Care Coordination for Older People: An Exploration of Emergent Arrangements for the Provision of Care at Home

Research and Policy Update

EDITORIAL

It can be argued that the blue print for the development of community based care over the last twenty years has been the Griffiths Report '*Community Care: Agenda for Action*' which preceded the community care reforms of the 1990s. At the level of the individual service user, this report recommended: an assessment of need involving the service user and their carer; that identified needs were met via a care package, tailored to need and provided within budget; the provision of long-term support even if the care package was stable; and that the process was overseen by a care manager. Furthermore the report sought to identify core tasks which local authorities must undertake in order to provide this mode of care for users and carers. These were: the identification of the needs of the population; the diversion of resources from institutional care to support people at home; and the development of residential and nursing home provision in order that it meet the individual needs of those who could not be cared for in their own homes. The latter constitute the development of the strategic planning and commissioning roles of the social services authorities.

Recently there have been several changes in the care environment relating to the delivery of services for vulnerable older people arising from the introduction of the personalisation agenda. However, it is interesting to reflect that to a greater or lesser extent the pursuit of many of the principal recommendations of the Griffiths Report remain aspirational goals for those currently charged with responsibility for the planning and delivery of services for older people and their carers. At the outset of the introduction of the community care reforms it was recognised both that these changes required a significant reconfiguration of services in order to provide high quality cost-effective care and that the time frame in which these would be made would be a long one. More specifically it was envisaged that the primary role of the local authority would be as an 'enabling' agency arranging for the provision of care rather than being the primary provider of it. Increasingly it was envisaged that the care for vulnerable older people would be provided by the independent sector including voluntary, not-for-profit, and for-profit organisations, thereby increasing the

range of options and widening consumer choice. Another hallmark of the reforms was that services should respond flexibly and sensitively to the needs of service users and carers. It was also axiomatic to the community care reforms that there should be an improvement in the quality of services provided.

This bulletin presents research findings from three studies relevant both to some of the principal themes of the current personalisation agenda and the enduring goals of the community care reforms. The first explores the practice and procedures which facilitate the flexible use of resources within local authorities with respect to the provision of care at home for vulnerable older people. To complement this, the second study investigates and documents the role of organisations independent of local authorities in the provision of care coordination for older people and their carers. The third study presents findings from a national survey of commissioning and contracting arrangements employed by local authorities in respect of services for vulnerable older people with a particular focus on human resources processes and practices.

CARE COORDINATION FOR OLDER PEOPLE AND THE PSSRU AT MANCHESTER

The Personal Social Services Research Unit at Manchester undertakes research into health and social care issues and receives some of its funding from the Department of Health. The Unit's work focuses predominantly on community based long-term care, particularly in relation to services for older people. Increasingly the research spans the interface between local authorities and other providers of care in the local health and social care economy.

Recently the Department of Health commissioned the PSSRU to undertake an evaluation of arrangements made by local authorities responsible for social care to discharge their responsibilities to support vulnerable older people. Findings from two of the studies within this programme of research entitled *Coordinated Care, Care Management and Service Integration* are reported here. Additionally, findings from the first of a three phase research study: *Recruitment and Retention of*

a Care Workforce for Older People are described. This provides additional information about some of the factors that influence the delivery of coordinated care to vulnerable older people. Overall, the aim of this work is to investigate the emergent arrangements for the provision of social care to older people and their carers and the extent to which services address the range of needs and wishes of older people by offering greater flexibility, choice and responsiveness.

THE RESEARCH TEAM

The PSSRU staff conducting this study are *David Challis, Jane Hughes, Helen Chester, Caroline Sutcliffe*, and *Chengqiu Xie* at the University of Manchester.
This Update was edited by Jane Hughes and Helen Chester, sub-edited and typeset by Asha Myers and printed by Paramount Print.

EXPLORING THE FLEXIBLE USE OF BUDGETS – KEY FINDINGS

In this study we define the flexible use of budgets as the allocation of money which permits the provision of assistance in response to identified need in a manner which is characterised by an individually tailored response. It is, therefore, a resource administered by the local authority in order to provide a service in response to assessed need and thus management arrangements are necessarily different from those employed when following assessment, service users receive a cash payment to make arrangements for their care.

Using data from two national postal surveys, 23 authorities were identified that had such arrangements. Semi-structured telephone interviews were conducted with representatives of 20 of these. Characteristics and arrangements in respect of 26 schemes described by them are reported here.

Characteristics of the schemes

The schemes were available to adult service users; carers of adults; or carers of older people. The majority was targeted on carers of adults and only four were specifically for carers of older people. The commonest methods of transaction were by cash or cheque direct to the user or carer; via a broker; or by voucher to purchase services and / or equipment.

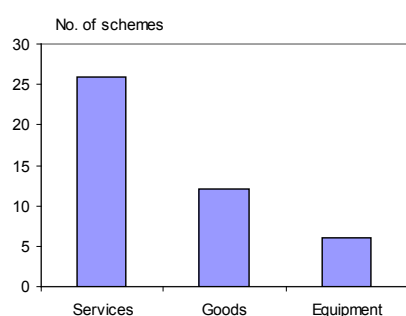### Figure 1: Type of service receipt

Figure 1 demonstrates that fewer than half the schemes funded the purchase of goods, and around a quarter the purchase of equipment. The level of budget specified varied considerably, some being limited by a sum of money and others by the amount of time provided. Just over one third of schemes did not impose any specific cost ceiling. Some had particular limits, for example 25 hours per week. In terms of specified cost, schemes ranged from a limit of £100 per year to £40,000 per year. Most allowed the use of their schemes once in any financial year with users and carers being able to apply again in subsequent years.

Operational arrangements

Eligibility for the schemes or services is shown in Figure 2. Just over three-quarters were available via a user or carer assessment and under one-quarter employed written guidance. A small number cited self-assessment or a resource allocation system as determining budget size or a panel process to determine this: these are included in the 'other' category in the figure.

Whilst a majority of schemes could be accessed by all staff, around a third could only be so by qualified social care staff. Additionally some authorities permitted access by carer centre staff or other voluntary sector staff; general practitioners; or other health care staff.

Almost three-quarters of schemes provided assistance to carers in the form of sitting services or respite care within the person's home. Half the schemes permitted specific purchases of items that could be used within or outside the home, for example a wheelchair accessible garden and contributions to travel costs. Fewer specified the provision of personal care services such as Crossroads Care and laundry

services. Some were aimed at improving carers' well-being or health by allowing the purchase of gym membership, counselling or cookery courses. Budgets were also used to pay for services such as gardening or window cleaning.

Figure 2: Allocation of budget
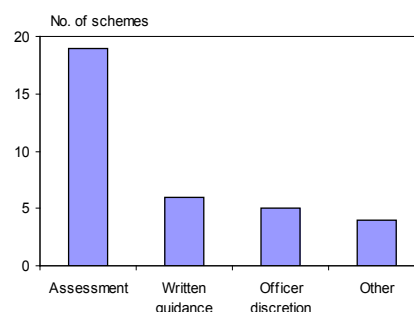
The majority of respondents reported that schemes imposed some boundaries or limits, both in terms of level of expenditure and type of service. Around half were restricted to the provision of agreed or assessed needs, or *Fair Access to Care Services* guidelines; many were for services unavailable elsewhere; and some had service-specific limits such as vouchers for respite residential care. A number of respondents had encountered no difficulties in the operation of the schemes. However, staff issues; excess demand or popularity; and costs or finances were reported as particular concerns, as reflected in Box 1.

Overall, it is notable that the majority of schemes described here were designed to support the carers of older people, ostensibly to help maintain them in their caring role, and some variation in their management and operational arrangements was apparent. Interestingly, in the light of developments in personal budgets, at the time of the survey there appeared to be limited evidence of flexible resource use within care packages.

Box 1: Operational dilemmas

Defining boundaries
Agreed / assessed needs
- don't serve anybody unless FACS substantial or critical
- achieving the needs of carers
- agreeing with the individual what they want

Not services available elsewhere
- shouldn't fund services available from mainstream
- not traditional care services
- if they needed regular respite they would use mainstream services

Service specific
- purely residential care
- limited by its nature - created for carers who don't want to use DPs
- can only be registered care home but anywhere in the country

Implementation challenges
Staff issues
- supporting staff to be creative
- wrestling with traditional model of social work
- difficulties of a new system, procedures and training

Demand / popularity
- massive increase in volume
- problem if take-up so global it has to be restricted
- people accessing it too often

Costs / finances
- managing the budget - may not all be spent
- issue of cost-raising for most expensive cases
- administration issues with voucher reconciliation

EXPLORING THE ROLE OF INDEPENDENT ORGANISATIONS IN CARE COORDINATION FOR OLDER PEOPLE AND THEIR CARERS - KEY FINDINGS

In this study we explore and document the role of organisations independent of local authorities (including voluntary, not-for-profit, and for-profit organisations) in the provision of care coordination for older people and their carers. Here care coordination is defined as assessment of needs undertaken by a worker with specialist knowledge, and / or the compiling, monitoring and review of a support plan by a care coordinator for older people with complex needs or their carers.

Using data from a national postal survey, 27 authorities were identified that had such arrangements. Semi-structured telephone interviews were conducted with representatives of 26 of these. Characteristics and arrangements in respect of 40 schemes described by the respondents are reported here.

Target group and characteristics of independent organisations

Figure 1 demonstrates that nearly half of the organisations provided care coordination for carers and just over a third for people with sensory impairments. Several organisations provided this service exclusively for people from an ethnic minority background. Very few of these arrangements were specific to older people.

All were voluntary organisations. Less than half operated solely within a single authority and the remainder had regional or national affiliations. Usually there were one or two staff undertaking care coordination tasks in each organisation but in a minority the number was larger with a maximum of

Figure 1: Target group
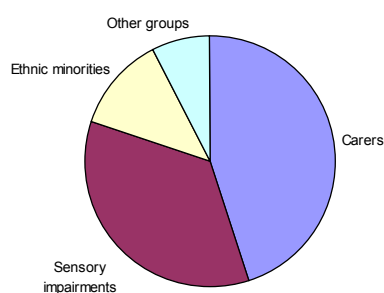
eight in one agency. About two-fifths employed staff with a social or health care qualification, and one quarter employed technically qualified staff such as qualified rehabilitation workers and specialist interpreters. In most organisations staff qualified by experience undertook care coordination tasks.

Care coordination tasks

As Figure 2 demonstrates, most organisations undertook some form of assessment. This was variously described as: initial, agency specific, statutory or to determine the appropriateness of equipment. Just over half undertook a brokerage role which usually involved referring and sign-posting to other services but rarely the commissioning or purchasing of care. Over two-thirds were involved in care planning and the compilation of a support plan and over half were reported to undertake tasks associated with the monitoring and review role.

Figure 2: Care coordination tasks
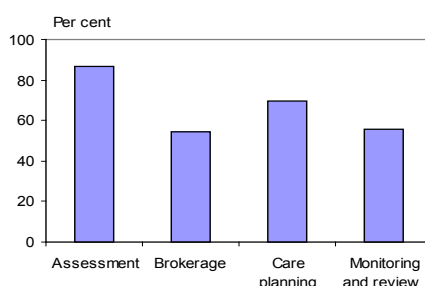
In addition to these core tasks, organisations also undertook a number of activities closely associated with care coordination. Some reported involvement in intensive care management, either as providers of assistance as part of the care planning and / or implementation processes. Additionally, some independent organisations in the study were providers of domiciliary care, equipment / assistive technology or day time activities.

Most respondents reported that their authority remained involved with service users following their referral to independent organisations. This usually took the form of the periodic review of user circumstances but otherwise it was in relation to the investigation of complaints about the organisation, its services and responding to changes in identified needs.

Commissioning and contracting arrangements

Three-quarters of the organisations were commissioned by local authorities and the remaining quarter were jointly commissioned by local authority and Primary Care Trusts or parent independent organisations. In the majority of cases, the interface between local authorities and the independent organisations was managed by contracts. About one-fifth of the organisations obtained funding from local authorities in the form of a grant. A small number of authorities described it as 'service level agreement'.

Figure 3 reveals that all organisations were required to make returns to the commissioning body relating to activity data. Additionally performance was monitored by use of user satisfaction measures in over two-thirds of the organisations. Meetings between service commissioners and providers were used less frequently as a means to monitor the latter's contractual performance. Furthermore, over three-quarters of the organisations had been subjected to a formal evaluation. Sometimes this was undertaken by consultants and separate from the contract monitoring and review process.

Overall, initial findings suggest that the role of independent organisations in care coordination arrangements for older people and their carers is still quite limited in terms of both the scale and extent of their involvement.

Figure 3: Means of monitoring and review
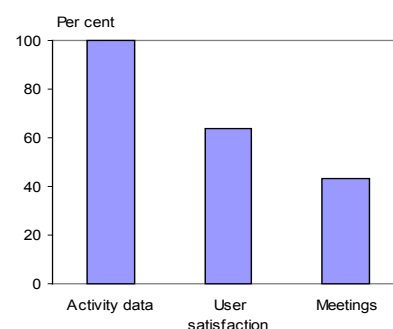
RECRUITMENT AND RETENTION OF THE SOCIAL CARE WORKFORCE FOR OLDER PEOPLE – PHASE I FINDINGS

This study is being conducted jointly by the PSSRU and the European Work and Employment Research Centre at the University of Manchester. Using a mixed methods approach it seeks to explore the influence on recruitment and retention issues within the workforce of different approaches to commissioning and contracting services for older people. In the first phase, a postal survey of local authorities in England was undertaken to which almost three-quarters responded. Here some of the findings relating to commissioning and contracting arrangements, with a particular emphasis on domiciliary care services, and partnership working are reported.

Commissioning arrangements

Nearly all authorities commissioned older people's domiciliary care services. Adult placement schemes and specialist domiciliary provision were commissioned to a lesser extent. Additionally, several types of care home provision were commissioned by most authorities.

A wide range of stakeholders were routinely consulted in the commissioning process. However, whilst nearly all authorities canvassed the views of current service users and their carers, less than half consulted with next generation older people. Furthermore, whilst most included providers of social care services, only around a third involved employee representatives.

Contracting arrangements

Three-quarters of local authorities reported having block purchase contracts for independent residential / nursing home services for older people. A majority also used block contracting to purchase domiciliary care, although nearly two-fifths did not. Typically these were fixed term contracts and two to three years in length.

Figure 1 provides details of contract specifications relating to the training and development of hands-on care workers. In relation to domiciliary care, most authorities specified: induction and training for new staff; and staff development and appraisal. However, less than half included specialist training for the care of older people with dementia and less than a third payment for staff attending training. With regard to residential care, around four-fifths specified: training achievement levels; and induction and training for new staff. Three-fifths required that care workers should receive specialist training for dementia, however, only around a quarter of authorities specified payment for staff attending training.

Contract monitoring

Monitoring of in-house domiciliary care provision was most likely to be undertaken through a contractual framework or the use of quality assurance systems. For independent sector provided services this process utilised a greater variety of information sources including Commission for Social Care Inspection reports and user satisfaction surveys. Around four-fifths of authorities monitored contracts with independent domiciliary care providers in relation to staffing and human resource policies. The most frequently reported areas of reviews were: staff development and training; recruitment procedures; conditions of service; and retention of staff.

Partnership working

Most local authorities negotiated with one Primary Care Trust (PCT), whilst a fifth negotiated with more than two. Figure 2 reveals that in terms of joint commissioning, over three-quarters of authorities had joint plans and planning processes with PCTs. In contrast, only a minority pooled total agency budgets for older people's services, and less than a third had a single lead commissioner for health and social care. Almost all authorities jointly commissioned with their PCT(s) for intermediate care services, with local authority / NHS staff most likely to provide these services. Less, but over half jointly commissioned old age mental health services, with these most likely to be provided by the independent sector.

Only a minority of authorities had an integrated service provider for all provision. Where local authorities had one for selected services this was most likely to be for intermediate care.

Most local authorities had formed a training partnership with other agencies, typically independent providers, and to a lesser extent with local NHS organisations. A wide range of training courses were provided to care staff. However, these were more likely to be made available to in-house staff than to those in the independent sector. Nearly all local authorities had a provider forum which met on a number of occasions throughout the year.

In the light of recently established targets for the transformation of social care, these data provide baseline information against which changes in partnership working, commissioning, and contracting processes may be measured.

Figure 1: Specifications in contracting for domiciliary and residential care

Per cent

- Induction and training for new staff
- Staff development and appraisal
- Supervision of staff
- Training achievement levels
- Provision of management training
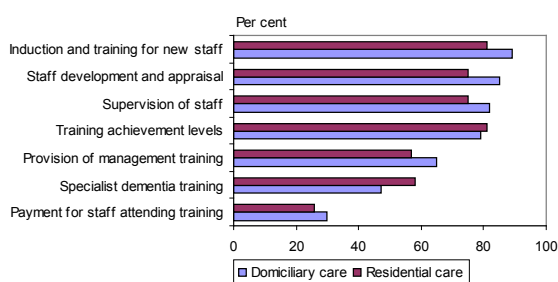- Specialist dementia training
- Payment for staff attending training

Domiciliary care Residential care

Figure 2: Joint commissioning arrangements

Per cent

- Joint plans and planning processes
- Pooling of ring fenced monies
- Joint specification of contracts
- Single lead commissioner
- Pooling of total agency budgets