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Professional Community Based Teams for Older People with Dementia in the North West of England

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EXECUTIVE SUMMARY

1.1 Introduction

This research into the work of professional community based teams working with people with dementia in North West England forms part of a larger study undertaken to identify and describe a range of specialist dementia services in this region. 'Specialist' services were defined as: services or resources which are provided exclusively, or which have part of them dedicated specifically, for older people with dementia and/or their informal carers. A broad definition of dementia was adopted, which encapsulated both those formally diagnosed with dementia, and also those who could be described as 'confused'. A number of team types were identified, in particular, multi-disciplinary and single discipline teams, and the results contain an analysis of the differences between them.

The aims of the project were to:

- Identify and describe professional community teams for people with dementia
- Capture variations in standards
- Capture variation in capacity
- Assist service development by making the findings available to managers

1.2 Methods

Data collection took the form of a postal questionnaire sent to all professional community teams in the North West of England identified by service managers in the NHS and social service departments as providing some level of care to people with dementia. Eighty-eight teams were identified of which 36 either did not respond (n=19) or were excluded, as they did not meet the inclusion criteria (n=17). The final sample comprised of 52 teams, representing a response rate of 59 per cent. Seventeen single discipline and 35 multidisciplinary teams were identified. Data was analysed using SPSS 10.1.

Measures of quality were developed from current policy and recent research literature. Variations were explored in the whole sample and between multi-disciplinary and single discipline teams.

1.3 Key findings

The results demonstrate that overall, teams scored highly on measures relating to good practice in assessment and care planning, carer support, targeting, access to a specialist service, and care worker good practice. However they performed less well on other measures, in particular measures of structural integration and flexibility. In all but one measure, the provision of culturally sensitive services to ethnic minorities, multi-disciplinary teams scored higher than single discipline teams though differences were not always statistically significant.

1.3.1 Findings for the whole sample

Specialist service
Eighty-six per cent of teams were based in a specialist division. Overall, fifty per cent of the caseloads of all teams were people with dementia.

Integration
A greater degree of practice level integration, as opposed to structural level integration, was found, indicating that teams were finding ways to work together even when they lacked the formal structures to do so.

Assessment and care planning practices
High quality practice was found on many measures relating to assessment and care planning. Despite this, assessment documents only partially covered the full range of areas needed in order to fully assess an individual's needs. Improvement was also needed in relation to involving carers and users in assessments. Forty per cent of teams were found not to do this. Carer level support was found to be of a high level.

Flexibility
The majority of teams produced low scores on the flexibility standard. Less than one third of teams had provision for emergency access and in only six per cent of these could staff be contacted directly outside normal office hours. Over half the sample (54%) operated a waiting list in the twelve months prior to data collection.

Care worker/team good practice
Sixty-six per cent of teams held regular team meetings and three quarters had attended a joint training session in the last twelve months. There was a ratio of approximately one qualified staff member for every 30 people on a team's caseload.

1.3.2 Differences between multi-disciplinary and single discipline teams

Specialist service
Multi-disciplinary teams offered a more specialist service than single discipline teams based on a number of standards relating to structure, content and quality measures. Only three per cent of multi-disciplinary teams compared with 35 per cent of single discipline teams were based in a generic division.

Integrated service
Multi-disciplinary teams also appeared to offer a more integrated service than single discipline teams.

Assessment practice
The use of standardised scales was a health rather than a social care practice. They were used in 91 per cent of multi-disciplinary teams and only 23 per cent of single discipline teams. Three of the latter were health only teams.

Culturally sensitive practice
An interpreter was available in 76 per cent of single discipline teams and 57 per cent of multi-disciplinary teams. Seventy one per cent (n=12) of single discipline teams had translated leaflets available compared with only 23 per cent (n=8) of multi-

disciplinary teams. The composite measure on this theme was also statistically significant indicating more culturally sensitive practice by single discipline teams.

1.4 Conclusions and recommendations

Overall, teams were found to provide high quality assessments and good support to carers, whilst their policies and procedures resulted in a high degree of access to specialist services. High scores were also evident in terms of management practices that supported care worker good practice, such as training and holding regular team meetings. However, on many other measures the outcomes were less positive. Low scores were generally found with regard to structural and practice level integration, care planning, services to ethnic minorities, person-centred care, specialist training, flexibility, and quality assurance.

Multi-disciplinary working was found to be generally producing higher standards of care, on the measures used, than the single discipline team model.

The findings both offer support to the government's integration agenda, and highlight the level of work still needed to achieve it. The standards of care used and the results identified should facilitate planners and practitioners in health and social care in meeting the requirements of the NHS Plan (Cm 4818, 2000a) and the National Service Framework for Older People (Department of Health, 2001a).

2. INTRODUCTION: UNDERSTANDING QUALITY IN DEMENTIA CARE

This report forms part of a larger study undertaken to identify and describe specialist dementia services in the North West of England. The aims and methods described below relate to professional teams only, though they are compatible with the approach used in the larger study, which also examines long-term, day, and home care services.

The aims of the project were twofold. First, to identify, describe and note the location of all professional teams providing a service for people with dementia and their carers within the North West of England. Secondly, to capture the variations in service provision; the standard of care and the capacity of those services, between services and between local authority areas within the region. It is hoped that the information obtained in meeting these aims will assist in service development.

This research focuses on teams, based in the community, who provide assessment, care planning, monitoring and reviewing services to people with dementia. They work largely with people in the community and with those returning to the community following discharge from hospital. They also provide some level of service to older people living in residential care homes, and to home staff in the form of training. They come from both the health and social care professions and from old age and mental health fields and are increasingly working together more closely to reflect current policy.

2.1 Method

Following identification, specialist teams or those offering a degree of service to people with dementia were sent a postal questionnaire. Responses were analysed by researchers using the conceptual framework explained below as a means of describing service structures, processes and practices in order to measure the standards of care provision.

2.2 Conceptual framework

A framework of standards was loosely conceptualised around Donabedian's (1980) evaluation criteria of structure, process and outcome in order to measure the quality of service delivery at a number of different levels. Structure is defined by Donabedian as the physical resources of a care facility, for example, its staff, funding and building, and are regarded as providing the "environment" of care (Donabedian, 1980, p80). Process is defined as the manner in which care is carried out and includes assessment and care planning practices. Outcomes are the results of both structure and process and include concepts such as privacy and person focused care. All three criteria are not attributes of quality themselves but are "approaches to the acquisition of information about the presence or absence of the attributes that constitute or define quality" (Donabedian, 1980, p90). The standards, which form the backbone of the report, have been identified in both the literature and recent policy as being central to the provision of good quality care for older people with dementia. The thematic index/contents table, outlined in the methods section (Table 4.1) enables particular themes and standards to be traced throughout the report. The

literature review is grounded in this conceptual model whilst the results section also follows this design.

One of the main themes of the report is the nature of teams and whether a particular model offers a better quality of service than another. This is identified and discussed in the literature review in relation to single and multi-disciplinary teams and ties in with the government's agenda of developing an integrated primary health and social care service for older people (Department of Health, 2001). The results both highlight overall findings and differences between single and multi-disciplinary teams.

3. A SELECTIVE LITERATURE REVIEW

3.1 Introduction

The number of older people with dementia in Britain, as in Europe as a whole, is set to double over the next fifty years. Already it stands at approximately one in five people over the age of 80 and accounts for over 600,000 people in the UK at the start of the twenty-first century (Department of Health, 2001a).

Concern about how to provide good quality services to these people and their carers is one of the key concerns of the present government. The Health Act 1999, the Health and Social Care Act 2001 and the National Service Framework for Older People (NSFOP) (Department of Health, 2001a), all highlight deficiencies in the current system. Their commitment is to develop an accessible service which provides an "integrated mental health service" for older people provided by health and social care agencies "to ensure effective diagnosis, treatment and support" for service users and their carers (Department of Health, 2001a, p90). The vision is of a service where the professional boundaries of health and social care are blurred to enable a joined-up service to be offered to people who have too often fallen between health and social care agencies on the one hand and mental health and old age services on the other (Sheard and Cox, 1998). The establishment of Care Trusts (Department of Health, 2000a), integrated health and social care providers, in 2002, and the implementation of the Single Assessment Process in 2004 (Department of Health, 2001b), are the latest initiatives in this transformation of service delivery.

A number of recent studies are considered below which focus on the themes of integration, good practice and service delivery. The conceptual framework referred to in the methods section is also used to structure the literature review. The chapter begins by considering the debate regarding whether specialist or generic services are more appropriate for people with dementia. This is followed by a brief and selective history of the development of multi-disciplinary working in the field of dementia care. Workforce issues in relation to the type of professional employed in this sector are also discussed. Following this review of structural issues, process and practice issues are highlighted through a discussion of the nature of assessment and care planning. Finally, indicators of outcome are discussed in relation to access issues (including access for ethnic minority elders) and carer involvement. Not all themes fit neatly into these categories. Many overlap and, as Table 4.1 in the methods section shows, can arguably be placed in more than one of them. The table and Donabedian's model nevertheless offer a framework and a meaningful structure to a large and complex set of measures and standards.

3.2 Service structure

3.2.1 Generic versus specialist service

Ovreveit's research (1993) identified that vulnerable groups of people were more likely to receive a quicker and better service where a permanent team with representatives from different services and professions was "formed to serve a particular client population" (Ovreveit, 1993, p56). Despite such findings it appears that service providers have been slow to develop such services for older people with

mental health problems (Challis et al., 2001). In 1997 the SSI found that in most of the local authorities they investigated, older people with dementia were dependent on generic services, "not always tailored to meet their particular needs as closely as they might (have been)" (1997a, p7). Where specialist services were developed they tended to be in the form of individual projects and therefore location specific. Thus the quality of service received depended on the service user's address as opposed to their level of need. Herbert, in her review of services for older people with mental health problems (1997) found that some areas were beginning to recognise the need to separate services for those with functional and organic illness in old age. She noted the negative impact on service users of trying to provide one service for both, which are described as exacerbating difficulties and detracting from quality of life and recovery prospects of either group.

The work of Weiner and colleagues (2002) suggests that it is becoming more common for services for older people to be provided by specialist teams. They found that 66 per cent of local authorities across England provided care management services to older people via specialist teams. Only a minority (4%), however, had specialist teams for older people with mental health problems. In relation to a multi-agency approach, Challis and colleagues (2001) found that less than half (46%) of the local authorities across England had a specialist dementia service in conjunction with their local health trust and that there was significant variation in service availability across the country.

Related to the issue of specialisation is that of targeting services at those in greatest need. This was one of the key aims of the community care reforms of the 1990's, influenced by a severe demand on resources and concerns that services were being received by people not strictly eligible for them. The history of this development is not straightforward, nor is it without its critics. Peck (1994), tracing the history of the community mental health teams for younger adults in the U.S. in the 1960's to its central position in mental health services in Britain in the early 1990's, noted that although these teams set out to offer a range of services to those with severe mental health problems, they misinterpreted the call for a comprehensive service "as meaning providing a limited range of services to a broad range of people" rather than a comprehensive service to those with the most severe conditions (1994, p152). Challis and colleagues have also argued that a similar misinterpretation took place in the implementation of care management after 1993 (1995). There are also those that express concern over such targeting of those in greatest need as limiting intervention for those who might be more simply and cheaply supported at an earlier stage (Schneider et al., 1999).

3.2.2 Recent developments and findings on integration

Anderson (1999), citing reports from the Alzheimer's Disease Society (1997) and Clinical Standards Advisory Group (1998), as evidence, has argued that the current system of service provision for older people with dementia, is ad hoc, uncoordinated, inefficient, inequitable and disorganised (1999). He maintains that the "ideology that separated social and health care has failed" in relation to offering services to older people in the community (1999, p1).

The nature and extent of collaboration between health and social care agencies is an international concern (Aiken et al., 1975). In the UK the debate goes back to at least the 1970's. Following the Local Authority Social Services Act of 1970 which created the social services departments that we know today (Cmd. 3073, 1968), came the National Health Re-organisation Act (1973) which emphasised the importance of collaboration between social services and health authority professions and agencies at both planning and service delivery levels (Gray and Hunter, 1983, Hunter and Wistow, 1987). Sir Keith Joseph, the secretary of state at the time, regarded the National Health Re-organisation Act as a means of creating "two parallel but interacting structures" (Webb and Wistow, 1986, p147). As Webb and Wistow comment, this analogy was unfortunate as parallel lines never meet, except at infinity. Joint working thus became the target to achieve the best outcomes for service users. In 1996 Dickie and Iliffe examined how social services and primary health care might work more closely in the light of the lead role of social services in assessment and care management. Their recommendations included the need for primary health care developments to integrate with social services, and the requirement for collaboration and research, particularly in the development of equivalent outcome measures. This objective was re-emphasised in the NSFOP which noted that:

> "The hallmark of good mental health services is that they are: comprehensive, multidisciplinary, accessible, responsive, individualised, accountable and systematic." (Department of Health, 2001a, p91)

Yet despite the evidence of significant commitment to the process of integrated practice, development has been laboured and uneven across the country and across agencies with success often being achieved at project rather than mainstream level (Baillon et al., 1996; Herbert, 1997; Sheard and Cox, 1998; Molyneux, 2001; Mountain, 2002). Services have remained characterised by divisions between agencies and professions, concerned with their own professional boundaries and status, with differing professional cultures and budgetary constraints, all of which have hampered good practice and the achievement of positive outcomes for service users (Ovreveit, 1993; Fitzsimmons and White, 1997). The Audit Commission (1997) found that services for older people were often poorly coordinated with health and social services failing to agree their respective responsibilities, resulting in confusion and sometimes delays to discharge from hospital. The Audit Commission (1997) and the SSI (1997a) also noted that people with dementia were receiving a better service where good collaboration between health and social services was found. In the same year however the SSI found that "many agencies involved in community care had been concentrating on their own internal organisation and resources to the detriment of effective joint planning and working" (SSI, 1997b, p8). Two years later another SSI report, noted that the NHS and Social Services Departments seemed to be working in parallel with poor communication and consequently not achieving a user centred approach (SSI, 1999a).

Murphy (1997) noted that an effective dementia care system should deliver care that is "coordinated, guaranteed, available when needed and seamless in its integration of various providers" (Anderson, 1999, p.1.). Challis (1998), taking up this point has noted that the concept of a seamless service is an unrealistic ideal and that it is:

> "the appearance of smooth transition, ensuring that existing boundaries do not provide negative incentives for effective flows of care, that must be the goal of successful integration" (Challis, 1998, p11).

There are critics of this drive towards a more integrated multi-disciplinary service. Schmitt (2001), for example, recently highlighted the complexities of researching this field in the U.S. noting that collaboration itself is not "a dichotomous variable, simply present or absent, but is present in varying degrees" (2001, p51). She challenges some of the assumptions that collaboration equals better care and demonstrates that many research findings of US health based studies are methodologically flawed and do not stand up to close scrutiny. She urges researchers to get on with research in this area in order to demonstrate "what mix of collaborators, for what purposes, for whom, with what outcomes and at what costs" are effective (2001, p63). Mountain (1997) and Brown and colleagues, more recently (2003) raised a similar point noting that research in this field to date predominantly evaluates service structures with "little evidence of the relationship between service inputs and outcomes; for example, which aspects of multi-disciplinary working are most effective in meeting user and carer needs" (Mountain, 1997, 4).

3.2.3 Models of integration

There have been a number of randomised controlled trials (Hinchcliffe et al., 1995; Banerjee et al., 1996), and other studies (Challis, 1994, 2002a; Hardy et al., 1996), that demonstrate, to some extent, the effectiveness of multi-disciplinary working. Although some sceptics remain (Galvin and McCarthy 1994; Mountain, 1997; Schmitt, 2001), there is now broad agreement between practitioners and policy makers about the benefits of multi-agency specialist services for people with dementia and their carers as the means to provide high quality services for these people (SSI, 1997a; Sheard and Cox, 1998; Challis, 2002a). The findings of a number of SSI studies (1997a, b) in the late 1990's, however, together with more recent research (Chevannes, 2002; McNally et al., 2003), have demonstrated the complexities involved in putting this into practice. The challenge is to both separate (specialise) and combine (integrate) appropriately. People with dementia need a unified (combined) health and social care service specific (targeted) to their needs. Many types of integration and collaboration have been tried in different contexts and with differing degrees of success, in recent years. A number of these models are outlined below and are considered in relation to their success in terms of service delivery. Is there an optimum level of collaboration? The different models highlight a number of issues that were found to strengthen collaboration between agencies. Good working partnerships, however, are far from simplistic and collaboration, at whatever level, will not automatically result in successful outcomes for service users (Bland & Hudson, 1994, Hardy et al., 1996, SSI, 1999a). As Bland has noted:

> "Putting a group of people from different training backgrounds together and expecting them to become a 'team' spontaneously is unrealistic" (1994, p15).

Ovreveit (1993) offers a view of integration from low though medium, to high, noting that only at the latter level, where a team has formalised practice agreements supported by a team manager, can the full benefits of integration be achieved for the service user. Challis and colleagues separated out levels of coordination and

integration in relation to inter-agency and inter-professional working (Challis, et al., 1995). Challis (1998) also made a distinction between horizontal and vertical types of integration. The former describes the integration of activities that complement each other, whilst the latter describes the more radical development of integration between services sequentially, around a particular client group in order to improve final outcome. The models of integration used below: information sharing, linking, co-location, were identified by Sheard and Cox (1998) as a means of describing different levels of integrated practice. They mirror Ovreveits' low, medium, and high categories.

Information sharing:
At its most basic level, professionals and agencies need good systems of communication in order to offer an effective service to older people with dementia. Ovreveit (1993) argued that a "true multi-disciplinary team record system which everyone uses is one of the quickest ways to achieve closer co-operation (whilst) professional control of records is an effective way to prevent team work" (1993, p19). The NSFOP (Department of Health, 2001) stresses the importance of sharing information in order to minimise the all too frequent experience of service users and carers of repeating the same information to a range of professionals. The findings of a number of recent studies suggest that the majority of local authorities have basic formal arrangements in place for information sharing, most commonly by an exchange of written documentation (Challis et al., 2002b; Weiner et al., 2002). How effectively these worked in practice is unclear. Information exchange via regular meetings was found, in Challis's survey, to be not as common. Content analysis of six liaison meetings between a community mental health team and two primary health care teams, by Midgley and colleagues (1996) revealed positive practices resulting from this approach such as shared care plans and monitoring of service users at risk.

Linking/attachment:
The next level of integration is described by Ovreveit (1993) as the 'network team', whereby team members meet formally with managerial support and where one or two might even share a base. Ovreveit notes that at this level there is still the possibility of managers directing 'out-posted' or 'attached' workers to operate in ways that diminish integrated practice. Nevertheless, this model provides regular face-to-face contact between agencies without basing one within the other. In practice it has often been achieved by having a named care manager from a social services team 'linked' to a primary health care practice. The model has a long history and was applauded by the Department of Health (1994) for its positive impact on working relationships and outcomes for service users (Hardy et al., 1996). In written evidence to the House of Commons in 1993, the Audit Commission argued that:

> "At the operational level, closer working could also be engendered by locating care managers in GP and primary health care teams. Professionals who know each other personally and who work together have a much better chance of sorting out the boundary disputes together" (written evidence from the Audit Commission to the House of Commons Health Select Committee, 1993, para 1b, p2).

O'Neill-Byrne & Browning (1996) identified a related practice, that of mental health professionals holding specialist clinics in primary health care settings. They noted that this resulted in referrals being filtered to different professionals according to their age and mental health history. The SSI supported this model, noting that they found that collaboration worked best between health and social care agencies "where there was clear alignment between the two, for instance where care managers were allocated a geographical patch based on a GP's catchment area" (SSI 1997b, p18).) Glendinning and Rummery (2003) note that prior to 1997 'attachment' was largely initiated between individual social service departments and GPs and was as a consequence far from widespread. Hudson and colleagues (1998) found that 40 per cent of their respondents reported social care and primary health care staff located in the same premises, though in some instances these arrangements were only partial and patchy (Hudson et al., 1998, p28). Challis and colleagues (2001) national survey of local authority practices found that about one-fifth of local authorities had care management staff based in primary care settings, although often involving only small numbers of staff. Weiner and colleagues (2002) found that nearly all local authorities had care management staff based in hospitals and about half had care managers based in specialist old age teams. A number of commentators (Cameron and Lart, 2003; Glendinning and Rummery, 2003) have also noted that out-posted social services staff often felt isolated whilst the unequal power relations that operated between them and GPs discouraged true collaboration. Professional supervision for staff located at a distance from their traditional base was seen as vital in these circumstances (Hodgson, 1998).

Co-location:
High-level integration, according to Ovreveit, occurs when managers develop policies, which formalise arrangements, roles and responsibilities, where there is a single team leader for each team member and where this person manages the operational running of the team. Only then can a formal multi-disciplinary team be said to exist (1993, 62). Onyett and Ford (1996) believe that multi-disciplinary teams offer the possibility of both best practice and cost effectiveness. They suggest that positive outcomes can be achieved by the relative ease of coordinating care between different professionals within, rather than between, teams and by the availability of a wide range of skills relevant to the service users. Hardy and colleagues (1996) compared a project team that was co-located with other two other models practiced in an English local authority; linking and information sharing. They noted a number of positive outcomes for the co-located team, compared with the other models reviewed. A higher rate of comprehensive needs led assessments, a faster response and one leading to appropriate care planning with more emphasis on monitoring and review were all found in the co-located team. On the other hand, no increase in multi-disciplinary assessments was found. The authors describe the full-time co-location of one (or more) social services staff members at a GP practice as the optimal model. This falls short of Ovreveit's definition of high level integration (1993), which maximises proximity and consistency, in turn, improving the responsiveness of services to the changing needs of individual service users.

In their study of old age psychiatry services in England, Challis and colleagues (2002b) found that 59 per cent of these teams had full time social services staff within them. This figure reduced to 12 per cent for social services staff who were also managed by the old age psychiatry teams. The Audit Commission (2000)

reported that specialist community mental health teams for older people with a multi-disciplinary professional staff base could be found in two-thirds of the country at the end of the twentieth century, although the staff mix varied considerably. In 2002 they reported a fall in the number of these teams, which then stood at 44 per cent of the country.

Challis and colleagues (2002a) study of intensive care management services in Lewisham is an example of integrated multi-disciplinary home support for older people with dementia. They found that this type of service resulted in real benefits to both service user and carer. For the former, there was a reduction in admissions to residential care (when compared with a comparison group), a reduction in need relating to activities of daily living, and a better maintenance of social contacts than the comparison group. For the latter, they found a reduction in stress, burden and input and that, compared with the comparison group, these carers expressed less need and received greater support. The authors suggest that their data shows that intensive care management can make a cost-effective contribution to the lives of older people and their carers. The specialist service they researched had a joint health and social care agency setting, enabling quick and easy access to both services for service users, carers and workers. Care managers were free from initial screening and assessment work, making the service both 'intensive' and 'clinical' as opposed to broad based and administrative (Challis, 1994).

Joint commissioning and managing:
Anderson (1999) has called for a single funding agency for dementia care in England matched by a multi-disciplinary service in the community. Like Anderson (1999), O'Neill-Byrne & Browning (1996) conclude that integrated health and social care services, jointly commissioned and managed, provide a better service for the public. This model was identified as occurring to a greater or lesser degree in a number of the services described in Sheard and Cox's review (1998). They define it as being where accountability is to both the NHS and the social services department, supervision of the team's manager is from both agencies, and the service is run according to the policies and procedures of both agencies. Such jointly commissioned and managed services are seen as a way of facilitating the development of a "philosophy of care which extends across all service elements and organisations involved in service delivery" (Mountain, 1997, p.5). Reilly and colleagues (2003a), however, in their comparison of old age psychiatry departments in England and Northern Ireland found that although there was greater integration in the latter where health and social care are structurally integrated and managed by a single body, practice level integration remained limited. The development of jointly managed Care Trusts in England is intended to facilitate such structural level integration and make it more possible to bring integrated practice into the mainstream. Where practice level integration has preceded this policy development, integration at all levels might prove easier to achieve.

3.2.4 Obstacles to effective integration and opportunities to overcome them

Freeth (2001) noted a number of difficulties involved in sustaining inter-professional working, highlighting a number of dimensions to this including funding strain, communication complexities, conflicting agendas, structural differences between organisations, sustaining regular evaluation and planning, turnover of staff and the

loss of key individuals (2001). Johnson and colleagues noted a number of factors that they claim are required to positively influence collaboration. These include multidisciplinary teams with local budgetary control, pooled funding, joint training, a single management entity, accurate population information, and 'clearly articulated goals around clearly consistent (and senior) commitment to meeting these goals' (2003, p81). A number of key obstacles to integrated practice are discussed below together with suggestions from the literature about how to tackle them.

Cultural differences:
Differences in professional culture, leading to mistrust and insecurity, are often cited as a significant phenomenon resulting in unsuccessful collaboration (Bland, 1994; O'Neill-Byrne & Browning 1996). Dalley's study (1991) of health and social care professionals outlined a number of professional ideologies that influenced outlook and practice and resulted in different approaches to service users. Huntington, for example (1981) found a sharp distinction between general practitioners, who were oriented around cure and individual pathology, and social workers, who were focused around social functioning. Laidler (1991) uses the term 'professional adulthood' to describe those individuals and professions secure enough not to be threatened by collaboration. Loss of professional identity, of power, autonomy, and status, are very real concerns that must be tackled if such professional maturity is to be achieved (Sheard and Cox, 1998). Hudson (1998) also noted that a lack of clarity regarding of roles and responsibilities, was found to cause conflict and result in poorer integration. Transferable roles and responsibilities, along with skills and tasks need to be identified, as do those that are specific to a particular profession (Galvin and McCarthy, 1994; Moss, 1994).

Joint training:
Joint training has been identified as one way of achieving a greater understanding of the roles and philosophies of different professionals (SSI, 1997b, 1999a). The Health Advisory Service (1997) suggest that this type of training could make a significant contribution to moving from working in parallel to working in partnership. Yet evidence from both the SSI (1999a) and the Audit Commission (2000) showed that such training had been given both comparatively low priority and inadequate funding. The NSFOP (Department of Health, 2001a) states that "specialist mental health services should provide training and advice for other professionals and staff whose responsibilities include providing care and treatment for older people with mental health problems" and that this training should include a cognitive impairment and a depression screen (Department of Health, 2001a, p 105). One recent study found that this occurred in just over half the old age psychiatry teams they studied (Challis et al., 2002b).

Shared ownership:
Social service departments were given the lead role in developing the care management approach in the Community Care reforms of the early 1990's. However, later legislation, in particular the Single Assessment Process (Department of Health, 2001) requires this role to be shared with colleagues in primary health to a much greater extent. Research suggests that involving primary health care teams in the care management of people with dementia over the last decade has been a difficult process, given the cultural divisions outlined above, with varying degrees of success. The most difficult professional group to engage in the assessment process

has been general practitioners. Low-level participation by general practitioners was found by a number of different research studies (Hardy et al., 1996; Hudson, 1998; Weiner et al., 2002, 2003). A recent Scottish study (Rae, et al., 2001) noted that alongside general practitioners, practice nurses were found not to regard themselves as having a central role to play in the care of people with dementia in the community. The same study found that these staff often had negative attitudes towards people with dementia, lacked knowledge about local specialist dementia services, and did not undertake regular screening in order to promote early diagnosis. The Health Advisory Service (1997) noted that in some primary health care teams there was "scepticism about improving the functional status of older people" (HAS, 1997, p88). These results are supported by previous findings (Haley et al., 1992; McLean, 1993; O'Connor et al., 1993). These findings are cause for concern as general practitioners can play a vital role in the early diagnosis of dementia (Hardy et al., 1996; Trickey et al., 1998). Challis and colleagues noted that four-fifths of the old age psychiatry teams in their study reported links with primary care teams, with 12 per cent holding regular sessions in GP surgeries. They comment that this "may reflect a growing trend that general practitioners are becoming more sensitive to mental health problems" (2002b, p1023).

Going mainstream:
Many of the innovative examples of successful collaboration between social services and health, old age and mental health services have initially, not surprisingly, been set up as projects. As such they have been in a privileged position, able to offer a 'Rolls Royce' service (Bland, 1994), to circumvent bureaucracy, and to develop creative problem solving approaches. Hardy and colleagues (1996) compared the speed and appropriateness of responses between a multi-disciplinary project team and the mainstream service in the same areas. He found that the project team were able to offer a speedier response as a result of:, established relationships, a shared understanding of 'urgent', being a single and clear point of contact, being immediately and directly available, and adopting a more holistic approach. However, even successful teams of this nature have been shown to be vulnerable if they remain outside the mainstream of service provision (Sheard and Cox, 1998). Changes of personnel, of funding arrangements or other variables throw such teams open to closure. Freeth (2001) noted that collaboration can be stretched to breaking point if it exists outside of the ordinary organisational framework. The relationship of flexible service to mainstream bureaucratic approaches remains a complex and fraught one with immense difficulties in adaptation (Challis et al., 1995; 2002c). It is nevertheless vital that successful projects are integrated in to the "broader system of care" (Sheard and Cox, 1998, p11; Challis, et al., 2002b) if they are to succeed in the long term.

3.2.5 Workforce issues

A number of studies over recent years have looked at the makeup of multi-disciplinary teams whilst comparing the results of their work with other team models. They have shown that there is a high degree of variability within the multi-disciplinary team model. The SSI (1997b) found that there was considerable variation between study sites across the country in relation to both the profession of staff represented in specialist community mental health teams for older people and the numbers of these staff represented in teams. Community psychiatric nurses ranged in number

from less than one full-time equivalent to over eight, whilst social workers ranged from less than one to seven. The range was smaller for approved social workers, being from less than one to two. A national report into the work of the community psychiatric nurse (Brooker and White, 1997) also found a large variation between the numbers of these staff found in different Health Trusts. They found that some had as few as three community mental health nurses compared with others with over 90. Brooker and White also noted that there appeared to be a reduction in the work of community psychiatric nurses with elderly service users (from 64% in 1990 to 34% in 1996) and an increase in their work with younger adults with severe mental health problems (from 17% in 1990 to 48% in 1996). In 2002 the Audit Commission found that approaching 80 per cent of specialist community mental health teams for older people had community psychiatric nurses, over 50 per cent had occupational therapists and just under 50 per cent had social workers. Approaching 40 per cent had consultant psychiatrists.

Another trend noted by a number of studies was the growth of part time staff in the primary health and social care sector. Onyett and colleagues (1994) noted that approximately 25 per cent of staff in community mental health teams, at that time, were part-time. Brooker and White (1997) found that 10 per cent of community psychiatric nurses studied in 1996 were working part-time. This wide variability has led to a situation where the impact of multidisciplinary working is difficult to assess.

3.3 Care process and practice

3.3.1 Assessment issues

Standardisation:
The NSFOP (Department of Health, 2001a) states that under the Single Assessment Process, all assessment domains must be completed with no assumptions made about what might or might not be important to a particular service user. This view is the result of research that has shown that the nature and extent of assessment domains covered has varied considerably depending to the profession of the assessor, resulting in both inequity of care provision and low capacity to generate standardised information (Stewart et al., 1999). Nocon and Qureshi (1996) commented that there was no recommended standard set of assessment tools before 1993 that reflected the objectives of the work of the personal social services. Both Challis and colleagues (1996) and Stewart and colleagues (1999) found that assessment documentation differed widely between social service departments with few assessment forms having been inspected to check for either reliability or validity. In particular, both Stewart's study and the SSI (1997b) found that assessments rarely addressed emotional and psychological needs. The SSI report noted "a pre-occupation with physical care…(resulting) in care plans, which did not specify the need for social work support or counseling (SSI, 1997b, p18). They also reported that many assessments were insufficiently thorough to ensure that users and carers would receive the most appropriate services. Stewart and colleagues (1999) response was to call for a more standardised approach to information collection in anticipation of increasing multi-disciplinary assessments and the potentially large number of different professionals involved in the care of older people.

Multi-disciplinary work:
Comprehensive needs led assessments for people with dementia require the input of a range of professionals in order to ensure that the full range of potential needs are appropriately addressed. The challenge for professionals is how to achieve this without the duplication of assessment which has been the experience of many service users and carers (SSI 1996; Audit Commission, 1997), resulting in both user dissatisfaction, and waste of resources (SSI, 1997a; Audit Commission, 2000). The NSFOP (Department of Health, 2001a) argues that the solution to this problem lies with the Single Assessment Process which hinges on the flow of information between professionals, in order to avoid duplication.

Clinical and social models:
One of the challenges for professionals and policy makers, charged with the task of developing a strong multi-disciplinary assessment model, is how to merge two quite different approaches, the social and the clinical, and produce a process which keeps the strengths of both. One of the concerns recently expressed by social service professionals working with older adults, is that with the development of the Care Trust model, the person-centred approach of social services to assessment (and other aspects of service provision) would be subsumed under a more favoured and more powerful medical model (Community Care, 2003). By contrast, Steiner's review (1997) of the literature on intermediate care, noted the move away from a medical approach by nurses in these services and towards a care and rehabilitation approach. One of the strengths of the clinical or medical model in the identification of need is the use of assessment scales. The use of standard scales during assessments has been shown to improve the quality of information gathered from identification to the measurement of the impact of treatment over time (Reilly et al., 2003b). The NSFOP (Department of Health, 2001a) stresses the importance of these tools, among a range of practices used in diagnosis. Recent guidance on the Single Assessment Process in England (Department of Health, 2002a) advised both social service departments and local NHS bodies to use assessment tools and scales to support rather than replace professional judgment and good practice during assessment. Stewart and colleagues (1999) also noted that the use of standardised assessment tools to identify impaired cognition "could significantly contribute to appropriate case identification by social care staff and enhance effective working between social services and old age psychiatry" (Stewart et al., 1999, p155). Reilly and colleagues (2003b) found that the vast majority of old age psychiatrists and the teams with which they were involved in England (96%) were using assessment scales as part of their assessments for older people with mental health problems in the community. In contrast, Moriarty and Webb (2000) found that questions designed for screening for cognitive impairment were only sometimes used in assessments by social workers.

The Single Assessment Process:
The development of the Single Assessment Process, recently formalised in the NSFOP (2001a), puts multi-disciplinary work at the heart of good service provision. The aims of the single assessment process are to raise the standard of assessments, ensure that assessments are proportionate to need, and to standardise practice across agencies and areas. It regards as a priority the establishment of good working relationships between primary health care and social services teams in order to operationalise this goal. The SSI commented that "the

most effective combinations of services resulted from skilled assessments where a variety of relevant professionals were involved" (1997b, p12).

Research findings from the 1990's right up to the publication of the NSFOP (Department of Health, 2001a) highlight the reason why these are important goals. In 1997 The Health Advisory Service found that routine multi-disciplinary care was patchy, that it was not being conducted as effectively as health authority and social services department commissioners intended, and that there was poor awareness of the need for multi-disciplinary assessment in some primary health care teams. Petch and colleagues (1996) found that 52 per cent of older people in their sample were reported to have received a specialist assessment by medical or nursing staff or staff in professions allied to medicine *in addition* to that completed by the practitioner in the social work department (Petch et al., 1996). Just under half the assessments in Moriarty and Webb's study (2000) of community services for older people with dementia were found to have involved consultation from another professional. In this study the most frequently involved professionals were old age psychiatrists and ward or day hospital nursing staff. One-third of the research sample carried out a 'joint assessment' where social services staff, other professionals involved and the person being assessed met together. This was most likely to happen when the social work team was hospital based, suggesting that shared setting facilitated joint working practices (Moriarty and Webb, 2000). Challis and colleagues (2001) also found limits to the range of professionals involved and the types of service user need identified that resulted in the practice of multi-disciplinary assessments. They noted that most authorities reported involving a health service colleague where assessment was for nursing home care. About three-fifths of authorities reported that this was usually the case for either residential or intensive domiciliary care. Weiner and colleagues (2002) noted that a quarter of local authorities in England involved health staff in the assessment of adult service users.

The Single Assessment Process and the Care Programme Approach:

In 1995 the Department of Health report *"Building Bridges"* pointed out that the principles underlying the Care Programme Approach (CPA) and care management were the same and that it was essential that health and social services co-ordinate the implementation of these processes in order to avoid both duplication and waste (Schneider, et al., 1999). Despite this the SSI (1997a), in their inspection of services for people with dementia, found that only 10 per cent of the cases sampled used the CPA. More recently, Hughes and colleagues (2001) noted that only four per cent of local authorities across the country reported that the CPA was "accorded a priority in the context of services to older people with dementia" (Hughes et al., 2001, p269). There has always been confusion around the similarities and differences of care management and the CPA (Burns and Leiborwitz, 1997) and with the introduction of the Single Assessment Process (SAP) for older people with mental health problems (Department of Health, 2001b) this confusion was initially compounded. Guidance from the Department of Health in both 1999 and 2001 advised that the principles of the CPA were relevant to older people with mental health problems. In 2002, however, Department of Health Guidance stated that older people with mental health problems should be dealt with under the SAP rather than the CPA framework. Recent guidance from the Department of Health has finally clarified the relationship between the SAP and the CPA in relation to older people with mental health problems. It states that the full implementation of the CPA should be restricted to

older people with schizophrenia or other psychoses. Others, including older people with dementia should be assessed under the SAP with the application of only "critical aspects" of the CPA (Department of Health, 2003).

3.3.2 Access issues

Access is a complex issue consisting of a number of different elements such as availability, quality, cost, and information, all of which might vary between population groups (Goddard and Smith, 2001). The level of need in a community cannot be simplistically equated with the level of service take-up. Rather it is related to the awareness of availability and usefulness of these services, which might vary amongst the community considerably, as a result of language or cultural differences (Moriarty and Webb, 2000; Goddard and Smith, 2001). If these differences could be reduced by action on the part of the agency, then in Goddard and Smith's views, they "may constitute legitimate components of access" (2001, p1151). In turn, 'availability' must be examined not just in terms of *what* is available but also *when* and *how appropriate* it is. A survey in 1995 of community mental health teams providing services for younger adults, found that less than one quarter of these teams provided access to their service users after office hours (Onyett, 1995). In relation to the appropriate nature of services, Mountain (1997) has pointed out that although community health and social care services are available to the frail elderly and to adults with mental health problems, they are not always available or appropriate for older people with mental health problems. In their inspection of eight social service department emergency duty teams in 1999, the SSI found that in only one could a social worker be accessed directly. Only one such team advertised their service, others deciding against this for fear of raising the expectations of the public (SSI, 1999b).

Eligibility criteria:
Concerns about the lack of consistency of assessments and services between local authorities were highlighted in a government White Paper in 1998 (Cm 4169). It was noted that lack of consistency resulted in someone with long-term care needs receiving a "high level care in their own home from social services and the NHS in one place, whereas in another they might have to go into residential or nursing home care" (Cm 4169, 1998, 2.27). In response to these findings the government announced a framework of Fair Access to Care Services (Department of Health, 2002b). The aim of this initiative is to improve the way in which local authority social services departments define and apply eligibility criteria for adult social care services and reduce inconsistencies within and between local authorities over the targeting and provision of services. This includes the requirement that eligibility criteria should be compatible with criteria for continuing health care, housing and other relevant services (Department of Health, 2002b)

Waiting lists:
Most local authorities were found to have major problems in managing the volume of their work according to the SSI (1997b). Moriarty and Webb (2000) found that metropolitan authorities coped better, in terms of response times, than other types of local authority. Their study found a mean interval of 19 days between referral and assessment with a range of one to 130 days. A similar study in Scotland found a range of 1 to 168 days and that 80 per cent of those measured were assessed within

a month of their referral (Petch, 1996). Weiner and colleagues (2002) found that care managers had less than 30 cases in almost one third of teams, 30-50 cases in half teams and over 50 cases per full-time worker in the remaining 18 per cent of teams. They note the benefits of small caseloads and continuity of care for older people with long–term care needs, as did Challis and Davies (1986) some years earlier. No research has been found that compared caseload size and mix with the length of time between referral and assessment.

Referral routes:
Referral routes offer a means of assessing the accessibility of a service. Services that accept referrals direct from the public representing a more accessible service than those that do not. A study by Sinclair and colleagues (1990) found that it was unusual for the public to get in touch with statutory services themselves. In contrast, a decade later, Moriarty and Webb (2000) found that almost one third of their sample had been referred to social services by a carer or relative. This study also found that unlike earlier research (Levin et al., 1994), many carers and relatives were much clearer about the professional background and title of their assessor rather than as 'someone from the council'. Information on referrals for all older people also showed that about half came from health sources, emphasising the importance of improving partnerships between health and social services (Moriarty and Webb, 2000). There has been concern amongst professionals regarding direct access to services by the public. It has been the view that this would lead to an increase in the amount of inappropriate referrals thereby delaying access to those in greatest need. A study by McDonald and colleagues (1994) however, found that referrals to a community based multidisciplinary psycho-geriatric service were no more inappropriate when channelled through an 'open access' route than when they were restricted to 'traditional' medical procedures (Baillion et al., 1996).

Equity of access for ethnic minorities:
In 1997 the report "At Home with Dementia" (SSI, 1997a) noted that the number of ethnic minority people with dementia was likely to increase as more people from these communities aged and that as this happens social service departments would face specific challenges "to develop and provide a range of services that will meet their individual needs in a way that is sensitive to their cultural traditions" (SSI, 1997a, p26). They noted that most social service departments had equal opportunity policies at this time but that staff familiarity with these varied considerably. In the same year, the SSI (1997b) noted that staff acknowledged a level of ignorance and inexperience about the process of working with and identifying appropriate services for ethnic minorities. Representatives from Indian and Bangladeshi communities reported that social services staff believed that these communities "looked after their own" (SSI, 1998, p31). The SSI urged social services departments to collect information on ethnic minorities and use this to shape future services (SSI, 1997a) whilst observing that currently such information was incomplete with workers having limited understanding of its purpose and significance (SSI, 1997b). A further SSI report in 1998 focusing on services for ethnic minorities noted that although efforts were being made to improve access, via translated leaflets, services remained of an ethnocentric nature, meaning that black elders continued to have difficulty in accessing appropriate care. They also pointed out that although the production of leaflets, translated into various community languages was valuable, they would, in themselves, not result in improved access unless they were combined with a

programme of effective communication (SSI, 1998). This view was reiterated in the NSFOP (2001a), which noted that information for ethnic minority elders that relies on translated leaflets or posters may not be effective. The 2001 census reported that 2.7 per cent of the ethnic minority population of the North West of England was from an ethnic minority. This small but growing population will have a number of distinct needs which long-term care services are required to address if they are to meet the standards laid down in the NSFOP (Department of Health, 2001).

3.4 Service outcomes

3.4.1 Person-centred care

One of the key principles of the NSFOP (Department of Health, 2001a) is that the service must be designed around individuals' needs and must put the service user at the centre of its model. Whilst a number of professional groups would claim to have traditionally operated a person-centred approach, albeit using a number of different terms to describe this process (Challis et al., 2004) research demonstrates that a gap has existed between theory and practice in this area. Person-centred care involves professionals transferring control to the service user. Despite statements of support for this practice, a number of researchers found that professionals, including social workers and primary health care workers, were unwilling or unable to undertake this transfer in practice (Ellis, 1993; Myers and McDonald, 1996; Hardiker and Baker, 1999; Lloyd, 2000; Richards, 2000; Worth, 2001; Kennedy, 2002). The NSFOP (2001a) produced a number of indicators to judge whether assessment upheld a person-centred approach. These include the notion of assessment proportionate to need, an absence of cultural bias, user participation, and the production of a detailed care plan. In all areas the findings from the literature suggest limited achievement (Ellis, 1993; Myers and McDonald, 1996; Hardiker and Baker, 1999; Lloyd, 2000; Richards, 2000; Worth, 2001; Kennedy, 2002). A number of studies identified contradictions between the ideal of person-centred care and the practice constraints of working within the framework of the community care reforms as the primary reason for the failure of practice to keep pace with theory, noting the fear that social workers had of raising users' expectations only to have them dashed when faced with inflexible eligibility criteria (Myers and Macdonald, 1996). Other studies identified professional culture as a significant factor in limiting effective person-centred care (Ellis, 1993, Barnes and Wistow, 1994). Professionals in these studies were regarded as 'blinkered' and unable to hear perspectives of service users that were different from their own.

3.4.2 Support for carers

Over one million people currently care for a person with dementia in England (Department of Health, 1997b). Whilst caring is recognised as a stressful role in itself, caring for someone with dementia is associated with particularly high levels of distress, taking many forms (Brodaty and Hadzi-Pavlovic 1990; George and Gwyther 1986; Huckle 1994; Schultz et al.,1990). Calls to address the needs of carers go back to the late 1940's (Sheldon 1948; Thompson 1949) and have been repeatedly articulated by UK governments since that time (Department of Health 1977; Cm 849 1989; Department of Health 1995). The Carers' (Recognition and Services) Act (1995) brought formal recognition for carers of both the importance of their work and

the need to provide support for them. The legislation required social services departments to offer carers an independent assessment and to take this assessment into account when planning care for the 'service user' (HAS, 1997). More recently the NSFOP (Department of Health, 2001a) has enshrined in policy the rights of carers of older people with mental health problems to information, advice and practical support, whilst current policy, in the form of the National Strategy for Carers (Department of Health, 1999), emphasises the need for services that impact on carers directly, to be improved.

Findings since the Carers Act of 1995 suggest that the support offered to carers over the last few years has fallen short of that envisaged by legislators. The SSI (1997a) found only a modest amount of work being done to support carers. Stewart and colleagues' analysis of assessment documentation found that carer's needs were either not mentioned at all or not in detail on many such documents (Stewart, et al., 1999). Moriarty and Webb (2000) noted that although sixty per cent of carers reported that their needs were considered when assessing the service user, no carer had received their own assessment. They also noted that despite campaigns to raise awareness of the needs of carers they found that some carers were not receiving adequate information to improve their understanding of dementia, increase their knowledge of service availability, or access other sources of help from national and local voluntary organisations.

An issue of continued debate is whether carers are best supported by services which address their needs directly or by those which are aimed primarily at the service user (Parker, 1999; Zarit et al., 1999). A number of studies that addressed this issue found that the receipt of community services provided for the cared for was significantly associated with reduced strain in the carers of confused older people (Levin et al., 1989; Parker 1993; Twigg and Atkin, 1994). In contrast, Woods and colleagues (2003) evaluated a model of carer support that is directed specifically at carers. The research compared carers of people with dementia in receipt of a service exclusively designed to support carers themselves (Admiral Nurse Service), with other carers of people with dementia, in receipt of more conventional support. Overall the findings suggested that the service had little additional impact, though carers in receipt of this service did have significantly reduced levels of insomnia and anxiety. The combination of an integrated and intensive care management approach to both carer and dementia sufferer was found to yield positive results for carer and service user alike (Challis et al., 2002a).

In relation to the impact of a multi-disciplinary approach on carers, one study prior to the Carers Act (Bland and Hudson, 1994) found that although there appeared to be a reduction in stress levels, for those caring for someone who did *not* have dementia, this was not the case for those caring for someone with dementia. In contrast, a study by Challis and colleagues (2002a) of service users in receipt of intensive case management from a community mental health service, found that carers of people with dementia did appear to benefit from this approach, which was characterised by long-term involvement with both service user and carer and a blurring of the purchaser provider divide. They note that carers often experience high levels of stress as shown by other studies (Gilleard et al; 1984, Levin et al., 1989; Burns and Rabin 2000) and that support to them is a crucial element of dementia care in the

community (Zarit et al., 1985; Levin et al., 1989 & 1994; Lieberman and Kramer, 1991).

The SSI (1997b) also considered the level of involvement of carers in service development work. They found that the majority of social service departments used service users and carers in the development of their charters and plans but tended to rely heavily on those users and carers involved in pressure groups or voluntary organisations. They noted that “little work [was] being done on behalf of the range of people receiving community care services” (SSI, 1997b, p23).

3.5 Conclusion

This review has highlighted a number of major themes identified in the literature regarding the development of good practice in care management services for older people with dementia. It demonstrates that the content and delivery of services for this group of people are dynamic with increasing levels of integration between health and social care, the development of assessment and care planning practices, and services to support carers. It also indicates areas of concern where development has been slow, for example in relation to access to services for ethnic minorities. These themes are addressed further in the findings of this research.

4. METHOD

The current study, which forms part of a larger research project mapping the nature of four types of services for people with dementia in the North West of England, was designed to identify professional community teams that had a specific focus on dementia care. These were defined as: teams that either provided an exclusive service, or those that had part of their service dedicated specifically, for older people with dementia and/or their informal carers (Audit Commission, 2000). A broad definition of dementia was adopted, which encapsulated both those formally diagnosed with dementia, and also those described as 'confused' by the service provider. It was not essential that service users had a diagnosis of dementia; what was important was 'the presenting pattern of need' (Spicker and Gordon, 1997, p49). There were two phases to the data collection.

4.1 Phase one: Data collection - Identification of services

Specialist dementia services were initially identified by means of a screening questionnaire sent to key personnel in the NHS Trusts, Health Authorities, Social Services Departments and voluntary organisations in the North West of England. Mailing lists were compiled using various sources including: local health authority directories, the Association of Directors of Social Services, contacts in inspection units and voluntary sector directories. Targeted respondents were asked to identify existing community teams on a short postal questionnaire. Information was also requested on: service users; whether or not the services were currently in existence or were at the planning stage (with secured funding); a brief service description and contact details.

The services identified in these processes were entered onto a Microsoft Access database and North West Dementia Centre staff checked for duplicate entries. The accuracy of the results was also checked by local health and social care professionals including those attending three local conferences on dementia care (around 200 local delegates*).* Adjustments to the database were made as required.

4.2 Phase two: Data collection - Description of specialist dementia services and standards of care

Service configuration, resources and patterns of service were ascertained by means of a postal questionnaire survey. This was developed through reviewing the relevant literature, in particular evidence about the most recent models of service provision and standards of care. A series of standards, or measures of quality, were developed to provide criteria by which services could be assessed. These were recorded under the four themes shown in Table 4.1. Quality issues were identified through the literature review which included government reports, and which identified key components of service provision and of factors likely to inhibit or encourage high standards. Questions were related to indicators of good practice on a range of themes to capture important constructs of the 'new culture of dementia care' (Kitwood and Benson, 1997). Data was collected within a conceptual framework to reflect the health service evaluation criteria of Donabedian (1980), namely, structure, process and outcome. 'Structure' refers to the resources used in the provision of care, 'process' refers to the activities that constitute care, and 'outcomes' are the

consequences of the care provided (Donabedian, 1980). Outcomes may be considered broadly as of two types. 'Intermediate outcomes' are a probable contribution to or correlate of well-being, such as receipt of a needed service, whereas 'final outcomes' represent the effect of care upon an individual, an effect valued in its own right, such as an improvement in well-being (Challis, 1981; Davies and Knapp, 1981). In the present study the outcomes were necessarily intermediate, reflecting the patterns of service output, for example ease of access to service by members of the public. Respondents were also asked for information relating to the organisational context: service type; availability; access; capacity; utilisation and whether or not they were aware of any gaps in local services for people with dementia. At the end of the questionnaire, respondents were invited to assess their level of confidence in the information provided as a check on the reliability of the data.

Data collection took place between 2001 and 2002. Each of the teams identified in the initial phase were sent the questionnaire (see Appendix A). A researcher contacted non-respondents by telephone; and an additional questionnaire was sent if required. This method proved particularly effective at increasing the response rate.

To ensure the data analysed were of good quality, returns that were deemed unreliable were excluded. These were:

- Respondents who indicated that they only felt confident answering a few of the questions;
- Respondents with missing data on one question central to the identification of the resource as providing specialist care for older people with dementia (question 4).

Fifty-two teams were included in the sample.

Table 4.1: Themes/standards of care measured

Service configuration and standard of care data [a]	Chapters					
	Summary page	Review page	Results		Discussion Box no.	Appendix Tables
			Section	Table		
Service structure						
Activity rates - number places/ attendees			38-40	5.5-5.8		
Integration of services	8	14-21	40-42	5.9-5.11	6.1	1-2
Funding / funding continuity [a]						
Management and staffing		21-22	42-45	5.12-5.17	6.2	19-20
Care process						
Assessment	8	22-25	45-47	5.18-5.20	6.3	3
Care plans	8		47-48	5.21		6
Rehabilitation potential (stimulating activities) [a]						
Equity of access to services for ethnic minorities	8	26-27	48	5.22-5.25		7
Service content						
Service specialism / targeted at people with dementia	8	13-14	51	5.26		8
Promotion of early intervention [a]						
Prevention [a]						
Equity of access to specialist input		25-26	52-3	5.29		9
Flexibility and around the clock services	8		53-54	5.30-5.32		10
Crisis response/ emergency access			54-5	5.33		
Independence - good practice & building design [a]						
Transport [a]						
Service quality						
Privacy [a]						
Individuality		27	55	5.34	6.4	11
Specialist dementia care training for staff			58	5.37		14
Carer involvement (& respite)		27	57	5.36		13
Care worker good practice	8		56	5.35		12
Quality assurance			58	5.38		15

[a] These standards were not measured in the survey of professional teams but were measured in relation to one or more of the other three surveys: day care; home care or residential care

4.3 Data analysis and categorisation

The measurement of each standard consisted of a combination of items of individual descriptive data (for example, total number of places) and composite variables (for example, flexibility). The latter were derived from multiple items judged by the researchers to reflect a standard more fully. Explanations of these are found within the results section. Each positively answered item was assigned one point and these were summed to compute a composite score within each standard. In order to reduce the chances of social desirability bias, the questionnaire was deliberately not structured according to each standard in turn. A scoring system was devised for the composite variables as a means of showing at a glance whether measures were met at a high or low level. Scores were derived from the number of variables in each composite. If a team achieved the highest possible score on a particular composite they were considered to have met 100 per cent of that measure and were therefore given a 'High' score. Although it is the norm to analyse data by inter-quartiles and to only award a high score to the top 25 per cent, it was decided to award this to the top 33 per cent in this research because of the relatively small sample size. High scores are therefore those achieving above 66 per cent of the possible maximum.

The results are designed to describe services provided by specialist community teams for people with dementia in the North West of England in terms of the standards outlined in Table 4.1. Comparisons are made throughout the report between multi-disciplinary and single discipline teams and these are reported alongside findings for the whole sample. Although there are some differences within these two groups, dividing them further, for example, into single discipline health and single discipline social care, multi-discipline health only and multi-discipline health and social care teams, resulted in very small numbers in some groups, making any statistical analysis and comparison invalid.

The two team types selected for this analysis: multi-disciplinary and single discipline, broadly represent the difference between traditional single profession teams and a newer model which is less bound by professional distinctions, and which current policies seek to promote. The current debate about quality of service provision for older people centres around the notion that an integrated service will provide better quality care compared with a service working within strict professional boundaries (e.g. Sheard and Cox, 1998). Comparing the standards of care between multi-disciplinary and single discipline teams distils this concept and will contribute evidence to the integration debate. Some differences, however, between multi-disciplinary and single discipline teams will undoubtedly be lost by this categorisation, in particular whether multi-disciplinary teams were made up solely of health professionals or of both health and social care workers, and whether single discipline teams were from the health or social care fields.

Four of the 22 local authorities in the North West of England were not represented in the research as they failed to return any questionnaires sent to them. One of these was a county authority and the other three were metropolitan districts.

Data was entered and analysed using SPSS version 10.1. Differences in the characteristics of team types were explored using descriptive statistics. Statistical comparisons on basic service characteristics were made by examining the

distribution of the data using chi square. Variations between service types on composite variables were summarised using mean values, and statistical comparisons were made using t-tests (Anova, or Mann Whitney U (MW) where the standard deviation was larger than half the mean). Grouping variables are usually shown in table columns for cross tabulations and in table rows when comparing means. The level of significance adopted was 0.05. Where the level of significance was less than 0.01 the exact statistic is listed. If the result was higher than this it is listed as ns. Composite mean scores are shown in the tables of the results section. A breakdown of these scores for each composite is placed in Appendix B. Missing data was recoded as negative where this assumption had face validity, for example, where there was no response to a question requiring a tick for a positive response. Where this assumption was not reasonable information was coded as missing and the valid response thereby reduced.

The construct validity of the composite measures was tested by comparing the scores of contrasting groups (Streiner and Norman, 1991). The internal reliability of the constructs was tested by using Cronbach's alpha calculations (Sonquist and Dunkelberg, 1977). The Alpha co-efficient ranges in value from 0 to 1, with a higher score indicating greater reliability. Nunally (1978) suggested that 0.7 was an acceptable cut-off, but lower thresholds have been used in the literature (Santos, 1999). Table 4.2 below shows the Alpha co-efficient for each of the composite variables used in the present study.

Table 4.2: Alpha scores

Composite measure	Number of items	Alpha score
Structural integration	3	.24
Practice level integration	7	.27
Assessment	7	.30
Care planning	4	.46
Equity of access for ethnic minorities	4	.16
Targeted service	4	.19
Access to specialist input	4	.23
Flexible service	3	.16
Individuality/person-centred care	5	.33
Management/care worker good practice	4	.45
Carers needs direct	4	.15
Carers needs	8	.01
Specialist training	2	.01

The low scores of some of the composites indicate a lack of correlation between the separate items within them. These composites nevertheless have validity as, although the possession of one indicator does not mean a team is more likely to possess one of the other indicators, the more indicators found within these composites will point towards a better quality of care.

5. RESULTS

5.1 Respondents and response rates

The final sample comprised 52 teams, a final response rate of 59 per cent, from an initial sample of 88. Table 5.1 shows the breakdown of the response rate by local authority. Nineteen teams did not respond. A further 14 were excluded because they either did not offer a service to people with dementia, were a head quarters address, were no longer functioning, or were a different type of service (for example, home care). A further three were excluded as they offered a specialist dementia service to younger people. Four local authorities are not included in the results as all the teams contacted in these authorities were non-respondents.

Table 5.1: Overall response rate and final sample by local authority

Local authority	Questionnaires sent*	Non returns	Returns	Exclusions	Final Sample		
	n	n	n	n	n	% of total 88	% of final 52
Cumbria	1	1	0	0	0	0	0
Bolton	4	3	1	0	1	1	2
Bury	1	0	1	0	1	1	2
Manchester	12	3	9	4	5	6	9
Oldham	2	0	2	1	1	1	2
Rochdale	2	0	2	0	2	2	4
Salford	5	1	4	1	3	3.4	6
Stockport	10	1	8	0	8	9	15
Tameside	3	1	2	1	1	1	2
Trafford	2	2	0	0	0	0	0
Wigan	3	1	2	0	2	2	4
Knowsley	2	2	0	0	0	0	0
Liverpool	6	1	5	1	4	5	7
Sefton	7	0	7	4	3	3.4	6
St Helens	1	1	0	0	0	0	0
Wirral	4	0	4	1	3	3.4	6
Cheshire	5	0	5	1	4	5	7
Halton	1	0	1	0	1	1	2
Warrington	4	0	5	1	3	3.4	6
Lancashire	10	2	8	0	8	9	15
Blackburn with Darwen	1	0	1	0	1	1	2
Blackpool	2	0	2	1	1	1	2
Total	88	19	69	17	52	59	100

*(excluding duplicates)

5.2 Structure

This section outlines the results of the study in relation to the structural characteristics of the sample: team type, location, activity patterns, levels of integration, and personnel.

There were 35 multi-disciplinary teams in the sample. Eighteen of these were staffed by health professionals only and 17 by both health and social care personnel. The remaining 17 teams consisted of 13 social care teams and 4 health care teams.

These groups can be seen in Table 5.2. Table 5.3 shows the four groups conflated into two: multi-disciplinary and single discipline. These two groups are used throughout the analysis.

Table 5.2: Types of teams represented in the sample

Team type	n	%
Single discipline social care	13	25
Single discipline health	4	8
Multi-disciplinary health only	18	35
Multi-disciplinary health and social care	17	33
Total	52	100

Source: Question 3: Which of the following best describes your team/service structure?

Table 5.3: Types of teams used in the study

Team type	n	%
All multi-disciplinary teams	35	67
Single discipline teams	17	33
Total	52	100

Source: Question 3: Which of the following best describes your team/service structure?

5.2.1 Team location

Eighty-six per cent of all teams were located in a specialist division, either an adult/old age mental health service (42%) or a specialist older person's service (44%). A statistically significant difference was found between team types in this respect with 97 per cent of multi-disciplinary teams compared with 65 per cent of the single discipline teams being found in one of these two specialist divisions (Table 5.4).

Table 5.4: Location of team in specialist or generic division

Division	All multi-disciplinary teams		Single discipline teams		Total	
	n	%	n	%	n	%
Specialist older persons	16	46	7	41	23	44
Mental health	18	51	4	24	22	42
Generic	1	3	6	35	7	14
Total	35	100	17	100	52	100

χ^2p .004

Source: Question 4: Is your team located within (one of the following)?

5.2.2 Activity rates

Approaching half of all teams in the sample stated that their referrals were rising with no difference found between team types (Table 5.5). Overall, people with dementia represented approximately 50 per cent of both new referrals and existing caseloads of these teams. As can be seen in Table 5.6, a greater proportion of new referrals to multi-disciplinary teams were people with dementia compared with single discipline teams (57% vs 39%, p=<.05). Multi-disciplinary teams also had a slightly higher

mean percentage of people with dementia on their existing caseloads (51%) than single discipline teams (45%) though this was not statistically significant (Table 5.7).

Table 5.5: Referral rate patterns

Referrals	All multi-disciplinary teams		Single discipline teams		Total	
	n	%	n	%	n	%
Stable	9	26	4	24	13	25
Rising	16	46	8	47	24	46
Fluctuating	10	29	5	29	15	29
Total	35	100	17	100	52	100

χ^2: ns

Source: Question 13: Is the referral pattern in your team currently stable, rising, fluctuating, other?

Table 5.6: Mean percentage of new referrals from people with dementia.

Team type	n	Mean	SD
All multi-disciplinary teams	35	57.5	29.46
Single discipline teams	17	39.0	29.33
Total	52	50.8	30.28

MW: p .<05

Source: Question 9: Please indicate the approximate number of (new referrals to your team) who are people with dementia?

Table 5.7: Mean percentage of people with dementia on team caseload

Team type	n	Mean	SD
All multi-disciplinary teams	35	51.4	32.62
Single discipline teams	17	45.0	29.46
Total	52	49.3	31.47

MW: ns

Source: Question 9: Please indicate the approximate number of (your team's caseload) who are people with dementia?

Respondents were asked to state the approximate percentage of the people with dementia on their team's caseload that were in receipt of services listed on the questionnaire. The results (Table 5.8) demonstrate that community teams working with people with dementia are by and large working with service users in the community. Only a minority (13%) were in residential care. No differences were found between team types.

Table 5.8: Percentage of people with dementia on team caseload who are in receipt of other services

Team type	Mean % (SD)	Day Care	Home Care	Hospital Respite Care	Residential Care
All multi-disciplinary teams (n=35)	Mean (SD)	35 (25.62)	57 (29.95)	3 (4.66)	13 (11.98)
Single discipline teams (n=17)	Mean (SD)	32 (26.08)	55 (28.07)	3 (5.79)	11 (12.61)
Total (n=52)	Mean (SD)	34 (25.55)	56 (29.09)	3 (5.00)	13 (12.11)
MW	P value	ns	ns	ns	ns

Source: Question 10: To the best of your knowledge what percentage of people with dementia on your team's caseload are currently in receipt of..?

5.2.3 Levels of integration

Integration was measured at both structural and practice levels and composite variables were created for these concepts. Multi-disciplinary teams had greater levels of integration between health and social care services than single discipline teams. Results were statistically significant at the structural level but not at the practice level. Details of these results are outlined below.

Structural level integration:
A composite variable measuring aspects of integration at a structural level was compiled using the responses from three individual variables which identified teams as either multi-disciplinary health and social care or not; whether they were formally linked to a primary health care practice or general practitioner; and whether they believed that their service could be said to have a 'fair' level of integration based on a five point scale. Thirty-one per cent of all teams were formally linked to a primary health care practice. This was the case in significantly more multi-disciplinary teams than single discipline teams, as seen in Table 5.9.

Table 5.9: Structural integration

Structural integration measures	Multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Multi-disciplinary health and social care team	17	49	0	0	17	33	<.001*
Formally linked to GP	15	43	1	6	16	31	.007*
A fair level of integration perceived	12	35	4	24	16	31	ns*
Composite score (max=3) [Mean (SD)]	.91 (.74)		.18 (.39)		.67 (.73)		<.001**

* χ^2 **Anova

Source: Question 3: Which of the following best describes your team/service structure?/ Question 43: Is your team formally linked to a named GP or Primary Care Team/Group? Question 40: For older people with dementia please indicate on the scale below what you perceive to be the current level of integration between health and social care across your service?

Practice level integration:

Seven variables made up the composite measuring integration at a practice level. The results of both the individual variables and the composite mean score can be found in Table 5.10. Ninety per cent of all teams used a standardised assessment process, whilst 75 per cent had attended a joint training course on dementia in the last twelve months. Twenty-three per cent shared a client database and 19 per cent shared a referral point. None of these results showed differences of statistical significance in relation to team types. There was a statistically significant finding in relation to training others. This was the case in 67 per cent of teams overall, 77 per cent of multi-disciplinary teams, and 44 per cent of single discipline teams. Sixty-five per cent of teams stated that they were in contact with other specialist dementia care services in their area. This result almost reached statistical significance with 74 per cent of multi-disciplinary teams and 47 per cent of single discipline teams responding positively to this question.

Table 5.10: Integration at practice level

Integration measures	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Standardised assessment process used	32	91	15	88	47	90	ns*
Standardised assessment process shared	21	66	4	27	25	53	.013
Joint training on dementia attended in last twelve months	24	71	14	82	38	75	ns*
Team members provide training to others	27	77	7	44	34	67	<.05*
Contact with local dementia services	26	74	8	47	34	65	.053*
Shared Client data base	9	26	3	18	12	23	ns*
Shared Point of Referral	6	17	4	24	10	19	ns*
Composite score (max=7) [Mean (SD)]	3.83 (.95)		3.53 (1.18)		3.73 (1.03)		ns*

* χ^2**Anova

Source: Question 5: Does your team share any of the following with any other service?/ Question 5: Does your team share any of the following with any other service?/ Question 20: Do any of your staff provide formal training in dementia to any of the following professionals and practitioners?/ Question 21: Do members of your team attend joint training sessions on dementia in older people with other professionals and practitioners outside your team?/ Question 26: Do you/your team use a standard assessment process in assessing an individual's needs?/ Question 41: Do you have contact with other specific dementia services in your area? If yes, please provide details?/ Question 25: Does your team have any formal links between care management and the Care Programme Approach as applied to older people with mental health problems?

Respondents were asked to name the local dementia services with which they were in contact. Coding was available for two entries. Of the thirty-four teams that stated that they had contact with other dementia teams, thirty gave details of these services. Twelve teams gave two examples. Table 5.11 below shows the results. Of the nine types of service mentioned by teams, the most often cited by all teams was the old age psychiatric service. There were just two services, specialist day centres and the Alzheimer's Society, where statistically significant differences were found between team types. In both cases multi-disciplinary teams cited these services more frequently than did single discipline teams.

Table 5.11: Local dementia services with which teams are in contact

Service	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Older person's psychiatric services/Memory clinic	5	22	6	86	11	37	ns
Specialist day care	8	35			8	27	<.05
Alzheimer Society/other voluntary organisation	8	35			8	27	<.05
Under 65s Mental Health service/Young onset dementia	3	13	2	29	5	17	ns
Social Services Team	2	9			2	7	ns
Respite service	1	4	1	14	2	7	ns
Carer service/Admiral nurses	2	9			2	7	ns
Another CMHT	2	9			2	7	ns
Other	1	4			1	4	ns

Source: Question 41: Do you have contact with other specific dementia services in your area?

5.2.4 Management and staffing

There were 704 staff in total (excluding managers) in the 52 teams with a mean number of 13 per team. Twenty-five per cent had less than eight team members whilst 25 per cent had more than 18. Qualified staff made up almost three quarters of the workforce of these teams (Table 5.12). There was no difference found between team types. Forty-seven per cent of qualified staff were nursing staff, 18 per cent were medical staff, and 35 per cent were social care staff. Table 5.13 shows the breakdown of staff by profession and their respective teams. Overall, the largest numbers of staff came from either the nursing or social work professions. Not surprisingly significant differences were found between team types in relation to the type of professional employed. Multi-disciplinary teams were dominated by non-medical health care staff (59%) whilst single discipline teams were dominated by social care staff (76%). Over a quarter (27%) of the staff of multi-disciplinary teams were medical staff whilst 14 per cent were social care staff (see Table 5.14).

Table 5.12: Percentage of qualified to total staff

Team type	n	Mean	SD
All multi-disciplinary teams	35	75	17.39
Single discipline teams	17	72	20.31
Total	52	74	18.24

Anova: p .ns

Source: Question 16: We are interested in how many staff your team employs.
In the table below please provide details of the total number of workers (whether full or part time) for each staff group.

Table 5.13: Professional groups represented in teams

Professional	All multi-disciplinary teams		Single discipline teams		Total teams		p value
	n	%	n	%	n	%	
CPN	28	80	2	12	30	58	<.001
Nursing assistant	29	83	1	6	30	58	<.001
Qualified SW/CM	17	49	13	76	30	58	<.056
OT	27	77	1	6	28	54	<.001
Old age psychiatrist	27	77			27	52	<.001
Non-consultant medic	23	66			23	44	<.001
Assistant OT	16	46			16	31	<.001
Unqualified SW/CM	3	9	10	59	13	25	<.001
Physiotherapist	11	31			11	21	.009
Community nurse	7	20	2	12	9	17	ns
Assistant physiotherapist	5	14			5	10	ns
Total teams	17	100	35	100	52	100	

Source: Question 16: We are interested in how many staff your team employs.
In the table below please provide details of the total number of workers (whether full or part time) for each staff group.

Table 5.14: Qualified staff groups represented in different teams as a proportion of total qualified staff

Team type		% of qualified health care staff (non-medical) to total staff	% of qualified medical staff to total qualified staff	% of qualified social care staff to total qualified staff
All multi-disciplinary teams (N=35)	Mean (SD)	59 (23.52)	27 (20.94)	14 (20.22)
Single discipline teams (N=17)	Mean (SD)	23 (43.72)	0 (0)	76 (43.72)
Total (N=52)	Mean (SD)	47 (35.37)	18 (21.23)	35 (41.67)
MW	P value	.002	<.001	<.001

Source: Question 16: We are interested in how many staff your team employs.
In the table below please provide details of the total number of workers (whether full or part time) for each staff group.

Ratios of qualified staff to workload:

By dividing the number of those qualified staff most likely to be case holders per team by the number of new referrals and by the total team caseload, the ratio of qualified staff to service users was estimated. This is shown in Table 5.15 and Table 5.16. The staff groups identified in this calculation were community psychiatric nurses, other community nurses, social workers, and occupational therapists. It is unlikely that other qualified (or unqualified) staff members would be key workers for service users. Table 5.15 indicates that for every two new referrals there was one qualified member of staff in the team and for every new referral of a person with dementia there was one qualified member of staff. The result was statistically significant with multi-disciplinary teams having two new referrals per qualified staff member compared with three new referrals in single discipline teams. Table 5.16 shows that for every twenty-eight cases on the current team caseload there was one

qualified member of staff. Though not statistically significant, multi-disciplinary teams had a slightly higher mean than single discipline teams. The results also show that there was one qualified worker to every sixteen people with dementia on the team's total caseload. There were no differences between team types on this measure. The proportion of this staff group that are full-time or part-time remains an unknown. If 20 per cent of these staff are said to be part-time then the ratio of qualified staff to total caseload falls to 1:34 and 1:19 for people with dementia.

Table 5.15: Ratio of qualified staff to total new referrals and new referrals of people with dementia

Team types		New workload	New workload people with dementia
Multi-disciplinary teams (n=31)	Mean (SD)	1:2 (1.23)	1:1(0.92)
Single discipline teams (n=14)	Mean (SD)	1:3 (1.46)	1:1 (1.12)
Total (n=45)	Mean (SD)	1:2 (1.36)	1:1 (0.93)
MW	p value	.014	ns

Source: Question 16: We are interested in how many staff your team employs.
In the table below please provide details of the total number of workers (whether full or part time) for each staff group; Question 9: We are interested in the amount and flow of your team's workload in the last week. a) Please indicate the approximate number of new referrals received by your teams last week. b) Please indicate the approximate number of these who are people with dementia. c) Please indicate the approximate number of your team's caseload last week. d) Please indicate the approximate number of these who are people with dementia.

Table 5.16: Ratio of qualified staff to total team caseload and team caseload of people with dementia

Team types		Total workload	Total workload people with dementia
All multi-disciplinary teams (n=30)	Mean (SD)	1:30 (22.29)	1:18 (14.83)
Other team type (n=14)	Mean (SD)	1:23 (12.84)	1:12 (9.59)
Total (n=44)	Mean (SD)	1:28 (19.94)	1:16 (13.59)
MW	p value	ns	ns

Source: Question 16: We are interested in how many staff your team employs.
In the table below please provide details of the total number of workers (whether full or part time) for each staff group; Question 9: We are interested in the amount and flow of your team's workload in the last week. a) Please indicate the approximate number of new referrals received by your teams last week. b) Please indicate the approximate number of these who are people with dementia. c) Please indicate the approximate number of your team's caseload last week. d) Please indicate the approximate number of these who are people with dementia.

Managers' professions

Thirty-one teams supplied information about the profession of their team manager. As can be seen in Table 5.17 below, 35 per cent of managers overall were social workers whilst 58 per cent were nurses. It was not surprising to find statistically significant differences between multi-disciplinary teams and single discipline teams on this measure. Seventy-seven per cent of multi-disciplinary teams were managed by a nurse, whilst 89 per cent of single discipline teams were managed by a social worker.

Table 5.17: Managers' professions (n=31)

Profession	All multi-disciplinary teams		Single discipline teams		Total	
	n	%	n	%	n	%
Social worker	3	14	8	89	11	35
Nurse	17	77	1	11	18	58
Other	1	4	0	0	1	3
Health and Social care managers	1	4	0	0	1	3
Total	22	100	9	100	31	100

MW: p=<.001

Source: Question 16: We are interested in how many staff your team employs…Managers (specify profession).

5.3 Process

This section describes a number of key processes of the service provided by the sample, in particular as they relate to assessment and care planning. It also considers the nature and extent of provision for ethnic minority communities in the form of culturally sensitive provision.

5.3.1 Assessment practices

Respondents were asked a series of questions in relation to their assessment practices (Table 5.18). The majority (86%) of teams had formal links between care management and the Care Programme Approach. Two-thirds of teams completed assessments on the majority of people with dementia that they came into contact with. Over half involved users and carers in assessments (58%) and the vast majority (90%) used a standardised assessment process. There were no differences between team types on these measures. Sixty-three per cent of teams stated that they carried out separate risk assessments, whilst sixty-nine per cent stated that they used standardised scales in their assessments. A significantly greater proportion of multi-disciplinary teams used standardised scales than single discipline teams (91% vs 23%, p = <.001).

Seven individual items were combined to form a composite measure of assessment practices. The result of this analysis showed that overall teams scored five out of a maximum possible score of seven with a statistically significant difference between team types, multi-disciplinary teams scoring more highly than single discipline teams (p= .010) (Table 5.18).

Table 5.18: Assessment practices

Assessment practice	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	ns
Formal links between CM and CPA	32	91	13	76	45	86	ns
81-100% *PWD full assessment	23	66	11	65	34	65	ns
Standardized assessment process	32	91	15	88	47	90	ns
Carer involved in assessment	20	57	10	59	30	58	ns
Service user involved in assessment	20	57	11	65	31	60	ns
Separate risk assessment	25	71	8	47	33	63	ns
Standardised scales	32	91	4	23	36	69	<.001
Assessment composite (max=7) [mean (SD)]	5.26 (1.12)		4.23 (1.60)		4.92 (1.37)		.010

(*PWD = people with dementia)

Source: Question 23: Does your team have any formal links between care management and the Care Programme Approach as applied to older people with mental health problems; Question 25: Approximately what percentage of people with dementia known to your team receive a full comprehensive assessment; Question 26: Do you/your team use a standard assessment process in assessing an individual's needs; Question 29a: Do service users participate in assessments; Question 29b: Do carers participate in assessments Question 30: Do you usually complete a separate risk assessment? Question 31: Does your team use any standardized scale as part of the assessment process for older people with mental health problems in the community?

Multi-disciplinary assessments:

Respondents were asked to name the professionals, other than themselves, who were most likely to be involved in a service users assessment, as a means of measuring the extent to which assessments might be called multi-disciplinary. A breakdown of these findings can be found in Appendix B Table 4. They show that the most often cited professional other than the key worker, was the old age psychiatrist (86%) and the community psychiatric nurse (86%), where the key worker was a social worker, and the social worker (79%) where the key worker was a nurse. The mean number of professional routinely involved in assessments of people with dementia was four. As would be expected, a slightly higher mean was found in single discipline teams but this was not statistically significant. Only five teams (10%) were found to involve less than two other professionals.

Ninety per cent of teams stated that they used a standard assessment process. Fifty-three per cent of these teams also stated that their standard assessment process was used by other professionals and disciplines involved in the assessment of a person with dementia. There was a finding of statistical significance in relation to this result with 27 per cent (n=4) of single discipline teams responding positively to this question compared to 66 per cent (n=21) of multi-disciplinary teams (p = .013) (Table 5.19).

Table 5.19: Standard assessment process used by more than one professional

Standard assessment process	Multi-disciplinary teams		Single Discipline Teams		Total	
	n	%	n	%	n	%
No	11	34	11	73	22	47
Yes	21	66	4	27	25	53
Total	32	100	15	100	47	100

χ^2: p = .013

Source: Question 26: Do you/your team use a standard assessment process in assessing an individual's needs; Question 26a: If yes and you are a multi-disciplinary team, is a standard assessment process used by all team members; Question 26b: If yes and you are a single discipline team, is the standard assessment process you use shared by other disciplines involved in an individual's assessment?

Assessment documents:

Respondents supplied details of the items specified on their assessment forms. These were grouped, by researchers, into four domains that together represent the information required to complete a comprehensive assessment. Out of a total of sixteen items listed, the mean score for all teams was nine, with no difference found between team types. Table 5.20 below shows the breakdown of items by domain. A full breakdown by individual item can be found in the Appendix B Table 5.

Table 5.20: Assessment domains completed

Team type		Functional domain (Max = 4)	Clinical domain (Max = 4)	Cognitive domain (Max = 3)	Social domain (Max = 5)	Total items (Max = 16)
All multi-disciplinary teams (n=35)	Mean (SD)	2.69 (1.367)	2.23 (1.11)	2.17 (1.01)	2.97 (1.62)	9.4 (4.09)
Single discipline teams (N=17)	Mean (SD)	2.59 (1.50)	2.12 (1.27)	1.88 (1.27)	3.00 (1.77)	9.5 (4.51)
Total (n=52)	Mean (SD)	2.65 (1.40)	2.19 (1.15)	2.08 (1.10)	2.98 (1.65)	9.4 (4.17)

Anova = ns

Source: Question 29: Does your assessment form specify the following?

5.3.2 Care planning

Care planning encompasses practice that follows from assessment and is measured here by the production of a care plan and the involvement of different stake holders in reviews. Care plans were produced in 96 per cent of cases following assessment with no significant differences between team types. Perhaps not surprisingly, staff were reported as participating in reviews in almost all cases (94%). Respondents stated that carers were routinely invited to reviews in ninety-two per cent of cases whilst in fifty-six per cent of teams, planned reviews usually took the form of meetings (Table 5.21). This was the case in 74 per cent of multi-disciplinary teams compared with 18 per cent of single discipline teams (p=<.001). A composite variable measuring good practice in care planning was created using these four measures. The mean result from this was 2.4 for all teams. There was a statistically significant difference between team types with multi-disciplinary teams having a mean of 2.8 and single discipline teams a mean of 2.3 (p =.021). A full breakdown of these results is found in Appendix B Table 6.

Table 5.21: Care planning

Care planning practice	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Care plan always	34	97	16	94	50	96	ns*
Staff participate in reviews	33	94	16	94	49	94	ns*
Planned reviews usually meetings	26	74	3X	18	29	56	<.001*
Carers routinely invited to reviews	33	94	15	88	48	92	ns*
Care planning composite (max=4) [mean (SD)]	2.63 (0.69)		2.00 (0.71)		2.42 (0.75)		.004**

* χ^2 **Anova

Source: Question 32: Do you make a care plan for each service user as a result of an assessment; Question 35: Do you're your staff participate in planned reviews of each service user; Question 35a: Do your staff participate in planned reviews of each service user? If yes, how is this review most frequently conducted; Question 35c: Do you routinely invite carers to reviews?

5.3.3 Equity of access for ethnic minorities

Respondents were asked to state how many ethnic minority elders were on their team's caseload. The mean figure overall was 3 per cent (Table 5.22). Thirty-seven per cent of the sample (19) had no people from ethnic minorities on their caseloads whilst 12 per cent (6) had between 10 and 20 per cent. In terms of special provision for ethnic minority service users and carers, 63 per cent of teams stated that they had access to an interpreter whilst 39 per cent stated that leaflets were translated into appropriate community languages. There was a statistically significant difference between team types on the latter measure with many more single discipline teams than multi-disciplinary teams responding positively (p =.001). When a composite variable measuring equity of access for ethnic minorities was produced from the two individual measures outlined above plus an option to include another service, and whether one per cent or more of the team's caseload were from an ethnic minority, the overall result was a mean of 2 out of a maximum of four (Table 5.23). There was a statistically significant difference between types of teams with single discipline teams scoring more highly on this measure.

Table 5.22: Percentage of caseload from ethnic minority groups

Team type	n	Mean	SD
All multi-disciplinary teams	35	3.1	4.62
Single discipline teams	17	3.8	5.04
Total	52	3.3	4.72

MW: p = ns

Source: Question 11: What percentage of **all** your current service users have the following ethnic origin?

Table 5.23: Services available to ethnic minorities

Variables	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
1% or more ethnic minority service users	21	60	11	65	32	61	ns
Interpreter available	20	57	13	76	33	63	ns
Translated leaflets	8	23	12	71	20	39	.001
Other service	8	23	4	23	12	23	ns
Ethnic minorities Composite (max=4) [mean (SD)]	1.63 (1.06)		2.35 (0.70)		1.86 (1.01)		.013

Source: Question 7: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups…?

Further analysis on the two main service initiatives for ethnic minorities, translated leaflets and interpreters, showed that only fourteen per cent of multi-disciplinary teams compared with 53 per cent of single discipline teams were found to offer either one or both of these services, (Table 5.24). When single discipline teams were looked at more closely, all nine (100%) offering these amenities were found to be social services teams. Of the five multi-disciplinary teams that reported to offer this type of service, three were health and social care teams and two were health only teams. Thus 12 (86%) of the 14 teams offering some level of culturally sensitive service were either social service teams or teams with a social services input. Only two (5%) of the thirty-eight health care teams in the sample offered any degree of cultural sensitivity as measured by these two variables.

Table 5.24: Teams offering a culturally sensitive service

All multi-disciplinary teams (n=35)		Other team type (n=17)		Total (n=52)	
n	%	n	%	n	%
5	14	9	53	14	27

χ^2 p = .003

Source: Question 7: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups…?

Table 5.25 shows the geographic location of the more culturally sensitive teams and the percentage of the populations of these local authorities that are from ethnic minority groups and are aged over 65 years (Census, 2001). Nine local authorities had above average (2.7%) ethnic minority populations over the age of 65 for the North West of England. Of these, four (44%) had at least some teams offering a service with a degree of cultural sensitivity to these populations (in the form of translated leaflets and/or the availability of an interpreter service). Only two local authorities achieved a high score (above 66%) on the composite measure, of which one (Oldham) has a higher than average ethnic minority population. However, it is not possible to generalise from this data due to the small number of teams representing individual local authorities in the sample and the less than full geographical coverage of the teams.

Table 5.25: Local authority ethnic minority population size and teams offering a culturally sensitive service

Local authority	Number of teams in the study	% Ethnic minority population over 65 (Census, 2001)**	Teams with at least 1% ethnic minority service users	Teams offering interpreter &/or translated leaflets	Composite Mean (SD)	*Score (Based on composite measure)
Cumbria	0	0.9		0	0	
Bolton	1	5.0	1	0	2 (0)	L
Bury	1	3.5	1	0	1 (0)	L
Manchester	5	9.2	4	1	2.2 (.84)	L
Oldham	1	5.4	**4**	1	3 (0)	**H**
Rochdale	2	5.3	2	1	2.5 (2.12)	L
Salford	3	2.3	**3**	1	2.7 (.58)	**H**
Stockport	9	2.6	5	5	2.3 (.71)	L
Tameside	1	3.6	1	0	2 (0)	L
Trafford		4.5		0		
Wigan	2	1.0	2	1	3 (0)	L
Knowsley		1.3		0		
Liverpool	4	3.2	1	2	1.7 (1.26)	L
Sefton	3	1.3	1	0	1.3 (.58)	L
St.Helens		0.9		0		
Wirral	3	1.4	2	0	1.3 (.58)	L
Cheshire	4	1.5	2	0	1.5 (.58)	L
Halton UA	1	1.0	1	0	1 (0)	L
Warrington UA	2	1.4	1	0	1.5 (.71)	L
Lancashire	8	2.3	4	2	1.5 (1.41)	L
Blackburn with Darwen UA	1	7.1		0	1 (0)	
Blackpool UA	1	1.2		0	0	L
Total	52	2.7		14	1.9 1.01)	L

*H score = top 33% of composite score (2.7 and above from a maximum of 4)
**Excludes Irish

5.4 Content

In this section the extent to which the teams provide specialist services are considered as well as how accessible these services are.

5.4.1 *Targeting*

One of the key themes running through the research has been the extent to which services that state that they provide a service to people with dementia are targeted at this group of people. How much of a team's caseload, for example, consisted of people with dementia? What percentage of people with dementia received a full assessment once they had made contact with the team? Was the team located within a specialist older person's and/or mental health division? Overall 86 per cent of teams were located within a specialist division whilst over 60 per cent fulfilled the three remaining measures. There were statistically significant differences between team types on two of these variables with multi-disciplinary teams scoring more highly than single disciplinary teams on both of these. Seventy-seven per cent of the former had over 40 per cent people with dementia on their team's caseload compared with 41 per cent of single discipline teams (p = .011). In relation to team

location, almost all (97%) of the multi-disciplinary teams were located in a specialist division compared with 65 per cent of single discipline teams (p =< .001). A composite variable was compiled, using these separate items, in order to measure this standard. The results alongside those for the individual measures can be seen in Table 5.26. The overall mean score was 2.8 out of a maximum of four with minimal differences between team types.

Table 5.26: Targeting service for people with dementia

Targeting measures	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Specialist division	34	97	11	65	45	86	.001
40% or more new referrals *PWD	27	77	7	41	34	65	.011
40% or more caseload *PWD	23	66	9	53	32	62	ns
81-100% *PWD are assessed	23	66	11	65	34	65	ns
Targeted service composite (Max=4) [mean (SD)]	3.06 (0.99)		2.23 (1.44)		2.79 (1.21)		.045

(*PWD = people with dementia)

Source: Question 4: Is your team located within. Question 9: We are interested in the amount and flow of your team's workload in the last week. a) Please indicate the approximate number of new referrals received by your teams last week. b) Please indicate the approximate number of these who are people with dementia. c) Please indicate the approximate number of your team's caseload last week. d) Please indicate the approximate number of these who are people with dementia; Question 25: Approximately what percentage of people with dementia known to your team receive a full comprehensive assessment?

5.4.2 Early intervention: Staff provision of training to others

Early intervention was measured by whether teams offered dementia care training to other care workers and/or carers. Overall 65 per cent of teams provided training to others. This was the case in 77 per cent of multi-disciplinary teams and 41 per cent of single discipline teams (Table 5.27). Table 5.28 details to whom training was supplied. The most common group to be offered training were carers (50%), followed by residential care staff, where there was a finding of statistical significance, with more multi-disciplinary teams offering training to this group of staff than single discipline teams (51% vs 18%, p = .020). Social Services and primary health care staff were offered training by 35 per cent and 29 per cent of these teams, respectively.

Table 5.27: Teams provide training to others

Team type	n	%
Multi-disciplinary teams	35	77
Single discipline teams	17	41
Total	52	65

MW: p = .011

Source: Question 20: Do any of your staff provide formal training in dementia to any of the following professionals and practitioners?

Table 5.28: Groups for whom training is provided

Group	All multi-disciplinary teams		Single discipline teams		Total		P value
	n	%	n	%	n	%	
Carers	20	57	6	35	26	50	ns
Residential care staff	18	51	3	18	21	40	.020
Social Service staff	15	43	3	18	18	35	.073
Primary health staff	13	37	2	12	15	29	.053
Others	4	11	1	6	5	10	ns
CMHT staff	3	9	2	12	5	10	ns
Total	35	100	17	100	52	100	

Source: Question 20: Do any of your staff provide formal training in dementia to any of the following professionals and practitioners?

5.4.3 Equity of access to specialist input

The level of access to specialist input was measured by combining four variables each indicating an aspect of access. Two assessment measures along with two measures indicating public accessibility were used. The assessment measures used relate to the percentage of people with dementia who are fully assessed by the teams and consequently are also indicators of access. The results of these measures together with the mean score for the composite measure can be seen in Table 5.29. Eighty-one per cent of teams provided leaflets about their service to the public. Forty-eight per cent of all teams had at least some referrals from the public. Less than one third had over 10 per cent of referrals from the public. The mean figure for the composite measure on access was 2.7 with no difference between team types.

Table 5.29: Equity of access to specialist input

Specialist input measures	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Leaflets to public	26	74	16	94	42	81	ns*
Referrals from public greater than1%	16	46	9	53	25	48	ns*
81-100% people with dementia are assessed	23	66	11	65	34	65	Ns*
Assessment form completed on all people with dementia	31	89	9	53	40	77	.004*
Access composite (Max =4) [mean (SD)]	2.74 (1.01)		2.65 (0.99)		2.71 (0.99)		ns**

* χ^2 **Anova

Source: Question 6: Does your team have any of the following which are available to users/carers of your service; Question 8: Please indicate the approximate percentage of your referrals that come from; Question 20: Do any of your staff provide formal training in dementia to any of the following professionals and practitioners; Question 28**:** Do you complete an assessment form on all people with dementia once they have been referred to your team?

5.4.4 Flexibility and crisis response

Service flexibility was measured by whether teams could be contacted in an emergency outside normal office hours, whether they had operated a waiting list in the last twelve months and whether they offered a time limited service to people with dementia or not. The results of these individual measures along with the composite measure that combined them, can be seen in Table 5.30. Overall, 83 per cent of teams offered an open ended service, 46 per cent had not operated a waiting list in the last year and 31 per cent could be contacted out or hours in the case of an emergency. Differences between team types were not significant. The mean score for all teams on the composite measure of flexibility was just below one from a maximum possible score of three.

Table 5.30: Flexibility

Nature of service	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Not time limited service	30	86	13	76	43	83	ns*
No waiting list	19	54	5	29	24	46	ns*
Emergency access available	9	26	7	41	16	31	ns*
Flexibility composite (max =3) [mean (SD)]	.94 (0.80)		.94 (0.89)		.94 (0.83)		ns**

* χ^2**Anova

Source: Question 12: Does your team usually offer a time limited service to people with dementia (e.g. short term intervention only); Question 14: Within the last 12 months have you had cause to operate a waiting list; Question 15: Can your team be accessed in the case of an emergency outside of your normal 'office' hours?

Table 5.31 shows the most common reason for closing a case for those teams that offered an open-ended service. As can be seen, by far the most common reason was that the person with dementia was entering residential care (41%). A stable care package was the reason in 27 per cent of cases. No significant differences were found between types of team.

Table 5.31: Most common reason for closing a case of person with dementia for teams offering a long-term service (n=41, 11 non-respondents)

Reason	n	%
Residential care	17	41
Stable care package	11	27
Referred to other agencies	6	15
Assessment complete	2	5
Death	2	5
Needs based	1	2
Other	2	5
Total	41	100

Source: Question 12a: what is the one most common reason in your team for closing a case of someone with dementia? (e.g. admitted to residential care/ referred to other agencies.

Table 5.32 shows the length of wait between referral and assessment in those teams operating a waiting list. Of the 26 teams who responded, nearly 90 per cent stated that the wait was greater than two weeks.

Table 5.32: Length of wait between referral and assessment (n=26, 26 non-respondents)

Time	n	%
1 week	3	12
2-4 weeks	18	69
Over one month	5	19
Total	26	100

Source: Question14a: currently, how long on average does a person with dementia have to wait before an assessment begins?

Of the 16 teams that reported that they were accessible in an emergency, outside normal office hours, 14 gave details of the nature of this access. As can be seen in Table 5.33, direct access to staff members was only available in three teams. Approaching half the teams (43%) provided an answer phone service for these circumstances. Arrangements for out of hours emergencies in two-thirds of the teams stating that they could not be accessed themselves, were in the form of the NHS accident and emergency department or the social services emergency duty team.

Table 5.33: Types of access or alternative arrangements (7 non-respondents)

Type of out of hours access available	(n =14)	%
Telephone service to staff	3	21
Telephone answering service	1	7
Answer phone	6	43
Other	4	28
Total	14	100
Out of hours arrangements when team cannot be accessed	n (n=31)	%
SSD emergency duty team	10	32
NHS accident and emergency	9	29
Other	12	39
Total	31	100

Source: Questions 15a and 15b: If yes, is this via …? If no, what arrangements are there for out of hours access…?

5.5 Service quality

The final section within the results chapter outlines the nature and extent of person-centred care as an overarching theme of quality: what is the level of service user and carer involvement in the team's practices? It also describes the extent to which work practices that are recognised to encourage good practice at the care interface are features of the team's work, the level of staff training in dementia care and the nature of recent service evaluation.

5.5.1 Individuality

The extent to which a team offered an individualised or person-centred service was measured by a number of separate indicators that were again combined to create a measure of good practice in this area. Both the individual measures and the mean composite score can be found in Table 5.34. Sixty per cent of teams stated that service users participated in their assessments. Eighty-six per cent stated that seeking consent to share information about a service user's assessment with other professional and /or carers was part of their team's policy. Two-thirds of the sample reached the median score (3) on the social/environmental assessment domain, and one third had evaluation questionnaires about their service, for the public. No statistically significant differences were found between team types. The overall mean score for the composite measure was 3.3, out of maximum possible score of 5.

Table 5.34: Individuality

Individuality measures	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	N	%	
Service users participate in assessments	20	57	11	65	31	60	ns*
Seeking user consent	31	89	14	82	45	86	ns*
Leaflets to public	26	74	16	94	42	81	ns *
Evaluation questionnaires	13	37	3	18	16	31	ns*
Social domain score 3 or more	23	66	12	71	35	67	ns*
Individuality composite (max=5) [mean (SD)]	3.2 (1.19)		3.3 (0.98)		3.3 (1.12)		ns**

* χ^2 **Anova

Source: Question 29b: Do carers participate in assessments? /Question 33: Is seeking consent from the service user to share information about them with either carers or other professional's part of the team's operational policy? / Question 6: Does your team have any of the following which are available to users/carers of your service? / Question 29: Does your assessment form specify the following?

5.5.2 Care worker good practice

Care worker good practice was indicated by a composite variable made up of four separate variables that individually measured management practices that supported care worker good practice. These included aspects of staff training, regular team meetings, and staff involvement in reviews. Regular team meetings were held in 56 per cent of teams, whilst in 58 per cent of teams at least one non-professional member of staff had attended training in dementia care, or was working towards one. This was the case in significantly more multi-disciplinary teams (69%) than single discipline teams (35%) (anova p = .023). Seventy-three per cent of teams had attended joint training sessions with other professionals in the last year, whilst, as already stated, almost all teams (94%) involved their staff in reviews of service users (Table 5.35). The composite mean score for this measure was of almost three with no statistically significant differences found between team types.

Table 5.35: Care worker good practice

Practice	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Regular team meetings held	20	57	9	53	29	56	ns*
Team attended joint training	24	69	14	82	38	73	ns*
Non professional staff attended training in dementia care	24	69	6	35	30	58	.023*
Staff regularly participate in reviews	33	94	16	94	49	94	ns*
Care worker good practice composite (max=4) [mean (SD)]	2.88 (1.10)		2.65 (0.99)		2.81 (1.07)		ns**

* χ^2**Anova

Source: Question 22: How many of your non-professional staff have or are working towards formal qualifications which include caring for people with dementia? (NVQ level 2 equivalent or above). / Question 19: Do you have regular team meetings? /: Question 35: Do your staff participate in planned reviews of each service user? / Question 21: Do members of your team attend joint training sessions on dementia in older people with other professionals and practitioners outside your team?)

5.5.3 Carer involvement

Carer involvement and support were measured by eight individual variables which were combined into a composite measure of good practice in carer support (Table 5.36). Four questions produced data about direct support offered to carers, a further three indicated the level of involvement of carers in service users' care, and finally, one further question elicited information about the level of carer involvement in service development work. Overall, 77 per cent of teams stated that they had formal arrangements for supporting carers whilst 56 per cent offered carers their own assessments. Although this finding was not statistically significant, this was an unusual finding, showing more single discipline (71%) than multi-disciplinary teams (49%) provided this service. Thirty-three per cent of all teams provided carers with their own care plans, and 75 per cent stated that they routinely reviewed carers needs. Fifty-eight per cent of teams involved carers in service users assessments, 92 per cent routinely invited carers to service users reviews, and 86 per cent stated that they formally requested feedback from carers at service users reviews. Finally, 44 per cent stated that carers were involved in development forums with team members both within and across different agencies. This was the only factor that produced a statistically significant difference between types of team on this standard. Sixty-three per cent of multi-disciplinary teams compared with 6 per cent of single discipline teams responded positively to this question (Anova p =.001). The overall composite score was just over five out of a maximum possible score of eight for all teams.

Table 5.36: Carer involvement

Type of service	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Formal arrangements	29	83	11	65	40	77	ns*
In receipt of own assessment	17	49	12	71	29	56	ns*
Own care plan	12	34	5	29	17	33	ns*
Routinely reviewed	27	77	12	71	39	75	ns*
Involved in users assessment	20	57	10	59	30	58	ns*
Routinely invited to service users reviews	33	94	15	88	48	92	ns*
Feedback formally requested	30	86	15	88	45	86	ns*
Involved in development	22	63	1	6	23	44	<.001*
Carer composite (max=8) [mean (SD)	5.43 (1.14)		4.76 (1.35)		5.21 (1.24)		.070**

* χ^2 **Anova

Source: Question 36: Do you have any formal arrangements or resources for providing support for close relatives/friends of users with dementia? /37: Do carers usually receive a separate assessment by your team? /Question 38: Do carers receive their own care plan? / Question 39: Are carers needs routinely reviewed by your team? / Question 29b: Do carers participate in assessments? / Question 35c:Do you routinely invite carers to reviews? / Question 35d: Do you formally request feedback from carers at reviews? / Question 45: Are you involved in any forums where service development is discussed? If yes, are carers involved?

5.5.4 Specialist training

Two separate variables were combined to form a measure of good practice in relation to specialist training in dementia care. Both these measures, joint training sessions and non-professional staff who had attended training in dementia care, have been reported in other sections but they are listed here again together with the results of the standard (Table 5.37). The mean score for all teams was 1.3 out of a maximum of two.

Table 5.37: Specialist training

Type of training	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Team attended joint training	24	69	14	82	38	73	ns*
Non professional staff attended training in dementia care	24	69	6	35	30	58	.023*
Specialist training composite (max=2) [mean (SD)]	1.37 (0.69)		1.18 (0.63)		1.31 (0.67)		ns**

* χ^2 **Anova

Source: Question 21: Do members of your team attend joint training sessions on dementia in older people with other professionals and practitioners outside your team? / Question 22: How many of your non-professional staff have or are working towards formal qualifications which include caring for people with dementia? (NVQ level 2 equivalent or above).

5.5.5 Quality assurance

Quality assurance was measured by whether teams had evaluation questionnaires, whether they were involved in team and service development work and whether they had been evaluated in the last twelve months. As noted earlier, 31 per cent of teams had evaluation questionnaires. Eighty-one per cent stated that team members were involved in service development forums. Just over half of the sample (52%) stated that they put time aside as a team for service development work, such as team building days. Finally, 61 per cent stated that they had undergone a service evaluation in the last year. A significantly greater proportion of multi-disciplinary teams had undergone service development (63% vs 29%, p=.024) and had had their service evaluated in the preceding year (71% vs 41%, p =.035) (Table 5.38). A quality assurance composite was formed by combining these four measures. Multi-disciplinary teams scored more highly than single discipline teams (2.6 vs 1.6, p =.003).

Table 5.38: Quality assurance

Practice	All multi-disciplinary teams		Single discipline teams		Total		p value
	n	%	n	%	n	%	
Evaluation questionnaires	13	37	3	18	16	31	Ns*
Team involved in development forums	30	86	12	771	42	81	Ns*
Team involved in service development work	22	63	5	29	27	52	.024*
Service evaluated in last 12 months	25	71	7	41	32	61	.035*
Quality composite (max=4) [mean (SD)]	2.6 (0.98)		1.6 (1.17)		2.2 (1.13)		.003**

* χ^2 **Anova

Source: Question 6 Does your team have evaluation/satisfaction questionnaires which are available to users/carers of your service? Question 45**:** Are you involved in any forums where service development is discussed? Question 46: Is team time/resources put aside for service development work? Question 47: Has your service undergone any service evaluation, monitoring or auditing in the last year?

6. CONCLUSION AND DISCUSSION

This research has examined, via a postal questionnaire, the work of professional community teams providing services for people with dementia in the North West of England. The findings are based on fifty-two such teams, from an original target group of eighty-eight. The relatively high response rate achieved (59%) suggests that the results are representative of the whole of the North West of England, although it is clear that many more teams exist than we were able to contact.

The population aged over 65 years living in the North West of England represents 14 per cent of the population of England aged over 65 (Census, 2001). The North West of England has a similar age group percentage breakdown to England as a whole with 28 per cent aged between 65 and 69, 25 per cent between 70 and 74, 21 per cent between 75 and 79, 14 per cent between 80 and 84, 8 per cent between 85 and 90 and four per cent being over the age of 90. The 22 local authorities in the North West of England represent 19 per cent of England's local authorities outside London that provide social care services (Local Government Association, 2001). The standards measured are of importance to the whole country.

Although there are undoubtedly some gaps in the information and some limitations in the methodology – a reliance on team managers for data, a relatively small sample, and a focus only on the more quantifiable – the study presents a useful starting point for further research.

The key findings of the research are discussed below in relation to:

- Quality measures in overall service provision
- Differences between multi-disciplinary and single discipline teams

Findings are related to, and compared with, other recent research and policy initiatives in order to assess their position in this wider context. Finally, observations are made in the light of the direction of current social policy which requires the development of an integrated, person-centred service for older people with dementia within the community.

6.1 Overall results

Table 6.1 below summarises the overall findings of the research, using the composite measures designed to capture several elements of a particular standard, together with the high / low scoring tool identified in the methods section (high score= 67% or more of composite measure achieved). Although the detailed analysis showed that improvement was still required, teams nevertheless provided high quality assessments and good support to carers, whilst their policies and procedures resulted in a high degree of access to specialist services. Management practices that supported care worker good practice, such as training and holding regular team meetings, also scored highly. However, on many other measures the outcomes were less positive. Structural and practice level integration, care planning, services to ethnic minorities, person-centred care, specialist training, flexibility, and quality assurance, all achieved low scores. These scores were particularly low (below 33% of composite measure achieved) for structural level integration and flexibility.

Table 6.1: High and low scoring variables for all teams

Composite Variables	Items in variable	Mean	SD	Score
Structural level integration	3	0.7	.73	L
Practical level integration	6	3.7	1.03	L
Assessment	7	4.9	1.37	H
Care planning	4	2.4	.75	L
Ethnic minorities	3	1.9	1.01	L
Targeted service	4	2.8	1.21	H
Equity of access to specialist service	4	2.7	.99	H
Flexibility	3	0.9	.83	L
Individuality	5	3.2	1.12	L
Care worker good practice	4	2.8	1.07	H
Carer involvement	7	5.2	1.24	H
Specialist training	2	1.3	.67	L
Quality	4	2.2	1.13	L

6.1.1 Team location

In 1997 the SSI (Department of Health, 1997a) found that in most of the local authorities they investigated, older people with dementia were dependent on generic services. Weiner and colleagues (2002) found that 44 per cent of local authority care management services to older people were provided through generic adult teams. In this study, 86 per cent of the fifty-two teams were located in a specialist division, roughly equally split between mental health and specialist older people's service divisions (42% and 44% respectively). Thus specialist teams for people with dementia appeared to be located under specialist management.

6.1.2 Capacity

Fifty per cent of the new referrals and existing caseloads of the whole sample were made up of people with dementia. These figures are explored further below in relation to targeting and to staffing levels.

6.1.3 Integrated service

Research findings (e.g. O'Neill-Byrne & Browning, 1996), expert commentators (e.g. Anderson, 2001), and policy documents (e.g. Department of Health, 2001) largely agree that there is a need for integrated health and social care services, jointly commissioned and managed, as these are likely to provide a better service for the public. In this research, integration has been measured at both a structural and practice level. Overall, a mixed picture emerged from the sample in relation to levels and patterns of service integration. Some of the practice level aspects measured were found in the majority of teams, for example, standard assessment processes (90%) and joint training sessions (75%), whilst others were found only to a limited extent, for example, shared service user databases (19%) and referral points (23%). These findings, nevertheless, suggest a greater degree of integration within and across these teams than that found by Schneider and colleagues in their analysis of services for younger adults with severe mental health problems (1999), a similar degree of shared documentation as found by Weiner and colleagues (2002), and a

significant improvement in the levels of joint training found by the SSI in 1999 (SSI, 1999a). However, although the vast majority of teams claimed to use a standard assessment document, far fewer used the same process across teams and professions, a standard laid down in the Single Assessment Process (Department of Health, 2001b). This finding was similar to that found by Weiner and colleagues (2002). Analysis of the current sample found that of the 17 single discipline teams, only 4 (24%) used a standard assessment process that was shared with other disciplines involved in an individual's assessment. This was the case in 19 (54%) of the 35 multi-disciplinary teams in the sample.

In relation to structural measures of integration, the fact that one third of this sample were made up of multi-disciplinary health and social care teams and that almost one third had formal links with a primary care practice are both findings comparable with earlier research. Hudson, for example (1998), found a 40 per cent health and social care co-location figure. That 86 per cent of the teams in this sample stated that they had formal links between care management and the Care Programme Approach, shows a significant development in relation to this practice compared with both the SSI finding, which was reported as patchy (1997b) and Hughes and colleagues (2001) who reported that only 4 per cent of local authorities across the country said that the Care Programme Approach was "accorded a priority in the context of services to older people with dementia" (Hughes et al., 2001, p13).

Box 6.1 below summarises the findings for these measures. Of the nine factors measured, four were achieved by over 50 per cent of teams, five achieved a low score (below 33 per cent) and one achieved a high score (over 66 per cent).

Box 6.1: Integration measures in teams

90% Standardised assessment process 75% Joint training in dementia care
65% Team members train others
65% Contact with other local dementia care services
33% Multi-disciplinary health and social care teams
31% GP linked
23% Shared client database
19% Shared point of referral
3% Fair or greater level of integration perceived

6.1.4 Staffing

Three-quarters of staff in the teams in the sample were professionally qualified with a dominance of non-medical health care staff found. The majority of managers were also non-medical health care staff. Social care teams were managed by qualified social workers and health care teams predominantly by qualified nurses. Of the seventeen multi-disciplinary health and social care teams in the sample, 13 gave details of their manager's profession. Of these, 23 per cent (n=3) of teams were managed by a social worker with 69 per cent (n=9) managed by a nurse. Eight per cent (n=1) described themselves as having both a health and social care manager. The ratios of qualified staff to new referrals and to team caseload for people with dementia stood at 1:1 and 16:1 respectively. This represented 50 per cent of the team's total workload meaning that qualified staff had an overall caseload of approximately 34 with two new referrals per qualified staff member per week. It is unlikely that all team members worked full-time in these teams suggesting that real

caseloads would have been higher than these figures. However, as data was only collected on total staff numbers as opposed to full-time equivalents a reliable calculation of real caseload ratios to qualified staff cannot be made. Box 2 below summarises the results of all the individual measures for this theme.

Box 6.2: Staffing issues found in teams

74% Qualified staff
47% Non-medical health care staff
35% Qualified social care staff
18% Medical staff
58% Managers were nurses
35% Managers were social workers
2 qualified staff per each new referral to team
1 qualified staff per each new referral from a person with dementia to team
28 qualified staff per each service user on team caseload
16 qualified staff per each service user with dementia on team caseload

6.1.5 Assessment: comprehensive and multi-disciplinary?

The assessment of need (Department of Health, 2000) is at the heart of primary health and social care services and its nature has rightly been thoroughly explored by many researchers. Today, the expectation is that an assessment of a person with dementia should be both comprehensive and multi-disciplinary (Department of Health, 2001a), avoiding both duplication and assumptions (Department of Health, 2001b). In 1997 the SSI noted that "the most effective combinations of services resulted from skilled assessments where a variety of relevant professionals were involved" (SSI, 1997b, p12). The most frequently cited professionals to be involved in an assessment alongside the key worker amongst the 52 teams in this study were the old age psychiatrist (86%) and community psychiatric nurse (86%) if the care manager was from social services; and a social worker/care manager (79%) if the care manager was from the health care professions. In Moriarty and Webb's study (2000) the most frequently involved professionals had been the old age psychiatrists and ward or day hospital nursing staff, whilst Hudson's study (1998) found that community nurses were the most often cited professional to be involved, alongside the social services care manager. These findings suggest that the role of the old age psychiatrist in community care assessments is expanding, whilst the roles of both the social worker/care manager and the nurse remain key.

In 1998, Hudson and colleagues found that there were still local authorities where no multi-disciplinary assessments were being carried out, whilst just under half of the assessments in Moriarty and Webb's study (2000) were found to have involved consultation from another professional. One third had involved discussions with more than one professional. In the current study only five teams (10%) stated that they did not routinely involve more than one professional in their assessments of people with dementia, whether from within the team, as in the case of the multi-disciplinary teams, or from outside, as in the case of the single discipline teams. From a list of nine different professions, a mean of four were routinely involved. This information indicates that the majority of teams are now routinely involving several staff in the assessments of people with dementia.

In relation to the content of assessment, the findings of this research are similar to earlier findings by the SSI (1997b) and Stewart and colleagues (1999) who noted that assessment domains were only partially covered. In the current research 40 per cent of items listed on the questionnaire, designed to encourage a comprehensive assessment approach, were not covered by the teams. Whereas Stewart and colleagues (1999) had found that deficiencies were more pronounced in the areas of social and psychological need, the deficiencies in the current sample came from all domains. Such deficiencies are likely to result in inappropriate diagnoses and consequently inappropriate care packages. The findings on the use of assessment scales also match earlier research and comment, which point to both the importance and limited use of these scales by social services teams. Only two of fourteen social services teams in the sample used these scales. There is an issue here perhaps of professional and role demarcation with social care professionals regarding assessment scales as a medical tool which should be administered by health care staff.

All the measures considered in relation to good practice in assessment were achieved by over 50 per cent of teams with a mean assessment composite variable score of 5 out of a possible 7. A high score was achieved in four of the measures. See Box 6.3 below for a breakdown of these results. In relation to the content of assessments documents, a mean overall score of 9 (60%) from a possible 16 was achieved.

Box 6.3: Good practice in assessment covered by teams

90% Single assessment process
86% formal arrangements between care management and CPA
69% standard assessment scales
65% people with dementia get full assessment
63% carry our separate risk assessments
60% involve users in assessments
58% involve carers in users assessments

These results suggest that the type of service offered by professional community teams is of a high standard, though more emphasis could be placed on involving users and carers in assessments. The quality of this service is less certain, given the character of assessment documentation assessed.

6.1.6 Care planning

Measures relating to care planning, i.e. the production of a care plan and the nature of reviews, generally scored well in the current research. Care plans were always produced following an assessment in 96 per cent of teams. Staff were involved in reviews in 94 per cent of teams and carers were routinely invited to reviews in 92 per cent. The only variable with a lower score, related to whether reviews where in the form of meetings with less than half the teams (44%) normally reviewing users needs in this way.

6.1.7 Ethnic minorities

Just over 3 per cent of service users on the caseloads of these teams came from ethnic minority communities, a figure in line with their numbers in the general

population over 65 in the North West of England. However, despite these encouraging figures, the numbers accessing a service is only part of an indication as to its appropriateness. The SSI (1998) and the NSFOP (Department of Health, 2001a) have both noted that services remain ethnocentric and that although translated leaflets are a step in the right direction, they are unlikely to be enough to result in improved access or a more sensitive service. One-third of teams in this research had leaflets translated into minority community languages, whilst two-thirds had access to an interpreter service. All but two of the 14 teams with both these services were either social services teams or multi-disciplinary health and social care teams.

6.1.8 Targeted service

Relatively recent research into services for younger adults with severe mental health problems (Schneider, et al., 1999) found a limited level of targeting. In contrast, the current research suggests services with a significant degree of their provision targeted at this user group. On all the four measures considered teams scored over 60 per cent with a greater degree of targeting in multi-disciplinary teams compared with single discipline teams. In two thirds of the teams in the sample over 40 per cent of new referrals and current team caseload were from people with dementia. These findings represent a modest increase on those of Brown and colleagues who noted that 40 per cent of caseloads of old age psychiatry teams in their London sample were made up of people with dementia (Brown et al., 1996).

It could be argued that these figures do not represent targeting of people with dementia but rather that the overall level of dementia in the community is increasing as a consequence so are referrals of people with dementia to community teams.

6.1.9 Flexibility

In 1997 the Audit Commission accused services of being inflexible. The findings of this research largely echo this message. In this study less than one third of the sample had over 10 per cent of referrals from the public whilst just below half had at least one per cent. This result is an improvement on Sinclair's finding from 1990 (Sinclair et al., 1990) but not as good as the third found by Moriarty and Webb in 2000 to have been referred by a relative or carer. Over half the teams had operated a waiting list for assessments in the last twelve months. Nine teams, 17 per cent, offered only a time-limited service. Less than one third had arrangements in place for emergency access, a slightly higher proportion than the quarter found by Onyett in 1995. However, when probed further, only 6 per cent, three teams, could be accessed directly.

6.1.10 Individuality/Person focused care

In 1999 the SSI reported that social service departments and the NHS were working in parallel rather than in partnership with a consequent negative impact on a user-centred approach (1999a). The NSFOP (Department of Health, 2001a) puts person-centred care at the core of its message and ethos. Over 60 per cent of the teams in the current research stated that they carried out or had in place all but one of the measures considered under this heading. Box 6.4 sets these results out at a glance.

Over 80 per cent of teams met two of the five measures. Three achieved a high score (over 66%). A high score was also achieved for the standard overall.

Box 6.4: Person focused care

60% service users participate in assessments
86% seek consent from service users to share information is routine practice
81% leaflets available to the public
31% evaluation questionnaires for public
67% scored 3 (median) or more in social domain in assessments

6.1.11 Care worker good practice

A mixed picture emerges for this area of practice. Over 50 per cent of teams met all four measures considered, relating to team meetings, staff training and staff involvement in reviews. However 44 per cent did not have regular team meetings whilst a quarter of the sample had not attended any joint training in dementia care in the last year. Joint training has been highlighted as a key requirement for staff, who will be required to work more closely with one another in order to carry out new policy initiatives such as the Single Assessment Process (Department of Health, 2001a).

6.1.12 Carers

The SSI (1997b) noted only modest work being undertaken with carers at that time. Stewart and colleagues' (1999) analysis of assessment documentation found that carers needs were either not mentioned at all or not in detail on many such documents. Moriarty and Webb (2000) reported that sixty per cent of carers reported that their needs were considered when assessing the service user but that no carer had received their own assessment. Three-quarters of the carers sampled had been given the opportunity of involvement in their relative/friend's assessment and ninety per cent of this group actually attended. In the present study 56 per cent of the sample stated that they offered carers their own assessment, whilst 58 per cent were routinely involved in the service users assessment. Ninety-two per cent of carers were routinely invited to service users reviews, whilst 79 per cent were said to attend them. Fifty per cent of teams achieved six of the seven measures considered under the heading of carer involvement and support. These findings are encouraging and when placed alongside earlier research findings, suggest a steady improvement in the nature of carer involvement and assessment.

6.1.13 Specialist training

Two variables were measured in relation to this theme; unqualified staff who had attended training in dementia care, and participation in joint dementia care training sessions in the last twelve months. Both these measures were met in over half the sample.

6.1.14 Quality assurance

Three of the four measures considered under this heading were met by over half the sample, including involvement of teams or their representatives in service development work.

6.2 Differences between multi-disciplinary teams and single discipline teams

Statistically significant differences were found between the team types analysed in relation to a number of individual measures and composite indicators of quality. These are summarised in Table 6.2 and discussed in the text below. In all but one measure, relating to services for ethnic minorities, multi-disciplinary teams scored more highly than single discipline teams.

Table 6.2: Significant differences between multi-disciplinary and single discipline teams

Indicator of quality	Team types		
	Multi-disciplinary	Single discipline	p value
Specialist location	**97%**	65%	.004
Capacity/targeting			
New referrals are people with dementia	**56%**	40%	.031
Integration			
GP links	**43%**	6%	.007
Structural integration composite	**.91**	.18	<.001
Team provides training to others	**77%**	44%	.019
Contact with other local dementia services	**74%**	47%	.053
Assessment and care planning			
Standardised scales used in assessments	**91%**	23%	.001
Planned reviews are meetings	**74%**	18%	.001
Care planning composite	**2.6**	2	.004
Ethnic minorities			
Translated leaflets	23%	**71%**	.001
Ethnic minorities composite	1.6	**2.4**	.013
Targeted service			
Targeted service composite	**3**	2.2	.045
Assessment form completed on all people with dementia	**89%**	53%	.004
Care worker good practice/training			
Non-professional staff with dementia care training	**69%**	35%	.023
Carer support			
Carers involved in development forums	**63%**	6%	<.001
Quality			
Team involved in service development work	**63%**	29%	.024
Service evaluated in last 12 months	**71%**	41%	.035
Quality composite	**2.6**	1.6	.003

6.2.1 Specialist service

Multi-disciplinary teams offered a more specialist service than single discipline teams based on a number of standards relating to structure, content and quality measures. Almost all multi-disciplinary teams (97%) were located in a specialist division compared with 65 per cent of single discipline teams. Fifty-six per cent of new

referrals were from people with dementia in multi-disciplinary teams compared with 40 per cent in single discipline teams. One or more non-professional member of staff had, attended training in dementia care in 69 per cent of multi-disciplinary teams compared with 35 per cent of single discipline teams. Assessment forms were completed on all people with dementia in 89 per cent of multi-disciplinary teams compared with 53 per cent of single discipline teams. Although the other targeted service measures did not prove to be statistically significant between team types, overall the result suggested that multi-disciplinary teams offered a more targeted service.

6.2.2 Integration

Multi-disciplinary teams also appeared to offer a more integrated service than single discipline teams. On one level this is not surprising, given multi-disciplinary teams are an integrated service in themselves. However, it also suggests, as did Hardy and colleagues (1996), that the co-location model offers the optimum level of service compared with other models such as shared systems of information and linking. On two integration measures multi-disciplinary teams scored significantly more than single discipline teams. Seventy-seven per cent of multi-disciplinary teams offered training to others compared with 44 per cent of single discipline teams whilst 74 per cent of the former compared with 47 per cent of the latter were in contact with at least one dementia care service in their locality. Multi-disciplinary teams also achieved a statistically significantly higher score on the structural integration composite.

6.2.3 Assessment, care planning and development work

Assessment and care planning practices were generally of a high standard among all the teams in the sample. In relation to assessment the only finding of statistical significance was in relation to the use of standardised scales. This was done in 91 per cent of multi-disciplinary teams and only 23 per cent of single discipline teams. Four of the latter were health only teams and this was clearly a health care worker and not a social care worker practice. In relation to reviews, these were usually in the form of meetings in 74 per cent of multi-disciplinary teams and in only 18 per cent of single discipline teams. Support to carers did not vary significantly between team types apart from in relation to their involvement in development work. This showed a distinct variation between multi-disciplinary and single discipline teams with 63 per cent of the former and only 6 per cent of the latter fulfilling this measure, a finding of statistical significance. Multi-disciplinary teams were in general found to be more involved in development work (63%) than were the single discipline teams (29%) in this sample.

6.2.4 Ethnic minorities

Surprisingly, given all the other findings of the study, services for ethnic minority service users, were found to be more culturally sensitive in single discipline teams than multi-disciplinary teams. Despite a similar proportion of ethnic minority service users on team caseloads (3%), 71 per cent (12) of single discipline teams had translated leaflets available compared with only 23 per cent (8) multi-disciplinary

teams. The composite measure on this theme was also statistically significant in favour of single discipline teams.

6.3 Concluding comments

Integration of health and social care services is a key objective of the NHS Plan (Cm 4818, 2000), the NSFOP (Department of Health, 2001a) and The Single Assessment Process (Department of Health, 2001b). The particularly low level of integration found by this research, at the structural level of service, is indicative of how far, in practice, this major policy initiative has come, and how far it still has to go. Jointly managed multi-disciplinary health and social care teams, continue to be a minority experience. Closer working relationships, however, identified through practical level integration measures, were found to be more positive.

The flexibility measures used in this study also indicated minimal 'out of hours' provision. Crisis support is a vital component of care for people with dementia in the community and the limited availability is cause for concern. Clearly this element of care poses a significant dilemma, balancing the needs of an already overstretched workforce with the needs of service users and their carers in the community.

The findings suggest that the model of multi-disciplinary working appeared to be producing better quality care, on the measures used, than the single discipline team model. This was the case on all but one variable: equity of access to ethnic minorities. The single discipline teams in this study were largely social care teams and it was from within this sector that more culturally sensitive practice was found. Given that integration between health and social care agencies and personnel working with older people with dementia is set to increase, it is important that the positive practices developed in the social service sector in this area are built upon and not lost.

Overall results provide essential information to aid the local planning and improvement of service provision. They also provide a means to identify and measure standards of care and access to local specialist dementia services, a key requirement of the NSFOP (Department of Health, 2001a). Finally, they should enable planners and practitioners to complete the milestone that demands that health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems by 2004 (Department of Health, 2001b).

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Appendix A

North West Dementia Centre

(1-5) ☐☐☐☐☐

MAPPING DEMENTIA SERVICES IN THE NORTH WEST OF ENGLAND

PROFESSIONAL TEAMS QUESTIONNAIRE

NOTES

- *This questionnaire is designed for a range of service providers and not all the questions will be relevant for all services. Please complete as far as possible.*
- *All questions refer to **team** workload and composition. Most questions only require inserting the correct figures, selecting the relevant number from the options given and inserting into the question boxes or ticking relevant boxes.*
- *We realise that some services are part of larger organisations that operate across a wider area. Please ensure that a separate questionnaire is completed for each site /separate facility for people with dementia in the North West.*

If you need further information or require help please telephone 0161 275 6851 or email michele.abendstern@man.ac.uk

Thank you for your time

Contact Details

Name of service /facility: .....

(If you are completing this form on services which span more than one site please complete a separate form for each facility)

Address:.....

.....

Postcode ☐☐☐☐ ☐☐☐ (6-12) *(Please ensure each facility has the correct post code)*

Telephone:.....

Fax number: .....

Email address: .....

Your name: .....

Your role: 1=Team Manager / deputy manager ☐ (13)
2= Team member
3= Administrator
4= Other (please specify)……

☐☐ (14-15)

PLEASE REMEMBER …

…to send us any documentation relating to your service on the following areas to inform the NWDC's Service Directory:

Extra documents enclosed	*(tick box)*
Assessment documents	☐ (16)
Care Plans	☐ (17)
Service information	☐ (18)
Other publicity material	☐ (19)

PLEASE RETURN COMPLETED FORMS ALONG WITH ANY OTHER DOCUMENTS TO:

North West Dementia Centre,
Personal Social Services Research Unit,
Dover Street Building,
The University of Manchester,
Oxford Road, Manchester, M13 9PL
by 28 June 2002 (Pre-paid envelope enclosed)

(*We are defining dementia in its widest terms by using the term to describe those who suffer from dementia or are confused, though they might not necessarily have a diagnosis of dementia)

For office use only

SERVICE DESCRIPTION

1. Please indicate the lower age boundary for **people with dementia** *(*see note above)* who can be referred to your team.

   0 = no age boundary
   1 = 60 years
   2 = 65 years
   3 = 70 years
   4 = 75 years
   5 = other (please specify)…….

   ☐ (20)

   ☐☐ (21-22)

2. In which organization is the line management of your team located? (*tick all that apply)*

   N.H.S. ☐ (23)
   Social Services ☐ (24)
   Other (please specify)…… ☐ (25)

   ☐☐ (26-27)

3. Which of the following best describes your team/service structure?

   Single discipline (health **or** social care) ☐ (28)
   Multi-disciplinary (health only) ☐ (29)
   Multi-disciplinary (social care only) ☐ (30)
   Multi-disciplinary (health **and** social care) ☐ (31)

4. Is your team located within: ☐ (32)

   1 =Adult/old age mental health services
   2 =Generic adult services
   3 =Generic adult services with specialist worker (outposted or not)
   4 =Specialist older persons services
   5= Other (please specify)……
   …….

   ☐☐ (33-34)

5. Does your team **share** any of the following with any other service(s):

	(tick boxes)	**if yes** for any, please specify service(s) & nature of relationship	
Accommodation	☐ (35)	……	☐☐☐ (36-38)
Management	☐ (39)	……	☐☐☐ (40-42)
Telephone number	☐ (43)	……	☐☐☐ (44-46)
Point of referral	☐ (47)	……	☐☐☐ (48-50)
Assessment forms	☐ (51)	……	☐☐☐ (52-54)
Care plan forms	☐ (55)	……	☐☐☐ (56-58)
Client record databases system	☐ (59)	……	☐☐☐ (60-62)
Case files /filing system	☐ (63)	……	☐☐☐ (64-66)
Other	☐ (67)	……	☐☐☐ (68-70)

6. Does your team have any of the following which are available to users/carers of your service?

   Leaflets /information packs describing the services offered ☐ (71) *(Tick all relevant boxes)*
   Evaluation/ satisfaction questionnaires ☐ (72)
   Other material (please specify)……..... ☐ (73)

   Please send us any information /publicity material about your service (see front page).

   ☐☐ (74-75)

7. Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups? *(tick relevant boxes)*

   Language resources *e.g.* translated leaflets, ☐ (76)
   Interpreter service ☐ (78)
   other (please specify) ☐ (77)
   ……

   ☐☐ (79-80)

8. Please indicate the approximate **percentage** of your **referrals** that come from:

   Primary Health Care/ GP ☐☐☐% (81-83)
   Other health professionals ☐☐☐% (84-86)
   Social care professionals ☐☐☐% (87-89)
   The public ☐☐☐% (90-92)
   Other (please specify)…… ☐☐☐% (93-95)
   (The numbers you insert should add up to 100%)

   ☐☐ (96-97)

SERVICE USERS AND TEAM WORKLOAD

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9.We are interested in the amount and flow of your team's workload in the last week.

a) Please indicate the approximate **number** of **new referrals** received by your team **last week** ☐☐☐ (98-100)
b) Please indicate the approximate **number of these** who are **people with dementia** ☐☐☐ (101-103)
c) Please indicate the approximate **total number of your team's caseload last week** ☐☐☐ (104-106)
d) Please indicate the approximate **number of these** who are **people with dementia**. ☐☐☐ (107-109)

10. To the best of your knowledge what **percentage** of **people with dementia** on your team's caseload currently:

Are in Residential or Nursing home care ☐☐☐% (110-112)
Attend day care (L.A, NHS , voluntary) ☐☐☐% (113-115)
Receive home care ☐☐☐% (116-118)
Are in hospital respite care ☐☐☐% (119-121)

11.What percentage of **all** your current service users have the following ethnic origin?

European-Caucasian ☐☐☐% (122-124)
African ☐☐☐% (125-127)
Afro Caribbean ☐☐☐% (128-130)
Asian ☐☐☐% (131-133)
Chinese ☐☐☐% (134-136)
Other ethnic minority ☐☐☐% (137-139)
Not known ☐☐☐% (140-142)

12. Does your team usually offer a time limited service to people with dementia (e.g. short term intervention only)?
Yes☐ No☐ (143)

a) **If no,** what the one most common reason in your team for closing a case of someone with dementia? (e.g. admitted to residential care/ referred to other agencies) ☐☐ (144-145)

Please specify……..

13.Is the referrals pattern in your team currently: ☐☐ (150-151)

Stable ☐ (146)
Rising ☐ (147)
Fluctuating ☐ (148)
Other (Please specify) ☐ (149)
……

14.Within the last 12 months have you had cause to operate a waiting list? Yes ☐ No ☐ (152)

a) **If yes**, currently, how long on average does a person with dementia have to wait before an assessment begins? ☐☐ (154-155)

1 = 1 week
2 = 2weeks
3 = 3 weeks
4 = 4 weeks
5 = over one month *(please specify)*_____ ☐ (153)

15. Can **your team** be accessed in the case of an emergency outside of your normal 'office' hours?
Yes ☐ No ☐ (156)

a) **If yes**, is this via a:

Telephone service to your staff ☐ (157)
Telephone answering service ☐ (158)
Answer phone ☐ (159)
Other (please specify) ☐ (160)
……

b) **If no** what arrangements are there for out of hours access?

Social Services Emergency Duty Team ☐ (161)
NHS Accident and Emergency ☐ (162)
Other (please specify) ☐ (163)
……

☐☐ (164-165)

PERSONNEL

For office use only

16. We are interested in how many staff your team employs.
In the table below please provide details of the **total number of workers** (whether full or part time) for each staff group.

Please include direct employees, agency staff /self employed care workers and volunteers.

	Number of actual workers
Managers (*specify profession*)……	(168-169)
CPN/Community mental health nurse practitioner	(170-171)
Community Nurse	(172-173)
Nursing assistant (unqualified /support workers)	(174-175))
Consultant Psycho geriatrician	(176-177)
Non-consultant medical staff	(178-179)
Qualified Social workers /care managers	(180-181)
Unqualified social worker/care manager	(182-183)
Occupational therapists	(184-185)
Occupational therapists helpers	(186-187)
Physiotherapist	(188-189)
Physiotherapist helpers	(190-191)
Other (*please specify)*	(192-193)

(166-167)

(194-195)

17. **If you have described your team membership above as multi-disciplinary,**
Which of the following management arrangements does your service / team have?

(Tick all relevant boxes)

An overall manager for the flow of work to whom all staff are accountable (196)
Separate line management for professional issues (197)
An overall manager responsible for the flow of work and professional issues (198)
Other (please specify)…….. (199)

(200-201)

18. Do all team members operate from one base? Yes ☐ No ☐ (202)

19 Do you have regular team meetings? Yes ☐ No ☐ (203)

if yes, how frequent are they?
Weekly (204)
Fortnightly (205)
Monthly (206)
Other (207)

if yes, who normally attends?
all team members (208)
most team members (209)
some team members (210)

TRAINING

20. Do any of your staff **<u>provide</u> formal training** in dementia to any of the following professionals and practitioners?

Residential or nursing home staff (211)
Primary health care teams/GPs (212)
Social services departments (213)
Community mental health teams (214)
Carers (215)
Other (please specify)…… (216

(217-218)

For office use only

21. Do members of your team **attend joint training** sessions on dementia in older people with other professionals and practitioners outside your team? Yes ☐ No ☐ (219)
If yes: how frequently did joint training sessions on dementia occur within the last 12 months ?
1 = once 3 = three or more times ☐ (220)
2 = twice

22. How many of your **non-professional** staff **have or are working towards** formal **qualifications** which include caring for people with dementia? (NVQ level 2 equivalent or above).

Nurse assistant	☐ (221)	Physiotherapist helper	☐ (222)
Unqualified social worker/care manager	☐ (223)	OT helper	☐ (224)
Other (please specify)……	☐ (225)		

☐☐ (226-227)

PERSON FOCUSED CARE

We are interested in finding out how people with dementia are assessed.

23. Does your team have any formal links between care management and the Care Programme Approach as applied to older people with mental health problems? Yes ☐ No ☐ (228)

24. **If** you are a **multi-disciplinary team**, who usually undertakes **initial assessments** of older people with dementia who are referred to your team? (*Please indicate approximate percentages)*

Health care staff only	☐☐☐ %	(229-231)
Social care staff only	☐☐☐ %	(232-234)
Either health **or** social care staff	☐☐☐ %	(235-237)
Multi-disciplinary staff (health **and** social care)	☐☐☐ %	(238-240) (*numbers should add up to 100%)*

25. Approximately what percentage of people with dementia known to your team receive a full comprehensive assessment? ☐ (241)
0 = none 3 = 41-60%
1 = 1-20% 4 = 61-80%
2 = 21-40% 5 = 81-100%

26. Do you/your team use a standard assessment process in assessing an individual's needs? Yes☐ No ☐ (242)

a) **If yes**, and you are a **multi-disciplinary** team, is a standard assessment process used by all team members? Yes☐ No ☐ (243)

b) **If yes** and you are a **single discipline team**, is the standard assessment process you use shared by other disciplines involved in an individual's assessment? Yes☐ No ☐ (244)

27. Does your team routinely involve the following groups in full assessments of people with dementia?

Psychiatrists	☐ (245)	Geriatricians	☐ (248)	Physiotherapists	☐ (251)
O.T.s	☐ (246)	Speech therapists	☐ (249)	Psychologists	☐ (252)
CPNs	☐ (247)	Social workers/care manager	☐ (250)	Other (please specify).....	☐ (253)

☐☐ (254-255)

28. Do you complete an **assessment form** on all people with dementia once they have been referred to your team? Yes ☐ No ☐ (256)

<u>If yes, please send us copies of your assessment forms.</u>

We would prefer you to send copies of your assessment form, but if this is not possible please complete Q**29**, otherwise go to Q**30**:

29. Does your assessment form specify the following? *(Tick relevant boxes)*

Mobility & ADL	☐ (257)	Vision patterns	☐ (262)	Religious observance	☐ (268)
Daily routine /preferences	☐ (258)	Continence	☐ (263)	Carer needs /support given	☐ (269)
Teeth and nutrition	☐ (259)	Depression /anxiety/mood state	☐ (264)	Disease /health conditions	☐ (270)
Skin & foot care	☐ (260)	Cognitive patterns	☐ (265)	Medication	☐ (271)
Communication /speech /hearing pattern	☐ (261)	Social /recreational activity	☐ (266)		
		Familiar cultural traditions	☐ (267)		

(a) Do service users participate in assessments? ☐ (272) (b) Do carers participate in assessments ☐ (273)

30. Do you usually complete a **separate** risk assessment? Yes ☐ No ☐ (274)

31. Does your team use any standardized scale as part of the assessment process for older people with mental health problems in the community? Yes ☐ No ☐ (275)

a) **If yes**, please indicate which of the following scales are used. (***please tick relevant boxes)***

Mini Mental State Examination	☐ (276)	CAPE BRS	☐ (280)
Geriatric Depression Scale	☐ (277)	Barthel Index	☐ (281)
HoNOS 65+	☐ (278)	Clock Drawing	☐ (282)
Crichton Royal Behaviour Rating Scale	☐ (279)	Other (Please specify)…….	☐ (283)

32. Do you make a **care plan** for each service user as a result of this assessment? Yes ☐ No ☐ (286)
If yes, please send us a blank copy of a care plan form

33. Is seeking **consent** from the service user to share information about them with either carers or other professionals part of the team's operational policy? Yes ☐ No ☐ (287)
a) **If yes**, is this obtained : Verbally ☐ (288)
In writing ☐ (289)

34. Are your case records computerized? Yes ☐ No ☐ (290)
a) **If yes**, does this include:
Service user referral data ☐ (291)
Service user assessment data ☐ (292)
Service user care plan ☐ (293)
Other service user data ☐ (294)
(please specify) ……

35. Do your staff participate in planned **reviews** of each service user? Yes ☐ No ☐ (296)

a) **If yes**, how is this review **most frequently** conducted? ☐ (297)
1= Formal meeting convened by CPA care co-ordinators/ manager
2= Informal discussion with care co-ordinator/ manager
3= Completion of written report for care co-ordinator/ manager
4= Other (please specify) …….

b) Which professionals **usually** attend reviews?

Team managers	☐ (300)	OT	☐ (307)
Social workers/care managers	☐ (301)	OT aide	☐ (308)
Consultant psychiatrist /psycho geriatrician	☐ (302)	Physiotherapist	☐ (309)
CPN/community mental health nurse practitioner	☐ (303)	Physiotherapist aide	☐ (310)
Community nurse	☐ (304)	Support worker/	☐ (311)
Nurse assistant	☐ (305)	community care worker	
Non-consultant medical personnel	☐ (306)	Other (please specify)	☐ (312)

c) Do you **routinely** invite carers to reviews? Yes ☐ No ☐ (315)
If yes, how often do carers attend ? ☐ (316)
1= usually 3= other (please specify) ……
2= occasionally ……

d) Do you formally request feedback from carers at reviews? Yes ☐ No ☐ (319)

For office use only

☐☐ (284-285)

☐ (295)

☐☐ (298-299)

☐☐ (313-314)

☐☐ (317-318)

SERVICES AVAILABLE FOR INFORMAL CARERS

For office use only

36. a) Do you have any formal arrangements or resources for providing support for close relatives/friends of users with dementia? Yes ☐ No ☐ (320)

b) **If yes,** do you provide:

Carers with information on how to access support services? ☐ (321)
Carers with information on how to deal with problem behaviour? ☐ (322)
Carers with support services directly ☐ (323)
Any formal or group training opportunities for carers? ☐ (324)
Any informal or individual training opportunities for carers? ☐ (325)
Other arrangements please specify…… ☐ (326)

☐☐ (328-329)

37. a) Do carers usually receive a separate assessment **by** your team? Yes ☐ No ☐ (327)
b) **If yes,** how often do carers receive their own assessment by your team?
1= usually 3= other (please specify) …… ☐ (330)
2= occasionally

☐☐ (331-332)

c) **If no,** are carers usually referred elsewhere for an assessment of their needs? Yes ☐ No ☐ (333)

☐☐ (336-337)

38. Do carers receive their own care plan? Yes ☐ No ☐ (334)

☐☐ (338-339)

39. Are carers needs routinely reviewed by your team? Yes ☐ No ☐ (335)

☐ (340)

LINKS WITH OTHER SERVICES

40. For older people with dementia, please indicate on the scale below what you perceive to be the current level of integration between health and social care across the service.
(*Please place a tick at the most appropriate point)*

Integrated | | | | | | Not integrated

41. Do you have contact with other specific dementia services in your area? Yes ☐ No ☐ (341)
a) **If yes**, please provide details……

☐☐ (342-343)

42. **If you have specialist EMI worker(s) out-posted from your team please tell us more about them here:**
(a) How many are there? …….
(b) What are their profession(s)? …….
(c) Where are they based? …….
(d) Which professionals or professional team does this worker(s) relate to on a daily basis?……
…….
(e) What contact does this worker(s) have with your team? 1 = regular meetings ☐ (344)
2 = regular supervision
3 = other (please specify)……

☐☐ (345-346)

☐☐ (348-349)

43. Is your team formally linked to a named G.P. or Primary Care Team / Group? Yes ☐ No ☐ (347)

☐☐ (350-351)

a) **If yes**,
Is this linked to one practice only ☐ (352)
More than one practice ☐ (353)
b) **If yes**, what form does the link take?
Team member(s) is a named contact for the practice ☐ (354)
Team member(s) has regular meetings with practice staff ☐ (355)
Team member(s) hold sessions at the practice ☐ (356)
Other (please specify)_____ ☐ (357)

☐☐ (358-359)

For office use only

GAPS/SERVICE DEVELOPMENT

44. Are you aware of any serious gaps in services for people with dementia in your area? Yes ☐ No ☐ (360)

a) **If yes,** are these in:

Own service	☐ (361)	Respite care	☐ (365)
Home care	☐ (362)	Carer support services	☐ (366)
Residential care	☐ (363)	Old age psychiatry services	☐ (367)
Day care	☐ (364)	Other (please specify) ……	☐ (368)

☐☐ (369-370)

Please use the space below to outline in more detail the service gaps you have identified.

……

……

……

…… ☐☐ (371-372)

(If necessary please continue on a separate sheet)

45. Are you involved in any forums where service development is discussed? Yes ☐ No ☐ (375)

If yes, is this

a) within your agency	☐ (373)	are carers involved?	Yes ☐ No ☐ (376)
b) across different agencies	☐ (374)	are carers involved?	Yes ☐ No ☐ (377)

46. Is team time/resources put aside for service development work? Yes ☐ No ☐ (378)

If yes, what form does this take? **Please specify nature and extent**

……

……

……

47. Has your service undergone any service evaluation, monitoring or auditing in the last year? Yes ☐ No ☐ (379)

a) **If yes**, please provide details……..

☐☐ (380-381)

Finally,

48. How much of the questionnaire did you feel able to answer with confidence?

1= All questions 3= Some questions ☐ (382)

2= Most questions 4= Few questions

OTHER SERVICES & ADDITIONAL COMMENTS

Please add any additional comments you might have in the space provided below if

a) there are any other services provided by your establishment for people with dementia

b) you would like to elaborate on any of the questions you have already answered

c) you would like to raise any other issues.

If necessary, please continue on a separate sheet

☐☐ (383-384)

☐☐ (385-386)

…… ☐☐ (387-388)

…… ☐☐ (389-390)

…… ☐☐ (391-392)

…… ☐☐ (393-394)

……

……

Many thanks for your assistance in completing this form. (See front sheet for return address)

Appendix B: Composite scores on service standards

Table 1: Composite scores for integration at a structural level (maximum =3)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	11	34	14	82	25	48
1	16	46	3	18	19	37
2	8	23			8	15

MW: <.001

Table 2: Composite scores for integration at practice level (maximum =7)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
2	2	6	4	24	6	11
3	12	34	4	24	16	31
4	12	34	6	35	18	35
5	8	23	2	12	10	19
	1	3	1	6	2	4

Table 3: Composite scores for good practice in assessment (maximum = 7)

Scores	Multi-disciplinary n=35		Single discipline n=17		Total n=52	
	n	%	n	%	n	%
2			3	18	3	6
	2	6	2	12	4	9
4	7	20	6	35	13	25
5	11	31	2	12	13	25
6	10	29	2	12	12	23
7	5	14	2	12	7	13

Source: Question 23: does your team have any formal links between care management and the Care Programme Approach as applied to older people with mental health problems; Question 25: Approximately what percentage of people with dementia known to your team receive a full comprehensive assessment; Question 26: Do you/your team use a standard assessment process in assessing an individual's needs; Question 29a: Do service users participate in assessments; Question 29b: Do carers participate in assessments Question 30: Do you usually complete a separate risk assessment? Question 31: Does your team use any standardized scale as part of the assessment process for older people with mental health problems in the community?

Table 4: Most frequently cited professional involved in assessment alongside care manager/other key worker

Professional	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
Psychiatrist	29	83	16	94	45	86
OT	26	74	13	76	39	75
CPN	29	83	16	94	45	86
Geriatrician	4	11	5	29	9	17
Speech therapist	7	20	4	23	11	21
Social worker/care manager	28	80	13	76	41	79
Physiotherapist	12	34	10	59	22	42
Psychologist	6	17	7	41	13	25
Other	7	20	2	12	9	17
Mean (SD)	4.2 (2.12)		5 (2.12)		4.5 (2.13)	

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Source: Question 27: does your team routinely involve the following groups in full assessments of people with dementia?

Table 5: Individual items specified on assessment documents

Item	Multi-disciplinary n=35		Single discipline n=17		Total n=52		p value
	n	%	n	%	n	%	ns
Mobility	31	87	15	88.	46	88	ns
Daily routine	20	57	11	65	31	60	ns
Teeth & nutrition	14	40	5	29	19	36	ns
Skin and foot care	6	17	4	23	10	19	ns
Communication/speech/ hearing	28	80	12	75	40	78	ns
Vision	15	43	10	59	25	48	ns
Continence	20	57	10	59	30	58	ns
Depression/anxiety/mood	30	86	13	76	43	83	ns
Cognitive patterns	26	74	11	65	37	71	ns
Social/recreation	24	69	11	65	35	67	ns
Familiar cultural traditions	18	51	11	65	29	56	ns
Religious observance	14	40	6	35	20	38	ns
Carers needs/support given	25	71	13	76	38	73	ns
Disease/health conditions	30	86	15	88	45	86	ns
Medication	28	80	14	82	42	81	ns

Source: Question 29: does your assessment form specify the following…?

Table 6: Composite scores for care planning (maximum =4)

Scores	All multi-disciplinary teams (n=17)		Other team type (n=18)		Total (n=17)	
	n	%	n	%	n	%
0	1	3	1	6	2	4
1	1	3	1	6	2	4
2	8	23	12	71	20	38
3	25	71	3	18	28	54

Source: Question 32: Do you make a care plan for each service user as a result of an assessment; Question 35 Do you're your staff participate in planned reviews of each service user; Question 35a: Do your staff participate in planned reviews of each service user? If yes, how is this review most frequently conducted; Q**35c**: Do you routinely invite carers to reviews?

Table 7: Composite scores for equity of access for ethnic minorities (maximum =4)

Scores	All multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	5	14			5	10
1	12	34	2	12	14	27
2	10	9	7	41	17	33
3	7	20	8	47	15	29
4	1	3			1	2

Source: Question 7: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups…?

Table 8: Composite scores for targeting (maximum =4)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0			3	18	3	6
1	3	9	2	12	5	10
2	7	20	4	23	11	21
3	10	29	4	23	14	27
4	15	43	4	23	19	36

Source: Question 4: Is your team located within. Question 9: We are interested in the amount and flow of your team's workload in the last week. a) Please indicate the approximate number of new referrals received by your teams last week. b) Please indicate the approximate number of these who are people with dementia. c) Please indicate the approximate number of your team's caseload last week. d) Please indicate the approximate number of these who are people with dementia; Question 25: Approximately what percentage of people with dementia known to your team receive a full comprehensive assessment?

Table 9: Composite scores for equity of access to specialist input (maximum =4)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	1	3			1	2
1	2	6	3	18	5	10
2	11	31	3	18	14	27
3	12	34	8	47	20	38
4	9	26	3	18	12	23

Source: Question 6: Does your team have any of the following which are available to users/carers of your service?/ Question 8: Please indicate the approximate percentage of your referrals that come from…? / Question 20: Do any of your staff provide formal training in dementia to any of the following professionals and practitioners?/ Question 28**:** Do you complete an assessment form on all people with dementia once they have been referred to your team?

Table 10: Composite scores for flexibility (maximum =3)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	11	31	6	35	17	33
1	16	46	7	41	23	44
2	7	20	3	18	10	19
3	1	3	1	6	2	4

Source: Question 12: Does your team usually offer a time limited service to people with dementia (e.g. short term intervention only)?/ Question 14: Within the last 12 months have you had cause to operate a waiting list?/ Question 15: Can your team be accessed in the case of an emergency outside of your normal 'office' hours?)

Table 11: Composite scores for Individuality (maximum =5)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	1	3			1	2
1	1	3	1	6	2	4
2	6	17	2	121	8	15
3	14	40	6	35	20	38
4	7	20	7	41	14	27
5	6	17	1	6	7	13

Source: Question 29b: Do carers participate in assessments? / Question 33: Is seeking consent from the service user to share information about them with either carers or other professional's part of the team's operational policy? / Question 6: Does your team have any of the following which are available to users/carers of your service? / Question 29: Does your assessment form specify the following?

Table 12: Composite scores for care worker good practice (maximum =4)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	1	3			1	2
1	3	9	2	12	5	10
2	8	23	6	35	14	27
3	10	29	5	29	15	29
4	13	37	4	23	17	33

Source: Question 22: How many of your non-professional staff have or are working towards formal qualifications which include caring for people with dementia? (NVQ level 2 equivalent or above). / Question 19: Do you have regular team meetings? /: Question 35: Do your staff participate in planned reviews of each service user? / Question 21: Do members of your team attend joint training sessions on dementia in older people with other professionals and practitioners outside your team?)

Table 13: Composite scores for carer support and involvement (maximum =8)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
2			1	6	1	2
3			2	12	2	4
4	9	26	4	23	13	25
5	10	29	4	23	14	27
6	9	26	5	29	14	27
7	6	17	1	6	7	13
8	1	3			1	2

Source: Question 36: Do you have any formal arrangements or resources for providing support for close relatives/friends of users with dementia? / Question 37: Do carers usually receive a separate assessment by your team? / Question 38: Do carers receive their own care plan? / Question 39: Are carers needs routinely reviewed by your team? / Question 29bb: Do carers participated in assessments? / Question 35c:Do you routinely invite carers to reviews? / Question 35d: Do you formally request feedback from carers at reviews? / Question 45: Are you involved in any forums where service development is discussed? If yes, are carers involved?

Table 14: Composite scores for specialist training (maximum =2)

Scores	Multi-disciplinary (n=17)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0	4	11	2	12	6	11
1	14	40	10	59	24	46
2	17	49	5	29	22	42

Source: Question 21: Do members of your team attend joint training sessions on dementia in older people with other professionals and practitioners outside your team? / Question 22. How many of your non-professional staff have or are working towards formal qualifications which include caring for people with dementia? (NVQ level 2 equivalent or above).

Table 15: Composite scores for quality assurance (maximum =4)

Scores	Multi-disciplinary (n=35)		Single discipline (n=17)		Total (n=52)	
	n	%	n	%	n	%
0			3	18	3	6
1	6	17	6	35	12	23
2	9	26	4	23	13	25
3	14	40	3	18	17	33
4	6	17	1	6	7	13

Source: Question 6 Does your team have evaluation/satisfaction questionnaires which are available to users/carers of your service? Question 45 Are you involved in any forums where service development is discussed? Question 46: Is team time/resources put aside for service development work? Question 47: Has your service undergone any service evaluation, monitoring or auditing in the last year?