Mapping and Evaluation of Care Management Arrangements for Older People and those with Mental Health Problems

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EDITORIAL

Integrated care for frail older people is increasingly central to government initiatives in long-term care, exemplified by such strategies as partnership arrangements between health and social services. Older people with mental health problems may be those who could benefit most from this. The Audit Commission's report, *Forget Me Not*, published last January, presented the results of a recent study of services for this group of people.

Key findings of the report were:

- Carers need information and advice at an early stage in order to carry on caring.
- GPs often have difficulty in providing appropriate assistance, partly due to insufficient training in diagnosis and management.
- The availability of specialist services was very variable across areas. Where they were available, there was a relative lack of support to residential and nursing homes, although this could avoid hospital admissions and provide better quality of care.
- Flexible, home-based care provided by joint health and social services teams could enable people to continue to live at home, rather than enter a residential setting.

The report concluded that there is considerable scope for improved co-ordination between health and social services. It identified the crucial role of commissioners of services in pulling together the elements of a comprehensive service, and the role of annual Joint Investment Plans in identifying the resources available and specifying service outcomes.

This bulletin presents findings from the national study of care management arrangements in the Mapping Study relating to older people with mental health problems. These provide a baseline measure of the arrangements from which the Audit Commission's report suggests changes must be made if current policy goals of independence and more consistent and integrated care are to be achieved. Continuing this theme, this issue also includes an article by Michael Donnelly on the integrated health and social care system in Northern Ireland.

THE MAPPING STUDY AND THE PSSRU

The PSSRU undertakes research into social and health care issues, and receives its main funding from the Department of Health. The focus of the Unit's work is community-based and long-term care, and increasingly it addresses issues relating to the interface between health and social care.

The Department of Health commissioned the Mapping Study to evaluate the different forms, types and models of care management which have emerged since 1993 for the two major groups: older people and those with mental health problems.

The study started in 1996 and will have three phases:

- In the first phase, questionnaires on assessment and care management were sent to all local authorities in England. 85% returned the overview questionnaire for all adult service user groups, and 77% returned the separate questionnaires for older people and those with mental health problems.
- In the second phase, more detailed data are being collected in a small subset of authorities representative of the different care management types for the two service user groups.
- In the third phase, a small number of different sets of arrangements for these two service user groups will be evaluated, to examine their relative efficiency and effectiveness.

Information from the overview questionnaire contributed to a special study on care management by the Social Services Inspectorate (see page 4 for details). The first two issues of *Research and Policy Update* presented results from the overview and the old age services questionnaires. The next issue will present results from the mental health services questionnaire.

THE RESEARCH TEAM

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KEY FINDINGS ON CARE MANAGEMENT ARRANGEMENTS FOR OLDER PEOPLE WITH DEMENTIA

This article presents some of the key findings specifically concerning dementia services from the Mapping Study questionnaire on old age services. This was sent out in autumn 1997 to 111 local authorities in England that had responded to an initial overview questionnaire on care management arrangements for the main adult service user groups. Responses to the old age services questionnaire were received from 101 authorities. It should be noted that the completion rate for the questions relating to dementia reported here were lower than for the questionnaire overall, and ranged from 70 to 95 authorities. Key findings relating to care management arrangements in respect of all service user groups were described in Issue 1 of *Research and Policy Update* and more detailed findings relating to older people were reported in Issue 2. A forthcoming article by Jane Hughes and others contains a fuller discussion of the findings relating to dementia services (see page 4 for details).

Specialist services

46% of authorities provided a specialist dementia service in conjunction with health providers. In the majority of these (37% of authorities) this was available throughout the authority, and in the remainder (9% of authorities) the service was available in only part of the authority. As figure 1 shows, there was considerable variation between the types of authorities. This type of service was available in 65% of London boroughs, 56% of metropolitan districts, 27% of counties and 48% of new unitary authorities. Moreover, there was some variation in the degree to which the services were available throughout an authority or in part of the authority only. Where a specialist service was reported, it was available throughout the authority in all London boroughs and new unitaries, but this was not the case in the metropolitan districts and the counties.

Care Programme Approach

82% of authorities reported that the CPA was applied to older people suffering from dementia in at least one health trust with which they collaborated. Again, there was variation by authority type, with the proportion being somewhat higher in the London boroughs and the new unitary authorities compared with metropolitan districts and counties. Authorities were also asked to state the proportion of users of dementia services in receipt of care management who were also subject to the CPA. 60% of respondents reported that the CPA was not applied to older people with dementia who were in receipt of care management or was applied in fewer than 20% of cases. On the other hand, 20% of respondents indicated that over 80% of older people with dementia and receiving care management were subject to the CPA. This suggests that, whilst in the majority of authorities the CPA may be applied to older people with dementia, in practice it is applied to relatively few users. Furthermore, it suggests that authorities tended to fall into two groups: first, those in which the CPA is rarely if at all applied to people with dementia receiving care management; and second, those in which it is the norm.

Assessment

Approximately one-quarter of authorities reported that there was a single set of assessment documents for people with dementia that was common to both health and social services, for at least one trust with which they collaborated. 43% of authorities reported that assessments of need made under the CPA for older people with dementia were accepted as assessments for care management. As figure 2 demonstrates, this was more likely to be the case in the London boroughs than in other types of authorities. However, whilst this facility is available, as suggested above, it may not occur frequently in practice.

Figure 1. Specialist dementia service available in part or throughout authority

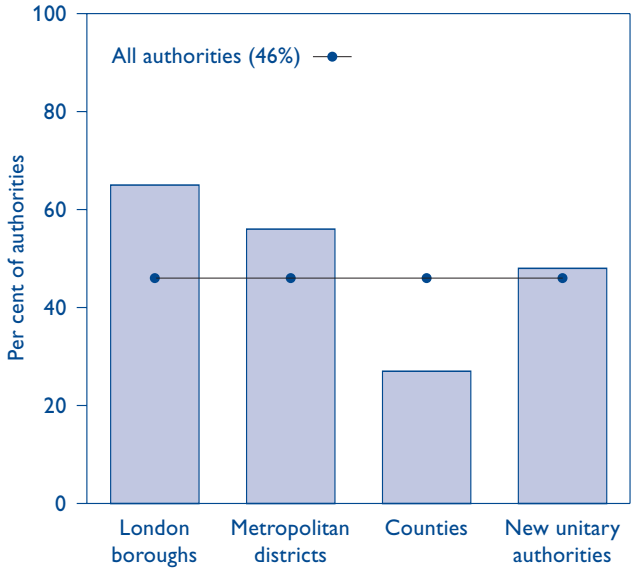
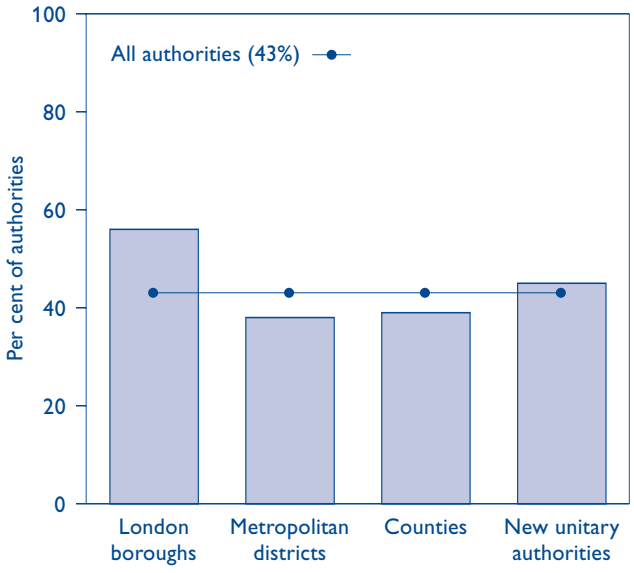


Figure 2. CPA assessments accepted as assessments for care management for older people with dementia



PARTNERSHIP IN HEALTH AND SOCIAL CARE: THE CASE OF NORTHERN IRELAND

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The need for closer integration between health and social services has been a consistent policy theme for many years. The PSSRU study of care management is being extended to Northern Ireland (NI) to identify the impact of an integrated health and social care system. The comparative study will identify and describe the different forms of care management in Northern Ireland; assess their relative costs and their impact on older people and people with mental health problems; and compare the advantages and disadvantages of the integrated system with the separate arrangements under which care management has been implemented in England.

This study is particularly relevant in view of the 1998 Department of Health Discussion Document *Partnership in Action*, which aimed to remove barriers to joint working through mechanisms such as pooled budgets, lead commissioners and integrated provision.

Integrated health and social care in Northern Ireland

Northern Ireland's four integrated health and social services (HSS) boards were established in 1973. Each board had responsibility for delivering health and social services at an 'area' level and at a 'district' or local level. The integrated structure seemed to aid inter-professional collaboration in community care and other areas such as child protection procedures.

In the early 1990s the HSS boards became commissioners of health and personal social services, and smaller sub-organisations known as trusts assumed responsibility for the provision and delivery of services. There are eleven community health and social services trusts (out of a total of 19 trusts). The HSS boards are responsible for monitoring statutory (mainly social work) functions delegated to HSS trusts. Services in community trusts such as elderly care may be managed by individuals from any disciplinary background. The only service area where an integrated management arrangement does not apply is child care, due to statutory requirements for professional social work line management.

The Audit Commission's 1992 report, *Community Care: Managing the Cascade of Change*, described Northern Ireland as a successful example of structural unification of local health and social services. Many benefits have been attributed to the Northern Ireland model of joint commissioning boards, including:

- creation of a framework for comprehensive care
- reducing organisational problems
- simplifying resource allocation difficulties

Community care arrangements

In 1991, following the 1989 White Paper on community care in England, *Caring for People* (Cm 849), the DHSS (NI) published *People First: Community Care in Northern Ireland for the 1990s*, which reiterated one of the key objectives of the community care reforms: 'to make proper assessment of need and good case management the cornerstone of high quality care.' Responsibilities for the coordination of assessment and provision and delivery of community care were not assigned to a specific professional discipline. It was left to the HSS boards, then units of management, and now trusts to implement community care and care management in the context of the organisationally integrated service.

An example of an integrated service

The structure and organisation of the integrated service varies between community HSS trusts. For example, one provides health and social care via integrated teams comprising nurses, social workers, care managers and other specialist staff. The management of each team is undertaken by a nurse-social worker dyad: when the disciplinary background of the manager is social care the assistant manager is selected and recruited from the nursing profession, and vice versa.

Each team is attached to one or more general practitioner (GP) practices and covers a patch or a 'natural community' encompassing GP practices and their lists of patients. There are six natural communities ranging from 16,000 to 42,000 patients on the lists of between 10 and 29 GPs.

The manager is responsible for a devolved budget encompassing primary healthcare and social care including community care and care management. This person determines eligibility for assessment, the required level of assessment, and then allocates the case to a practitioner, who is usually a care manager but may be any member of the integrated team. The care manager requests and coordinates contributions to the assessment from the GP and appropriate members of the integrated team as well as from the client and their carer. A care plan is devised based on assessed need and matching services are commissioned or purchased from the trust and/or the independent sector. Clients' needs are reviewed regularly by the care manager.

Evaluating the integrated system

One of the alleged benefits of the integrated system in the context of care management is the way in which it facilitates multidisciplinary working and enables funding to be managed and used by multidisciplinary teams. It is notable that the care management system appears to work in the integrated system without the need for the Care Programme Approach in mental health services, which has been the subject of much debate in England. However, there is relatively little empirical evidence for the benefits of the integrated service noted in, for example, local policy documents and reports. Empirical research in care management is also lacking.

The extension of the PSSRU study will lead to the first proper evaluation of the impact of the integrated system upon the organisation, provision and delivery of care management and community care. A report of the results of phase one of the evaluation which focuses on the structure and organisation of care management in Northern Ireland's 'partnership' system will be produced later this year.

RELATED RESEARCH

TOWARDS A NATIONAL STANDARD ASSESSMENT INSTRUMENT IN CONTINUING CARE HOMES: USE OF THE MDS/RAI

Assessment has become one of the key components of government policies which are designed to avoid inappropriate placement and ensure cost effective high quality long-term care. Assessment information may be useful, not only to improve the care of the individual resident, but also at an aggregated level to understand the quality of care within a home or group of homes.

In the late 1980s, following concern about a series of scandals relating to quality of care which had arisen in the long term care industry, the US Government Health Care Finance Administration contracted with a consortium of professionals for a system which would record individual need, provide reliable information for quality and link needs to costs. The result was the Minimum Data Set/Resident Assessment Instrument (MDS/RAI).

The MDS/RAI

The MDS/RAI consists of the Minimum Data Set, a structured assessment tool (box 1) covering the range of domains of need appropriate for assessing the needs of vulnerable older people in care homes, and 18 Resident Assessment Protocols (box 2). The latter are triggered by the assessment tool and guide the assessor through areas of potential need to identify whether further action is required in the care plan. It is completed as an admission assessment to provide baseline data and periodically reviewed.

Box 1. The MDS/RAI Assessment Domains

- Identification & background information
- Cognitive patterns
- Communication/hearing patterns
- Vision patterns
- Mood & behaviour patterns
- Psychosocial well-being
- Mobility & activities of daily living
- Continence in last 14 days
- Disease diagnoses
- Health conditions
- Oral/nutritional status
- Oral/dental status
- Skin condition
- Activity pursuit patterns
- Medications
- Special treatments & procedures
- Discharge potential/overall status
- Assessment information

Box 2. The MDS/RAI Resident Assessment Protocols (RAPs)

- Acute confusional state
- Cognitive loss/dementia
- Visual function
- Communication
- ADL function/rehabilitation potential
- Urinary continence & indwelling catheter
- Psychosocial well-being
- Mood state
- Behavioural symptoms
- Activities
- Falls
- Nutritional status
- Feeding tubes
- Dehydration/fluid maintenance
- Dental care
- Pressure sores
- Psychotropic drug use
- Physical restraints

Using the MDS/RAI in the UK

A pilot study of the assessment tool in the UK found that 78% of staff reported that they had learned new information about the resident. In general it was seen as a good comprehensive assessment document, which had the potential to indicate changes in residents' needs through time. It also improved staff perceptions about the need for rehabilitation and other possible interventions to improve care.

The Joseph Rowntree Foundation has commissioned the PSSRU to produce a UK version of the MDS manual for use in care homes. This has now been published: *UK Long Term Care Resident Assessment Instrument User's Manual, MDS/RAI UK*, by D. Challis, K. Stewart, D. Sturdy and A. Worden, inter*RAI* UK, York, 2000. (Available from York Publishing Services Ltd, 64 Hallfield Road, York YO31 7ZQ, ISBN 0-9538733-0-7.)

RECENT AND FORTHCOMING PUBLICATIONS

Care Management Study: Report on National Data. Mapping and Evaluation of Care Management Arrangements for Older People and Those with Mental Health Problems
David Challis et al., Department of Health, London, 1998. (Available from the Department of Health, PO Box 777, London SE1 6XH, reference CI(98)15.)

Community Care, Secondary Health Care and Care Management
David Challis, Robin Darton and Karen Stewart (eds), Ashgate, Aldershot, 1998. (ISBN 1 84014 581 1)

A new version of the Geriatric Depression Scale for nursing and residential home populations: the Geriatric Depression Scale (Residential) (GDS-12R)
Caroline Sutcliffe et al., *International Psychogeriatrics*, 2000, **12**, 2, 173-181.

Care management and the Care Programme Approach: towards integration in old age mental health services
Jane Hughes et al., *International Journal of Geriatric Psychiatry* (forthcoming).

Care management: prevention and an alternative to institutional care?
David Challis et al., *Age & Ageing* (forthcoming).

Dependency in older people recently admitted to care homes
David Challis et al., *Age & Ageing*, 2000, **29**, 3, 255-260.

Psychiatric symptomatology in elderly people admitted to nursing and residential homes
Caroline Mozley et al., *Aging & Mental Health*, 2000, **4**, 2, 136-141.

Recognition of depression by staff in nursing and residential homes
Heather Bagley et al., *Journal of Clinical Nursing*, 2000, **9**, 3, 445-450.

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