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

Research and Policy Update

PSSRU

at the University of Kent at Canterbury, the London School of Economics and the University of Manchester

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EDITORIAL

Integrated care for adults with mental health problems has been the principal theme in successive policy initiatives, particularly in the last decade. Currently, service development toward this goal is taking place within the National Service Framework for Mental Health (NSFMH), which specifies seven standards of expected good practice addressing five areas:

- mental health promotion
- primary care and access to services
- effective services for people with severe mental illness
- assistance to carers
- prevention of suicide

It places an emphasis on the implementation of changes necessary to achieve an increase in the quality of services and a reduction in unacceptable variations in health and social care, and on measuring progress. The Commission for Health Improvement, the National Performance Indicators and the National Survey of Patients have been accorded a key role in promoting quality in the NHS. For social care it is anticipated that this will be achieved through the Performance Assessment Framework, including performance indicators. In the Department of Health's policy booklet relating to the modernisation of the Care Programme Approach (CPA), arrangements for integration with care management were specified, in order to provide a single care co-ordination approach for adults with mental health problems.

This bulletin presents research and practical initiatives relevant to the themes of service integration, modernising services and performance management. We report findings from a national study of care management arrangements, the Mapping Study. These provide baseline measures from which changes must be made to achieve the goals outlined in the NSFMH. Continuing this theme, we describe a small research study which audited links between care management and the CPA. Additionally, Andrew Butters comments on the process of establishing a formal partnership agreement between health and social care designed to deliver more integrated services for users of mental health services and their carers, and the strengths of the new organisation.

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 were 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.

The first three issues of *Research and Policy Update* presented results from the overview and the old age services questionnaires. This issue presents results from the mental health services questionnaire.

THE RESEARCH TEAM

The PSSRU staff conducting this study are David Challis, Jane Hughes, Paula Mandall and Karen Stewart at PSSRU, University of Manchester, and Robin Darton at PSSRU, University of Kent. Kate Weiner was also a member of the team until October 2001. The project secretaries are Charlotte Makin at PSSRU, University of Manchester (0161 275 5681; e-mail charlotte.r.makin@man.ac.uk), and Glenys Harrison at PSSRU, University of Kent (01227 823862; e-mail G.Harrison@ukc.ac.uk).

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KEY FINDINGS ON MENTAL HEALTH SERVICES

This article presents some of the key findings from the Mapping Study questionnaire on mental health services. This was sent out in autumn 1997 to 111 local authorities in England who had responded to the initial overview questionnaire on care management arrangements for the main adult service user groups. Responses were received from 101 authorities.

Risk assessment

The majority of authorities (84 per cent) reported that their assessment documents included a specific section relating to risk. Almost three-quarters (73 per cent) explicitly covered the areas of danger to others and the same number covered deliberate self-harm. Sixty-nine per cent covered accidental self-harm and 59 per cent covered abuse/exploitation. Authorities were also asked about the people from whom information was routinely sought for the risk assessment. This was most commonly from three groups: psychiatrists, psychiatric nurses and the service users' families (by 60, 59 and 58 per cent of authorities respectively). Fewer than half of the authorities routinely required collection of information from GPs or other groups.

Joint commissioning

The number of health providers (trusts) with which authorities negotiated ranged from one to 11, approximately two-fifths negotiating with only one provider. Nearly all authorities (95 per cent) had formal arrangements with their NHS colleagues for sharing information at the level of the individual service user. This most commonly involved multidisciplinary locality meetings, exchange of written information, shared assessment documents and access by care managers to hospital patient records. Each of these arrangements was used by more than three-quarters of authorities with at least one of the trusts with which they worked in partnership. At an authority-wide level, most authorities had joint plans and planning processes in place. About two-fifths had some joint management arrangements and a similar proportion had examples of joint specification and overseeing of contracts. Figure 1 shows details of the types of services that were jointly commissioned. The most common services were day care, vocational programmes and residential care.

Team structure

About two-fifths of authorities had the formal title of care manager in services for people with mental health problems. A variety of staff acted as care managers or undertook the equivalent role. Qualified social workers did this in all authorities. Social work assistants, community care workers and support workers were involved to a lesser extent (in 28, 19 and 18 per cent of authorities respectively). In addition, NHS staff worked as care managers in approximately two-fifths of authorities. This most commonly involved community psychiatric nurses, but also included occupational therapists or psychologists in some authorities. Care management staff for people with mental health problems, or staff undertaking the equivalent role, were based in community mental health teams in three-quarters of authorities and in specialist mental health teams within social services departments in half of the authorities. Fewer than a quarter of authorities had such staff based in generic adult services teams.

CPA & care management

Approximately four-fifths of the authorities had formal links between assessment and care management and the Care Programme Approach with at least one of the trusts with which they worked in partnership. This mainly involved the tiered approach specified in *Building Bridges*[1] or other tiered approaches. It should be noted that the mental health questionnaire preceded the introduction of two standardised levels of CPA, as specified in *Modernising the Care Programme Approach*[2]. A large proportion of authorities had shared arrangements for the provision of specialist psychiatric services with at least some of the trusts with which they worked in partnership. These covered the screening process, allocation of key workers and care managers and the monitoring responsibilities of these groups of staff (see figure 2). Social services department staff acted as key workers for users subject to the CPA in all but two authorities, and this role was combined with the role of care manager in about four-fifths of authorities. Furthermore, assessments of need made under the CPA were accepted for care management in approximately 70 per cent of authorities. In terms of the overall arrangements at the time of the survey, about 30 per cent of authorities prioritised assessment and care management arrangements, while 40 per cent prioritised the CPA. The remaining 30 per cent did not accord priority to either system.

1 Department of Health (1996) *Building Bridges. A Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People*, Department of Health, London.

2 Department of Health (1999) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet*, Department of Health, London.

Figure 1. Examples of jointly-commissioned services

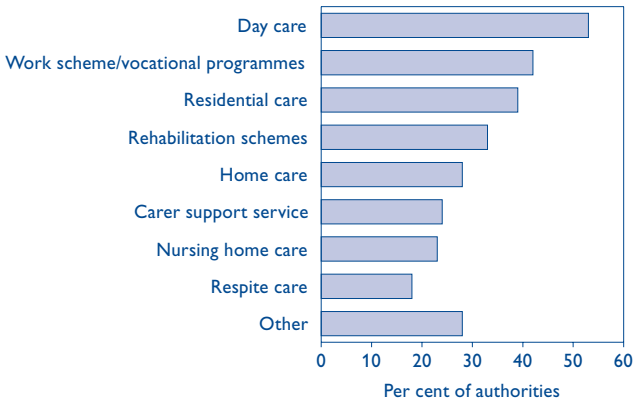
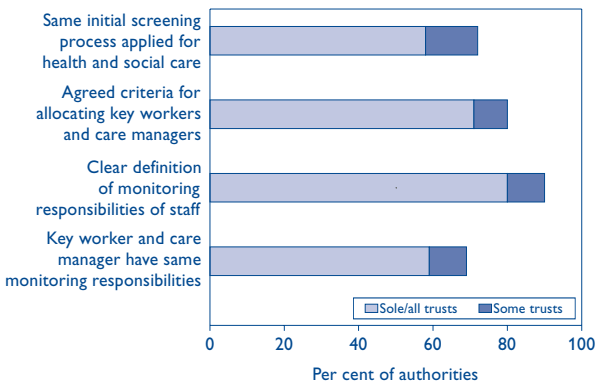


Figure 2. Shared arrangements within the specialist psychiatric services



MERGING MENTAL HEALTH SERVICES IN MANCHESTER

Andrew Butters, Chief Executive, Manchester Mental Health Partnership

Introduction

In October 2000, the mental health services of Manchester pooled NHS and social care resources to commission and provide integrated statutory services across the city. The commissioning budget is managed by a joint commissioning executive, and statutory services are provided by the Manchester Mental Health Partnership (MMHP), a subcommittee of the health authority. It has a budget in excess of £50 million and employs some 1300 people. The partners investing in this service do so through an agreement made possible by section 31 of the 1999 Health Act, which defines their relationship and obligations under the pooled fund arrangements (figure 1).

Structure

The MMHP board is designed along the lines of a NHS body, with positions on it divided between executive and non-executive. Apart from the nominations from the health authority and local authority to the board, all other positions were the subject of open advertisement. The non-executive posts are designed to reflect the range of stakeholders in the services. In establishing the executive team, a conscious decision was made to move away from a single profession approach and to attempt to model the team around the delivery of services. The governance directorate defines the framework within which the services should be delivered, and this is monitored by performance management which feeds back to the directorate (figure 2). The voluntary sector, community health councils (CHCs) and staff side participate in board meetings, while not being formally part of the board.

Experience to date

The MMHP has now been in operation for about a year. Local authority staff were seconded into the Partnership, although most new posts are recruited on NHS contracts. It is planned that most local authority staff will transfer across to NHS contracts after the initial two and a half years. Recruitment and retention of nursing and medical staff has improved since MMHP came into being.

Property used by MMHP is leased from the various owners, and many of the support services are provided under service level agreements with either the acute trust or the local authority. This allows the Partnership management to focus on issues arising from the delivery of mental health services, rather than the day-to-day maintenance of support services.

There have also been a number of notable practice developments. Bringing together people from different backgrounds has facilitated the design of a common risk assessment, needs assessment and care planning tool, reflecting experience from across the range of services. A complaints procedure has been created within the Partnership, whilst retaining the ultimate different appeal routes of the principal participating organisations. Furthermore, MMHP has enabled users and carers to debate the shortcomings and development of mental health services across the city by their involvement in most of the planning and co-ordination committees across the organisation. An advocacy strategy for Manchester has also been published.

Of particular benefit has been the establishment of wider links between the NHS and local authority services, via the link with social services. Links are being made to housing and employment services, and also to services for asylum seekers, who are emerging as significant users of mental health services. There are, of course, other difficulties to be overcome. Progress on the integration of community mental health teams has been slower than would have been wished. Discussions with neighbouring providers about moving to a registered population base, although proceeding, are taking time. You cannot change 20 years of history in nine months!

The aim of MMHP is to work towards providing a common set of city-wide standards of the highest quality, with no geographical barriers and with a single point of entry into the services. This will minimise the number of barriers within and between statutory services, and should lead to better patient experience and care.

The future

The current Partnership Agreement ends in March 2003. The move to larger health authorities has led us to review the legal basis for the Partnership. We are currently consulting on becoming a care trust from April 2002. The trick will be to manage the integration of these new factors, whilst retaining sufficient organisational stability to realise the service changes envisaged in the initial consultations.

Figure 1. Partnership agreement

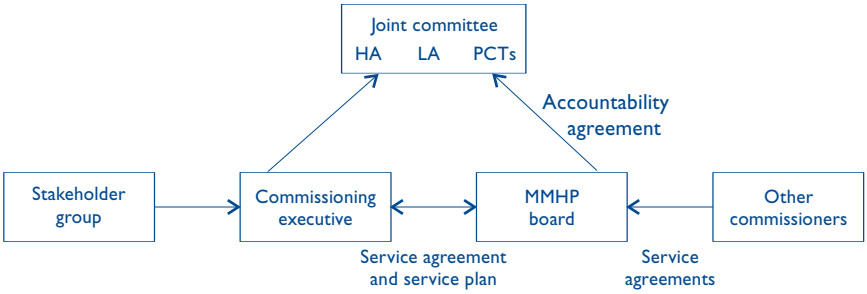
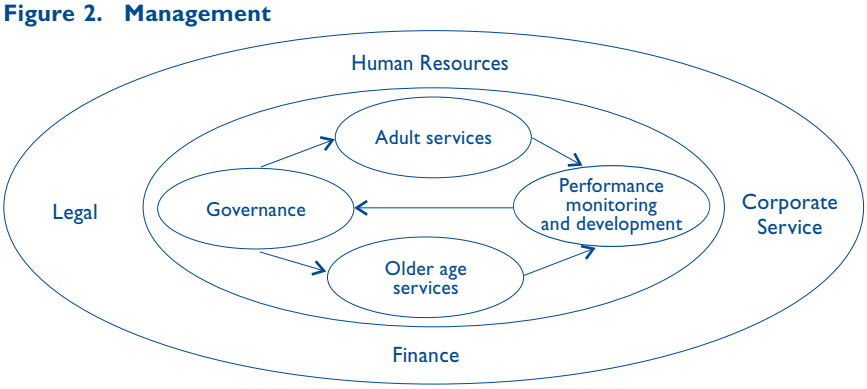


Figure 2. Management



RELATED RESEARCH

DEVELOPING AN AUDIT TOOL TO EXAMINE THE RELATIONSHIP BETWEEN THE OPERATION OF CARE MANAGEMENT AND THE CARE PROGRAMME APPROACH

The PSSRU at Manchester was commissioned by a social services department to examine the relationship between the operation of care management and the Care Programme Approach (CPA) throughout the authority, for adults with mental health problems under the age of 65 years. The emphasis of the review was on administrative process.

The task

Specifically, the authority which commissioned the research requested that systems, procedures and documentation were examined. The aims of the study were:

- to explore the similarities and differences in the arrangements between four trusts and social services
- to identify areas where health and social services were more or less integrated
- to suggest areas for future development

A key challenge was to devise a methodology that encompassed the views of the major stakeholders.

Method

The development of an audit tool was the most appropriate method of undertaking this research. Key policy documents and relevant literature relating to mental health services, the CPA and care management were scrutinised to identify procedures, processes and documentation indicative of integration between providers of health and social care. The aim was to identify factors that would contribute to the development of the key features of an integrated system of CPA and care management, as detailed in Department of Health guidance[1] (see box 1). Thirty-seven measures of integration were identified, and grouped in the five domains summarised in box 2. The domain relating to organisational arrangements included the largest number of measures. It was divided into four sections, which detailed joint agency arrangements; practice issues; procedural issues; and the development of an infrastructure which spanned the existing organisations providing health and social care to adults with mental health problems.

Multiple methods of data collection were used, with the aim of maximising the amount of information available and minimising the demands on staff time. Wherever possible, use was made of routinely-collected information, and permission was obtained to use part of a special data collection initiated by central government. In addition, relevant documents were scrutinised, and the main assessment documents used for both care management and the CPA were analysed. This was supplemented by the collection of qualitative data through interviews with key staff in each organisation. When the subjective views of respondents were required, the replies of all relevant staff groups were obtained. The main recommendations are summarised in box 3.

Box 1. Key features of an integrated system of CPA and care management

- A single operational policy
- Joint training for health and social care staff
- One lead officer for care co-ordination across health and social care
- Common and agreed risk assessment and risk management processes
- A shared information system across health and social care
- A single complaints procedure
- Agreement on the allocation of resources and, where possible, devolved budgets
- A joint serious incident process
- One point of access for health and social care assessments and co-ordinated health and social care

Box 2. Audit: key domains

- Policy requirements
- Organisational arrangements
- Practice procedures and protocols
- Management information
- Service development

Box 3. Audit: recommendations

- Eligibility criteria which span health and social care
- Integrated multidisciplinary community-based specialist mental health teams
- Clarification of roles and responsibilities within teams
- One case file for each patient/user, with shared assessment documents and care plans
- Systematic data collection to monitor performance and inform service development
- A single information leaflet detailing all service provision

1 Department of Health (1999) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet*, Department of Health, London.

RECENT AND FORTHCOMING PUBLICATIONS

Care management and the Care Programme Approach: towards integration in old age mental health services
Jane Hughes et al., *International Journal of Geriatric Psychiatry*, 2001, **16**, 3, 266-272.

Intensive care-management at home: an alternative to institutional care?
David Challis et al., *Age and Ageing*, 2001, **30**, 5, 409-413.

Care management arrangements for older people in England: key areas of variation in a national study
Kate Weiner et al., *Ageing and Society* (forthcoming).

Emerging patterns of care management for older people in England
David Challis et al., *Social Policy and Administration* (forthcoming).

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