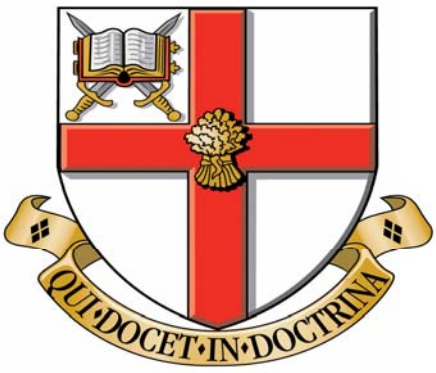

University of Chester

What Does The Future Hold for Intermediate Care?

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Theme: Planning and Forecasting for the Future of Intermediate Care Services

A study that looks at the development of Intermediate Care Services to meet future demand.

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Abstract

Intermediate care (IC) is seen as a key element in government policy to reduce hospital waiting lists, it was developed to promote independence for older people by developing a range of integrated health and social care services fully networked into local hospital, community Health, social services and primary care services. It was specifically designed around the needs of older people to facilitate hospital discharges and prevent admissions in other words; it is a bridge between home and hospital.

In some localities older people with mental health problems or varying degrees of cognitive impairment including dementia are deliberately being excluded from intermediate care. This is based on the assumption that older people with dementia cannot benefit from rehabilitation.

The UK has an ageing population as a result of declines both in fertility rates and in the mortality rate. The older people population growth combined with the prevalence of dementia increasing with age has implications for local authorities, and to meet the challenges of an ageing society, and address the needs of all older people there needs to be a rethink in intermediate care service delivery.

This study looks at planning and forecasting models that can be used to predict service demand and plan for future the future of IC. A total of seven authorities including Liverpool City Council (LCC) participated in this research. Interviews and surveys explored current service provision to determine what if any specialist intermediate care was available for older people with a diagnosis of dementia. It then went on to establish what if any planning and forecasting systems were being used by the authorities to assist in meeting the challenges of an ageing society.

Results drawn from the data analysis showed that even among top performing authorities the approach to forecasting and forward planning is not very sophisticated, only a couple of authorities seem to be taking an objective, quantitative and systematic approach to determine future requirements in older peoples services.

Declaration

This work is original and has not been submitted previously for any academic purpose. All secondary sources are acknowledged.

Signed: _____

Date: _____

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1. Introduction

1.1 Background to the Research

Intermediate care (IC) was developed to promote independence for older people by developing a range of integrated health and social care services. It is seen as a key element in government policy to modernise health and social care to meet the national priority of reducing hospital waiting lists as highlighted in the national bed enquiry 2000.

The National Beds Inquiry was set up to ensure that the number and type of hospital beds meets patients needs looking 10 to 20 years ahead. It suggests that the trend of the last decade or more of reductions in hospital bed numbers cannot keep pace with changing needs. It also called for another level of care – an intermediate level – fully networked into local hospital, community Health, social services and primary care services. In other words, a bridge between home and hospital, specifically designed around the needs of older patients (as the enquiry has shown that two thirds of hospital beds are occupied by people aged 65 or over) both for prevention and for a period of rehabilitation to speed their recovery. The relevance of intermediate care for people with mental health problems, including dementia or varying degrees of cognitive impairment, has been a matter for debate. "Specifically, there have been concerns that people with mental health needs are deliberately being excluded from intermediate care in some localities" NSF (2002)

1.2 Research Question

What Does the Future Hold for Intermediate Care?

Given the aging population and that the prevalence of dementia increases with age how are local authorities planning the future of intermediate care services?

This research focuses on issues of how to identify, collect and interpret appropriate data to answer the main research question. It has been developed by examining Liverpool City Council (LCC) and other local authorities planning and forecasting systems to determine

what tools if any are being used to gather data to plan for and forecast future demand for older people's services.

'We use the phrase "forecasting the future" to refer to managers' information gathering, analyzing and planning activities' Raspin & Terjesen (2007).

Since its development many studies of IC have been undertaken with the focus on establishing if it is meeting national priorities and the challenges faced in its current provision. Very little research looks at the challenges that will be faced in the provision of IC in the next 10 to 20 years given the ageing population and that the prevalence of dementia increases with age. Lotti (2005) draws attention to the importance of market research (MR) to anticipate the direction and velocity of market development 'To participate in decision making and keep its seat at the table, MR must have a point of view on what the business situation will become. It is critical to anticipate the changes in direction and velocity of market development. That is, we must try to "see around the corner" to anticipate where the road might lead us'

.

The aims of this study are as follows;

- To identify how many local authorities are currently providing specialist intermediate care for older people with dementia.
- To identify what if any planning and forecasting systems are used by local authorities to estimate future demand for older people's services including intermediate care (Given that the prevalence of dementia increase with age)
- To evaluate the importance of using planning and forecasting systems in local authorities.
- Identify potential impacts of population ageing on local authority service provision.
- Make recommendations based on the findings.

1.3. Justification for the Research

This research has been conducted to determine if local authorities are using planning and forecasting systems that are market responsive to meet future requirements associated with the needs and demands for the future of an older generation. Also to establish if by using these marketing techniques it will allow local authorities (LA) to tailor services to meet the changing needs of an ageing society. As Proctor (2000) implies "Trying to understand the key factors which govern a firm's success are very important and organizations need to have a firm grasp of the methods of assessing market size and forecasting the size to which a market will grow".

Whilst the Department of Health (DOH) emphasizes the role that intermediate care can play in supporting older people with mental health problems the National Service Framework (NSF) follow up document Moving Forward (2002) and the Nuttfield Institute for Health (2002) in a programme 'Exclusivity or Exclusion' found that there was evidence that people with mental health needs were deliberately being excluded from intermediate care in some localities. The 2005 Care Services Improvement Partnership (CSIP) service development guide 'Everybody's Business' also noted that recent evidence suggests that particularly people with a diagnosis of dementia are excluded from intermediate care based on a combination of factors including an assumption that older people with dementia cannot benefit from rehabilitation.

1.4 Methodology

While research studies do not actually solve problems or make decisions, they can generate information that can guide the decisions and actions of management. Milliken (2001)

Methodology refers to the choice and use of particular strategies and tools for data gathering and analysis and Punch (2000) subdivides data for empirical research into two main types:

- ❖ Quantitative data-which are data in the form of numbers (or measurements), and
- ❖ Qualitative data-which are data not in the form of numbers (most of the time, though not always, this means words).

The rational for the design of this research was to obtain appropriate qualitative data to answer the main research question. Furthermore as the term intermediate care is generally descriptive and includes different models of support that integrate health and social care, it was difficult to obtain quantitative data to accurately forecast whether there are sufficient resources to meet the challenges of an ageing population."Qualitative models are especially useful when subjective factors are expected to be very important or when accurate quantitative data are difficult to obtain" Render et al (2000)

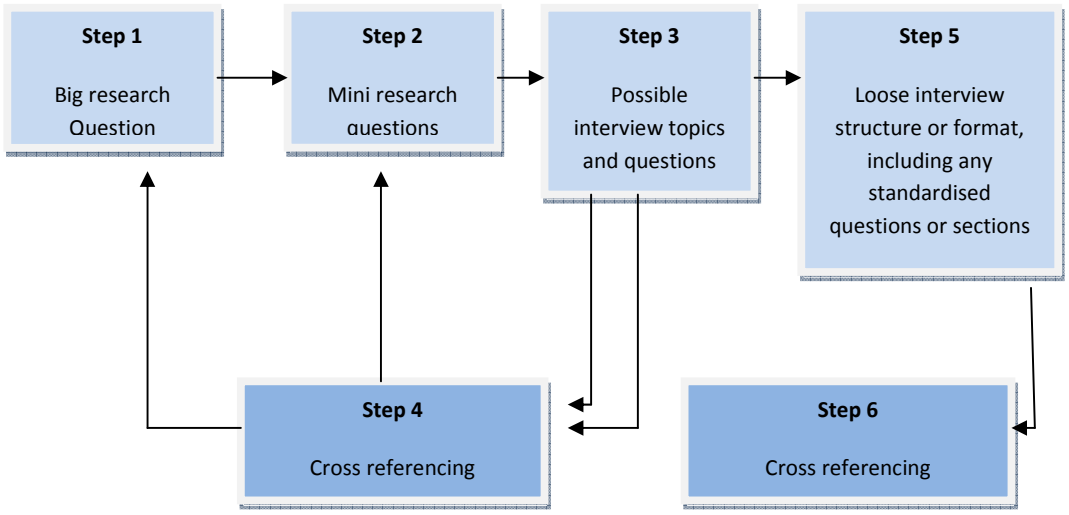
To establish a methodology for this research that focused on quality data collection and to determine the how and why of the research question different research methods were used to gain lots of qualitative information including:

- **Fact finding structured e-mail and postal questionnaires.** Jankowicz (2005) states that response rates can be surprisingly high for the e-mail medium. First contact was established via e-mail to engage support for the research. A fact finding questionnaire was then used to establish firstly, what intermediate care provisions were available in given authorities. Secondly to determine what if any forecasting and planning systems were in use.

- **Qualitative semi structured interviews** Mason (2002) planning and preparation procedure was used as a guide for the qualitative interviews (Figure 1). The interviews focused on a small sample of organizations having first engaged the support of key people. Interviews were conducted face to face with people who had the knowledge and experience in the research area. By using this method it gave the opportunity and flexibility to vary or omit questions as appropriate to the situation.

As Saunders et al (2003) states "In *semi-structured interviews* the researcher will have a list of themes and questions to be covered, although these may vary from interview to interview"

Figure 1- Overview of the planning and preparation procedure for qualitative interviews



Source: Qualitative Researching 2002

1.5 Outline of MBA

Chapter 1-Introduction

This chapter sets the scene for the whole dissertation. It gives the background to the area of research and introduces the reader to the research area and question. *What does the future hold for intermediate care?* It also informs the reader of the aims and the justification for carrying out the research and the methodological approach used in the quest to obtain relevant data to answer the research question.

Chapter 2-Ltererature Review

This chapter initially gives the history of IC, it then goes on to review the literature in the parent/discipline fields focusing on market planning and forecasting. The literature also considers demographic changes and how they may influence the future of older people's

specialist services. In addition this section examines the strengths, weaknesses, opportunities and threats associated with intermediate care to determine how well it is positioned to meet the needs of an ageing society in Liverpool. It then goes on to looks at demand forecasting in adult social care and evaluates forecasting and planning models currently used in Local Authorities.

Chapter 3- Methodology

The methodological approach and the justification for the selected paradigm and methodology are presented in this chapter. It continues by evaluating qualitative research and discusses rejected methods and considerations. Following this it looks at the design procedure used to answer the main research question. And as the sampling frame came from three star rated authorities registered through the Commission for Social Care Inspectorate, (CSCI) it gives an overview of the commission and explains its main purpose in adult social care. Finally the chapter details the process of events, the research phases and ethical considerations.

Chapter 4-Data Analysis

The beginning of this chapter goes through the application of the methodology to show how the research was accomplished. It then goes on to detail the findings for each research question and analyse the data.

Chapter 5-Conclusions and Implications

This chapter starts by evaluating the adopted methodology. It then presents detailed conclusions about each of the research aims and the main research question. Finally it describes the contribution to theory, gives details as to the limitations of the study and presents opportunities for further research.

Chapter 6 – Recommendations

Based on conclusions this chapter presents recommendations for future action in LCC Intermediate Care Services to meet the needs of the ageing society. Taking into consideration that the prevalence of Dementia increases with increasing age.

1.6. Definitions

IC	Intermediate care
CSCI	Commission for Social Care Inspection
CSED	Care Services Efficiency Delivery
CSIP	Care Services Improvement Partnership
DOH	Department of Health
EMI	Elderly Mentally Infirm
LA	Local Authority
LCC	Liverpool City Council
MR	Market Research
NSF	National Service Framework
NHS	National Health Service
PCT	Primary Care Trust
PM	Performance Management
ONS	Office of National Statistics
POPPI	Projecting Older People Population Information.

1.7. Summary

This chapter started by giving a background to the research it then presented a brief overview of the research areas investigated to answer the main research question. *What does the future hold for intermediate care?* It then went on to give just a short summary of the justification and methodology used in the research as this is discussed in more detail in later chapters. A short outline of the report is also offered and a table presents definitions and abbreviations used throughout the research. The dissertation now progresses in the following chapters to give a detailed description of the research.

2. Literature Review

2.1 Introduction

This chapter outlines the current literature considered relevant to comprehend how planning and forecasting systems may assist organisation's perform under known and or presumed conditions. It will ultimately depend on evaluating models and systems that look to the future to explore the range of possible future scenarios and plan against unwanted future outcomes.

The literature review has been conducted to determine what researchers in the field already know about planning and forecasting, to demonstrate my grasp of the topic, to review the basic techniques and models, and establish why they may be seen as important tools for LA's to use to determine the future of older people's services. It also includes looking at what models if any are currently being used by LA's so a comparison can be made of reasonable methods and models that can then be adapted and used by LCC.

"The ability to accurately forecast future demands has always been an important organizational capability" Sanders & Ritzman (2004).

A key note addressing the challenges of planning for an ageing society by the Joseph Rowntree Foundation Task Group recognize, that there is a market failure to meet the demands for the type of products and services that older people want, in order to retain independence, choice and control and for quality of life and well being there needs to be a

rethink of approaches to service delivery and initiatives to create a level playing field and an equitable approach to address the needs of all older people.

The theoretical framework used for this study comprises of 4 parts:

Part-1- A table indicates the parent discipline fields examined as part of the study.

Part-2-Gives the history and an overview of current IC services

Part-3-A review of the planning and Forecasting literature is provided with an overview of demographic changes that are likely to impact on older people's service provision in the future.

Part-4- Is a review of the models currently being used by LA's to forecast future demand for older people's services.

Finally, through the findings of the study for the future of intermediate care, recommendations are made which can assist LCC to:

A)-Project the most probable future for intermediate care services

B)-Assist LCC to plan and forecast for the future of specialist services to meet the challenges of an ageing society.

2.2 Parent disciplines/fields

Research has revealed that domain experts- people who know a lot about the situation being forecast, are the ones who can influence the success of planning for the future. To achieve success certain characteristics have to be taken into account to obtain an estimate of the current situation to reduce the chances of planning and forecasting errors. Some of these characteristics are detailed in the table below (Table 1)

To inform the study a literature review was carried out with the focus on solving the research problem '*What Does the Future Hold for Intermediate Care'*.

Table 1: Parent discipline/fields.

Parent Disciplines	Fields
Marketing	**Planning**
Marketing	**Forecasting**

2.3 History and Overview of Intermediate Care Services

2.3.1 National Context

IC was developed to promote independence for older people by developing a range of integrated health and social care services. The Delivery of the NSF framework places emphasis on providing the right care to people in the right place at the right time (Department of Health, March 2001). Services that use a multi-disciplinary approach to promote faster recovery from illness prevent unnecessary hospital admissions and support timely discharges from acute hospital settings.

The audit commission reports of 1997 and 2000 placed a strong emphasis on IC and since the national bed enquiry 2000 it has been growing ever since. The National Beds Inquiry was set up to ensure that the number and type of hospital beds meets patients needs looking 10 to 20 years ahead, it suggests that the trend of the last decade or more of reductions in hospital bed numbers cannot keep pace with changing needs. It also called for another level of care – an intermediate level – fully networked into local hospital, community Health and social services and primary care services. The Inquiry has deliberately taken a "whole system" approach to hospital services and beds cannot be considered in isolation from other parts of health and social care systems such as primary, community, rehabilitative and long-term care. The need for hospital services and beds is influenced by the availability of these other services. They can help prevent the need for acute interventions, can enable safe

discharge to community or home-based care and can act as either substitutes for or complements to hospital services. (DOH 2000)

IC is seen as key element in the government policy to modernise health and social care to meet the national priority of reducing hospital waiting lists. However the Care Services Improvement Partnership (CSIP) service development guide (2005) 'Everybody's Business' noted that recent evidence suggests that particularly people with a diagnosis of dementia are excluded from intermediate care based on a combination of factors including an assumption that older people with dementia cannot benefit from rehabilitation. Furthermore Dewing (2003) explains, whilst there has been an increasing awareness of the value of rehabilitation for maximising the potential of older people. "Older people living with dementia do not always have their potential fully realised. It should not be assumed that having dementia means a complete loss of abilities, as some abilities are enhanced and new ones can be acquired". Moreover CSIP (2005) also state that whilst "Older people with mental health needs were often explicitly excluded from intermediate care services, and this has remained a pattern for service developments. This notion has been gradually challenged and several projects have been established which either include or are specifically targeted at older people with mental health needs" (Key publications on Dementia can be found as appendix 1)

2.3.2 Local Context

The development of IC services in Liverpool preceded the Government requirements to develop this type of service, by several years. The first IC unit opened in 1997, as a nurse led service based on a ward in a non-acute hospital. LCC has contracts with three separate nursing homes to provide IC beds and has two local authority residential units which opened in 1998. In 2002 a specialist IC day centre was opened attached to one of the local authority residential establishments with the focus of promoting daily living skills for people with a diagnosed dementia to help them maintain their skills to live at home for longer. In 2003 another day centre was opened attached to the other local authority

establishment this centre provides therapy treatment and a re-enablement service to people from the community to assist them to remain living in their own home in the longer term.

In 2003 negotiations began with Mersey care Mental Health Trust, LCC senior managers, service managers and residential managers. The result of the negotiations was that 10 specialist beds were opened with the focus on the rehabilitation of people with a diagnosed dementia.

2.4 Demographic Changes

"Demographics is a marketing research term which involves the study of human populations. Demographics measure the size, density, location, age, gender, race and occupation, as well as other variables related to population statistics" Sutherland & Canwell (2004).

POPPI- (Projecting Older People Population Information) is a recent development brought about by the Institute of Public Care for the Care Services Efficiency Delivery Programme (CSED). It can be used by local authority planners and commissioners of social care provision in England as, "the POPPI tool is an important step forward to assist councils to better plan for future demand in adult social care. POPPI saves time and effort collating this information and gives a consistent starting point for Strategic Needs Assessment". CSIP (DU). It is designed to help explore the possible impact that demography and certain conditions may have on populations aged 65 and over. Table 2 presented below give projections from 2008 to 2025 of the population in Liverpool aged 65 and over in five year age bands. Table 3 Presents People aged 65 and over predicted to have dementia in Liverpool from 2008 to 2025. (Notes relating to these tables can be found as appendix 2 and projections for the whole of England can be found as appendix 3)**.** The estimates given are on the basis that, current rates as a proportion of the elderly population are set to continue .In actuality these figures may be higher as firstly "The stigma attached to dementia may put people off seeking a diagnosis" and secondly it is recognised that "especially among the "oldest old" (over 80s) numbers affected are set to rise more steeply in England than many developed and developing countries" NAO (2007)

Table 2- Population by age Liverpool- (Population aged 65 and over, in five year age bands, projected to 2025)

	2008	2010	2015	2020	2025
People aged 65-69	17,600	17,100	21,100	20,700	23,300
People aged 70-74	16,600	16,500	15,100	18,700	18,500
People aged 75-79	13,600	13,200	13,500	12,500	15,700
People aged 80-84	8,900	9,300	9,500	10,100	9,600
People aged 85 and over	7,000	7,000	7,700	8,600	9,800
Total population 65 and over	63,700	63,100	66,900	70,600	76,900

Table 3- Population by Age Predicted to have Dementia in Liverpool

(People aged 65 and over predicted to have dementia in Liverpool, by age band (65-69, 70-74, 75-79, 80-84 and 85 and over) and gender, projected to 2025)

	2008	2010	2015	2020	2025
Males aged 65-69 predicted to have dementia	118	115	139	134	148
Males aged 70-74 predicted to have dementia	239	239	217	267	260
Males aged 75-79 predicted to have dementia	330	330	342	314	392
Males aged 80-84 predicted to have dementia	347	377	408	449	428
Males aged 85 and over predicted to have dementia	431	451	549	666	784
Total males aged 65 and over predicted to have dementia	1,465	1,512	1,654	1,830	2,013

Females aged 65-69 predicted to have dementia	**138**	**135**	**168**	**167**	**191**
Females aged 70-74 predicted to have dementia	**196**	**196**	**178**	**222**	**222**
Females aged 75-79 predicted to have dementia	**540**	**525**	**525**	**490**	**618**
Females aged 80-84 predicted to have dementia	**776**	**790**	**776**	**804**	**761**
Females aged 85 and over predicted to have dementia	**1,348**	**1,320**	**1,348**	**1,430**	**1,595**
Total females aged 65 and over predicted to have dementia	**2,996**	**2,966**	**2,995**	**3,112**	**3,387**
Total population aged 65 and over predicted to have dementia	**4,461**	**4,478**	**4,649**	**4,942**	**5,400**

Figures may not sum due to rounding

"The UK has an ageing population. This is the result of declines both in fertility rates and in the mortality rate. This has led to a declining proportion of the population aged under 16 and an increasing proportion aged 65 and over" National Statistics (2005). "According to recent estimates, the number of people in the UK over 60 could rise by 40 per cent in the next in the next 30 years. In 1995 there were less than 9 million over 65 in the UK- by 2030 there may be about 13 million" Shaw (2002)

Almost every year since 1901, with the exception of 1976, there have been more births than deaths in the UK and the population has grown due to natural change and until the mid-1990s, this natural increase was the main driver of population growth. "We have been witnessing perhaps the most important demographic shift in the history of mankind-the rapid aging of the worlds population" Moschis (2003)

"The implications of an ageing society for public spending on health and welfare will depend heavily on the extent to which people are able and expected to provide for themselves in old age. The proportion of over 60s will not grow substantially until after 2010, but resolution of the problem of future support for older people will become an increasingly urgent matter for government towards the end of the decade" LGA (2000).

"Public services still focus, by and large, on the most vulnerable older people at times of

crisis (some fifteen per cent of the older population) rather than adopting an approach which enables the wider older population (the other eighty-five per cent) to remain independent for as long as possible and live their lives to the full. What's more Britain's Ageing population statistics state that 1in 20 people over the age of 65 years are affected by dementia and this increases to 1 in 5 over the age of 80 and that the incidence of dementia and Alzheimer's disease increases with increasing age Hatcher (1999).

Knickman and Snell 2002 in attempting to assess the coming challenges for caring for large numbers of frail elderly as the Baby Boom generation ages state that "the challenge is to develop integrated formal and informal services to integrate the elderly into a caring society thus the economic burden of ageing in 2030 should be no greater than the economic burden associated with raising large numbers of baby boom children in the 1960s". In a 2004 study Young et al stated that global demographic changes have prompted health and social care services to address the needs of older people as a priority and Alemayehu and Warner (2004) in estimating the magnitude and age distribution of lifetime healthcare expenditure projected that the number of people 65 and over will increase from 13% to 20% by the year 2030 and the population of the "old-old" (85+) will quadruple over the next few decades. Population change is a basic function of long range planning in a marketing operation and as Carpenter et al (2002) in his commentary; Clinical and research challenges of intermediate care commented that health care systems of today did not evolve to provide optimum care to an ageing population and many people may find themselves disadvantaged if the clinical challenge of Intermediate Care is not met as alternatives to acute hospital care may or may not be viable.

The Nuffield Institute for Health, (2004) also recognises that: "A radical change of perspective is needed if public services are to meet the challenges of our ageing society. This approach may not cost more; it involves a better use of resources and more effective ways of public services working together in the interests of citizens."
Demography is perhaps the most predictable of the drivers of future service requirements so all future service developments must therefore plan for uncertainty. "The most important feature about the future is its uncertainty" DOH (2000)

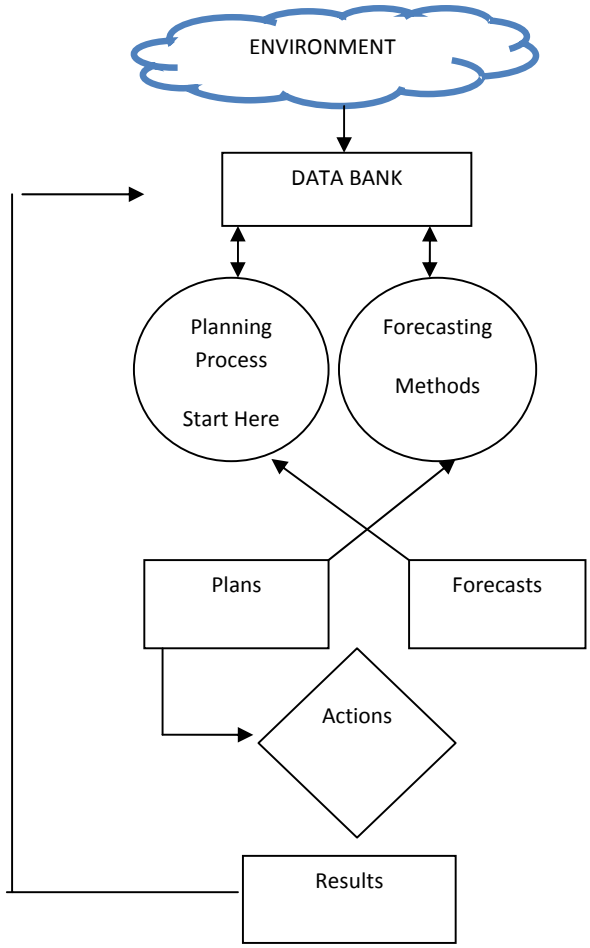
2.5 Planning and Forecasting

This review now will now focus on the literature associated with planning and forecasting and make reference to factors that can influence their failure and success.
Armstrong (1983). Notes that: "Individuals and organizations have operated for hundreds of years by planning and forecasting in an intuitive manner. It was not until the 1950s that formal approaches became popular. Since then, such approaches have been used by business, government, and nonprofit organizations". Furthermore, Golden, Milewicz and Herbig (1994) declare that:. "Forecasts are only "ballpark" figures which permit the planning function to commence" moreover Waddell & Sohal (1994) state that "The notion that planning and forecasting are different functions deserves special mention. Forecasting is generally used to predict or describe what will happen (for example, to sales demand, cash flow, or employment levels) given a set of circumstances or assumptions. Planning, on the other hand, involves the use of forecasts to help in making good decisions about the most attractive alternatives for the organization". However Armstrong (1983). Notes the distinctions between forecasting and planning. "Planning provides the strategies, given certain forecasts, whereas forecasting estimates the results, given the plan. Planning relates to what the firm should do. Forecasting relates to what will happen if the firm tries to implement a given strategy in a possible environment. Forecasting also helps to determine the likelihood of the possible environments". Armstrong also gives a framework for formal planning and forecasting (Figure 2).

Structure of the framework:

- The left hand side examines planning-Drawing on information from the data bank and forecast evidence of the future.
- The right hand side examines forecasting-gaining information about the company's proposed strategies and examination of the forecasting methods to determine what data is required from the data bank. Forecasts are then used a inputs to the planning process

Figure 2- Framework for formal planning and forecasting



Forecasting has been described as "the art of saying what will happen and then explaining why it didn't." The converse is also true, namely saying what *won't* happen and then explaining why it did. Chatfield (2007) "Forecasting has been a Cinderella in many companies for far too long. It's time to move forecasting improvement closer to the top of the agenda and to recognize the crucial role that accurate forecasting can play in helping organizations to achieve success". McCarthy T.M et al (2006). Accurate forecasting is the key driver that allows for better planning, and anticipation of demand opportunities, it has the ability to forecast customer demand which translates into improved and more predictable future performance. It is a method for translating past experiences into estimates of the future to anticipate demand before it happens and prepare for what is

ahead. “One very common reason for poor forecasting is failure to define the objectives of the forecasting exercise at the beginning”. Golden J et al (1994).In order for local authorities to instigate the forecasting process key questions need to be asked (Table 4)

Table 4-Forecasting-Key Questions

What is the purpose of the forecast?	**To determine what the future holds for Intermediate care**
What specifically do we wish to forecast?	**Will we meet the challenges and have the appropriate resources to meet the needs of an ageing society**
How important is the past in predicting the future?	**Important to translate past experiences into estimates of the future. Thus establishing if demographic changes and ageing society is going to be the problem it’s made out to be.**
What systems will be used to make the forecast?	**Demand forecasting systems**
What are the forecasting horizons?	**Medium-term 2 to 3 years** **Long term 10 to 20 years**
What forecasting methods would be used?	**Qualitative forecasting methods based on educated opinions of appropriate persons. Market research through questionnaires and surveys. Expert judgment of senior management and other knowledgeable people Quantitative methods using census and ‘POPPI’ population forecast data**

Organizations forecast so that they can plan and help shape their future. Forecasting is a crucial input for planning in almost all companies Smith et al (1996). In addition Proctor (2000) identifies that: “Forecasting amounts to estimating some future event that is outside the control of the organisation. Such information is a useful starting point from which to determine how resources should be allocated among markets and products or services and

which provides a basis for managerial planning". "Which method is best? Although this question is crucial for forecasters, we now know there is no simple answer. The choice of method depends on the type of problem, the length of the series, the forecasting horizon, the number of series to forecast, the level of expertise available and other factors". And "like most subjects, forecasting is best learned by actually doing it" Foresight (2007). Furthermore Sanders (1995) notes that "Effective forecasting leads to better planning activities and means enhanced organizational performance. However, properly implementing and managing the forecasting process is often met with numerous barriers and problems". Sanders then moves on to identify organizational problems and associated solution strategies (Appendix 4)

2.6 Demand Forecasting in Adult Social Care

Demand forecasting is also sometimes referred to as demand planning, demand management or demand analytics, and is a subset of predictive analytics. "The ability to accurately forecast future demands has always been an important organizational capability". Sanders & Ritzman (2004)

As mentioned in a previous chapter CSED work collaboratively with all councils throughout England supporting them to achieve sustainable efficiency improvements in adult social care and has introduced a web based demand forecasting and capacity planning system 'POPPI'

This has involved preparing guidance notes for councils including a straightforward checklist of issues to consider, a starting set of data, standard approaches to forecasting, and an overview of some of the existing tools and articles around demand forecasting and market planning. The 'POPPI' demand forecasting and capacity planning team is working directly with 23 Councils and is now also working with the Institute of Public Care (IPC) to launch a web based tool to assist all Councils in accurately predicting and managing future service demands' **"**The Care Services Efficiency Delivery Programme was set up in response to the Gershon recommendations as a collaborative programme to help councils achieve their targets in adult social care. CSED seeks to encourage councils to adopt its

initiatives by demonstrating their value. Demand Forecasting and Capacity Planning is one of six CSED workstreams" CSED (2007). Appendices 5 & 6 display the process overview and management framework for demand forecast and capacity planning prepared by CSED.

Wilson (2003) identifies that a whole-systems approach in which acute hospitals are closely involved and deeply committed is required to meet the challenges faced in intermediate care.

> "It will require champions and early innovators of intermediate care to revisit, and sometimes let go of, cherished services, accepting that, in the context of delivering the intermediate tier, the original way is not necessarily still the best way. Admission criteria should be carefully reassessed to ensure that there is optimal use of resources. In some places this may need to include a review of the argument that prevents people with (even) mild dementia from gaining entry to intermediate care services"

Moreover, The National Audit Office (NAO) is currently studying the health and social care services available to help people with dementia and their carers to maintain good physical and mental health for as long as possible (NICE-SCIE 2006). What is more Dewing (2003) estimates that: "The number of older people with dementia accessing rehabilitation and intermediate care services either in hospital, or at home, is growing and will continue to increase" (Comas-Herrera *et al* 2003). Furthermore The Wanless Social Care Review 2005 recognises that "There is a great need for a review of the challenges and demands facing social care, and the resources that will be needed to deliver social care fit for the 21st Century".

The White Paper Our health, our care, our say highlights the need for councils to forecast future demand, suggesting that local authorities should undertake regular strategic needs assessments to forward plan for the next 10 to 15 years. One of Coupe 2006 observations or reflections offered by way of conclusion to his paper can also be applied in adult social care "planning" needs to be understood as the means by which the NHS (either whole communities or individual organisations within those communities) manages its future. Not to plan (or to refuse to recognise the need to plan) is to invite failure. "Effective Demand Forecasting and Capacity Planning Processes are essential for strategic needs assessment and a key input to service commissioning" CSIP (2007). The objectives are to add value for

decision makers and service managers, reduce corporate risk and enhance client value the key principles behind this are detailed in table 5.

Table 5- CSIP-Key Principles

Key principles
•Use capacity planning to focus decisions and local priorities
•Link to the planning cycle and use operational management data
•Generate value from operational database investments
•Detect and react to changing demand tactically and strategically

2.7 Internal/external Analysis

With increased pressure on Local Authorities to improve services and be accountable to taxpayers and other stakeholders the use of marketing techniques can allow them to tailor services to older people and meet the challenges of an ageing society. Matching a business to its future environment requires a clear understanding of the business's internal strengths and weaknesses and the external opportunities. Carrying out an analysis using a SWOT framework helps to focus on areas of strength, minimise weaknesses and take the greatest possible advantage of the opportunities available in terms of highlighting what needs to be done, and putting problems into perspective. The SWOT used for this research table 6 subdivides LCC services to look inside and outside of older people's care services to determine how well IC is positioned to fulfill the needs of an ageing society and identify weaknesses that could possibly be turned into opportunities.

Table 6- LCC-SWOT Analyses (Older people's Intermediate care services)

SWOT Analysis LCC Older peoples Care Services	
Internal	**External**
Strengths	**Weaknesses**
• Established generic Intermediate Care services • Skilled and trained in house workforce • key element in the government policy to modernise health and social care • Intermediate care specifically designed around the needs of older patients • Newly developed specialist Intermediate care unit • Well established domiciliary specialist home care services • Specialist IC can take place within current resources	• Limited Mental Health Intermediate care services • Limited funding • Lack of market planning and forecasting • reluctance to offer services and expertise to older people with dementia or a mental illness • Insubstantial partnerships • Eligibility criteria for generic intermediate care excludes people with a diagnosis of dementia • Not taking into account population forecasts or that the prevalence of dementia increases with age • Not meeting the needs of a specialised group
Opportunities	**Threats**
• Partnership with Mersey Care • Prevent admission to long term residential care • Demographic changes • Opportunity to plan for an ageing population and meet the needs of older people with a diagnosed dementia. • Reduce pressure on hospital beds • Opportunity to analyse patient referral characteristics • Services can be provided within current resources • Integrate specialist IC in the whole systems approach	• Complete NHS takeover • Loss of Government funding for IC • Current services will not meet future demand • Lack of investment in older people's mental health services • Lack of investment in older peoples dementia services • Failure of partnership working

"A SWOT analysis summarises the key issues from the business environment and the strategic capability of an organisation that are most likely to impact on strategy development" Johnson, Scholes and Whittington (2005).

What the SWOT tells us:

Strengths:-LCC has the advantage of well established IC services and a skilled in house work force. It has some knowledge and understanding of IC needs for older people with a diagnosed dementia and that staff and services are adaptable to change.

Weaknesses:-LCC could improve by forming meaningful partnerships with Merseycare-Mental Health Trust and negotiating funding for specialist residential and domiciliary intermediate care. The key weaknesses identified are that there is the lack of market planning to address the needs of an ageing population and unmet needs of a specialist target group.

Opportunities:-LCC has the opportunity to meet the demands of an ageing society and form meaningful partnerships with the prospect of negotiating joint funding. It also has the capacity to meet the challenges faced by demographic changes and changes in population profiles to develop specialist IC care within its current resources. It could develop the whole systems planning approach to IC to include specialist services. "Planning within one Whole System will impact on adjacent Whole Systems and this inter-relationship of Whole Systems must be recognised in planning". CAT (2003)

Threats:-There is a real threat of losing funding for IC services if what is presently being provided does not meet customer needs now and in the future. Given the aging population and the fact that the prevalence of dementia increases with age LCC will have missed the chance to develop services to meet the demand of this growing target group.

A “target market” is, at its most basic, simply the market or submarket (such as a segment) at which the firm aims its marketing message(s). Cahill (1997)

2.8. Market Segmentation

“A market segment is a section of a market which possesses one or more unique features that both give it an identity and set it apart from other segments” Proctor (2000). ‘Mental Health’ broadly defined, covers a wide range of services and problems. Those needs and demands are not homogeneous, however; they are composed of the specific needs of many smaller groups including-*The elderly*, who are at specific risk of disorders such as Alzheimer’s Disease. Winston (1984 p14)

If the claims for segmentation are true, it follows that managers who are familiar with the concept and its application should achieve better performance than those who do not apply it to their business. Dibb, Stern and Wensley (2002). However Hoek, Gendall and Esslemont (1996) question the belief that segmentation leads inevitably to better decision making, and suggest that segmentation research is more arbitrary than robust, and rarely, if ever, results in an objective outcome. In contrast Kotler 2005 states: “when all is said and done, segmentation analysis is a search for insight into customers and customer types and it can provide a rich reward for marketers who are the first to identify new variables for classifying customers”.

In their paper Simkin and Dibb (1998) suggest that Porter’s competitive forces are simply another way of expressing segmentation attractiveness criteria. And with such a diversity of issues and dimensions, it is not too surprising that marketing managers in practice apply a wide range of criteria. Having conducted a survey and presented the results of a data collection they clearly identify profitability, market growth and market size as the three most heavily used criteria in market attractiveness (Appendix 7). One of the most detailed examinations of this issue comes from Hlavacek and Reddy’s three-step scheme, which considers the targeting problem in industrial markets in terms of segment identification, segment qualification and segment attractiveness Simkin & Dibb (1998) Table 7. For the

purpose of this study the three-step scheme has been completed to determine the attractiveness of specialist Intermediate care in Liverpool (Table 8).

Table 7- Segment attractiveness criteria

SEGMENT IDENTIFICATION
Involves the process of aggregating customers into segments in order to satisfy a particular problem
SEGMENT QUALIFICATION
The process where the operational relevance of the segments identified is assessed. This relates to how easily the segments can be characterised, measured, targeted and served.
SEGMENT ATTRACTIVENESS
Concerns deciding which segments to serve and which to ignore. This involves a range of market attractiveness criteria, such as market growth, future potential, level and structure of competition, company assets, nature of customer needs and entry barriers.

Table 8-Segmentation attractiveness for Specialist IC in Liverpool

SEGMENT IDENTIFICATION
Older people with a diagnosed Dementia within LCC boundary
SEGMENT QUALIFICATION
Characterised-Older people with a diagnosis of dementia **Measure-**Ageing population. Prevalence of dementia increasing with age **Target-**Avoid hospital admissions & facilitate early discharges to release pressure on hospital beds **Serve-**Provide specialist Intermediate care services both residential and domiciliary.
SEGMENT ATTRACTIVENESS
Market growth-Demographics-Increasing long-term demand **Future potential-**reduce the need for long term care. Release pressure on NHS beds. To meet the challenges of an ageing society **Assets-**Matches LCC capabilities. Experienced work force. Govt funding. Can meet demand with current resources **Customer needs-**Enjoy a healthy old age in their own homes. Stakeholders see that we are meeting our mission and objectives. Avoid financial burden of long term care

2.9. Review of Local Authority Planning and Forecasting systems

A Demand Forecast model currently in use Swindon. is very sophisticated and its purpose is to provide commissioners with a template for completion, to be used whilst undertaking demand forecasting locally (Appendix 8). Activities included in the model include a population needs assessment or population profiling, local prevalence rates calculated from national rates, of: Dementia and Mental ill health including others. It then goes on to survey anticipated future need examples of which are, a review of national and local studies and housing needs assessment. The review of service user profiling then goes more in depth to determine amongst other things: To what extent do OSH and extra care schemes currently support people who are physically frail or who suffer from dementia, mental ill health or cognitive impairment. It also looks at the volume of intermediate care and delayed discharges where housing is the only or predominant factor in inhibiting a return home. Having determined the topics and examples of activities in the model it then goes on to establish what the authority has done, what it needs to know, and what it needs to do. The overall concept of the model can be used as a blue print for market planning to identify gaps and target markets as it assesses how well the organisation is doing. It identifies strengths and weaknesses and establishes objectives to be achieved in the future.

An inspection of social care services for older people in Surrey County Council in 2004 documented in their report that Surrey council and its key partners had recognised the need to better understand the complexities of the social care market. To this end, they had commissioned independent market research from Laing and Buisson, The market research set out in detail a range of issues including: demographic trends at ward and county level, projected demand for care services, workforce challenges, and the structure of the social care market and problems of supply, cost pressures, and future commissioning scenarios. Laing and Buisson (2004) using the CSED methodology brief stated that: 'the forecasting model was based on an extensive analysis of historical and existing supply and demand arrived at through various interviews and surveys with staff in the county council, partners such as health, local providers, care associations and other local experts. The model is constructed as a step by step guide through the key investment decisions' (Appendix 9).

2.10 Summary

This chapter has presented a review of the literature relevant to the area of study. It concentrates on planning and forecasting for the future of older people's services, focusing on the future for older people's with a diagnosed Dementia in IC services. Chapter 3 will now give a detailed explanation of the methodology adopted in undertaking this research.

3. Methodology

3.1 Introduction

The previous chapter reviewed the relevant literature to determine how demographic changes may impact on the provision of intermediate care and how planning and forecasting systems can be used to meet the needs and demands for the future of an ageing population. The topic areas for this study include; older people's mental health and intermediate care. Whilst studies of IC are not unique as such, the question of how Local Authorities are forecasting and planning for the future of this service to meet the challenges of an ageing society, given that the prevalence of dementia increases with age has not been explored in any depth and so forms the basis for this study.

Whilst chapter 1 gave an introductory overview of the methodology used in this research this chapter explores in more detail the approach, and design used to gather the necessary information. It also examines the justification for the paradigm, the methodological considerations, rejected methods and ethical considerations.

3.2 Methodological Considerations

Lehaney and Vinten 1994 give in total six brief analysis and meanings of the word methodology (Appendix 10)**.** However they do propose that "Within research work there are bound to be grey areas, where mixtures of methodologies arise, and it is not being suggested that the six areas are mutually exclusive or exhaustive. Furthermore Saunders,

Lewis and Thornhill (2003 p2) in simpler terms state: “the term methodology refers to the theory of how research should be undertaken”

The three main research philosophies are known as, positivism, realism and phenomenological these are more generally understood to be quantitative and qualitative paradigms.

“The simplest rule of thumb is that the purpose of qualitative research is to answer 'why' decision-makers behave as they do, while quantitative research measures 'how much' or to what extent this behavior is taking place” Mayernick (2003).

Given (2006) describes the nature of qualitative research as: “Research of high quality, regardless of paradigm, demands that appropriate methods are used to address the research problem at hand. However, in order to select appropriate methods researchers must first understand the types of data (and therefore the type of answers) that they will obtain when using particular research methods a researcher should start by asking “what do I want to know?” and “what method will guide me in that direction?”

What do I want to know?-What does the future hold for intermediate care?

What method will guide me in that direction?-A flexible qualitative design with data-gathering methodologies that include questionnaires semi-structured interviews and observation with an emphasis on a highly structured methodology to facilitate replication of this research.

3.2.1 Justification for the selected paradigm and methodology

Having evaluated the strengths and weaknesses using Silverman’s 2001 evaluation of qualitative research model (Table 9) and accepting Robson (2003, p.5) theory that the two labels ‘qualitative’ and ‘flexible’ capture important features in that: ‘they are flexible in the sense that much less pre-specification takes place and the design evolves, develops and ‘unfolds’ as the research proceeds’ a flexible qualitative design was chosen for this research

and the data-gathering methodologies include questionnaires, semi-structured one to one and a group interview and observation. This design was selected to generate information and obtain meaningful data that could be used to formulate theory: what is more, Coffey and Atkinson (1996, p. 194) state; 'that the contemporary popularity of qualitative research owes much to its flexibility and to the absence of methodological straightjackets.' Moreover, Greenhalgh and Taylor (1997) state that qualitative research begins with an intention to explore a particular area, then collect "data" and generate ideas and hypotheses from this data largely through what is known as inductive reasoning.

Table 9- An evaluation of qualitative research

Strengths	Weaknesses
• Depth and detail on each individual respondent may be high • Openness-respondents tend to be more prepared to be open if a personal approach is used • Can help avoid pre-judgments	• Fewer people studied • Less easy to generalize • Difficult to aggregate data • Highly dependant on researcher skills • Setting where a respondent is questioned may affect results

Source: D Silverman-interpreting qualitative data 2001

The emphasis was on using an inductive approach rather than a deductive approach to generate data for this research, Saunders, Lewis & Thornhill (2003) describe the differences between deductive and inductive as follows:

> 'The extent to which you are clear about the theory at the beginning of your research raises an important question concerning the design of your research project. This is whether your research should use the deductive approach, in which you develop a theory and hypothesis (or hypotheses) and design a research strategy to test the hypothesis, or the inductive approach, in which you would collect data and develop theory as a result of your data analysis"

Qualitative analysts who use such an approach do not 'jump' into a subject area without a competent level of knowledge about that area" Saunders, Lewis & Thornhill (2003 p394).

This methodology provided a framework that focused on solving the research question. *What does the future hold for intermediate care?* And whilst there were some limitations to using a qualitative approach it gave the flexibility required to bring together the necessary data.

3.2.2 Rejected Methods

"Everything you do your methodology, your research design, and sampling, the research methods you choose will revolve around the result: your **research question"** Jankowicz (2005 p38).

Having established the distinctions between quantitative and qualitative data (Table 10) **e**valuated the strengths and weaknesses of qualitative research using Silverman's 2001 model (Table 9) and examined White (2000) summary of the features of research design (Appendix 11). A qualitative paradigm was chosen as the appropriate method for this research over a quantitative paradigm due to its none standardised approach and the fact that quantitative data may be difficult to obtain in this area of research.

Table10- Distinctions between quantitative and qualitative data

Quantitative Data	Qualitative Data
• Based on meanings derived from numbers • Collection results in numerical and standardised data • Analysis conducted through the use of diagrams and statistics	• Based on meanings expressed through words • Collection results in non-standardised data requiring classification into categories • Analysis conducted through the use of conceptualisation

Sources: Developed from Dey (1993); Healey and Rawlinson; author's experience

To answer the research question and produce insight and findings regarding the area of concern the inductive approach of building the theory was used for this research rather than the deductive approach of testing the theory. Creswell 1994 cited by Saunders et al 2003 Suggests a number of practical criteria to determine the approach to be adopted.

> 'Perhaps the most important of these is the nature of the research topic. A topic on which there is a wealth of literature from which you can define a theoretical framework and a hypothesis lends itself more readily to the deductive approach. With research into a topic that is new, is exiting much debate, and on which there is little existing literature, it may be more appropriate to generate data and analyse and reflect on what theoretical themes the data is suggesting'

3.3. Research Design and procedure

The design used for this research focused on identifying, collecting and interpreting appropriate data to answer the main research question. *What does the future hold for intermediate care?* The sampling frame came from three star rated authorities registered through CSCI for the year 2005, (Table 11) LCC and local authorities surrounding the Liverpool area. The research was executed in four phases, each with its own methodology, i.e., written questionnaires; semi-structured one to one interviews, a group interview and observation.

3.3.1 About CSCI

The Commission for Social Care Inspection (CSCI) was set up in April 2004. Its main purpose is to provide a clear, independent assessment of the state of social care services in England. CSCI combines inspection, review, performance and regulatory functions across the range of social care services in the public and independent sectors (CSCI 2006).

Between 2002 and 2005, the Social Services Inspectorate and subsequently CSCI published star ratings combining judgements for both children's and adults' social care services, with

each receiving an equal weighting. This year's star ratings relate to councils' performance on adults' social care only. Councils are awarded separate judgements for both current performance and capacity to improve (CSCI 2006).

CSCI has a duty to annually inspect 150 English councils with social services responsibilities in adult social care and award star ratings which give an overall picture of how well councils are serving adults who use social care services and what potential they have for improvement. Table 11 details the CSCI 3 star rated authorities for 2005 and figure 3 displays these authorities on a map of England. Star ratings are a product of a wider performance assessment process, 'Assessments include evidence from inspection reviews, monitoring and performance indicators, to form an overall picture of performance over time of both qualitative and quantitative aspects of performance' (CSCI 2006).

On a scale of zero to three stars ratings are awarded are as follows;

*** three stars-excellent

** two stars-good

* one star-adequate-

zero stars-inadequate.

Table 11-CSCI-3 Star Rated Authorities 2005 (updated March 2006)

Three Stars

★★★

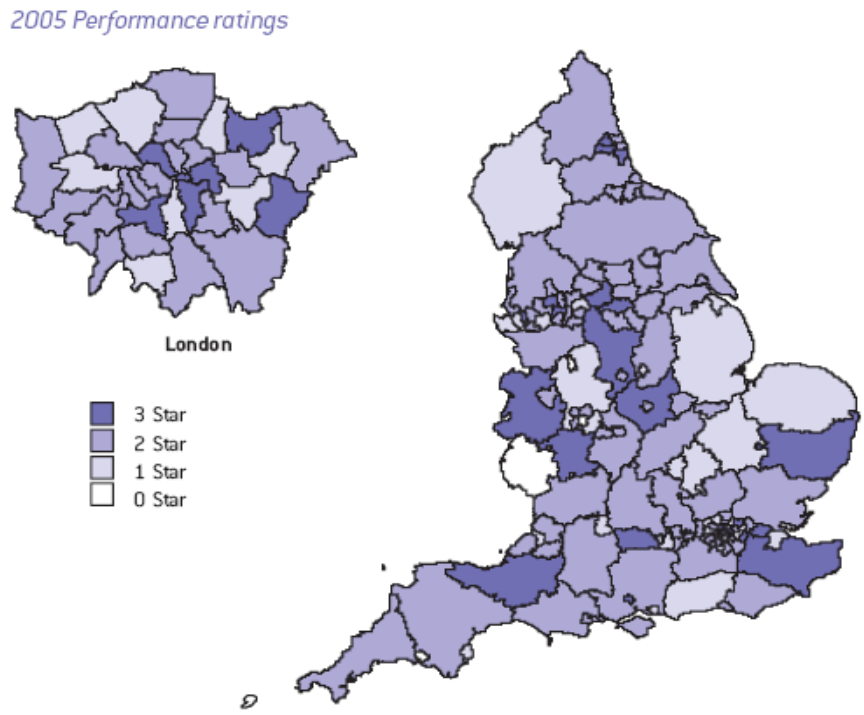
			Adults' Social Care				Children's Social Care				Star Rating	
Council	Type of Council	Region	Serving People Well?		Capacity to Improve?		Serving People Well?		Capacity to Improve?			
Barnsley	M	Y&H	Yes	↑	Excellent	↑	Most	↑	Excellent	↑	★★★	↑
Bexley	OL	L	Yes		Excellent		Yes		Excellent		★★★	
Bolton	M	NW	Yes	↑	Excellent		Most	↓	Excellent		★★★	
Camden	IL	L	Yes	↑	Excellent	↑	Most		Excellent	↑	★★★	↑
City of London	IL	L	Yes	↑	Promising		Yes		Excellent	↑	★★★	
Derbyshire	S	EM	Yes		Excellent		Most		Excellent		★★★	
Gateshead	M	NE	Most		Excellent		Most		Excellent		★★★	
Kent	S	SE	Most		Excellent		Most		Excellent		★★★	
Kingston upon Thames	OL	L	Most		Promising	↓	Yes		Promising		★★★	
Kirklees	M	Y&H	Yes	↑	Excellent		Most		Excellent		★★★	
Knowsley	M	NW	Most		Excellent		Yes	↑	Excellent		★★★	
Leicestershire	S	EM	Most		Excellent		Yes	↑	Excellent		★★★	
Newcastle upon Tyne	M	NE	Yes		Excellent		Most		Promising	↓	★★★	
Redbridge	OL	L	Yes	↑	Excellent	↑	Yes	↑	Promising		★★★	↑
Salford	M	NW	Yes	↑	Excellent	↑	Most	↑	Promising		★★★	↑
Shropshire	S	WM	Most		Excellent	↑	Yes	↑	Excellent		★★★	↑
Somerset	S	SW	Yes		Excellent		Most		Promising		★★★	
Southampton	UA	SE	Most		Excellent	↑	Most		Excellent	↑	★★★	↑
Southwark	IL	L	Most		Excellent		Most		Excellent		★★★	
Suffolk	S	E	Most	↑	Excellent	↑	Most		Excellent	↑	★★★	↑
Sunderland	M	NE	Most		Excellent		Most		Excellent		★★★	
Thurrock	UA	E	Most		Excellent	↑	Most		Excellent	↑	★★★	↑
Tower Hamlets	IL	L	Yes	↑	Excellent		Yes	↑	Excellent		★★★	
Wandsworth	IL	L	Most		Promising	↓	Yes		Excellent		★★★	
West Berkshire	UA	SE	Most		Excellent		Most		Excellent	↑	★★★	↑
Worcestershire	S	WM	Most		Excellent	↑	Yes	↑	Excellent		★★★	↑

The eight councils marked with an asterisk (*) had yet to complete their Joint Area Reviews for children's services when this report was originally published in December 2005. This update gives the children's social care judgements and overall star ratings for these councils.

Source: CSCI Performance ratings 2005

Key; Arrows indicate a change in judgement and/or star rating since November 2004. Key to Type of Council: Inner London=IL. Outer London=OL Metropolitan District=M. Shire County=S Unitary Authority=UAKey to Regions: North East=NE, North West=NW, Yorkshire & Humber= Y & H, East Midlands= EM, West Midlands=WM, Eastern=E, London=L,South East=SE, South West=SW

Figure 3-CSCI



(Source; CSCI Performance ratings 2005)

3.3.2 Process of Events

A detailed and complex process of events is listed on the following pages and a comprehensive timetable including dates can be found as appendix 12.

In an attempt to answer the research question LCC with the 26 three star rated authorities in 2005 and 3 authorities surrounding Liverpool which included 1 metropolitan authority were chosen for this research;

- Firstly to establish what if any forecasting systems Local Authorities are using to assess future demand of older people's services.
- Secondly to establish how each authority is planning to meet the needs of an ageing population taking into account that the prevalence of dementia increases with age.

The research started in earnest in October 2006 and took just over 9 months to complete. A colleague and I arranged to undertake research together although our topic areas differed they both included researching other authorities in the areas of mental health and older people's services this also had the added advantage of reducing costs and time.

October-December- 2006

Having downloaded a copy of Social Services Performance ratings for 2005 from the CSCI website we then went on line to each of the 29 authorities to get names and addresses of Social Services Directors excluding LCC.

Within three weeks we received 18 responses from the 29 authorities contacted and sent 11 reminders although, no responses were ever received.

Riddel 1998 noted that "One-third of business respondents claimed pre-alerting would have a great effect". So with this in mind we went on to contact the 18 Social Services Directors giving details of our research areas and to ask firstly for permission to undertake research in their authority, and secondly to obtain contact details for experienced social care managers in their authority who might be able to answer questions in our related research areas (Appendix 13).

In the following three weeks we received 14 responses some giving email addresses and some giving postal addresses for the person/s we were to contact. Others including: Suffolk and Kent asked that we complete a research proposal before we could proceed any further; St Helens asked us to complete a research framework and like Wandsworth wanted to know if we had approval from Association of Directors of Social Services (ADSS) to carry out this research and not until we did would they consider letting us proceed any further. Within a week 4 reminders were forwarded to Directors who had not responded to our request for permission to carry out research once again no further responses were received. Luckily of the responses received 3 were from the authorities surrounding Liverpool which was an advantage for us to carry out face to face interviews.

In an attempt to get the research underway, Kent and Suffolk research proposals were completed and forwarded at the end of November 2006 and a copy of the ADSS proposal was obtained. We also attempted to contact St Helens LA to discuss their request to complete a research framework. Unfortunately we were unable to establish contact.

Having come across barriers that were making it difficult for us to proceed with our research including ADSS approval and their financial implications we met our tutor to see if these could be overcome. He advised we contact T Hunter Executive Director for Supported Living at LCC to ask for his advice as a member of the ADSS before completing proposal and whilst waiting for approval from Kent and Suffolk we should carry out research with those authorities who had agreed to help us.

January –March- 2007

Early January 2007 my colleague and I formulated an initial questionnaire. "Questionnaire length and fatigue effects are generally considered relevant factors influencing several aspects of data collection including: drop out rates and data quality" Rathod & LaBruna (2005) With this in mind the questionnaire was kept simple, it was designed to establish the usefulness of further research in given authorities and comprised of just 7 questions (Appendix 14). Having compiled the questionnaire it was then pilot tried tested on colleagues to test for its appropriateness and simplicity.

Whilst waiting for feedback from colleagues re questionnaire design my MBA colleague emailed T Hunter as advised by tutor and received a response the same day. He was happy to support us in our research and advised that we forward the ADSS application and explain that no funding sources are available.

Having acquired feedback on the questionnaire design it was then forwarded to the ADSS with the completed research proposal and cover letter (Appendix 15). Copies of questions were then sent to the 14 LA's who had responded to our request to conduct research with a deadline for a response of 28th February 2007.

Between 11th and 28th of February we received 11 responses (1 was returned by post had no authorities address or contact on it so could not be used). Reminders were sent out with a

further copy of questions to the 4 none respondents (This included the 1 unknown respondent).

A spreadsheet was used to record responses (Appendix 16). My colleague and I agreed that the responses to questions 1 to 3 would be the determining factors in deciding if further research was necessary with the authorities who responded. As these questions were designed to establish if they were providing or considering providing intermediate care and (for my colleagues research) whether the authority worked in partnership in older people's services. And whilst the responses questions 1 to 7 were also important to our research areas the responses to these would then be used to guide us in the compilation of a more in depth survey. Having scored the 11 responses received 8 were chosen for further research.

Early March my MBA colleague and I met to compile a more in depth questionnaire with a covering letter that could be used as both an email survey and face to face questionnaire. (Appendix17). The questionnaire comprised of 14 questions some specific to my area of research, others specific to my colleagues and others that could be used by us both. Again time was set aside for six of our colleagues to assess the appropriateness of the questions and give us feedback on the structure and time it would take to complete. Also at this time we received notification from Suffolk that our research proposal had been agreed and despite contacting Kent we had heard nothing. We still awaited a response from the ADSS.

Middle March we sent out 3 email and 2 postal surveys. We also sent a copy of the questions to be asked to 3 surrounding authorities with a covering letter asking for permission to conduct a face to face interview at a mutually convenient time (Appendix 18)

At the end of March the 3 email surveys had been completed and returned and dates were set for face to face interviews with the 3 authorities surrounding Liverpool. Up to this date no postal surveys had been returned a reminder letter was sent to both of the authorities but still no response was received.

April-July 2007

On the 2nd May a response from the ADSS was received (3 months after forwarding it) unfortunately were informed that permission for research had not been granted as our research areas were seen as too simplistic (Appendix 19).

In May we conducted a semi structured face to face interview with the surrounding metropolitan authority and contact was made with senior managers at LCC and a date was set for a group interview. As a result of attending LCC interview in May I was invited along as an observer to the first steering group meeting being held to discuss the future of IC in LCC.

In June my colleague conducted an interview with one of the surrounding authorities on behalf of both of us as I was unable to attend. And finally in July the final interview was conducted in a nearby authority.

During the course of the research, models for planning and forecasting being used by LA's were uncovered. This meant other authorities may have also been using models and for the purpose of this research I needed to find out before I could analyse the data I had received. In early July I sent out Emails firstly one to Swindon Local Authority, whose demand forecasting model has been referred to in this research to, enquire why they use this model and what do they see are the benefits of using it. Emails were also sent to LCC and authorities who had participated in the surveys or interviews. The following questions were asked:

- Are you using a tool to forecast future demand of older people's services?
- If not why not?

3.4. The four research phases and constraints.

Greenhalgh and Taylor (1997) identified that the strength of qualitative research lies in its validity (closeness to the truth) – that is, good qualitative research, using a selection of data collection methods, really should touch the core of what is going on rather than just skimming the surface.

1. **Questionnaires;**

An initial questionnaire was forwarded either by post or email and it was purposefully kept short and simple to gain commitment from respondents and allow us to analyse responses without delay to establish which authorities needed to be contacted for further research. (For responses see Appendix 16). The second questionnaire was used as a more in depth survey and was designed firstly to collect data for both our research projects and secondly to minimise bias by using the same questions to gain information through postal and email surveys and during semi structured interviews. Questionnaires included an introductory letter explaining what was required from respondents and as my colleague and I were researching different areas within the context of older people's services and mental health, questions were assembled so the respondent could focus on one research area i.e. planning and forecasting and then move on to the other. Response rates and ethical considerations are noted further on.

The Constraints.

Time was a major constraint. Initially because my colleague and I had to formulate and agree to the questionnaire design and decide who would take responsibility for recording responses. Secondly pilot testing the design with colleagues and contacting none respondents took up time that we had not accounted for. Financially the cost of forwarding questionnaires was minimal as a lot were sent via email rather than post.

2. **Semi-structured one to one interviews:**

"Many people turning to research identify the interview as a suitable method for gathering information. It has its natural basis in human conversation and allows the researcher to

adjust the pace and style of asking questions so as to bring out the best in the respondents" Hannabuss (1996)

For interviews other than LCC the same amount of set of questions were used to gather the required data. To engage the respondent questions were forwarded prior to the interview to establish the area of investigation and gain commitment "Today respondents are asked in advance if they are willing to participate in an interview on a specific day, and they are also able to answer the questions at a time that is convenient for them". Bronner, Kuijlen (2007)

Interviews began with introductions and ensuring that respondent had received a copy of question prior to the interview. As my colleague and I conducted interviews together we gained consent of the participant for one to ask questions whilst the other took notes.

The first interview conducted acted as a real learning curve in that the respondent was not able to give all the necessary data and spent time going off in different directions as an alternative to answering the pre-set questions.

The constraints

A major constraint to conducing interviews was organising times when participant and both my colleague and I were available. Another was that in some instances the participant was more knowledgeable in one area than another and so the general focus of the interview stayed in that one area. It was then necessary to analyse documentation given during the interview to extract the information required.

3. **Semi structured group interview:**

Just one group interview was conducted this was within our own Local Authority LCC. The questionnaire design was altered after considering what information would be important for our research. Quality rather than quantity was the basis for this interview as through our work roles we had some knowledge of older people's service provision within LCC (Appendix 20).

Miles, Bright and Kemp (2000) noted that by focusing on the quality of the interview we can aim to ensure that the survey reflected positively not only on the parties involved but also on the image of market research as a whole.

For this interview we asked permission to tape responses (although in hindsight we should also have taken notes as the recorder used did not work)

The Constraints

This interview focused mainly on my colleague's research area as the senior participant felt I would gain more knowledge and understanding of my research area by attending a group meeting as an observer that was to look at the future of IC services in Liverpool.

4. O**bservation:**

The two types of observation as described by Saunders, Lewis and Thornhill (2003)- *Participant observation* is qualitative and by contrast *structured observation* is quantitative. The meeting was attended by senior LCC managers, GP's Clinical Directors from Health amongst others it was scheduled for 1 hour it started and ended promptly. As this was the first meeting the topic of IC care focused around whole systems planning in general terms only (Appendix 21).

The constraints

I was unable to ask questions during the meeting in relation to the future of IC. Also time restrictions for the meeting did not give me the opportunity to approach people afterwards to ask questions to gather data for my research. I am not sure that I fitted into either of the two types of observation as described above.

Research Response rates

Initial difficulties in obtaining permission for research impacted greatly on the research schedule as did the number of none respondents which continued to drop off as the research progressed. Not including LCC for each step of the research: we had a 62% response rate to out initial request for names and contact details for LA Social Services Directors, 78% response rate from Social Services Directors requesting permission to undertake research in their authority, 79% response rate to initial questionnaire and a 75% response rate of authorities who either completed survey or agreed to face to face interviews, all of which in turn had a bearing on data collection. Figure 4 displays response rates for each step of the process and figure 5 displays accumulative response rates for the whole research process. Tuckel & O'Niell (2002) state precisely "If and when contact is established, the next barrier, of course, is to secure the cooperation of potential respondents".

Figure 4- Research Response Rates

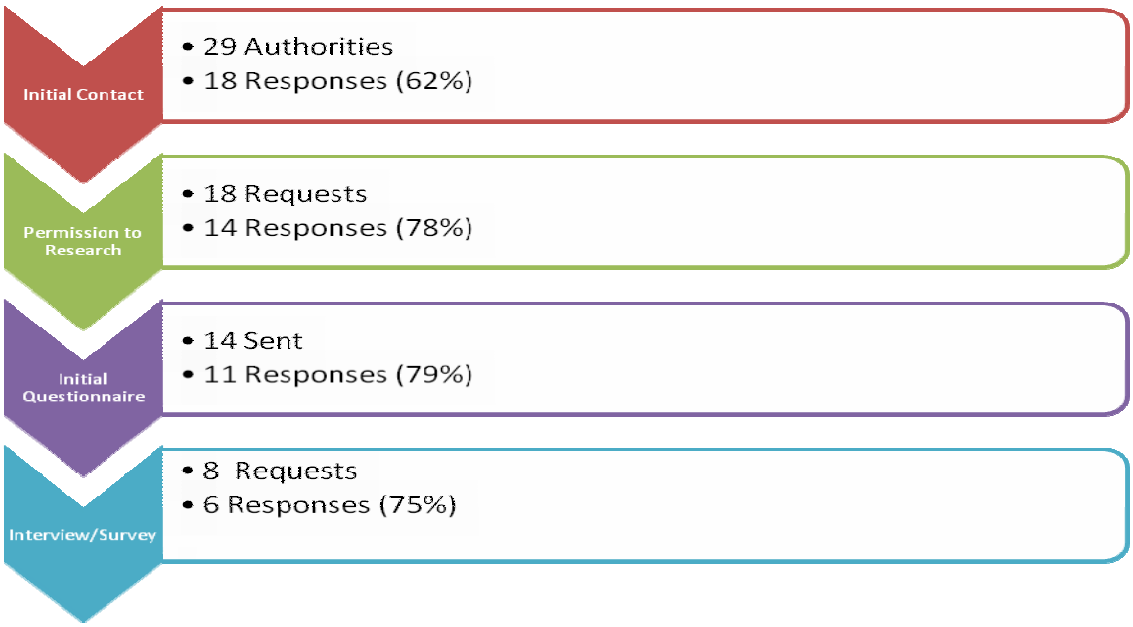
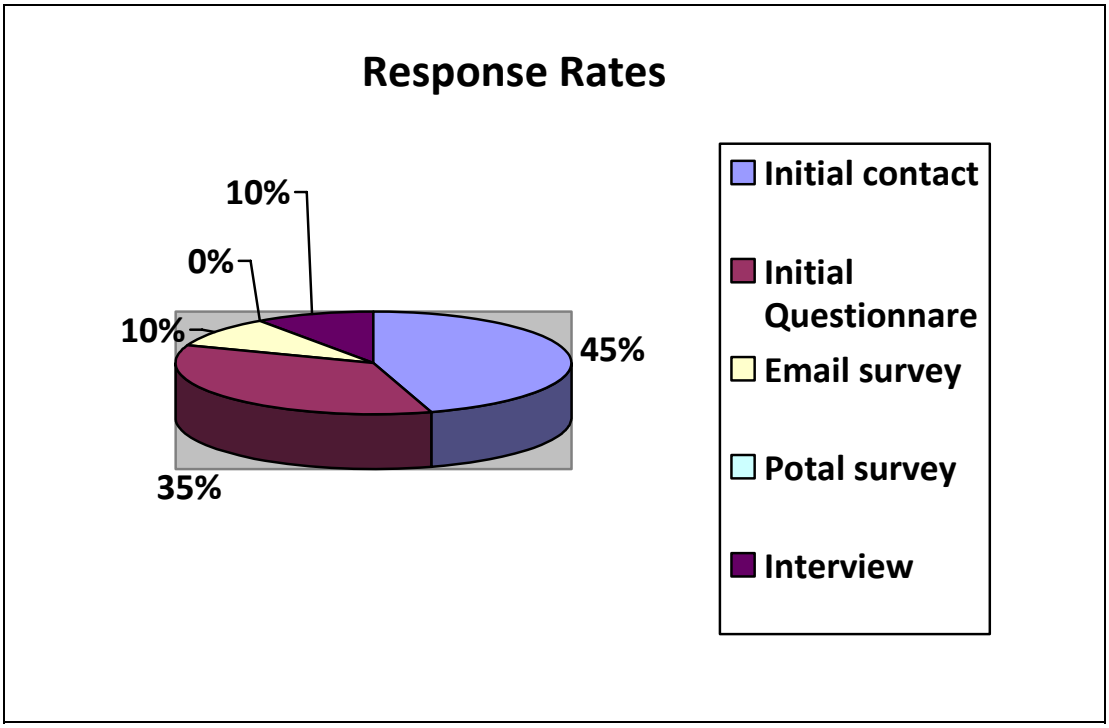


Figure 5- Accumulative Research Response rates



3.5. Ethical considerations

Jankowicz (2005 p62) suggests that; first, you need to *inform yourself* by obtaining a copy of some appropriate ethical guidelines (Appendix 22 details the Ethical standards for business and management research as proposed by Jankowicz 2000) he goes on to say should you need to, you can adjust them to your own circumstances.

- An explanation given as to how authorities were chosen for this research.
- Sought permission from Directors of each Authority before any research was conducted.
- Gave written and verbal assurances that information gained would remain confidential and that Local Authorities and individuals who took part in this

research would remain anonymous. (LCC had no objection to being named in the research)

- Initial contact letters gave an overview of research topics.
- The research questions were forwarded prior to face to face interviews.
- On the one occasion a tape was used permission was granted for its use by the interviewees. In all cases prior to commencing interviews verbal consent was given to take notes on the understanding that they would be destroyed on completion of research.
- If requested interviewees could have the opportunity to see transcripts and either add or withdraw information before completion of the research.

3.6 Summary

Lehaney and Vinten (1994) in their conclusion analyzing the use and meaning of methodology found that it appears in many contexts " However, a sufficient number of cases have been cited to show that it has different meanings, at different times, to different people; and that it would aid clarity if authors could define what they mean by methodology or explain why it is not possible to do so in a particular case."

In summary this chapter has given a step by step explanation of the methodological approach used to gather data for this research, and a justification and rationale for the selected methods used and rejected. The ethical considerations to be considered when undertaking research have also been noted and used to underpin the research process.

4. Data Analysis

4.1 Introduction

This chapter merely presents an analysis of the data collected during the course of the research whilst chapter 5 will discuss the findings in the context of the literature.

The aim of analysing the data is to provide useful evidence to answer the research question. *What does the future hold for intermediate care?*

The research method used a range of analytical techniques to generate information and the rationale for data analysis is to put the findings into context.

Section one focuses on the application of the methodology.

Section two presents the finding for the research question

The *third section*, presents the findings of the data analysis

4.2 Application of methodology

The research programme was accomplished by following an inductive and grounded theory approach to compare data from comparative sources. Questionnaires were purposefully designed to use as a survey and during the course of interviews to ensure that all data obtained was relevant and focused on the research area subsequently to answer the research question. *What does the future hold for Intermediate Care?*

Questions were subdivided; firstly to establish what if any forecasting systems were in place to assess demand of older people's services. Secondly to establish how each authority

is planning to meet the needs of an ageing population taking into account that the prevalence of dementia increases with age.

To gather data to answer the main research question a series of investigative questions were constructed. As noted in the previous chapter my colleague and I carried out research together and as a result a combination of 14 questions were asked of respondents, either through postal or email surveys and during interviews. Some questions were exclusive to my research as others were to my colleagues, whilst a few were generic and appropriate for both of us to use. Therefore only the findings for the questions and responses appropriate to my area of research have been listed in the next section. To ensure the data could be measured questions asked during the internal interview with LCC have been broken down so they are comparable with the first seven questions asked during external interviews.

4.3 Findings for each research question

In an effort to maintain anonymity of the people and authorities used in this research each authority apart from LCC is identified only by a letter as noted by Saunders, Lewis and Thornhill (2003) p139. The ethical issues of confidentiality and anonymity also come to the fore during the reporting stage of your research. Wells (1994) recognises that it may be difficult to maintain the assurances that have been given. However, it is vital to attempt to ensure that these are maintained.

1. ***Are you using a tool to forecast future demand of older people's services? If not why not?***

Authority A
No tool being used to forecast demand unsure why not

Authority B
The nature of the data we have been collating for our JSNA is very 'lumpy' in the sense that it is often collected across different geographical boundaries and timescales, and to inconsistent definitions. This makes it extremely difficult to approach with any formal or prescriptive 'ex-ante' demand forecasting model; Each data set has to be taken and analysed as it is on a case-by-case basis and on its own terms. The second issue is one of endogeneity i.e. how does one know what areas/groups are in need of attention before all the (reasonably) available data has been looked at. One of the risks in defining your target groups pre-data analysis is that you are assuming you know who the most in need groups in the community are, leading to a possibility of overlooking the needs of other, maybe less vocal/resource intensive groups (migrant workers for example seem to be overlooked in the Swindon document you attached, which also seems to have a very heavy emphasis on housing and very little on well being).Finally, it is important to remember that this is the first national iteration of JSNA. The limitations in data I mention above will often determine how it is collected and analysed/projected, quite possibly leading to JSNAs that look very different from different parts of the Country.

Authority C
Awaiting response

Authority D
A demand forecasting programme for the city has been developed, which encompasses all adults, which would include OPMH.

Authority E
Looking to use demand forecast model designed by CSED

Authority F
Population profile using POPPI but no formal systems in place as yet to forecast future demand. Awaiting Institute of Public Care (IPC) to launch a web based tool to assist in accurately predicting and managing future service demands

LCC
Recently taken possession of Acorn database detailing sectoral analysis of the population.

2. ***What systems/models are in place to forecast future demand for older people's mental health services?***

Authority A
Unaware of any systems in place but do have statistics to indicate the prevalence of mental health problems in older people by wards

Authority B
Current systems combine population projections, prevalence rates and the use of existing services. This gives ' if things stay the same as they are now' picture. This can be used to model assumptions about the availability of informal care, medication, and service profile The development of our strategic needs assessment tool will provide more comprehensive information that will include both LA and public health data including customer and carer feedback, workforce profiling, etc.

Authority C
Calculations from population projections.

Authority D
A demand forecasting programme for the city has been developed, which encompasses all adults, which would include OPMH. This is in its infancy and has been developed to strengthen our strategic commissioning. Work has been undertaken to look at prevalence of Dementia within the city in the next 5-20 years using a health assessment approach

Authority E
A number of things in place-population profile A piece of work looking at capacity for teams because as we see it the volume of work will increase substantially in the future.

Authority F
Population profile using POPPI but no formal systems in place to forecast future demand. Do have indicators of demand plan that identifies wards and highest areas of need for people over 55

LCC
No formal forecast systems in place. Will in the future be using a data base to make forecasts

3. ***How is this information gathered and who is involved?***

Authority A
Planning and forecasting is done by LA with Mental health and social care trust. As an authority we do not take this on as its very timely.

Authority B
LA commissioners, contracts and information managers who pool information sources

Authority C
L/A support staff use calculations from ONS (Office of National Statistics).

Authority D
The Health Needs Assessment was completed by a Public Health Specialist, Health Development Unit, Teaching Primary Care Trust, following the work being commissioned by the OPMH Group. A demand Forecasting programme will be led by the LA Performance Management Team using a multi agency approach to achieve the necessary information

Authority E
Management groups-SS and Health, Standard 7 sub group purely for Mental health this feeds into OP LIT chair groups and these all come together to gather information. Working relationships across the board are at different levels. We have Joint commissioning managers but not in mental health it is envisaged that it will grow to include MH given the projections for the future.

Authority F
Consultant advised on indicators of demand plan

LCC
L/A currently working with the Primary Care Trust (PCT) to deliver a long-term strategic needs assessments, they have the lead. Collective information gathering.

4. ***How much weight if any is given to mathematical models versus input from individuals in projecting future demand?***

Authority A
Statistical projections are mainly used to project future demand for services as people are living longer and there is higher prevalence of dementia this has been taken into account

Authority B
At the moment the forecasts rely on a mathematical model. The strategic needs assessment will allow us to include more input from service users and carers.

Authority C
No response

Authority D
The Demand Forecasting Programme involves the use of mathematical modelling, alongside understanding from individuals the current need and what is projected for the future.

Authority E
Place population profile incorporates models to look in to the future do not know how much weight is given to mathematical models

Authority F
POPPI statistical projections used. Discussions ongoing between health and LA so it's a mix so both.

LCC
Having attended steering group meeting it appeared input was mainly from individuals to project demand

5. ***How does your authority plan to undertake a strategic needs assessment to forward plan given that the number of people surviving beyond 85 is due to rise by two-thirds over the next 20 years?***

Authority A
Government drivers inform local area policy. LA with Mental health and social care trust working together in the integration of older adults mental health services to forward plan A joint commissioning strategy has just been written that looks at new ways for providing mental health services with the general focus on working with and keeping people in the community

Authority B
The joint strategic needs assessment between the LA and Public Health will include the needs of people with dementia. The figures used above have already been acknowledged and are being used to develop current commissioning strategies.

Authority C
Through the forthcoming Joint Strategic Needs Assessment with the Director of Public Health

Authority D
This is a statutory duty of the Director of Adult Services and is being planned with our Health colleagues – it will be informed by the Demand Forecasting Programme and will be driven by the commissioning framework which is being developed jointly.

Authority E
Currently working to meet demands of the population. Strategic plans are based on needs assessment that assist us to forward plan

Authority F
Joint strategic needs assessment with LA and health working together its more about looking at how we can work differently to provide services not about resources

LCC
We are working with Regeneration to pull together key indicators required for a comprehensive strategic needs assessment

6. ***Does your authority have an explicit written process for determining long range objectives in older people's mental health services?***

Authority A
No explicit process. But presently working with health as the projection is that people over 65 will increase by 15% over the next 25 years

Authority B
A specific action plan for dementia services will be included in this years commissioning strategy

Authority C
3 Year Service Plan for Community Based Services and 3 Year Joint Plan with the PCT

Authority D
The OPMH (Older peoples mental health) Strategy identifies priorities for OPMH services, although not on a long term basis. It sets out the ideal model based on Everybody's Business, but is not explicit in how this will be met.

Authority E
There is an expectation for future specialist services and long range objectives are being met through a joint approach to planning for the future

Authority F
No specific process for determining long range objectives but using information and statistics from POPPI to establish objectives.

LCC
No specific process for determining long range objectives but using a whole systems approach to planning in intermediate care

7. ***At present what specialist mental health services for older people does your authority provide if any?***

Authority A
Changes in the way services are being delivered July 07 the focus starts on re enablement services. Hospital discharges will be assessed and given in house re-enablement services were appropriate for a short period of time. Projection that this should create £1.5 million savings in long term needs if these services are offered at an early stage During re enablement period people will be assessed and should a care package be required on completion of assessment it will be provided by the independent sector. Currently 3 generic I/Care services provided that are joined up with Health and social care although there are no pooled budgets and the overall costs remain with social services. Each of these services works differently there is no agreed service specification so older people with a diagnosed dementia can access these services.

Authority B
We still retain 17 Homes for older people this is currently under review, within these homes we provide EMI (Elderly Mentally Infirm) residential care, respite and day care we commission from Age Concern EMI day care. We commission services from the 3rd sector e.g. sitting services through crossroads (Only those who fit FACS criteria)

Authority C
Assessment teams, respite/rehabilitation centre incorporates M/H, day centre, residential care, specialist home care, sitting service, carers' support, advocacy.

Authority D
Specialist mental health services provided by the LA are as follows: Community support workers for people with Dementia in House-Short break commissioned/in house-EMI placements commissioned-Intermediate care jointly provided in generic services -Telecare and overnight service in house
Authority E
There is a large older population in the area but only a small Home care specialist service and residential unit. Home care revamped and it is more about hospital discharges. enabling and end of life services. Dementia day care and family placement services are available these are flexible and are viable as a 1 to 1 service (Can be provided by a person who has had a CRB and willing to take a person into their own home for a day).Specialist I/Care beds (not dedicated services) are available that are outcome focused and time limited.

Authority F
I/C provision for people with a diagnosed dementia in generic Intermediate beds. We have specialist care including day care, respite and flexi care in peoples own homes as well as assisted technology. Providers are In house and independent.

LCC
Specialist intermediate care residential unit. (Funding and resources not the same as generic services LCC solely funds this service) Specialist home care and day care. (Specialist service not included in the Whole systems approach to generic intermediate care) (Appendix 21)

8. How do you see these services developing in the future?

Authority A
Integration of older peoples mental health services. In house initial assessments will continue and private sector will provide long term services

Authority B
By providing hard evidence based information to inform future developments. Commission from the independent sector

Authority C
Integration with Health; Local Authority largely a commissioner; LA greater third sector involvement. Incremental expansion of Individual Budgets.

Authority D
Further developments as described above, including overnight response and use of telecare.

Authority E
Integration of in house and independent sector provision. To meet demand for the increase in the older population and prevalence of dementia we need an increase in resources. At present we have a higher older population to younger but funding in this area is the smallest for older people. This has to be addressed if we are to meet demands for services in the future

Authority F
As previous its more about doing things differently within the current resources we have and integrating with health.

9. What does your authority estimate will happen to older persons mental health services in the next 10 to 20 years?

Authority A
Given the population projections there is likely to be an increased need of specialist services the plan is that these will be provided by private sector. The main concern with independent providers is that they may not focus on supporting independence and may in fact create more dependence

Authority B
10 to 20 years? More specialised services to include mental health these will be both integrated and commissioned- external market

Authority C
Integration with Health; Local Authority largely a commissioner; greater third sector involvement. Incremental expansion of Individual Budgets. More need for specialist services.

Authority D
Specialist services will develop and become our main business!! Better relationship regarding commissioning across social care and health.

Authority E
We need to look at redressing the balance as the children's population is dropping and there will be an increased need of services. Using Govt drivers -Your health your care your say to inform our planning for the future we aim to be more proactive in the area of MH and look at prevention and education looking at the future we need to change services rather than being reactive

Authority F
Priority will be given to open access to intermediate care for mental heath discussions underway as to how this can be done as its difficult to engage

4.4 Analysis of Data

The data analysis is shown diagrammatically were possible and explained in words to chart the number of samples falling into each category.

1. ***Are you using a tool to forecast future demand of older people's services? If not why not?***

7 authorities surveyed 1 none response (authority C). Authority, D is presently using a demand forecast tool to predict future requirements for the city. Authorities E, F and LCC (43%) answered that they are planning to use a tool to forecast future demand although LCC did state "We have a new data base and we are still trying to figure out what to do with it" Authorities A and B (29%) responded to say they are not currently using any tools to forecast future demand. Authority A did not give reasons why not whilst authority B answered in brief 'The nature of the data we have been collating for our JSNA is very 'lumpy' in the sense that it is often collected across different geographical boundaries and timescales, and to inconsistent definitions. This makes it extremely difficult to approach with any formal or prescriptive 'ex-ante' demand forecasting model; each data set has to be taken and analysed as it is on a case-by-case basis and on its own terms. The second issue is one of endogeneity i.e. how does one know what areas/groups are in need of attention before all the (reasonably) available data has been looked at'.

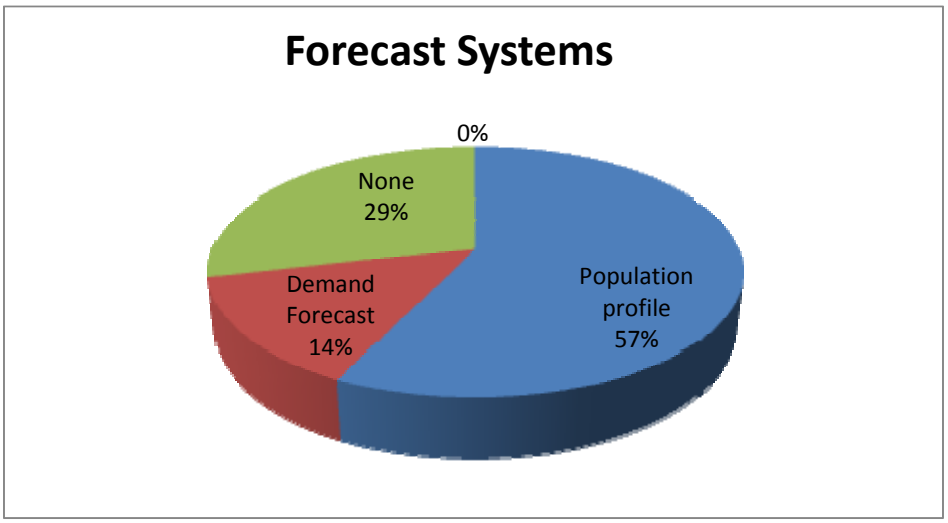
2. *What systems are in place to forecast future demand for older people's mental health services*

"Forecasting is anticipating, projecting, or estimating some future event, series of events, or condition which is outside the direct control of the organization". Waddell & Sohal (1994)

CSIP state that Councils with social care responsibilities face a challenging task in forecasting the likely future demand from adults who require care, given the large number of factors involved, an ageing population, migration patterns, lifestyle changes, fluctuations in supply, regulatory changes and innovations in assistive technology and prevention (2006)

Of the 7 authorities used in this research most (57%) are using population profiles to assess future demand but do not use any formal forecasting tools or models. Authority D (14%) has developed a demand forecasting programme for the city but does not have a specific model to forecast future demand for older people's mental health services. Authority A and presently LCC (29%) do not have any formal model in place. Figure 6 shows the forecasting systems presently used by local authorities who took part in this research.

Figure 6- Forecasting Systems used in Local Authorities



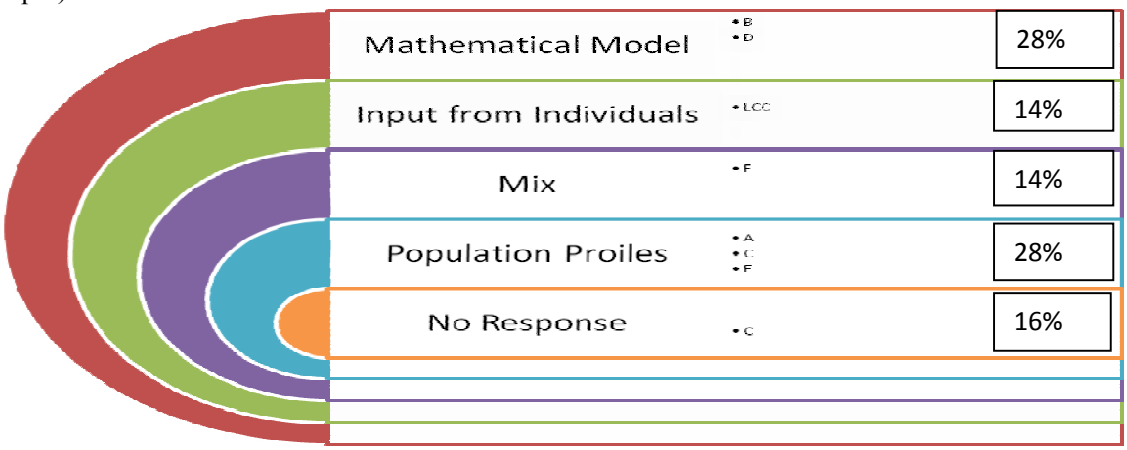
3. *How is this information gathered and who is involved?*

In most of the authorities researched no formal systems are in place to forecast future demand information is gathered collectively by bringing together population profiles and information based on opinions of appropriate people. No designated person or team takes the lead it is generally a mix of LA (Local Authority), NHS (National Health Service) and PCT (Primary Care Trust) who are involved in forecasting and planning for future demand.

"Informal methods are largely intuitive and depend on individual experience and abilities. Informal methods are used when there is insufficient time or data to use more formal means". Waddell and Sohal (1994)

4. *How much weight if any is given to mathematical models versus input from individuals in projecting future demand?*

Figure 7- Projecting Future Demand (Mathematical Versus Individual Input)

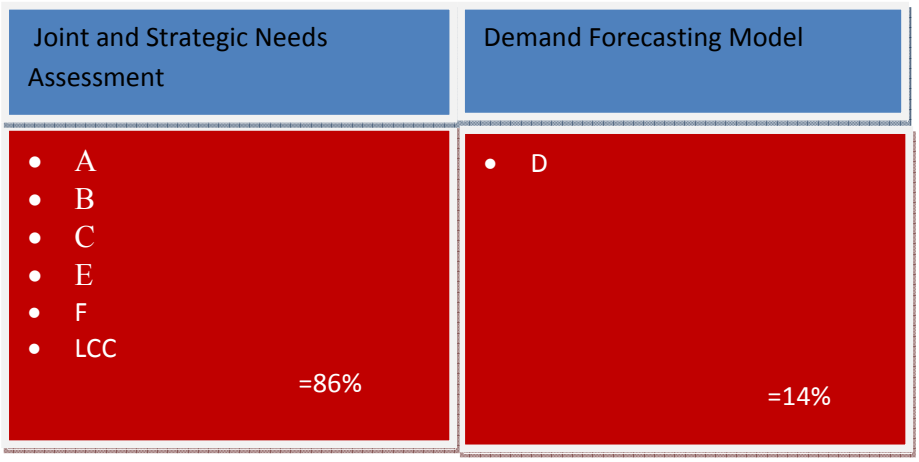


An evaluation of the mathematical model versus input from individuals in projecting future demand is presented in figure7. Two authorities B & D (28%) use mathematical models more than input from individuals to project future demand. Authority F (14%) uses a mix

of mathematical and input from individuals, LCC (14%) at present uses only input from individuals, and authorities A and E (28%) mainly use population projections Authority C (16%) did not respond to this question.

5. ***How does your authority plan to undertake a strategic needs assessment to forward plan given that the number of people surviving beyond 85 is due to rise by two-thirds over the next 20 years***

Table 12- Approaches to Forward Planning



An evaluation of Authorities who plan to undertake a strategic needs assessment is presented in table 12. Six authorities including LCC (86%) are using a combination of joint and strategic needs assessments just one authority D (14%) is using a demand forecast model.

"As a result of the low priority nationally, as well as poor quality information on local needs, health and social care economies in England have tended not to undertake any effective long-term planning for dementia care" NAO (2007)

6. ***Does your authority have an explicit written process for determining long range objectives in older people's mental health services?***

Whereas in most authorities there was no explicit process for determining long term objectives at least one is using POPPI projections to establish long range objectives. Others are either working with health or else have a joint approach to plan for the future with a specific action plan for dementia services. LCC is using a whole systems approach to planning in intermediate care services. Whilst other authorities are using a mix of strategies and service plans to, plan the future for dementia services.

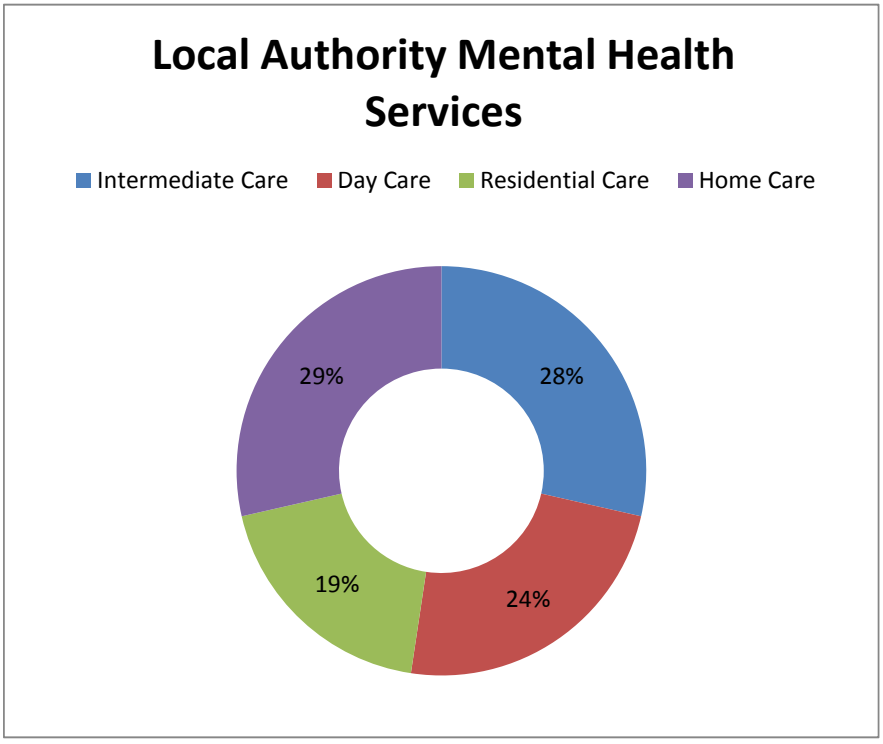
7. At present what specialist mental health services for older people does your authority provide if any?

Table 13 -Service Provision in Local Authorities

	Local Authorities						
	A	B	C	D	E	F	LCC
Intermediate Care	√		√	√	√	√	√
Home Care	√		√	√	√	√	√
Residential		√	√	√	√		
Day Care		√	√		√	√	√

Different terminology has been used to answer this question e.g. rehab comes under the umbrella of IC and community support worker, is also known as home care. To analyse the information, service provisions have been put into appropriate categories. Table 13 displays service provision for intermediate, home, residential and day care in each authority including LCC**.** There is a mix of four services two authorities provide all four services, the other five provide a combination of up to three services, and all but one authority provides an element of older peoples mental health intermediate care services. Only LCC has a specialist IC service designated for the rehabilitation of older people with Dementia**.** Figure 8 presents the proportion of Mental Health Services found in the seven authorities.

Figure 8- Proportion of Mental Health Services



8. How do you see these services developing in the future?

Of the Authorities surveyed a large proportion (43%) estimated that older people's mental health services would be integrated with health and a further portion (43%) felt these services would be commissioned whilst a small percentage (14%) felt that it would be a mix of integration and commissioning for service contracts (Figure 9).

Although given these estimates the majority (67%) felt there would be a mix of in house and independent providers in older people's mental health services. A proportion (33%) felt that in the future services would be exclusively provided by the independent sector. None of the authorities felt that in house services would continue to solely provide these services. Figure 10 displays individual views of each authority in how they estimate services developing in the future.

Figure 9- Estimation of Future Service Provision.

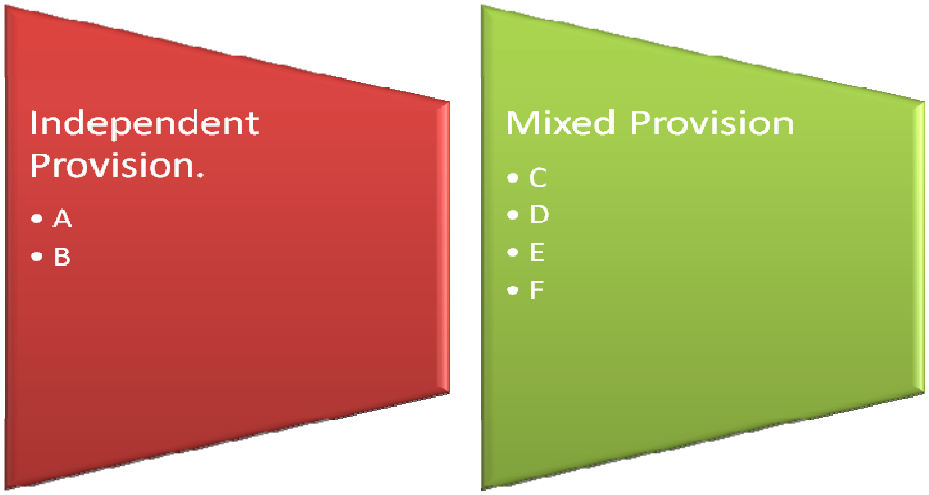
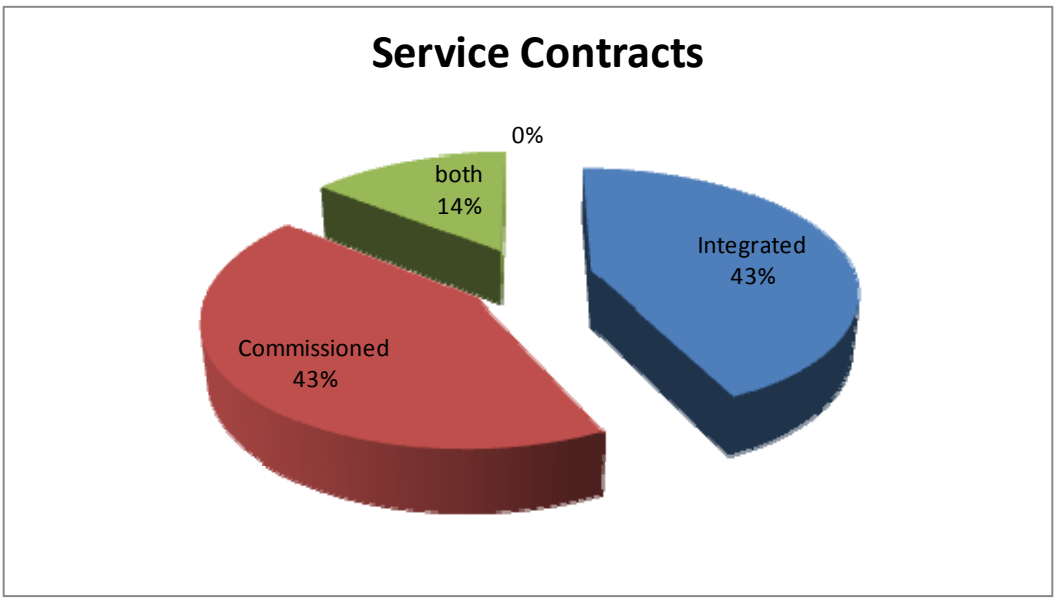


Figure 10- Estimation for Future Service Contracts



9. What does your authority estimate will happen to older persons mental health services in the next 10 to 20 years?

Of the Authorities surveyed the majority (67%) felt there would need to be an increase in services to meet demand others including authority F felt whilst there might be an increase in demand its more about doing things differently within the current resources.

4.5 Conclusion

Having analysed the data it became apparent that even among top performing authorities the approach to forecasting and forward planning is not very sophisticated only a couple of authorities seem to be taking an objective, quantitative and systematic approach to determine future requirements in older peoples services.

5. Conclusion.

5.1 Introduction

"The Healthcare Commission has proposed a National Clinical Audit of dementia in 2008-09; this is an important development and has the potential to help achieve a similar step change in awareness and understanding of dementia as has been done in stroke care", it also notes that "Intermediate care services can be reluctant to admit people with dementia, making discharge from hospital difficult for these patients". Comptroller and Auditor General (2007)

"The challenge will be to manage both the here and now and the future. This will require the reinvention of planning at the commissioner and provider levels" Coupe (2006)

The aims of this study included establishing what if any forecasting systems LA's are using to assess future demand of older people's mental health IC services. To ascertain how authorities are planning to meet the needs of an ageing population taking into account that the prevalence of dementia increases with age. And also to determine the potential impacts of population ageing on local authority service provision.

My intention having assessed the information is to make valuable recommendations in chapter 6 that will assist LCC to plan and forecast for the future for Older people's mental health IC services.

5.2 Critical evaluation of adopted methodology

> 'Once the research has been completed, the student has an obligation to explain to the reader how successful the chosen research methodology fitted the problem. Inevitably, with hindsight, the student will find areas where his or her selection of research method was perhaps inappropriate or unsuccessful in some way'. Page (2007)

A flexible qualitative design with data-gathering methodologies that include questionnaires semi-structured interviews and observation was the approach used in this research. As detailed in chapter 3 initial difficulties in obtaining permission for research impacted

greatly on the research schedule and data collection as did the number of none respondents which continued to drop off as the research progressed. On the whole there was no noteworthy disparity between postal and email responses.

In retrospect my colleague and I should not have delayed our research schedule, firstly waiting to obtain permission from the ADSS and some local authorities to undertake research. Secondly waiting for late responses as deadlines were clearly given with each questionnaire. As it was even after reminders were sent authorities who had not responded in the first instance did not reply even after reminders were sent.

On reflection the initial questionnaire was unsophisticated and this was noted when the ADSS felt it was unable to recommend our project as the panel felt that the questionnaire was too simplistic to generate information. Also in hindsight question 7 (asking if authorities were using or considering using tools to forecast and plan the future of older people's services) was important to my research and should have been included in scoring system used to determine which authorities were chosen for further research.

The second questionnaire/survey was very structured and it did not allow flexibility to the respondent with respect to response format. In addition a disadvantage of using the questionnaires was the inability to probe responses.

Semi-structured interviews were advantageous as they gave the opportunity to expand on topics as required to gain relevant information and data for the purpose of our research. Although it has to be noted as explained in chapter 3, that the first interview conducted acted as a real learning curve in that the respondent was not able to give all the necessary data and spent time going off in different directions as an alternative to answering the pre-set questions. This did have the benefit of ensuring my colleague and I were more structured in our approach when the next interviews were conducted

As an observer during a meeting to discuss the future of Intermediate care in Liverpool I was not invited to ask questions and did not have the opportunity to discuss my research areas with others present at the meeting.

Essentially this research was conducted by two novices who had, and may I say, still have a lot to learn about adopting an appropriate methodology to gather appropriate data to answer the main research question(s). Saunders, Lewis and Thornhill (2003 p289) suggest using a data requirements table and note that "A problem experienced by many students and organizations we work with is how to ensure that the data collected will enable the research question(s) to be answered and the objectives achieved"

5.3 Conclusions about each research aim.

Conclusions for the aims have been drawn over the course of this research. They are related to published studies as outlined in the literature review in chapter 2 and as a result of the findings in chapter 4. (Sections 4.4 and 4.5)

5.3.1 Aim 1-*To identify how many local authorities currently provide specialist intermediate care for older people with dementia.*

The DOH (2000) recognise that "One of the weaknesses in intermediate care services nationally is that there is a reluctance to offer services and expertise to older people with dementia or a mental illness and this has that local authorities may not be responding effectively to the needs of older people with a diagnosis of dementia in the area of IC". (2.3.1). Contradictory to these findings Rose (2006) felt that delivery of intermediate care has evolved and changed since its inception, and there is now more focus on people with dementia and mental health problems (2.3.1). However whilst Dewing (2003) recognised that there has been an increasing awareness of the value of rehabilitation for maximising the potential of older people, this did not include older people living with dementia. (2.3.1). Of the authorities used in this research, not including LCC, the majority do offer some IC for older people with dementia combined with generic services, however these services did not specialize in older peoples mental health rehabilitation. LCC meanwhile does provide specialist rehabilitation in older people's mental health, but it is not included under the general umbrella term for IC, and so does not have the funding or resources usually

associated with this service (4.3). A breakdown of mental health service provision in the local authorities surveyed is displayed in table 13 (4.4). The 2005 (CSIP) service development guide 'Everybody's Business' note that recent evidence suggests that particularly people with a diagnosis of dementia are excluded from intermediate care based on a combination of factors including an assumption that older people with dementia cannot benefit from rehabilitation. However the authorities surveyed did not have this assumption and the majority felt that there would need to be an increase in specialist Mental Health and Dementia services including IC and rehabilitation to meet future demand (4.3) Whilst others felt that priority will be given to open access to IC for mental heath it was more about doing things differently within the current resources and integrating with health. The Nuffield Institute for Health, (2004) are of the same opinion and recognise that: "A radical change of perspective is needed if public services are to meet the challenges of our ageing society. This approach may not cost more; it involves a better use of resources and more effective ways of public services working together in the interests of citizens."(2.4)

5.3.2. Aim 2-*To identify what if any planning and forecasting systems are used by local authorities to estimate future demand for older people's services including intermediate care (Given that the prevalence of dementia increase with age)*

A sophisticated demand forecast model currently in use Swindon (Appendix 8) is used to provide commissioners with a template for completion, to be used whilst undertaking demand forecasting locally. It includes a population needs assessment or population profiling, with local prevalence rates calculated from national rates, of: Dementia and Mental ill health. The overall concept of the model can be used as a blue print for market planning to identify gaps and target markets as it assesses how well the organisation is doing. It identifies its strengths and weaknesses and establishes the objectives to be achieved in the future (2.9). Remarkably of the authorities surveyed none of them had a specific process for determining long range objectives in older people's mental health services (4.3). Interestingly Surrey council and its key partners in 2004 recognised the need

to better understand the complexities of the social care market and commissioned independent market research from Laing and Buisson. The research set out in detail a range of issues including: demographic trends, projected demand for care services, workforce challenges, the structure of the social care market and problems of supply, cost pressures, and future commissioning scenarios. Laing and Buisson (2004) using the CSED methodology brief stated that: 'the forecasting model was based on an extensive analysis of historical and existing supply and demand arrived at through various interviews and surveys with staff in the county council, partners such as health, local providers, care associations and other local experts. The model is constructed as a step by step guide through the key investment decisions' (Appendix 9).

Armstrong (1983) offers an explanation of the differences between planning and forecasting in that, planning relates to what the firm should do. Forecasting relates to what will happen if the firm tries to implement a given strategy in a possible environment (2.5). Surprisingly despite Armstrong's explanation and Sanders & Ritzman (2004) stating that the ability to accurately forecast future demands has always been an important organizational capability. Also The White Paper highlighting the need for councils to forecast future demand (2.6) it was interesting to find that the majority of local authorities surveyed are not using any formal planning and forecasting methods. Just one authority surveyed had developed a demand forecasting programme for the city, which encompasses all adults, which would include OPMH (4.3-4.4 Q-1). And another in response, when asked if they were using a tool to forecast future demand of older people's services and if not why not? Stated; 'The nature of the data we have been collating is very 'lumpy' in the sense that it is often collected across different geographical boundaries and timescales, and to inconsistent definitions. This makes it extremely difficult to approach with any formal or prescriptive 'ex-ante' demand forecasting model'

Meanwhile LCC does have an inclusive 'Whole Systems Approach' to planning the future of generic IC services. Although these services do not include provision for older people with a diagnosis of Dementia (4.3) (Appendix 21).

CSED are working collaboratively with all councils throughout England supporting them to achieve sustainable efficiency improvements in adult social care and it has introduced a web based demand forecasting and capacity planning system 'POPPI' (2.6). However the majority of authorities are using a combination of joint and strategic needs assessments (4.4) and are relying on population profiles to assess future demand. (Figure 6) (4.4). It was recently noted by the NAO (2007) that, "As a result of the low priority nationally, as well as poor quality information on local needs, health and social care economies in England have tended not to undertake any effective long-term planning for dementia care" (4.4).

5.3.3. Aim 3- *To evaluate the importance of using planning and forecasting systems in local authorities.*

Winston (1984) (2.8) broadly defines Mental Health as "covering a wide range of services and problems although it is composed of the specific needs of many smaller groups including-*The elderly*, who are at specific risk of disorders such as Alzheimer's disease". Having accepted Proctor 2000 (2.6) assertion that; "A market segment is a section of a market which possesses one or more unique features that both give it an identity and set it apart from other segments".

LA's should start looking now to plan and forecast for the future of this growing population segment rather than focus, by and large, on the most vulnerable older people at times of crisis PAS (2004) (2.4). In the words of Kotler (2005) 'segmentation analysis is a search for insight into customers and customer types and it can provide a rich reward for marketers who are the first to identify new variables for classifying customers' (2.8). Moreover The Wanless Social Care Review (2005) noted that "There is a great need for a review of the challenges and demands facing social care, and the resources that will be needed to deliver social care fit for the 21st Century"(2.6).

Whilst most authorities surveyed felt it was important to use planning and forecasting systems the focus was on dealing with the here and now. Also in most authorities informal systems are in place to forecast future demand. As noted by Waddell and Sohal (1994)

‘informal methods are used when there is insufficient time or data to use more formal means’.

This information is gathered collectively by bringing together population profiles and information based on opinions of appropriate people, these people generally include a mix of representatives from the LA, NHS and PCT. (4.3) Smith et al (1996) is of the opinion that, forecasting is a crucial input for planning in almost all companies and that organizations forecast so that they can plan and help shape their future (2.5). In addition Proctor (2000) identifies that; “Forecasting amounts to estimating some future event that is outside the control of the organisation. Such information is a useful starting point from which to determine how resources should be allocated among markets and products or services and which provides a basis for managerial planning (2.5). Having accepted these opinions and Coupe (2006) observation that not to plan or to refuse to recognise the need to plan is to invite failure (2.6) The current lack of forecasting and planning being undertaken in local authorities (4.4) may well have serious consequences as two things are certain, the generation is getting older and prevalence of dementia increases with age (2.4).

5.3.4. Aim 4-*Identify potential impacts of population ageing on local authority service provision.*

POPPI projections table 3, represents people aged 65 and over predicted to have dementia in Liverpool based on the latest 2005/06 figures of 7%. The estimates given for up to 2025 are also based on 7% on the basis that, current rates as a proportion of the elderly population are set to continue (2.4). The POPPI predictions estimating the number of people who may have a dementia may in actuality be higher as the stigma attached to dementia may put people off seeking a diagnosis NAO (2007) (2.4)

Due to a lack of planning and forecasting authorities surveyed are not, taking into consideration life expectancy statistics in conjunction with, statistics for the prevalence of dementia in old age to target the population needing services now and in the future. This became evident as at present in the majority of authorities there are no plans to focus on specialism in older people’s mental health including dementia in IC services (4.3)

Significantly PAS (2004) note that many older people are still excluded from universal services and public services (2.4)

Furthermore taking into account Britain's ageing population statistics and that the incidence of Dementia and Alzheimer's disease increases with increasing age Hatcher (1999) (2.4). It was no surprise to find that most of the authorities surveyed acknowledged that there would need to be an increase in services to meet future demand. Although others felt whilst there would be an increase in demand for specialist services it would be more about doing things differently within the current resources (4.4).

Of the authorities surveyed all were of the opinion that services would no longer continue to be solely provided in house. Most believe that it will be a mix of in house and independent providers who will provide services in older people's mental health and Dementia care (Figure 9) (4.4).

If as Moschis (2003) states we are; witnessing perhaps the most important demographic shift in the history of mankind-the rapid aging of the world's population" (2.4). And that demography is perhaps the most predictable of the drivers of future service requirements so all future service developments must therefore plan for uncertainty DOH (2000) (2.4). Its time for LA'S to reduce corporate risk and enhance client value, by using the key principles for effective demand forecasting and capacity planning that are essential for a strategic needs assessment CSIP (2007) (2.6).

5.4 Conclusions about the research question.

What does the future hold for intermediate care?

Shaw (2002) estimates that in 1995 there were less than 9 million people over the age of 65 in the UK and by 2030 there may well be about 13 million (2.4). Alemayehu and Warner (2004) go further, to estimate that the population of the "old-old" (85+) will quadruple over the next few decades (2.4).

Hatcher (1999) reveals that statistics state that 1in 20 people over the age of 65 years are affected by dementia and this increases to 1 in 5 over the age of 80 (2.4). Combined with that, Dewing (2003) estimates that; The number of older people with dementia accessing rehabilitation and intermediate care services either in hospital, or at home, is growing and will continue to increase (2.6). However Carpenter *et al* (2002) believes that the clinical and research challenges of intermediate care and health care systems of today did not evolve to provide optimum care to an ageing population. (2.4).

LCC is currently using a Whole Systems Approach to planning IC services nevertheless this approach is not inclusive to incorporate specialist services for people with a diagnosed Dementia. (4.3-4.4) Wilson (2003) identified that; a whole-systems approach is required to meet the challenges faced in IC and in the context of delivering the intermediate tier, the original way is not necessarily still the best way. In his judgment to make optimal use of resources, the admission criteria should be reassessed and this may need to include a review of the argument that prevents people with (even) mild dementia from gaining entry to intermediate care services (2.6).

Furthermore, CSIP (2005) noted that recent evidence suggests that particularly people with a diagnosis of dementia are excluded from IC based on a combination of factors including an assumption that older people with dementia cannot benefit from rehabilitation. Contradictory to these findings Rose (2006) felt that delivery of IC has evolved and changed since its inception, and there is now more focus on people with dementia and mental health problems. (2.3.1) In opposition to this Dewing (2003) notes that: "Once a label of dementia (of any kind) has been applied, older people are wrongly dismissed as having little or no potential for rehabilitation" (2.3.1)

CSIP (2007) Acknowledge that Effective Demand Forecasting and Capacity Planning Processes are essential for strategic needs assessment (2.6). Nonetheless the white paper also highlights the need for councils to forecast future demand, suggesting that local authorities should undertake regular strategic needs assessments to forward plan for the next 10 to 15 years (2.6).

The results of the findings (4.4) show that the majority of authorities are using a combination of joint and strategic needs assessments nevertheless the NAO (2007) suggested that as a result of the low priority nationally health and social care economies in England have tended not to undertake any effective long-term planning for dementia care (4.4)

Having analysed the data it became apparent that, even among top performing authorities the approach to forecasting and forward planning is not very sophisticated and only a couple of authorities seem to be taking an objective, quantitative and systematic approach to determine future requirements in older peoples services (4.5).

However the results of the findings (4.4) did show that in most authorities there is some provision for specialist IC. Although most are combined with generic services and there were no obvious plans to increase or develop these services to meet the challenges of an ageing population.

The absence of forecasting and planning for the future of older people's IC, combined with not having explicit written processes for determining long range objectives, has resulted in a disparity in current service provision that does not always include mental health or people with a diagnosed Dementia. (4.4). Planning and forecasting specialist services should be seen as an integral part of IC as these variations could well result in missed opportunities that could compromise its future. In conclusion there is no simple answer as to which method is best "Like most subjects, forecasting is best learned by actually doing it" Foresight (2007) (2.5) in addition 'Not to plan (or to refuse to recognise the need to plan) is to invite failure' Coupe (2006) (2.6)

5.5 Contribution to Theory

The basis for this research was to determine what the future holds for IC. A qualitative approach was taken to discover, what if any planning and forecasting systems were in place in LA's to project future demand in older people's services.

Dementia presents a significant and urgent challenge to health and social care in terms of both numbers of people affected and cost, despite this little is known as to how authorities are going to meet the challenges faced in the future.
The major contribution of this research is that it illustrates how the apparent lack of planning and forecasting in local authorities may lead to missed opportunities to meet the future demands of an ageing society.

The research has identified some key characteristics that have influenced the use of planning and forecasting systems in local authorities. In theory most managers recognise the need to plan and forecast for the future of older people's services but there is resistance as it means taking time away from the real job also the perception of importance is to deal with the here and now. Managers also felt that they don't have any control and that there is a shortage of people who either lack the skills or else are just to busy to carry out this activity. In addition they were unsure of what data is and isn't available to assist them to project future demand. Only a couple of authorities were aware of POPPI population forecasts and CSED's Demand Forecasting and Capacity Planning workstream, that has concentrated on delivering pragmatic solutions to help councils detect and manage changing demand tactically and strategically.

The only way to resolve the shortage of planning and forecasting in local authorities is for these activities to be seen as an important organizational function and a process by which the organization manages its future.

5.6 Limitations of the study.

As mentioned in chapter in section 5.2 and detailed in chapter 3 initial difficulties in obtaining permission for research impacted greatly on the research schedule and data collection. Also as the number of none respondents continued to drop off as the research progressed, the findings and conclusions were based on only a small sample of authorities and may not be applicable to all UK authorities.

Terminology and language used to describe intermediate care also hindered the research process as for example it can also be termed rehabilitation. In addition the different interpretations and variations as such of intermediate care made research much more complicated. In Wilson (2003) experience he found that: "Intermediate care means different things to different people and, responsive as it is to changes in the external environment and to the diffusion of ideas, it can mean different things to the same people over time".

5.7. Opportunities for further research.

To determine what the future holds for older people's Intermediate Care services in local authorities the sample could:

- Be expanded to include all CSCI registered authorities.
- Look at the motives of senior managers who ignore the evidence for planning and forecasting in adult social care.

6. Recommendations for LCC

- To build on the current strengths of the specialist unit, assess demand, identify gaps and plan for the future of intermediate care services, consider a mapping exercise to uncover;

    - Number of generic IC referrals refused admission due to having a diagnosed Dementia.

    - Number of referrals who after admission are diagnosed with Dementia.

    - Number of hospital beds blocked by older people who have a diagnosed Dementia.

- Use POPPI long term population forecasts for Dementia and CSED Demand Forecast and Capacity Planning guidelines as a blue print to planning the future for IC services. What's more the long term benefits of planning will possibly out weigh the level of cost to switch or adapt current resources to meet the needs and demands of this target group.

- Develop the Whole Systems Approach to planning for IC in LCC. By firstly, including Mersey Care Mental Health Trust secondly, if such services are to be as effective as possible, they need to be planned with the full involvement of those providing specialist services, thirdly to have a truly inclusive whole systems approach, specialist services need to be incorporated within the IC framework. (This could be important in the creation of IC strategies for the future)

'Perhaps the biggest need is to summarize the useful research in the form of principles (guidelines, advice, actions, recommendations) so that practitioners can apply them properly'. (Armstrong, Fildes 2006)

7 Bibliography

Armstrong J.S, Fildes R, 2006. Making progress in Forecasting *(Forthcoming in the International Journal of Forecasting)*

Armstrong J. S, 1983 *Strategic Planning and Forecasting Fundamentals.* The Strategic Management Handbook. New York: McGraw Hill, pp. 2-1 to 2-32.

Alemayehu. B and Warner K.E, 2004 The Lifetime Distribution of Health Care Costs HSR: *Health Services Research* 39:3 p627-642.

Bronner Kuijlen 2007 The live or digital interviewer – a comparison between CASI, CAPI and CATI with respect to differences in response behaviour. *International Journal of Market Research.*

Cahill D. J, 1997 Target marketing and segmentation: valid and useful tools for marketing *Management Decision* PP10-13.

Care Services Efficiency Delivery Newsletter 2007 (Edition 8)

Care Services Efficiency Delivery Demand Forecasting and Capacity Planning. www.csed.csip.org.uk

Care Services Improvement Partnership, 2005 *Improving Intermediate Care for Older People with Mental Health Needs* - Good Practice & Key Issues.

Carpenter.I, Gladman J.R.F, Parker. S,G, Potter J. 2002 Clinical and research challenges of intermediate care. *British Geriatrics society.* Age and Ageing 31: 97-100

Change Agent Team 2003 *Defining a Whole Systems Approach*

Chatfield C 2007 *The international journal of Applied Forecasting* issue 6 Foresight. p5-8

Coupe. M. 2006 Target delivery, service modernisation and system reform Reinventing planning in the English National Health Service. *Journal of Health Organization and Management* Vol. 20 No. 3, pp 253-262

CSCI Performance ratings for Social Services in England 2005 p18

CSIP 2005 '*Everybody's Business' Integrated mental health services for older adults*: a service development guide

Dewing J 2003 Rehabilitation for older people with dementia. *Nursing Standard*.18,6, 42-48

Dibb S. Stern P.Wensley R . 2002 Marketing Knowledge and the Value of Segmentation. *Marketing Intelligence and Planning* 20/2 pp113-119

DOH 2000 Shaping the Future NHS*: Long Term Planning for Hospitals and Related Services.* Consultation Document on the Findings of The National Beds Inquiry

DOH 2002 NSF for Older People - *Intermediate Care: Moving Forward.*

Given L. 2006 Qualitative research in evidence-based practice: a valuable partnership *Library Hi Tech* Vol 24 No. 3 pp 376-386.

Golden J. Milewicz J.Herbig P. 1994 Forecasting: Trials and Tribulations. *Management Decision,* Vol. 32 No. 1, 1994, pp. 33-36.

Greenhalgh, T., and Taylor, R. (1997). How to read a paper: papers that go beyond numbers (qualitative research). *British Medical Journal*. 315, (7110), 740-743.

Greenley G, Hooley G,and Saunders J, 2004 Management processes in marketing planning *European Journal of Marketing* Vol. 38 No. 8, pp. 933-955.

Hannabuss S, 1996 Research interviews *New World Library* Vol 97 No 5 pp22-30

Hatcher S, 1999 Evid Based Ment Health Downloaded from ebmh.bmjjournals.com on 12 May 2006 pp 2-60.

Hoek J, Gendall P and Esslemont D, 1996 Market segmentation A search for the Holy Grail? *Journal of Marketing Practice*: Applied Marketing Science, Vol. 2 No. 1, 1996, pp. 25-34.

Hooley, G.J., West, C.J. and Lynch, J.E. 1984, Marketing in the UK: A Survey of Current Practice and Performance, Institute of Marketing, Maidenhead .*International Journal of Operations & Production Management* Vol. 24 No 5, pp 514-529

Jankowicz A.D. 2005 *Business research projects* (4th ed.) Thompson Learning p63-64 p298

Johnson G. Scholes K, 2001 Exploring public sector strategy Prentice Hall

Johnson, G. M., & Scholes. K, 2002 *Exploring Corporate Strategy*. England: Pearson Education Ltd, pp19

Knikman.J R, Snell E.K The 2003 Problem: Caring for Aging Baby Boomers. *Health Services Research* 37:4 P849-884

Kotler P, 2005 FAQS. Marketing answered by the Guru of Marketing. Marshall Cavendish Business p50.

Laing and Buisson 2004 Market Research Report on Surrey

Lehaney B.A. and Vinten. G. 1994 Methodology": An Analysis of Its Meaning and Use. *Work Study,* Vol. 43 No. 3, pp 5-8.

Local Government Association 2000

Lotti M. A, 2005. *Conference on Digital Futures,* ESOMAR

Lynch R 2003 *Corporate Strategy* (3rd ed.) Prentice Hall p650

Mason J 2002 *Qualitative Researching.* (2nd ed.) p72

Mayernick M. 2003, *Can You Be Half-Pregnant?* A few thoughts on the conflict between quant and qual Strategic Marketing Corporation Qualitative Research. ESOMAR

McCarthy, T.M., Davis, D.F., Golicic, S.L. & Mentzer, J.T 2006. Sales Forecasts are Becoming Less Accurate. The evolution of sales forecasting management: A 20 year longitudinal study of forecasting practices, *Journal of Forecasting*, 25, 303-324.

Moschis 2003, Marketing to Older Adults: an updated overview of present knowledge and practice *Journal of Consumer Marketing*

Miles K, Bright D and Kemp J, 2000 *Improving the Research Interview Experience* Market Research Society Annual Conference.

NAO 2007 *Improving services and support for people with dementia* P52

NAO 2006 *Clinical guideline on dementia.* Developed in conjunction with SCIE (no 42)

NHS 2000 Shaping the Future*: Long Term Planning for Hospitals and Related Services.* Consultation Document on the Findings of The National Beds Inquiry.

Nelson W. Garvey B 2005 Using Research To 'Futureproof' Strategies *Market Research Society*

Nuffield Institute for Health, 2004 (ADSS, LGA, BGOP, Audit Commission), Planning for an Ageing Society p5.

Office for National Statistics, 2005 Mid-year population estimates

Page S. 2007 MBA Dissertation (BUM 117) Handbook. Chester Business School

Piercy, N. 1992, *Market-led Strategic Change*, Butterworth-Heinemann,Oxford.

Proctor T, 2000 *Strategic Marketing An introduction* Routledge p3 p82, p87, p288

Punch K F, 2000 *Developing Effective research proposals* Sage Publications p3

Raspin P and Terjesen S, 2007 *Business Strategy Series* Vol. 8. No 2 pp121

Rathod S. La Bruna A, 2005 *Questionnaire length and fatigue effects - does size really matter?* ESOMAR

Render B. Ralph M. Stair J R.2000 *Quantitative analysis for management* (7th ed.) Prentice Hall p157

Riddel K. 1998, What Is In It For Me? *Gaining the Commitment of Business-to-Business Research Respondents.* Power of Knowledge Congress ESOMAR.

Rose S. 2006, *Health Management Intermediate Care.* NeLH Health Management Specialist Library

Sanders N R, 1995 Managing the forecasting function. The implementation of formal statistical forecasting can create a number of problems. *Industrial Management & Data Systems*, Vol. 95 No. 4, pp. 12-18

Sanders N. R, Ritzman L.P, 2004 *Integrating judgmental and quantitative forecasts*: methodologies for pooling marketing and operations information.

Saunders M, Lewis P and Thornhill A 2003 (3rd ed.) *Research Methods for Business Students* Prentice Hall p139 p246 p289

Shaw F, 2002 *Foresight* 4,3 pp 4-11

Simkin L, Dibb S, 1998 Prioritising target markets. *Marketing Intelligence & Planning* pp 407–417

Simkin L, 1996 addressing organizational prerequisites in marketing planning programmes *Marketing Intelligence & Planning* pp39–46

Smith III H. C, Herbig P, Milewicz J and Golden .J E, 1996 Differences in forecasting behaviour between large and small firms *Journal of Marketing Practice: Applied Marketing Science*, Vol. 2 No. 1, pp. 35-51.

Tuckel P, O'Niell H, 2002 The Vanishing Respondent In Telephone Surveys. *Journal of Advertising Research* Vol. 42, No. 5.

Waddell and Sohal, 1994 Forecasting: The Key to Managerial Decision Making. *Management Decision,* Vol. 32 No. 1, pp. 41-49.

Wanless Social Care Review 2005: Background briefing Kings Fund

Wilson. K.V, 2003 Intermediate Care: From Innovation to …Post-Mortem? *Journal of Integrated Care* p1-4

Winston J.W, 1984 *Marketing for Mental Health Services*. The Hayworth Press p14, p73

Young J. Robinson M. Chell S. Sanderson D. Chaplin S. Burns E. Fear J, 2004 *A prospective baseline study of frail older people before the introduction of intermediate care.* Health and Social Care in the Community service. Blackwell Publishing p307

Appendix1. Key- Publications on Dementia

Sep 1999	*National Service Framework for Mental Health*, Department of Health	Set out national standards, service models and priorities for improvement. Covered only adults up to age 65.
Jan 2000	*Forget me Not: developing mental health services for older people in England*, Audit Commission	Reviewed older people's mental health services across England and Wales. Found wide variation in practice and resources with specialist help patchy and uncoordinated. Recommended: more active identification by GPs and support from specialists; information and help for carers; improvements to specialist services; improvements to home-based services, day care and respite care; better support for staff in care homes; improved management of multidisciplinary community mental health teams; a shared vision and better coordination of health and social care services locally.
Mar 2001	*National Service Framework for Older People*, Department of Health	Launched a ten year programme of improvement for older people's services against eight standards. Standard 7 covered mental health in older people and stated that people should have access to integrated mental health services to ensure effective diagnosis treatment and support for them and carers. Explicitly mentions dementia as an area needing early identification and treatment.
Feb 2002	*Forget me Not 2002*: developing mental health services for older people in England, Audit Commission	Updated previous report that had set out the Audit Commission's analysis of mental health services for older people in England and Wales, underlining the continuing need for improvement against the 2000 recommendations.
Mar 2005	*National Service Framework for long-term conditions*, Department of Health	Set 11 quality requirements for services to support people with long term conditions, including person centred care, early recognition and diagnosis, appropriate emergency management, community support, attention to special needs in hospital, palliative care, support for carers. Focused mainly on neurological conditions other than dementia.
July 2005	*Securing better mental health for older adults* Professors Philp and Appleby, National Directors of Older People's Services and Mental Health	Position statement from the National Directors for Older People and Mental Health. Launched a new initiative to join forces across mental health and older people's services, recognising that separately they had not met the challenges
Nov 2005	*Everybody's Business – Integrated mental health services for older adults: a service development guide* Department of Health and Care Services Improvement Partnership	A guide describing the key elements of a comprehensive older adult mental health service, designed to inform local discussions on commissioning.
Dec 2005	*The State of Social Care in England, 2004-2005* Commission for Social Care Inspection	The first comprehensive overview of social care in England. While many aspects of social care continue to improve, it found many people were still not getting a good deal. Councils needed to work more closely with providers to drive up quality and avoid short-sighted cost-cutting that resulted in people unnecessarily admitted to hospital. Better support for carers should be a high priority. This was followed by the *State of Social Care in England 2005-2006*.

Appendix 2

POPPI projection notes for tables 3 & 4

Notes For men, 1.4% of 65-69 year olds; 3.1% of 70-74 year olds; 5.6% of 75–79 year olds; 10.2% of 80–84 year olds; and 19.6% of men aged 85 and over are predicted to have dementia.

For women, 1.5% of 65-69 year olds; 2.2% of 70-74 year olds; 7.1% of 75–79 year olds; 14.1% of 80–84 year olds; and 27.5% of women aged 85 and over are predicted to have dementia.

The most recent relevant source of UK data from population samples is the Medical Research Council's Cognitive Function and Ageing Study (MRC CFAS), February 2002. This study involved a longitudinal examination of population samples of people aged 65 and over in six sites across England and Wales.

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2025.

Appendix 3

People aged 65 and over predicted to have dementia in England, by age band (65-69, 70-74, 75-79, 80-84 and 85 and over) and gender, projected to 2025

	2008	2010	2015	2020	2025
Males aged 65-69 predicted to have dementia	15,505	16,519	20,054	18,288	19,921
Males aged 70-74 predicted to have dementia	29,366	30,346	33,288	40,672	37,290
Males aged 75-79 predicted to have dementia	41,070	42,022	46,838	52,164	64,204
Males aged 80-84 predicted to have dementia	49,960	52,153	58,283	67,116	76,143
Males aged 85 and over predicted to have dementia	69,874	75,852	92,571	112,504	137,396
Total males aged 65 and over predicted to have dementia	**205,775**	**216,892**	**251,033**	**290,744**	**334,954**
Females aged 65-69 predicted to have dementia	17,759	18,897	23,048	21,056	22,862
Females aged 70-74 predicted to have dementia	23,338	23,984	26,118	31,957	29,306
Females aged 75-79 predicted to have dementia	65,412	65,001	69,722	76,694	94,274
Females aged 80-84 predicted to have dementia	103,099	103,748	106,385	117,354	130,933
Females aged 85 and over predicted to have dementia	207,955	213,428	227,563	248,050	285,478
Total females aged 65 and over predicted to have dementia	**417,563**	**425,057**	**452,835**	**495,111**	**562,852**
Total population aged 65 and over predicted to have dementia	**623,338**	**641,949**	**703,868**	**785,855**	**897,805**

Figures may not sum due to rounding

Notes

For men, 1.4% of 65-69 year olds; 3.1% of 70-74 year olds; 5.6% of 75–79 year olds; 10.2% of 80–84 year olds; and 19.6% of men aged 85 and over are predicted to have dementia.

For women, 1.5% of 65-69 year olds; 2.2% of 70-74 year olds; 7.1% of 75–79 year olds; 14.1% of 80–84 year olds; and 27.5% of women aged 85 and over are predicted to have dementia.

The most recent relevant source of UK data from population samples is the Medical Research Council's Cognitive Function and Ageing Study (MRC CFAS), February 2002. This study involved a longitudinal examination of population samples of people aged 65 and over in six sites across England and Wales.

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2025.

Appendix 4

Sanders 1995-Identified organizational problems and associated solution strategies

Organizational forecasting problems	Solution strategies
Resistance to change	Pre-emptive organizational resistance training
Lack of forecast credibility	Highlight effective utilization
Forecast bias	Changing rewards and incentives evaluation
Lack of recent improvements in forecasting	Counteracting inertia
Lack of a base on which to build	Counteracting inertia
Lack of organizational support	Develop co-operative strategies

Appendix 5

Process overview

Appendix 6

CSED Management framework

Appendix 7

Criteria for selecting target markets						
CRITERIA	1	2	Score 3	4	5	Overall measure
1. Profitability	10	22	2	1	0	41
2. Market growth	6	20	7	2	0	30
3. Market size	3	23	7	2	0	27
4. Likely customer satisfaction	7	16	9	1	2	25
5. Sales volume	5	19	7	4	0	25
6. Likelihood of sustainable differential advantage	6	19	5	2	3	23
7. Ease of access of business	6	12	15	2	0	22
8. Opportunities in the industry	6	14	12	2	1	22
9. Product differentiation	3	17	14	0	1	21
10. Competitive rivalry	3	15	14	3	0	
11. Market share	4	17	5	8	1	15
12. Relative strengths in key functions	1	9	10	4	1	15
13. Customers' price sensitivity	3	14	13	5	0	15
14. Customer image of company	4	15	8	7	1	14
15. Technological factors	2	16	6	9	2	7
16. Fit with business strategy	3	8	16	8	0	6
17. Stability of market	1	10	16	8	0	4
18. Environmental factors	2	6	16	9	2	-3
19. Threat of substitutes	2	9	12	8	4	-3
20. Barriers to entry	3	7	12	9	4	-4
21. Negotiating power of buyer	1	8	10	11	5	-11
22. Ease of profiling customers	1	3	16	12	3	-13
23. Supplier power	2	7	8	9	9	-16

Note: The raw Likert scale data were converted into an overall usage measure of the target market criteria. This measure in the right-hand column allows the relative importance of individual criteria to be appraised. It was developed by allocating the following points to the five-point Likert scale: 1 = +2 points; 2 = +1 point; 3 = 0 points; 4 = –1 point; 5 = –2 points

Source -Simkin & Dibb (1998)- **Prioritising target markets**

Appendix 8

Demand Forecasting Template for Older People's Accommodation

Purpose of Tool
The purpose of this tool is to provide commissioners with a template for completion, to be used whilst undertaking demand forecasting locally. It aims to provide prompts as to what data needs to be gathered and what questions need to be asked of the information.

Topic and Example Activities	What have we done and/or what do we know?	What do we need to do?
Population needs assessment or population profiling Example: 1. What are the broad based characteristics now and in the future by age, gender, location and ethnicity? 2. What is the local mix of housing tenure among older people, and what proportion of older people are owner-occupiers? How do local house prices compare with the price of an extra care unit? 3. What is the local prevalence, calculated from national rates, of: a. Physical or sensory impairment; b. Dementia; c. Mental ill health; d. Learning Disabilities; e. What other estimates area available of local incidence and prevalence of these conditions?		

Topic and Example Activities	What have we done and/or what do we know?	What do we need to do?
4. What are the numbers of older people who live alone, older carers of older people, older people in poor housing etc? Do local older people feel isolated, vulnerable, unsafe, and what are the current levels of deprivation. 5. What is the quality of the housing stock in which older owner-occupiers are living? How many lack amenities?		
Surveys of anticipated future need Examples: Review of national studies. Review of recent local studies. Housing needs assessment. Service user profiling Examples: 1. How many older people currently live in OSH and extra care housing? What are their reasons for entry to that form of housing, length of tenure and reasons for departure? What data is available on void levels and ease of lettings for particular schemes? 2. To what extent do local OSH and extra care schemes currently support people who are physically frail or who suffer from dementia, mental ill health or cognitive impairment? Do wardens and scheme managers expect to offer continued support to frailer tenants, or are they encouraged to move into care homes?		

Topic and Example Activities	What have we done and/or what do we know?	What do we need to do?
3. What are the estimated numbers and proportion of residents currently in care homes, whom the experience of extra care would have enabled to renew or prolong their independent living skills? 4. What is the volume of intermediate care and delayed discharge where housing is the only or predominant factor in inhibiting a return home? Analysis of conditional demand 1. Are there needs being presented where targeted interventions could avoid poorer outcomes but where this is not occurring?		
2. Is the intensity of the service provided sufficient to achieve the outcomes desired? 3. Is the service's success being monitored through outputs rather than outcomes? 4. Is the intervention occurring at the most appropriate time?		

Appendix 9 CSED Methodology Brief Laing and Buisson

Title	**Laing and Buisson Market Research Report on Surrey**
Key Objectives of the Model	To provide an informed assessment of current and likely short/medium/long term demand and supply in the county of Surrey
Description	In 2004, Laing and Buisson were commissioned by Surrey County Council to research the demand for care services across the county based on the local projected demographic changes. The purpose was to help inform the Council's commissioning plans over the short, medium and long term. The report also included mapping the supply of care homes, homecare, extra-care and supported housing for service users who are older people and young disabled adults with learning disabilities, physical or sensory disabilities, mental health needs or HIV/AIDS.
Application areas	Methodology is a standard approach which could be used for other service areas including children services
Input	The forecasting model was based on an extensive analysis of historical and existing supply and demand arrived at through various interviews and surveys with staff in the county council, partners such as health, local providers, care associations and other local experts. The model is constructed as a step by step guide through the key investment decisions. Current and projected demand • Older people. • Adults with learning disabilities • Adults with physical, sensory or cognitive disabilities or HIV/Aids • Adults with mental health needs • Intermediate care Market supply • Supply of care homes • Supply of domiciliary care • Supply of extra care housing • Supply and use of community hospital places
Output	Assessment of the current supply and demand by service user group and PCT, district council or social services team area. Forecast of likely demand by 2010 and likely supply based on current projections. Projections are usually for 10-15 years.

	A review of issues of particular importance to Surrey including extra care housing, pensions time bomb and supported housing.
Resources External	Cost around £55,000 for basic research and report . Updating TBD.
Internal – initial set-up, ongoing support	Management time is required to meet with the research team and review progress. The original intention was to build up local expertise within the county council for updating/refreshing the report but cost/time pressures precluded.
Indicative Costs and timing	The time from project commencement to draft report was around two months. Total cost was around £60,000 in 2004 including presentations to council officers, elected Members and Surrey Care Association.
Additional considerations	This approach was especially useful to bring providers and purchasers to a common understanding of current and likely future needs. In the Surrey case, the report was publicly available and shared with the Surrey Care Association. The impartiality allowed greater trust between the different parties and facilitated discussions as to where investment into additional capacity would be most beneficial to service users, providers and commissioners. Gaining Member buy-in to the process and final report was important and other councils should be aware that the recommendations may challenge existing policies and may require a rethink. The report brought new information to the council, and combined this with dispersed existing knowledge to build a single comprehensive overview of care supply and demand.
Supplier contacts	Philip Mickelborough Email: info@laingbuisson.co.uk or pjm@mickelborough.com Telephone: 020 7833 9123 http://www.laingbuisson.co.uk/ See website for full range of services and sample report.
Council reference	Surrey County Council
Documentation	Laing and Buisson market research report for Surrey County Council (word document)

Appendix 10

Lehaney & Vinten 1994 -Four uses of methodology are outlined, and a further two are added here. Methodology is used to mean;

- the ways in which hypotheses become theories – scientific methodology;
- the ways in which techniques are chosen to address a particular problem;
- the ways in which problems are chosen, which addresses the question of sponsorship;
- methods or techniques;
- the modelling process, which include hard and soft systems approaches, and the ways in which the relevant variables are chosen for a model, and how reality is concomitantly simplified;
- the chronological planning of events – the research programme.

(Source-B.A. Lehaney and Gerald Vinten 1994
"Methodology": An Analysis of Its Meaning and Use)

Appendix 11

Features of research design

Appendix 12

Process of events

Date	Event	Note
20/10/06	Download CSCI performance ratings	Look at 3 star performing authorities
21/10/06	Email 26 three star authorities and three authorities surrounding Liverpool	To obtain Social Services Director contact details
21/10/06 to 25/10/07	Received 18 responses	Via email
25/10/07	Sent our 11 reminders	No further replies received
30/10/06	Sent out letters to directors	12 email 6 post
31/10/ 06 to 20/11/07	14 replies	8 email 6 post Suffolk & Kent want research proposals St Helens research framework and like Wandsworth want confirmation that we have obtained ADSS approval for research
21/11/07	Sent reminders to 4 Directors of Local Authorities	No further replies received
21/11/07	Down Loaded Research applications for Suffolk-Kent-ADSS	
26/11/07	Forwarded research applications to Kent and Suffolk	
26/11/07 to 5/12/07	Sent emails & left messages with St Helens	
5/12/07	Met with tutor to discuss ADSS application and financial implications	
5/1/07	Formulated questionnaire	

6/1/07 to 13/1/07	Pilot tested questionnaire on colleagues	
1/2/07	Email to T Hunter asking for advice re ADSS	Response received same day. Forward application and explain no financial resources for research
10/2/07	Questionnaires forwarded to 14 authorities(including those were we are awaiting permission to research)	10 email 4 post
10/2/07	Completed application forwarded to ADSS	
11/2/07 to 28/2/7	11 Responses to questionnaire received	8 email 3 post(1 post had no sender details could not be used)
3/3/07	Analysed data from questionnaires	8 to be used for further research-4 reminders sent out(one of these was obviously completed but had no details on it) to none respondents
8/3/07	Suffolk agreed research proposal	
8/3/07	Compiled survey questionnaire	
9/3/07 to 15/3/07	Pilot test of survey	
19/3/07	Forwarded surveys to 8 authorities	6 email (included 3 in surrounding authorities asking for dates for interview). 2 post surveys
30/3/07	3 surveys returned	email

30/3/07	3 dates set for face to face interviews	Via email-Participants had previously been sent a copy of survey
30/3/07	2 Postal survey reminders sent	Post-No response received
2/5/07	ADSS responded to research application	Application not granted
17/5/07	Face to face interview Manchester	
27/5/07	Contacted LCC senior manager	
31/5/07	Group interview with LCC senior managers	
12/6/07	Interview Halton	
21/6/07	Observation at steering group	
1/7/07	Sent emails-LCC-Manchester-Suffolk-Sunderland-Halton-Gateshead • Are you using a tool to forecast future demand of older people's services? • If not why not?	Received replies LCC-Suffolk-Manchester
1/7/07	Email Swindon-to ask • How they come to use forecasting model • What do they see as the benefits of using it	
5/7/07	Interview- Knowsley-asked additional questions as 1/7/07 during interview	

Appendix 13

Leighton Dene
Resource Centre
Long Lane
Liverpool
L9 6 DW

Dear …….

We are presently on the Master in Business Administration programme with Liverpool City Council and are about to start research for our dissertation

One of the research programmes will be around planning and forecasting looking at how other authorities are planning for the future in Older Peoples Mental Health and Intermediate Care.

The second part of this research project is also looking at Older Peoples Mental Health but specifically at what constitutes a good Health and Social Care Partnership.

This research will require contact with experienced social care managers in this field.

We have teamed up together to share costs and travel arrangements when visiting other authorities. We consider it good manners to approach the authorities Director in the first instance and with your permission would like to contact the relevant managers in your organisation to discuss the above projects. Would it be possible for you to provide us with contact names and email addresses/telephone numbers so we can make the initial contact. I have enclosed a stamped addressed envelope.

Thank you for your time

Yours sincerely

Irene Spiers Service Manager for Older Peoples Mental Health

Michelle Barry Older Peoples Mental Health Co-ordinator

Appendix 14

This Initial Survey requires you to answer the Questions below. If you receive a hard copy of this survey please indicate your answers by ticking the appropriate boxes.

If you receive this survey by E-mail please indicate your answers by ticking or highlighting the appropriate text

1-Does your authority provide Intermediate Care for Older People with Dementia?

Yes ٱ **No** ٱ **Considering for the future** ٱ **Not considering** ٱ

2-Does your authority work in partnership in older peoples services?

Yes ٱ **No** ٱ **Considering for the future** ٱ **Not considering** ٱ

3-Does your authority provide specialist home care for Older People with mental health needs?

Yes ٱ **No** ٱ **Considering for the future** ٱ **Not considering** ٱ

If you have answered no or not considering to questions 1 , 2 and 3 you need not proceed any further

4-If you do provide or are considering providing Intermediate Care for older people with Dementia will it be?

In a residential establishment ☐ **Domiciliary care** ☐ **Both** ☐

5-If you do provide or are considering specialist home care services for older people with mental health needs is it or will it be provided by the Local authority, independent sector or both?

L/A ☐ **I/Sector** ☐ **Both** ☐

6-Does your authorities present resources meet current demand for Intermediate Care for Older People with Dementia?

Yes ☐ **No** ☐ **Not Sure** ☐

7-Does your authority have systems in place to forecast future demand for older peoples mental health services?

Yes ☐ **No** ☐ **Not Sure** ☐

Responding Authority……..

Once again we would like to thank you for your time and ask that you return completed surveys in the stamped addressed envelope enclosed or by E-mail no later than February 28th 2007.

Appendix 15

M Barry/I Spiers
Leighton Dene Resource Centre
Community Services
Long Lane
Liverpool
L9 6DW
0151 525 9115
michelle.barry@liverpool.gov.uk
Irene.spiers@liverpool.gov.uk

ADSS Administrator
ADSS Business Unit
Local Government House
Smith Square
London
SW1P 3HZ

Dear Sir or Madam

My colleague and I are currently looking to carry out research to gather data as part of our MBA dissertation with Chester University. We both work for Liverpool City Council (LCC) in Older Peoples Services and as both our research areas will cover Older Peoples Mental Health we hope to conduct surveys and interviews together to reduce both time and costs as there are no funding sources for this research.

The 2 areas to be covered in this research include;

Partnerships-Looking at what constitutes a good health and social care partnership

Planning and Forecasting-Looking at how local authorities are planning for the future in Older Peoples Mental Health Services

Initially we wish determine if authorities are considering or else have partnership arrangements in place in Older Peoples Services and secondly to establish if authorities currently provide or are considering for the future providing home care and intermediate care for older people with dementia.

The initial survey should take only a few minutes to complete (Copy attached) and depending on individual responses we may need to make contact again to make arrangements to conduct a more in-depth survey either by post/email or face to face interviews

We are using multiple authorities in our survey to gather data and in doing so we would like to assure you that data/information gathered will be written up in our dissertations anonymously so that data and authorities cannot be identified. Both of our dissertations will be available on completion at Chester University to anyone who has participated in the research.

We have completed the research application as requested but as we require only limited information we are not sure that the information we require falls within the research governance framework

In anticipation of you granting us permission to carry out this research we would like to thank you for your time. Should you have any queries in relation to this application please contact us using either the postal/email address or telephone number at the top of the page.

Yours Sincerely

Appendix 16

Questionnaire response sheet

Appendix 17

Interview/Survey Questions

Q.1 What systems are in place to forecast future demand for older people's mental health services?

Q.2 How is this information gathered and who is involved?

Q.3 How much weight if any is given to mathematical models versus input from individuals in projecting future demand?

Q.4 Does your authority have an explicit written process for determing long range objectives in older people's mental health services?

Q.5 How do commissioners and service providers plan for Older Peoples Mental Health services collaboratively and are service users and carers involved?

Q.6 How does your authority plan to undertake a strategic needs assessment to forward plan given that the number of people surviving beyond 85 is due to rise by two-thirds over the next 20 years?

Q.7 How is your authority structured to meet the requirements of DOH guidance and legislation for working in partnerships with health in respect of Older peoples Mental Health?

Q.8 What governance arrangements are in place in relationship to working in partnership and have you a single agency document written in collaboration?

Q.9 Do you have integrated community mental health teams (Health) and older people's teams (social care)?

Q.10 At present what specialist mental health services for older people does your authority provide if any?

Q.11 Are these services provided in house, by other agencies or a combination of both?

Q.12 How is home care service purchased for people with mental health needs i.e. are they purchased in blocks of time or flexible? And are they outcome focused?

Q.13 How do you see these services developing in the future?

Q.14 What does your authority estimate will happen to older persons mental health services in the next 10 to 20 years?

Appendix 18

M Barry/I Spiers
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Community Services
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Liverpool
L9 6DW
0151 525 9115
michelle.barry@liverpool.gov.uk
Irene.spiers@liverpool.gov.uk

[Click here and type recipient's address]
Dear Sir or Madam:

Thank you for responding to our initial survey this information has been invaluable to us. Having compiled the information from the survey we would now like to make arrangements to meet with you for a face to face interview. The interview should take no longer than 1 hour and a copy of the questions to be asked has been enclosed for you to consider prior to our meeting. As we appreciate that the time you can offer us is limited, the length of the interview may be reduced by forwarding or presenting us with information in relation to the questions to be asked prior to the interview.

It would be useful if you could contact either Irene or me by email giving us details of dates when you will be available for interview or else give us a call on the numbers above.

Yours Sincerely

Appendix 19

ADSS RESPONSE LETTER

Appendix 20

Interview Questions for LCC Senior Managers

Q.1 What systems are in place to forecast future demand for older people's mental health services and is there an explicit written process to determine long range objectives. Does the authority undertake a strategic needs assessment in planning for the growth in the older population over the next 20 years?

Q.2 How is this information gathered and who is involved?

Q.3 How much weight if any is given to mathematical models versus input from individuals in projecting future demand?

Q.4 How do commissioners and service providers plan for Older Peoples Mental Health services collaboratively and are service users and carers involved?

Q.5 How is the authority structured to meet the requirements of DOH guidance and legislation for working in partnerships with health in respect of Older peoples Mental Health?

Q.6 What governance arrangements are in place in relationship to working in partnership and have you a single agency document written in collaboration?

Q.7 Does the authority have integrated community mental health teams (Health) and older people's teams (social care)?

Q.8 At present what specialist mental health services for older people does the authority commission if any?

Q.9 Are these services provided in house, by other agencies or a combination of both and how do you envisage the development of older people's mental health services to take account of future growth?

Appendix 21

Whole Systems LCC

Appendix 22

Ethical standards for business and management research: –

Source: Jankowicz 2005, p. 63-64.

Your work should…	That is…	Who is responsible?
…be Professional and Responsible	• Informed about, and consistent with, the standards of your theoretical and methodological perspective (passing off an impressionistic interview record as a reliable and objective record isn't just sloppy, it's unprofessional; reporting it following the guidelines pertaining to constructivist work. e.g. triangulation against other sources, would be entirely appropriate); • Based on information and techniques sufficient to prove appropriate substantiation of findings; • Based on a research plan which protects rights and welfare of the people researched; • Be limited to tasks in which you have competence or, as trainees, under appropriate supervision; • Conform to professional and legal standards, and the standards of your institution;	You; your tutor as a guide You; NB, literature review You; your sponsor Your tutor; your sponsor Your tutor

…use appropriate means of data collection	• Draws conclusions from techniques which reflect current professional knowledge about design, standardisation, validation, reduction of basis; • Taking care to make appropriate adjustments as required, to reflect factors such as gender, age, race, ethnicity, culture, sexual orientation, disability, language and socio-economic status; • Taking care to store data securely and confidentially (NB U.K Data Protection Act)	You; your tutor as a guide You; your sponsor You; your tutor
…involve informed consent	• Inform participants of the nature of the research in language they understand, documenting this; • Participation being voluntary, informed of the factors involved (e.g. risks, discomfort, adverse effects, limitations on confidentiality), the foreseeable consequences of declining being conveyed; • Provides protection from adverse consequences of declining, where you are in an authority relationship to respondents (e.g., personal subordinates, students of yours) • Obtain in advance where recording (e.g. taping, filming) is done, unless the observation uses only naturalistic observation in a public place and the record cannot	You You You You; your sponsor

	otherwise cause personal identification or harm; • Provides an opportunity to examine the nature, results and conclusions; correcting; misconceptions; • Describes who will see any results which might be personally identifiable, offering anonymisation if requested (this may make a real difference to the structure of your data tables) and pointing out any limitations on total anonymisation, if any , that may remain; • Describes who will see the final report or dissertation, offering an embargo if requested; • Avoids excessive or inappropriate incentives; where these involve a processional services in kind, its full nature, risks, obligations and limitations must be clear;	You You You; your tutor You
…careful control deception	• Avoid techniques dependant on deception unless justification by the research, educational or applied value AND no equally effective non-deceptive alternatives are feasible; • Avoid all deception which could affect voluntary consent (unpleasant emotional experiences, discomfort, physical risk);	You; your tutor; but should you have chosen this topic? You

	• Explain any otherwise legitimate deception as early as possible, preferably immediately after participation and no longer than the conclusion of data-gathering;	You
… be carefully interpreted	• Taking into account factors which reduce accuracy of interpretation providing evidence of reliability; indicating any significant reservations about accuracy or limitations on interpretation; • Preferably giving access to personal results together with an appropriate explanation of their meaning and inferences drawn; • Avoid conclusions from data that are out- of- date or obsolete for the current purpose.	You You You