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

The Old Age Services Questionnaire

David Challis, Robin Darton, Jane Hughes, Karen Stewart and Kate Weiner

PSSRU

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 that have emerged for the two major service user groups: older people and those with mental health problems. The programme of research is in three phases, the first of which has involved a national survey of care management arrangements. This consisted of three questionnaires and included the Old Age Services Questionnaire which focused on care management arrangements for people aged 65 and over. It was distributed to local authorities in autumn 1997. One hundred and one of the 131 social services authorities then in existence in England returned completed questionnaires, representing a response rate of 77 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, closer integration between health and social services and particularly for older people, multidisciplinary assessment, provide particular salience to these findings.

OBJECTIVES OF CARE MANAGEMENT FOR OLDER PEOPLE

The objectives of care management arrangements in the majority of authorities could be typified as providing assessment of need and implementation of care plans through the use of standardised procedures and protocols, providing a response to complex needs involving multiple services and concerned with providing long-term support and co-ordinated care at home. In terms of a differentiated approach to care management, most authorities typified their service as one provided to the majority of service users, with about two-fifths reporting that people with complex needs typically receive help different in nature and scope to other service users. Less than 20 per cent of authorities indicated that care management was a response provided to a limited number of service users and fewer still provided an intensive care management service involving small caseloads for older people.

ORGANISATIONAL ARRANGEMENTS

Most authorities had formal arrangements for sharing information with colleagues in the National Health Service (NHS), most commonly via an exchange of written documentation. In terms of joint commissioning, the majority of authorities had developed joint plans and planning processes. Only a minority of authorities had other arrangements in place, such as integrated funding or joint management. A variety of jointly-commissioned services were reported, with hospital discharge schemes being the most common. More than 80 per cent of authorities had eligibility criteria for care management. However only about one-quarter of authorities had separate criteria for residential and community-based care and only about one-fifth had specific criteria for older people.

Approximately half of all authorities had the formal job title of care manager in services for older people. Social workers undertook the role of care manager in all authorities, social work assistants in about two-thirds and occupational therapists in just under a half. NHS staff worked as care managers for older people in about one-fifth of authorities. Care management staff were based in hospitals in nearly all authorities and in specialist old age teams in about half of authorities. About
one-fifth of authorities had some care management staff based in primary care settings, although this tended to involve relatively small numbers of staff. Most authorities had computerised client record systems on which a variety of information was held, most commonly personal details and details of services received. About half of authorities had a computerised directory of services for older people, and about two-thirds of these included details of unit costs for at least some services.

**THE PROCESS OF CARE MANAGEMENT**

Responsibility for screening community referrals lay predominantly with care managers or social workers from either generic adult or specialist older people’s teams, although administrative or customer service staff also undertook screening in a large group of authorities. The proportion of assessments undertaken by a qualified social worker varied greatly, although fewer than 10 per cent of authorities estimated this to be 20 per cent or less of assessments and more than 20 per cent of authorities estimated this to be greater than 80 per cent of assessments. Nearly all authorities reported that a health service contribution to assessment was usually required for nursing home care. For residential care or intensive domiciliary care this was usually required in about three-fifths of authorities. The majority of authorities reported that their assessment documents included a section on risk, although fewer authorities reported that these documents explicitly covered particular areas such as danger to others, accidental self harm or falling.

About 80 per cent of authorities reported that at least some in-house services were costed within community-based care packages. External services were costed more universally, with nearly all authorities costing at least some and the majority costing all external services. Care managers were not able to commit any finance to or allocate any in-house services without further authorisation in 45 per cent of authorities. For external services the figure was 64 per cent. Entry into residential or nursing home care was authorised in a number of ways, the most prevalent of these being by the first line manager dependent on budget or by a panel of social services department (SSD) staff or SSD and NHS staff. In the majority of authorities care managers remained actively involved with 40 per cent or less of community-based cases after three months.

**MENTAL HEALTH SERVICES FOR OLDER PEOPLE**

The majority of authorities reported that there were formal links between assessment and care management and the Care Programme Approach (CPA) for older people with mental health problems. Just over half of responding authorities reported that they had joint arrangements in place with at least one health trust for screening this group of users for services. Slightly fewer than half of authorities provided a specialist dementia service in conjunction with health providers. A minority of authorities reported that they had shared assessment documents for people with dementia. Whilst more than four-fifths of authorities reported that the CPA was applied to this group of users in at least one of the trusts with which they worked in partnership, it seemed, from the limited data returned, that a relatively small proportion of people with dementia in receipt of care management were also subject to the CPA.