MAPPING AND EVALUATION OF CARE MANAGEMENT ARRANGEMENTS FOR OLDER PEOPLE AND THOSE WITH MENTAL HEALTH PROBLEMS

The Overview Questionnaire

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INTRODUCTION

The Department of Health has commissioned the Personal Social Services Research Unit to provide an evaluation of the different forms, types and models of care management which have emerged for the two major service user groups: older people and those with mental health problems. The study is in three phases, the first of which has involved a national survey of care management arrangements, consisting of three questionnaires. The overview questionnaire, covering aspects of care management for all the main adult user groups, was sent to local authorities in spring 1997. Two further questionnaires, focusing on care management arrangements for people aged 65 and over and for people with mental health problems, were distributed in autumn 1997 and will be reported on separately. One hundred and ten of the 131 social services authorities then in existence in England returned completed overview questionnaires, representing a response rate of 84 per cent. A summary of the main findings is presented below. Recent policy initiatives which emphasise greater consistency and equity in service delivery, a more differentiated approach to care management and, in respect of older people, multidisciplinary assessment, provide particular salience to these findings.

ORGANISATIONAL STRUCTURE

Social services formed a single department in the majority of authorities, with less than one-fifth having combined departments. Almost half of the authorities had some care management systems, including experimental schemes, in place prior to 1st April 1993. However, these were reported by a much greater proportion of counties and London boroughs than metropolitan districts. About half of the authorities had introduced a division between purchasing and providing for domiciliary care by the end of 1993, and only a very small proportion had not done so by the time of the survey. The majority of authorities located care managers solely within the purchasing sector.

Half of the authorities provided assessment and care management in the community through specialist teams only. Less than 10 per cent of the authorities used generic teams only, and the remainder had a mixture of specialist and generic teams. The London boroughs were more likely than other types of authority to have specialist structures in place. The most prevalent specialist teams were for

THE PERSONAL SOCIAL SERVICES RESEARCH UNIT

undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three sites:

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mental health (about 90 per cent of authorities) and for learning disabilities (about 70 per cent of authorities). Nearly all authorities had social workers or care managers based in hospitals.

**CARE MANAGEMENT TASKS**

Assessment arrangements involved a wide range of staff groups, with London boroughs more likely to use designated care managers than other types of authorities. Occupational therapists were more commonly used in counties and new unitary authorities, and home care managers were more commonly used in London boroughs and new unitary authorities than in other types of authority. Health professionals coordinated assessments in about a quarter of authorities overall. Most authorities had two or more levels of assessment. Levels of assessment were most commonly defined by service user need, followed by the number of agencies involved and the cost of the care package. Overall, more than 60 per cent of the authorities used generic assessment documents for all adult service user groups.

Care planning was undertaken exclusively by purchasers/assessors in over 60 per cent of authorities. In the remaining authorities, providers were involved in the formulation and implementation of some care plans. Basic grade staff or the first tier level of management had at least some authority to purchase care packages in 80 per cent of authorities.

Monitoring was nearly always the responsibility of care managers, with relatively little involvement by other agencies. Over four-fifths of authorities had formal guidance on the review process for both community-based and residential and nursing home care. In the majority of these authorities, and across all service user groups, the timing of the first and subsequent reviews was specified.

**IMPLEMENTATION ISSUES**

Continuity of staff, involving the same practitioner being responsible for assessment, care management, monitoring and review, was more likely for people with a mental health problem or a learning disability. Across all service user groups, continuity was greatest in the counties and least in the new unitary authorities. There were considerable differences in average active caseloads. Mental health services had the smallest caseloads and older people's services had the largest caseloads. London boroughs, in general, appeared to have smaller caseloads than elsewhere. About one-quarter of authorities provided or purchased an intensive care management service somewhere within the authority. These services were focused on a number of specific user groups, most commonly people with mental health problems. The majority of authorities costed externally purchased services and over 60 per cent costed both in-house and externally purchased services. Over three-quarters indicated that they had a ceiling on expenditure for community-based care packages for at least one of the service user groups, most commonly older people.

Since 1993, the main areas of change to care management arrangements were structural changes (recorded by over one-third of authorities), and changes in assessment and care management arrangements or to the associated information and documentation (both recorded by one-fifth of authorities). The main aspects of care management seen to be working well were the promotion of inter-disciplinary working and some specific elements of the process of care management. Reasons cited for this included an appropriate organisational structure and devolution of budgets. Aspects of care management judged not to be working well included the performance of reviews and some specific operational issues, including problems of speed of response, a lack of flexibility and inequity of resource distribution. The most commonly cited reasons for these difficulties included the lack of appropriate care management infrastructure, increasing workload and resource constraints.

**FURTHER INFORMATION**

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