available, and care managers. In order to exclude contacting people who lacked the capacity to consent to the research, a preliminary discussion was held with care managers and care home managers. Recruitment of participants was through letters to the care home manager and to the individuals and was time consuming. We sent letters to care home managers asking them to pass on letters to residents and carers. A total of 20 audio-taped interviews were carried out, including 5 interviews with older people on their own, 2 with an older person and their carer, 6 with carers on their own (3 were carers of people with dementia) and 7 interviews with care managers and care staff. The interviews covered the cases of 10 older people. The completed interviews were transcribed and an analysis of the transcripts carried out using qualitative data analysis software (NVIVO). The results of this analysis and those from the file audit were contrasted in order to test and inform our developing understanding of the reasons for admission within the authority.

Older people and their carers were asked about circumstances and experiences prior to entering a care home, including: the previous living arrangements of the older person; their health and need for care in the 4 to 5 years leading up to admission; the circumstances around the decision to go into care and whether there were any services or support that they felt could have enabled them to continue living in their own home for longer. This phase of the project also included mapping timelines for the older people who were interviewed to visually demonstrate their pathway into care (please contact authors for an example).

Results

The results are separated into the following sections: demographics, predisposing conditions, continence, dementia, falls, depression, health and social care services, informal carers.

Demographics

The median age at placement was 85.0 years with a range from 65 to 103.

The majority of people going into care were White British (97.5%) and nearly three-quarters (71%) were female. This is similar to the profile of older people in Oxfordshire, particularly those aged 85 and above and identical in terms of gender to an earlier national study based on 1995-1996 data (Bebbington *et al.*, 2001).

Prior to admission, more than 3 out of 5 older people aged 75 and over (63%) had been living alone, whilst 19% lived with a spouse or partner and 19% with another family member. In comparison, less than 50% of people aged 75 and over are estimated to live alone in Oxfordshire, reflecting in part a younger age profile. It is not known whether the higher proportion of older people living alone who are admitted to a care home reflects their higher age profile or indicates a greater likelihood to be admitted to a care home. However, a national study (Bebbington *et al.*, 2001) of care home admissions in 2001 found 70% of people admitted to a care home and 52% of people admitted to a nursing home lived alone.

More than two-thirds (70%) had been living in their own home, with 22% coming from sheltered housing, and 8% from their son or daughter's home. There may be scope to reduce the relatively high proportion of people moving to care homes from sheltered housing with greater provision of extra care housing as an alternative to sheltered housing. Bebbington *et al.* (2001) reported

6% of admissions were people coming from sheltered housing.

Predisposing conditions

The case file audit identified a number of conditions among those being admitted:

|	
Urinary incontinence	45%
Dementia	40%
Bowel incontinence	34%
Depression	25%
Visual impairment	21%
Stroke	19%
Diabetes	17%
COPD	6%
Learning disability	2%

Bebbington *et al.* (2001) found similar rates of dementia (38%) and stroke (21%), but lower levels of incontinence (29%), depression (13%) and visual impairment (10%) in their study of admissions to care homes. Broadly similar distributions of the conditions found by Oxfordshire were reported by Northamptonshire County Council (Woolham *et al.*, 2009).

More than half of those in our audit had multiple health problems at the time of admission: 56% with 3 or more conditions. Common combinations included: dementia and incontinence (19%); dementia and depression (17%); dementia and stroke (10%); and dementia and diabetes (9%). It is possible that there has been under-recording of the full range of health problems experienced by those in the audit. Interview data also revealed that all of the older people in the sample had experienced multiple health problems in the years leading up to their admission. These included: stroke and associated disability, incontinence and urinary tract infections (UTI), dementia, cancer, visual impairment and depression. In several cases, people were living with the consequences of a health condition from many years ago, e.g. a stroke in 1987:

He had the stroke in '95. But that limited his movement on his right side and you know I suppose getting older as well, he struggled getting around a bit more, then he got diagnosed with prostate cancer. ... And he had to have a catheter fitted and he gets quite prone to infection and he had falls and things. Carer 1

When she was admitted to the [care home] she had a chest infection, a UTI, her diabetes was ridiculously unstable. So add that to the dementia, it all blew up. Care Manager 3

Figure 1   Number of placements by age (n=115)
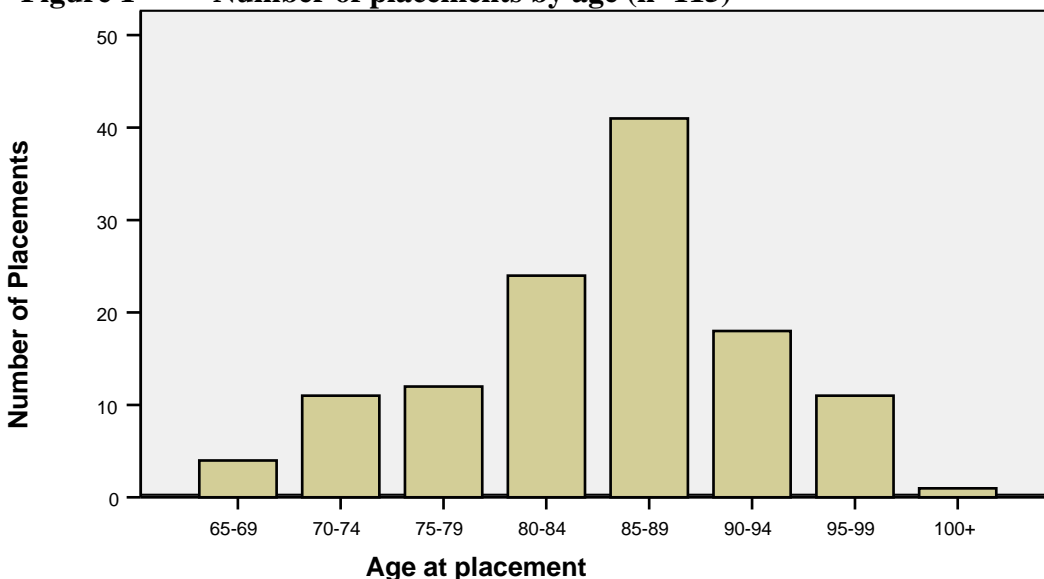
The file audit revealed levels of ill-health that were well above national prevalence rates for incontinence, dementia and stroke. However, prevalence data from directly comparable age groups is rarely available. Twenty per cent of men and 25% of women aged 85 and above in the general population are estimated to have dementia (Alzehimer's Society, 2007) and between 10% and 20% of those aged 65 and over is estimated to be incontinent (prevalence data for higher age groups are not available) (DH, 2000).

Continence

Incontinence was a common characteristic of those admitted to a care home: 51% of the sample in the file audit experienced some kind of incontinence. Seven of the 13 interviews with the older person, carer, or both highlighted continence issues prior to admission. These findings suggest continence is an influential driver towards care. This may be in terms of the condition itself leading to people concluding that they cannot remain in their own homes but also through secondary factors such as the stress that managing incontinence puts on carers, its apparent link to UTI and falls, or people restricting their mobility because of anxiety about their continence. Care managers commented on the significance of incontinence:

> *There is one particular couple we get that the wife is the primary carer and she consistently says, "oh I can't cope my husband has got to go in permanent care". And the trigger for her is the fact that he has problems with his catheter now that is just one thing that just tips her over.* Care Manager 4

> *It was terrible, it was terrible ... I suppose towards the end I'd got to the stage where I sort of resented it really, because the British Legion gave us an electronic bed for her, so that was nice, but it was just sponge, it was ruined and*

> *that was every morning. Mum was buying her own incontinence pads, because the doctor, we didn't even realise we could get them on prescription right up until probably 6 or 7 months before she came in here, before she went to hospital.* Carer 2

UTI was mentioned as a factor linked to falls:

> *But the paramedics kept coming because she kept having urinary tract infections. One after the other. She used to drink a lot and that's what they thought was causing a lot of this [falls].* Carer 3

> *UTI's is a biggie. We get lots of people coming in with urine infections .... But of course with a UTI quite often comes confusion, disorientation and falls.* Care Manager 1

The relationship between continence and night care services was mentioned by several care managers:

> *If you think for the sake of going to the toilet once, you go into a home, leave your own home, possibly your husband just for that reason. Until we realise that complex care does not stop at 9 p.m., I can't see how we can ever stop people going into homes unnecessarily.* Care Manager 3

Dementia

Dementia was the other condition common to a high proportion of those admitted to a care home. It was also an important factor mentioned in the interviews although, for ethical and practical reasons, people with dementia were not themselves interviewed. Carers mentioned concerns about the behaviour of those they had cared for with dementia in terms of wandering (particularly at night) and aggression. These concerns were echoed by care managers:

Yeah, he did get support but it is very difficult with dementia because the times that you need support are the times that are unpredictable. So someone went in everyday and the carers were great, they would pop in in the morning and if she didn't want to know in the morning they would come back at lunch time and get her up and dressed and all those things. Care Manager 4

This lady's dementia made her unsafe to be at home because, you know, we can't keep sending somebody home who is pulling out their catheter and a high risk to themselves really and I know that from reading back my notes her son and her daughter were very distressed and really struggling to hold the whole thing together. Care Manager 1

Falls

The data indicated that more than one quarter (26%) of people had fallen requiring a hospital admission in the last 12 months; whilst 18% had a recorded fall although this had not resulted in a hospital admission in the last 12 months. Falls were mentioned by several interviewees and there appeared to be a possible link with incontinence. The unpredictability of falls and concerns about frail elderly relatives falling while on their own were a common concern for carers:

I think everything was being done, I think it was just purely dad with his falls and his safety issue and I don't think anything else could have been done. He had the alarm, he had the carers coming in, but I mean ... I turned up one day and he was just laid on the floor. He hadn't been able to press his alarm because he was in such an awkward position. Carer 1

So what would you say was the main reason that you came into a care home? Researcher
M*ainly because my daughter didn't want to come home from work and find me on*

the floor. That's what she's frightened of. Older Person 1

Another carer stated:

She can't stand, she can't walk and I didn't want that. I used to work in London, before mum came in here and I'd very often get a phone call, "I've fallen" or "I've this or that", so really it's just for her own safety. I couldn't keep thinking about her constantly when I was at work all day. Carer 2

Depression

A quarter of those admitted to a care home (in the file audit) had suffered from depression. Mental health problems were mentioned in some of the interviews as factors contributing to the older person's admission to a care home. Bereavement and isolation had in a couple of cases resulted in depression:

He had depression but I think it got, well it did get worse when my step-mum became quite poorly so that put strain on dad because he was caring for her. Carer 2

Isolation and lack of social contact were mentioned in a number of instances as factors which contributed to an older person's deteriorating health and well-being:

... the other big one that I find that people tend to go into long-term care that aren't hospital admissions, a lot of it is isolation, is loneliness, is feeling vulnerable and at risk and especially during the winter months. Care Manager 7

I think she felt quite isolated at night in the flat. I think if there had been a warden there she would have been ... but even now I think they are finding that she doesn't sleep very well, and they make

*her a cup of tea in the night and that sort
of thing. And I think if somebody could
have been on hand at night she may have
been different.* Carer 3

Social isolation was sometimes due to or
compounded by a disability; for example, as
a result of visual impairment, one older man
stopped going out despite living in a
sheltered housing complex where
community rooms were available:

*He wouldn't go out. He was frightened
and so he got very isolated and although
they had a community room at [sheltered
housing scheme], because of the dark
nights and that, he wasn't going to go;
you know he didn't go so most days the
only person he saw would be the warden,
the lady who came to put him to bed, the
one who came in the morning. So that
was the only people he ever spoke to.*
Carer 4

Most people depended on their family and
formal carers for social contact and only one
older person had received a befriending
service. One care manager commented on
the waiting list for befriending services and
a lack of any service in one part of the
county.

Mainstream services

Prior to admission to a care home, at least
84% of older people had received social
care to help them live at home, including
50% who had received intensive home care,
i.e. more than 10 hours of home care or 6 or
more visits a week. However, this also
means that 50% of those admitted had not
been receiving an intensive care package
prior to admission. Of the smaller sample
who were interviewed all had been
receiving a care package prior to admission.

More than three fifths (61%) of people in
the file audit were admitted from hospital.
Where information was recorded nearly two
fifths (39%) had been in hospital for 8

weeks or more prior to admission. The
national study by Bebbington *et al.* (2001)
found only 10% of those admitted to a care
home had been in hospital for 8 weeks or
more prior to admission. The higher figure
for the file sample in Oxfordshire may be
due to higher need thresholds for admission
to a care home now in operation, but there
may be local factors at play, such as policies
and procedures around hospital discharge.
Nearly one fifth (18%) of people admitted
to a care home were known to have been in
hospital in the last 12 months (excluding the
time immediately before admission to the
care home).

Most of those participating in the interviews
were admitted to a care home directly from
hospital, often after a protracted stay. In
some cases, it appears that admission to
hospital was the first time that the older
person's health problems (such as dementia)
were properly assessed and diagnosed: in
other words, hospital provided an
opportunity to assess the whole person.
Some carers commented on the pressure on
beds leading to prematurely early
discharges:

*The most stressful time that my sister and
I had was when she [mother] used to go
into the (hospital) and they kept her in.
All they wanted to do was get rid of her
really quickly. Which I can understand
because this is … they couldn't wait to
get rid of her and sometimes they sent
her home and she was back in the next
day.* Carer 3

There was praise from some interviewees
for the hospital social workers and the
support they provided; "they were
wonderful". There were positive and
negative comments about the support
provided by social care staff. Some were
praised for their helpfulness but there was
frustration at the length of time home care
staff could stay for, delays in getting help
(carer of person with dementia "it was just
like hitting my head against a brick wall to

get any help") and lack of information. A carer commented that because her mother had not wanted personal care, the care staff were cut back even though the mother was suffering from social isolation.

Continuity was also mentioned as an issue by service users and care managers. One older person had 6 different care managers or social workers, partly as a result of admission to 2 different hospitals and alterations in her care package, over a period of 6 months:

> *I had lots of lovely people coming and going but you'd ring them the next time and I'd say "oh can I speak to so and so". "Oh she's not dealing with the case now. It's been handed on to so and so" and so you'd ring so and so.* Carer 5

Informal care

More than three quarters of the audit sample (82%) had received informal care in the shape of help with daily tasks and a smaller percentage (30%) of the total had received informal personal care from family or friends. Of those receiving informal care, the main informal carers prior to admission were sons or daughters (59%), followed by partners (14%) and other family members (14%). More than one third (37%) had family members living in Oxfordshire, although the closeness of informal carers and the frequency of the care provided varied. Of those who received informal care, in 12% of cases the carer had fallen ill or died in the last 12 months. From the small numbers where the breakdown in care was recorded (such as death of a carer), it is not possible to assess the extent to which the loss of a carer was a major factor in admission to a home. However, the low percentage is surprising given the perceived importance of informal carers in supporting people at home and other evidence from the audit (e.g. people living with someone less likely to be admitted to hospital) indicates there may be other factors at play.

Many carers had provided large amounts of informal care while working and bringing up their own families. The interviews highlighted the impact of caring on carers' health, income and family relationships. Carers spoke of the strain and practical difficulties which caring created:

> *On a Sunday morning I got a phone call and I'd only just finished a 10 hour shift at work and I had to spend all day at Banbury hospital with him, so it was causing a bit of strain all round. I think Dad realised that it was not just him, it was affecting me as well.* Carer 1

There were a variety of views about the amount of support provided to carers. Some felt that they had been provided with a lot of help. Others thought that the support offered had not been appropriate to their needs or sufficiently practical:

> *I was offered support as a carer but only through a group which I did not want. I didn't want to sit and listen to everybody else's troubles as I felt my brother and I were only just about coping and we had enough on our plates.* Carer 6

> *I needed good information and a 'kind word' from time to time. I didn't know what the implications were of my mother having dementia and it would have been really helpful to have someone to give advice, talk through options, and prepare me for what might happen in the future in terms of the progression of the disease.* Carer 6

Respite care was something that one carer mentioned as a form of support that would have been useful. However, the difficulties of obtaining respite care were evident:

> *As a service user that would have been something that would have been really helpful to me, to have easy access to respite care.* Carer 7

Research impact on service design

The purpose of this research was to find out how Oxfordshire can better support people in the community and avoid unnecessary admissions to residential care. There was a commitment from the Steering Group that the research should result in piloting at least one new or redesigned service and some funding was made available for this. There was a great deal of discussion on how best to target limited resources and this work is ongoing. However, decisions have been made on the areas to be piloted and below is a short outline of progress on current areas.

Continence

A key finding was the critical aspect of continence and its potential contribution to care home admission. Research shows that it is often under reported, under recognised, that there is a tendency to manage rather than cure and that cures might be very low cost (see Teunissen *et al.*, 2004). Funding was obtained from the Department of Health to scope the redesign of the continence service in Oxfordshire. Further work has been undertaken looking at how to raise awareness of continence issues and break down barriers of stigma and embarrassment. Both these pieces of work are ongoing and will be reported on in another paper.

The 'Turnaround' approach

Extensive discussions and research have been taking place in the design of a predictive model for identifying those most likely to be on a pathway to intensive care and most likely to benefit from services. It is likely that an outcomes-based holistic re-ablement service (called 'Turnaround') will be delivered through the case management model, targeting people in need of some extra support before they reach crisis point. However, there is concern that ostensibly spreading the social care net wider could encourage further dependency so how the service approaches this issue will be crucial.

It is important that we do not miss psychological issues; we have undertaken consultations on the concept and targeting of Turnaround which revealed that social isolation and bereavement can be debilitating. One older person described their loneliness thus: "I scream at the walls sometimes" (see Roberts, 2010). What is clear is that while older people are frequently dealing with huge issues of social isolation, loneliness and bereavement, social services has very little response to this, something Turnaround will attempt to redress.

Carers Training and Support (CTAS)

The research revealed important insights regarding carers. Given that most of the older people contained within the file audit and in the interviews did have a significant informal carer of some kind, it was notable that having a carer *per se* did not prevent an admission. In addition, in only 12% of cases in the file audit had there been a carer death or breakdown in the previous year, again suggesting that carers are not necessarily the sole factor in staying out of a care home. However, it can of course be hypothesised that admissions would have happened earlier and with more frequency but for carer support. In contrast to this aspect of the file analysis, the interviews revealed the physical and psychological toll on carers, particularly those caring for someone with dementia which makes up a large proportion of care home admissions. The interviews also revealed that support and information is patchy and often inadequate. As a response to this finding, Oxfordshire County Council has designed a package of training and support for people caring for people with dementia involving, among other things, condition-specific training and cognitive behavioural therapy. The service will run for 2 years and aims to support 400 carers. It will be important to examine if this programme of training and support adds decisively to the skills and preventive capacity of the carers.

Conclusion

The study highlighted that, although certain conditions and experiences were particularly prevalent, individual situations were both varied and complex. Therefore, delivering services that can help a range of people is challenging. The research revealed that most people going into care homes do have high levels of need and the data from all those interviewed and from the majority of audited files indicated that at the point of entry there seemed little other choice. However, the often lengthy period of deterioration coupled with a service interface with social care and health suggests that there are likely to be opportunities earlier along the pathway to support people to remain independent longer. Finding out what works and when is an ongoing challenge with which the Steering Group continues to grapple.

There were some obvious limitations to this study. As mentioned earlier, the file recording reflects the particular occupational perspectives of health professionals and is inevitably partial in that regard and cannot be expected to reveal the 'whole' story. A second limitation was that the older people who were interviewed were being asked about a time that was stressful and where their health was at a low point (i.e. the run up to entering a care home). We found the interviewees often had trouble remembering what had happened thereby making it less easy for us to identify retrospective opportunities for interventions. A third limitation was that we did not have access to health data which holds vital clues to the individual pathway and what support was available and given.

Further research would be valuable into what is happening in the hospital setting as there is anecdotal evidence that people develop health problems while in hospital for long periods as a result of enforced immobility. Similarly, it is thought that some health professionals may direct people unnecessarily towards residential care due to a lack of knowledge about other forms of support that may be available and more appropriate.

Another area that was not explored is the importance of the 'messages' older people get from carers, professionals and significant others about their potential to remain independent, active and valued. These messages could be vital for their sense of self-esteem and for their ability to remain living at home. Oxfordshire County Council plans to undertake a study into the 'characteristics of independence' which will aim to find out what personal qualities may be significant for remaining independent for longer.

Acknowledgements

References

Alzheimer's Society (2007) *Dementia UK: A Report into the Prevalence and Cost of Dementia,* London: Personal Social Services Research Unit LSE, and the Institute of Psychiatry, King's College London.

Arber, S. & Ginn, J. (eds.) (1995) *Connecting Gender and Ageing: A Sociological Approach*, Buckingham: Open University Press.

Barton, P., Bryan, S., Glasby, J., Hewitt, G., Jagger, C., Kaambwa, B., Martin, G., Nancarrow, S., Parker, S., Regen, E. & Wilson, A. (2006) *A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People*, Leicester: Leicester Nuffield Research Unit.

Bebbington, A., Darton, R. & Netten, A. (2001) *Care Homes for Older People, Volume 2 Admissions, Needs and Outcomes, The 1995/96 National Longitudinal Survey of Publicly-Funded Admissions*, Kent: PSSRU.

Curry, N., Billings, J., Darin, B., Dixon, J., Williams, M. & Wennberg, D. (2005) *Predictive Risk Project Literature Review*, London: King's Fund.

Department of Health (2000) *Good Practice in Continence Services*, London: DoH.

Department of Health (2008) *High Quality Care for All: NHS Next Stage Review Final Report*, London: DoH.

Department of Health (2009) *Transforming Social Care*, London: DoH.

Edwards, N. & Jones, D. (2001) 'The prevalence of faecal incontinence in older people living at home', *Age and Ageing,* **30**(6), pp.503-7.

Lewis, G. (2007) *Predicting Who Will Need Costly Care: How Best To Target Preventive Health, Housing And Social Programmes,* London: Kings Fund, DCLG, DoH.

National Centre for Health Outcomes Development Clinical and Health Outcomes Knowledge Base (2010) *Deaths Within 30 Days of Emergency Admission to Hospital: Fractured Proximal Femur (ICD 10 codes),* accessed 21/6/10 at http://www.nchod.nhs.uk/.

Roberts, D. (2010) *Oxfordshire County Council: Consultation Interviews Turnaround,* unpublished.

Scottish Intercollegiate Guidelines Network (2002) *Prevention and Management of Hip Fracture in Older People: A National Clinical Guideline*, SIGN Publication No. 56 accessed 21/6/10 at http://www.sign.ac.uk/guidelines/fulltext/56/section1.html.

Shaw, C., Atwell, C., Wood, F., Brittain, K. & Williams, K. (2007) 'A qualitative study of the assessment and treatment of incontinence in primary care', *Family Practitioner,* **24**(5) pp.461-7.

Tan, T.L. (2003) 'Urinary incontinence in older persons: a simple approach to a complex problem' *Ann Acad Med Singapore*, **32**(6), pp.731-9.

Teunissen, T., de Jonge, A., van Weel, C. & Lagro-Janssen, A.L.M. (2004) 'Treating urinary incontinence in the elderly: conservative therapies that work', *Journal of Family Practice,* **53**(1), pp.25-32.

Thom, D. (1997) 'Medically recognised urinary incontinence and risks of hospitalisation, nursing home admission and mortality', *Age and Ageing,* **26**(5), pp.367-74.

Tinker, A. (1997) *Older People in Modern Society*, London: Longman.

Wenger, G.C. (2000) 'How important is parenthood? Childlessness and support in old age in England', *Ageing and Society*, **20**(2), pp.161-82.

Woolham, J., Benton, C., Pittam, L. & Peter, D. (2009) *Factors associated with the permanent admission of older people into residential care: the policy environment, research evidence of causes, local practice and possible remedies*', Northamptonshire County Council: Unpublished Report.

Notes on Contributors

Rachel Taylor has been Research Officer in the Social and Community Services Directorate at Oxfordshire County Council since 2009. She manages and undertakes a range of research projects and chairs the research governance group. Previously she worked in marketing, communications and volunteer management in the voluntary sector and for 8 years in educational, health and social research for Oxford and Warwick Universities.

Liz Cairncross is Head of Research at the Institute of Public Care, Oxford Brookes University. She is a researcher and consultant with over 20 years experience in the housing, social care and health sectors. She is an experienced lecturer who has worked across the public, private and voluntary sectors. Liz was an expert adviser to the government's Beacon Council scheme and led programme evaluations for what is now the Department of Communities and Local Government.

Sara Livadeas is a Social Worker by training but has worked in health, social care and the voluntary sector principally with disabled people, people who are ageing and their families. She has worked for Oxfordshire County Council for a number of years commissioning services, managing front line health and social care teams and more recently working on strategy and performance. Her current role is in the Chief Executive's Office advising on policy.

Address for Correspondence

Rachel Taylor, Research Officer
Oxfordshire County Council
Social and Community Services
County Hall
New Road
Oxford
OX1 1ND