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Care management arrangements for older people in England: key areas of variation in a national study

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ABSTRACT
Care management has become a key component in the development of community-based care in many countries, and this paper examines the different care management arrangements for older people's services that are now emerging. It has been United Kingdom government policy since 1989 that the providers of social services develop care management systems, as confirmed in the White Paper, *Modernising Social Services*. The paper opens with the background to the policy changes and a discussion of the role of care management in the British social care system. Secondly, evidence from the early phases of care management development is examined; and thirdly, the evidence from a major national study of care management arrangements for older people on the patterns of variation on key dimensions is considered.

KEY WORDS – Social care, community care, social services departments, care management, older people's services, United Kingdom.

Introduction

Policy background

Service changes in the United Kingdom reflect what might be described as broad international community care convergence, which reflects the similar goals of many governments despite significant variations in organisational structure and patterns of funding (Challis *et al*. 1994). The trends which can be identified involve change at the level of service organisation in three closely related areas: first, a move away from institution-based provision; second, investment in the strengthened scale and content of home-based care; and third, a consequence of this shift in the balance of care, the development of various methods of co-ordination of care and case management (Kraan

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et al. 1991; Challis 1992, 1994a). This latter was particularly associated with two important factors. Enhanced home care for vulnerable people was seen as requiring the degree of individualisation and co-ordination associated with care management. Furthermore, the degree of fragmentation of service provision both within and between social and health care agencies necessitated their co-ordination.

It became British government policy in 1989 for local authority social services departments, the main agencies for the provision of social care, to develop care management systems. This was introduced as part of the wider community care reforms embodied in the White Paper *Caring for People* (Cm 849 1989) and leading to the 1990 National Health Service and Community Care Act, which was implemented in 1993. The policy was driven principally by the budgetary pressures of an ageing population and by funding anomalies. These anomalies had produced a bias in favour of the placement of older people in institutional care rather than the pursuit of a long-standing policy objective to provide care at home (Challis 1993). New levels of funding and responsibilities were given to social services departments. They were made responsible for undertaking assessments of need, the design and packaging of services tailored to meet such needs, and for the provision of care managers to monitor, review and act as a single point of contact for those receiving services. The more recent social services White Paper reiterated the importance of care management through its emphasis on promoting both independence and user-centred and individually tailored services (Cm 4169 1998).

Care management antecedents

One of the most influential early developments was the series of research and development studies undertaken by the Personal Social Services Research Unit (PSSRU) (Challis 1993). These studies, which were cited in the government White Paper (Cm 849 1989), attempted to evaluate the provision of care management using variations of a single model for a range of different high-need target populations. The model of care management involved devolving the control of resources within an overall cost framework to individual care managers, with the objectives of enabling more flexible responses to needs, the integration of fragmented services into planned patterns of care, and the creation of a realistic alternative to institutional care for vulnerable older people. Care managers were based at different key sites in the service provision network, the choice reflecting the appropriate response pattern for the target population.

The main findings of several studies of these arrangements were broadly similar (Challis and Davies 1986; Challis *et al.* 1988, 1990, 1995, 1997). The evidence indicated that it was possible to provide home-based care for a significant proportion of individuals who would otherwise have a high probability of entering residential, nursing home or long-stay hospital care, at similar or lower costs than would have been the case given the provision of the usual services they would otherwise have received. The only exception to this proved to be the dementia care programme, for which intensive home-based care proved to be more expensive, albeit offering significant gains to the caregivers of these individuals (Challis *et al.* 1997). Indicators of quality of life for older people and their caregivers also suggested that there were gains as a consequence of receiving intensive care management. It must however be noted that these care management interventions were focused upon tightly defined target populations whose needs were very substantial, and for whom the alternative to intensive home care was institutional care.

Following the introduction of the community care legislation in 1993, the implementation of care management by social service agencies has turned out to be more broadly defined and for a wider target population than these studies anticipated. The official guidance to managers and practitioners on care management from the Social Services Inspectorate and Social Work Services Group (SSI/SWSG) was not explicit about the selection of those for whom care management was appropriate (SSI/SWSG 1991a, 1991b). In these documents, care management was defined as a process of tailoring services to individual needs, with assessment seen as an integral part of the care management process. Assessment was identified as one of a set of seven core tasks. These were: publishing information; determining the level of assessment; assessing need; care planning; implementing the care plan; monitoring; and review. Similar developments, regarding the definition of core tasks, can be found in the care management literature in most countries.

Several studies have examined developments in care management arrangements since the 1993 implementation of the community care reforms. These have included: special studies and inspection reports by the government's regulatory and quality assurance body for social care, the Social Services Inspectorate (SSI) (Department of Health 1993, 1994, 1995a, 1995b, 1996, 1997a, 1997b, 1997c), studies of assessment (Caldock 1993, 1994, Stewart *et al.* 1999), and studies of care management (Hoyes *et al.* 1994; Lewis *et al.* 1997). These are reviewed in Challis (1999). Whilst not all relate specifically to old age services,

older people constitute the largest group of users of care management services. The common themes of the studies include eligibility and targeting; assessment; devolution of budgets; patterns of review; the continuity of involvement of a care manager; definition of the care management role; the bureaucratisation of social work; and the organisational arrangements for care management, such as the separation of purchaser and provider functions and links with health care providers. A recent SSI study of care management arrangements in community settings for adult service users found both diversity and common features. The greatest differences included: screening; who does assessment and whether this varies with complexity; direct access by health staff to social care resources; budget devolution; information provided to the assessor/budget holder; the person responsible for monitoring/review; the extent to which cases are reviewed; and the extent of feedback to those responsible for commissioning (Department of Health 1998a). Concerns about variations in service provision were raised in the 1998 social services White Paper and a commitment was made to 'a greater level of consistency and fairness in social care' (Cm 4169, 1998: para. 2.3.1).

The implementation studies described above have provided valuable information about patterns of arrangements that have developed since the introduction of the community care legislation, although each was based on only a few authorities. This paper presents data from the first comprehensive study of care management arrangements for older people, using a framework of key implementation issues developed previously (Challis *et al*. 1998). Information is drawn from a national survey of local authorities that achieved a response rate of 77 per cent.

Method

This paper examines 14 key indicators of variation in care management arrangements. Challis (1994b) undertook a review of the literature concerning factors influencing the development and variation in care management arrangements. In the early part of this programme of study, a framework of 14 indicators concerning the key implementation issues was developed from this review (Challis *et al*. 1998). The capacity of the indicators to discriminate patterns of care management organisation in five local authorities with markedly different approaches was then validated. The indicators were arranged under three main headings: organisational arrangements; the performance of the core tasks of care management; and the degree of differentiation of the

TABLE 1. *Key indicators of the implementation of care management*

Care management attribute	Indicator variable
Organisational arrangements:	
Record of innovation	Care management before 1993 (including pilot schemes)
Purchaser/provider split	Date of introduction for domiciliary care
Level of authority to purchase	Lowest level for community-based care packages
Performance of core tasks:	
Staff mix	Qualification and agency
Tiers of assessment	Number of levels for services for older people
Reviews	Extent of arrangements for community-based and residential care for older people
Continuity	Across assessment and care management tasks for older people
Role or process	Job title or organisational arrangements
Clinical or administrative	Acknowledgement or not of social work skills
Degree of differentiation:	
Specialism	Care management staff based in specialist older people's teams (including teams for older people with mental health problems)
Targeting	None, focused
Caseload size	Average active caseload size for older people
Intensive care management	Small caseload, high needs service, purchased or provided for older people
Selective care management	Service provided to some, but not to the majority of service users

Source: Challis *et al.* 1998.

care management response, *i.e.* the extent to which care management arrangements varied according to the individuals who received them (Table 1).

Information about the 14 key indicators was provided by two postal questionnaires distributed to English local authority social services departments in the spring and autumn of 1997. The first questionnaire covered aspects of care management arrangements for all adult service user groups, and the second focused on arrangements for older people. Most of the information presented in this paper relates to old age services, although some refers to services for all adult users. This is indicated in the findings section. Of the 131 social service local authorities in existence at the time of the survey, 101 completed both questionnaires, a response rate of 77 per cent. In England, authorities that provide social services are commonly divided into four types: London boroughs, metropolitan districts, counties and the new unitary authorities.[1] Variations in the response rate by authority type are shown in Table 2, from which it is evident that London boroughs are under-represented in the study.

TABLE 2. *Response rates by four types of social service local authority*

	Type of local authority				
	London boroughs	Metropolitan districts	Counties	New local authorities	Total
Total authorities	33	36	35	27	131
Number that responded	19	29	32	21	101
Response rate (per cent)	58	81	91	78	77

Variations in care management arrangements for older people

Organisational arrangements

The introduction of care management arrangements became mandatory in 1993 with the implementation of the NHS and Community Care Act 1990. *Evidence of innovation in adult services* is therefore indicated by the presence of care management arrangements prior to this date. Authorities created after 1993 are excluded from the analysis of this indicator. Almost half of the authorities reported having some form of care management arrangements for adult services prior to 1993 (see Table 3). Many authorities indicated that these took the form of specific schemes or pilot projects in limited areas of the authority or for specific user groups. Some of these focused on older people, as described by these two replies:

> [The authority has a] range of small scale, case group specific pilot projects to test out aspects of the care management process, documentation and inter-agency arrangements.

> [The authority has a] case management scheme for people living in the community with dementia.

At the passing of the 1990 Act, the government expected *the separation of purchasing from the provision of services* by local authorities to be in place by 1993 (Department of Health 1991). The separation was seen as a mechanism for shifting from a provider-led to a needs-led service, and for promoting the mixed economy of care, two aims of the community care reforms (Gostick *et al.* 1997). The collected data include the date at which the split was introduced for domiciliary services. While the data relate to all adult service user groups, the findings are particularly relevant to older people, as they constitute the main user group (Department of Health 1998b). The promptness of the implementation varied greatly. A small proportion (17 per cent)

TABLE 3. *Organisational arrangements*

Indicator of care management system	% of authorities
Record of innovation in adult services	
Care management prior to 1993	45
Introduction of purchaser/provider split in adult domiciliary services	
Before 1993	17
During 1993	37
After 1993	40
No split	6
Authority to purchase	
Lowest staff grade with authority to purchase for all adult services	
Basic grade	33
1st tier management	49
2nd tier management	16
3rd or higher tier management	2
Authority of basic grade staff in old age services to allocate in-house services	
All services	12
Some services	26
1 or 2 services	17
None	45
Authority of basic grade staff in old age services to allocate external services	
All services	6
Some services	14
1 or 2 services	16
None	64

introduced the separation in advance of the implementation of the community care legislation, and by the end of 1993 more than half (54 per cent) of the authorities had introduced this split. Of the remainder, six per cent had not introduced the split by 1997. It should be noted that the authorities created after 1993 are excluded from this analysis.

Two aspects of *the authority to purchase services* were examined: first, the lowest level in the organisation at which decisions were made to purchase individual community-based care packages for adult user groups; and second, the extent to which front-line care management staff in old age services were able to purchase, or allocate, both 'in-house' and 'external' services without consulting a senior member of staff. In-house services are those services provided by social services department staff, while external services are provided by other agencies, predominantly from the private and voluntary sectors.

The staff working with any of the adult user groups could purchase individual care packages in one third of the authorities, and in about half of authorities the lowest level with this competence was the first tier of management. In the remaining authorities, the responsibility lay at higher managerial levels. While this provides good base-line data, it

should be noted that the ability to purchase care packages could refer to all or to a limited range or number of services. The following data indicate the range of services that front-line staff working specifically with older people were able to purchase or allocate. These staff could allocate (or purchase) all in-house services in only 12 per cent of authorities. In 45 per cent of authorities, the staff could not allocate or purchase any in-house services, and in a further 17 per cent they did so for only one or two services. In terms of purchasing or allocating external services, the budgetary responsibilities of front-line staff in old age services were even more restricted. These staff could purchase or allocate all external services in only six per cent of authorities, and in most authorities (64 per cent) they were not permitted to commit any funds to external services. Thus, even where the authority to purchase was devolved to front-line staff, it often referred to a limited range of services.

Performance of core tasks

Two aspects of *staff mix* have been explored: first, the qualifications required of care managers and, second, whether these could be employees only of the local authority or also of the National Health Service. Only about one half of the authorities provided data on staff numbers, and the information is complicated by the great variety of job titles (with no consistent link to professional background). It was therefore difficult to discern the relative distribution of qualified and unqualified care management staff.

For all adult service user groups, most authorities used a mix of qualified and unqualified staff, with various professional backgrounds, to perform care management tasks. Only nine authorities employed only social workers or occupational therapists as care managers. The involvement of health services staff was indicated by the extent to which they were involved in each of the main core tasks – assessment, implementation of the care plan, and review. A quarter of authorities indicated that health staff had at least some involvement in assessing adult service users; in 15 per cent health staff were involved in implementing care plans; whilst in 20 per cent they could be involved in reviews (see Table 4). When authorities were asked whether NHS staff could act as care managers in old age services, only 21 per cent indicated that this was the case, and even in these cases it could involve very few staff.

The 1991 guidance on care management and assessment emphasised the need to move away from separate assessment procedures for

different services to an integrated system (SSI/SWSG 1991a, 1991b). This system allowed six *tiers of assessment* in older people's services, which were graded according to the type and level of need, and the types of staff and number of agencies involved. Subsequent SSI reports have stressed the importance of arrangements that differentiate simple and complex assessments (Department of Health 1995a, 1997b, 1998c). The survey collected information on the number of levels of assessment in use. Most authorities reported more than one level of assessment for older people. Just 14 per cent reported a single level, 47 per cent reported two levels, and the remaining 38 per cent had three or more levels of assessment. The definitions of a level varied greatly: some authorities included specialist assessment as part of their comprehensive assessment, whilst others defined this as an additional level. The maximum number of reported levels was six.

The assessment and care management guidance defined the *reviews procedure* as: 'To reassess, at specific intervals, needs and service outcomes with a view to revising the care plan' (SSI/SWSG 1991b: 83). It was expected that, through the implementation of care management, reviews would gain a higher profile, and that all users would be reviewed at regular intervals. It was suggested that authorities might set a guideline of not less than once per year for the minimum frequency of review. The survey inquired whether the agencies had a formal strategy for managing the reviews. With reference to services for older people, just over 80 per cent of authorities indicated that they had formal guidance on the review process for community-based care and for care in residential or nursing homes. Authorities were asked to indicate whether this guidance specified when the first and subsequent reviews should be undertaken.

For community-based reviews, 79 per cent of authorities reported that their guidance specified that the first review should be within eight weeks, and for 81 per cent their guidance specified that subsequent reviews should be at least annual. For reviews of clients in residential care or nursing home care, the comparable figures for first and subsequent reviews were 87 per cent and 82 per cent respectively. In the remaining authorities, the timing of reviews was discretionary. Overall, 56 per cent of authorities specified the timing of both first and subsequent reviews in both settings, while in the remainder the timing of at least one of the four instances was discretionary. Whilst information was collected on the guidance for reviews, this does not of course provide evidence of the degree to which reviews were actually undertaken.

The assessment and care management guidance suggested that

continuity of care was one of the key benefits of care management, particularly for people with long-term care needs (SSI/SWSG 1991a, 1991b). This reinforced the suggestion in *Caring for People* (Cm 849 1989), that while users with complex needs or who required considerable resources should be nominated a 'case manager', continuity of staff across the core tasks was not essential, although designated members of staff should be identified for each task. It has been suggested that in some authorities care managers would focus on assessment, whilst in others they would follow a service user through assessment, care planning, monitoring and review (Challis *et al*. 1998). In this study, continuity has been indicated by the extent to which the same practitioner remained responsible for assessment, care planning, monitoring and review for older people. Forty-four per cent of authorities reported that such continuity was usual, 48 per cent reported that it sometimes occurred, and eight per cent that it was rare or never achieved.

We turn now to whether care management was seen as a *role or process*: a specific job to be undertaken by specific individuals, or the process managed by the agency and undertaken by more than one person (Buglass 1993). The guidance suggested that all users and carers should experience the process of care management, whatever their level of need (SSI/SWSG 1991a), but that authorities could decide whether separate staff have specific care management responsibilities, or whether a larger number undertake the process among their wider responsibilities. With reference to care management in older people's services, 50 per cent of authorities described it as a specific job undertaken by designated staff called care managers, but with reference to adult services, only 16 per cent reported that it was a specific job, 63 per cent that it was a process, and 21 per cent that it was both. The data suggest that many care management systems have elements of both 'designated roles' and 'organisational process', and that the characterisation of a care management system by this single criterion is insufficient.

In terms of the content of care management, a distinction can be made between more *clinical or administrative approaches* (Challis 1994a, 1994b). This is reflected in the extent to which professional attributes and elements of social work skills, such as counselling, are seen as important components of care management. Fifty-six per cent of authorities described care management for older people as necessarily encompassing a social work style and approach, although the specific social work tasks that were undertaken were not well reported. Furthermore, whilst all authorities employed qualified social workers

TABLE 4. *Performance of core tasks*

System indicator	% of authorities
Staff mix	
Health staff involvement in core tasks for adult user groups	
Assessment	25
Care planning	15
Review	20
NHS care managers in older people's services	
Yes	21
No	79
Tiers of assessment in older people's services	
1	15
2	47
3 or more	38
Review guidance for older people's services	
Community-based, first review within 8 weeks	79
Community-based, subsequent reviews at least annually	81
Residential/nursing home, first review within 8 weeks	87
Residential/nursing home, subsequent reviews at least annually	82
All review periods specified	56
Some review periods discretionary	44
Continuity in older people's services	
Usually	44
Sometimes	48
Rarely/never	8
Role or process	
Care management in adult services defined as a process	63
Care management in adult services defined as a specific job	16
Care management in adult service defined as both a process and a role	21
Care management in older people's services is a specific job undertaken by designated members of staff called care managers	50
Clinical or administrative approach	
Care management in older people's services necessarily encompasses a social work style and approach	56

as care managers, the proportion of social workers relative to other staff groups could not be ascertained.

Degree of differentiation

Of the authorities that responded to the survey, 39 per cent had established *specialist teams for older people* to provide assessment and care management in the community, and 13 per cent reported having specialist 'older people/physical disability teams' (see Table 5). Four of the latter also had specialist teams for 'older people with mental health problems'. A further four per cent of authorities reported that, whilst they did not have specialist teams for older people generally, they did have specialist teams for older people with mental health

TABLE 5. *Degree of differentiation of care management approach*

Attribute of care management approach	% of authorities
Specialist teams for services to older people	
Specialist older people teams	36
Specialist older people teams and teams for older people with mental health problems	3
Specialist older people/physical disability teams	12
Specialist older people/physical disability teams and teams for older people with mental health problems	1
Teams for older people with mental health problems	4
Generic adult teams only	44
Targeting in adult services	
Evidence	52
No evidence	48
Average caseload size in older people's services	
Less than 30	31
30 to 50	52
More than 50	18
Intensive care management in older people's services	
Yes	5
No	95
Selective care management in older people's services	
Description of care management arrangements	
Care management provided to a limited number of service users	16
Care management provided to a majority of service users	64
Care management provided both to majority of service users and only a limited number of service users	3
Care management provided neither to majority of service users nor to a limited number of service users	17
Arrangements for commissioning or allocating in-house services	
Providers may assess and allocate services	18

problems. The remaining 44 per cent of authorities provided assessment and care management services to older people through generic adult teams, although some indicated that there were specialist old age workers in the teams. Despite the high response rate, the data may slightly under-represent the extent of specialisation, for it was most common in the London Boroughs.

One way an authority can differentiate its response to user need is by *targeting care management resources*, both in terms of the grade of staff involved and the allocation of resource or staff time. To be clear, we refer to targeting within the care management system as distinct from eligibility for a service or for care management *per se*. The collected indicators of targeting were: whether different levels of assessment were undertaken by different grades of staff or were associated with either the cost or type of care packages; whether different expenditure ceilings

or indicative care packages were associated with different levels of need; and whether an intensive care management service involving small caseloads was available. The presence of any of these was taken to indicate a differentiated care management service for older people. Evidence of targeting was found in just over half of the authorities (52 per cent).

The reporting of *average caseload size* in older people's services was complicated because of differences in practice among the authorities, *e.g.* whether workers carried generic or specialist caseloads, and whether cases remained open to individuals, to teams, or were closed following assessment. Nevertheless, 31 per cent of authorities reported that care managers (or their equivalents) for older people had average active caseloads of less than 30 cases. Fifty-two per cent reported average active caseloads of 30–50 cases, and the remaining 18 per cent reported that the average active load exceeded 50 cases.

Intensive care management in older people's services was defined as a specialist care management service for older people that worked exclusively with 'high needs/at risk' people and was carried out by staff with small caseloads (Challis *et al.* 1998). This service would be provided in addition to other care management services. Only five per cent of authorities reported that they either provided or purchased such services for older people.

Many more provided *selective care management in older people's services*, which is defined as a service provided to some but not all older people. One way of identifying this variant would be the extent to which certain referrals are passed directly to service providers, for both assessment and service provision, which pathway bypasses the old age services' assessment and care management systems. The information provided about these arrangements was unfortunately unclear, but 16 per cent of authorities provided care management for older people to a limited number of service users, 64 per cent provided it to the majority of users, 17 per cent described their provision as neither to the majority nor to a limited number of users, and the remaining three per cent claimed that they responded both to the majority and to a limited number of service users. Further evidence was provided about the mechanisms for commissioning or allocating in-house services, *i.e.* the services provided by social services department staff: 18 per cent of authorities reported that in some cases they both assessed and allocated services, although in three per cent it was the only method for allocating in-house services. Overall, the data suggest that services can be provided outside care management arrangements in a minority of authorities.

Discussion

Results from the first national study of care management arrangements confirm that considerable variation in care management arrangements has emerged since the implementation of the NHS and Community Care Act 1990. Only a few indicators departed from a general pattern of variability, the most consistent feature being the almost universal absence of *specialist intensive* care management services for older people, and furthermore there is little evidence of *selective* care management. In other words, care management services are in the main provided for the majority rather than for a selected group of older service users.

The survey findings provide a unique base-line profile of the state and structure of care management arrangements in the late-1990s. It could be argued that there is likely to have been much change in the arrangements since the fieldwork was undertaken, from the initiatives of the Labour government's modernisation agenda. Follow-up visits to authorities during 2000, however, found considerable stability in the arrangements, save possibly in the area of specialisation (discussed below). The evident changes appeared to be predominantly responses to the SSI's recurrent messages since the mid-1990s, rather than to the new prescriptions such as integration.

There may be several reasons for the variation that has emerged. The early guidance on care management was general, and defined care management broadly, permitting much latitude of interpretation (SSI/SWSG 1991a, 1991b). The lack of specificity was to some extent intentional, and authorities were encouraged to test various arrangements (Welch 1998). The timetable and process of implementation may also have contributed. While the community care legislation was enacted in 1990, full implementation was delayed until 1993. Furthermore, early guidance on the implementation focused the attention of health and local authorities on the key tasks of developing closer collaboration. Gostick *et al.* (1997) argue that this guidance distracted local authorities from the development of other aspects crucial to the implementation of the community care reforms, including care management. Overall, much of the variation can be understood as a consequence of the implementation process and the widespread tendency to underestimate both the complexity of the care management procedure and the difficulties of co-ordinating agencies and tasks (Pressman and Wildavsky 1973). In the case of care management, the key stages of the implementation process necessary to ensure 'implementation capacity' were not fully addressed (Williams 1971).

In contrast to the original guidance on care management, subsequent government reports have been increasingly explicit in their recom-

mendation of a differentiated approach to service provision. Such an approach would link the levels of user need to the skills of the responsible staff, and both of these to the assessment, monitoring and reviewing arrangements (Department of Health 1994, 1996, 1997b). Then the Social Services Inspectorate (1997) recommended the implementation of a system of care management for all users with three tiers of response: administrative, co-ordinating and intensive. The continuing importance to the government's modernisation agenda of targeted care management was made clear in the *National Service Framework for Older People*, as in the statement that: 'the most vulnerable older people will often require fuller assessment and more intensive forms of care management. For this reason dedicated care managers should work with the most vulnerable older people over time.' (Department of Health 2001: para. 2.39)

Similarly, the Scottish Executive (2000) have recommended that care management should be redefined as 'intensive care management', which would be reserved for people with complex or frequently changing needs. The introduction of the 'single assessment process' across health and social care for older people may well reinforce the development of differentiated care management services, with different levels of care management becoming linked to different types of assessments.

The survey found that whilst most authorities had at least two levels of assessment, only about one half had a differentiated approach to care management, that targets staff and resources according to user need. Furthermore, there was little evidence of a three-tiered approach, as recommended by the SSI, as only five per cent provided specialist intensive care management for older people. Such services have been demonstrated to be important for maintaining older service users in their own homes (Challis and Davies 1986; Challis *et al*. 1990, 1995). These services could address two aims of the modernisation agenda, promoting independence and preventing unnecessary admissions to residential or nursing homes (Cm 4169 1998; Cm 4818-I 2000; Department of Health 2001). It has been demonstrated, however, that for intensive care management to provide a cost-effective alternative to institutional care, it has to be targeted on those older people at the margins of entry to long-term care settings (Kemper 1988, 1990).

The national survey provided little evidence of other approaches to the provision of a differentiated response, such as selective care management. This implies that some service-users could access services directly rather than through the assessment and care management system. Selective care management is one way of excluding some people from the care management process, whilst not excluding them

from any services. There are of course several mechanisms that exclude people from either the care management process or services. At the formal level of the agency, eligibility criteria and other departmental procedures play an important part, and at an informal or bureaucratic level the discretion and interpretations of front-line staff are critical (Ellis *et al.* 1999; Rummery and Glendinning 1999). Variations in both formal and informal mechanisms have been reported (Challis *et al.* 2001a; Rummery *et al.* 1999). The resulting concerns underpin the government's *Fair Access to Care* initiative (Cm 4169 1998).

Overall, considerable variation has been reported as to what constitutes care management, in terms of its performance as a specific position or role undertaken by specified members of staff, or as a process undertaken by staff who carry a range of responsibilities (or both). Furthermore, there was wide variation in the extent to which a social work style, indicative of a clinical approach, was believed to be a necessary part of care management with older people. The SSI (1997) links these two aspects of care management in their definition of the 'differentiated approach', which suggests, on the one hand, that the *intensive* type of care management is undertaken by a designated care manager who combines the planning and co-ordination of the care with a therapeutic, supportive role and, on the other, that the *co-ordinating* type has a more administrative approach. In other words, there is an expectation that authorities will provide care management as both a specific role and as a process, but for different users with different levels of need. This reinforces the argument that a dichotomous definition of care management as either a role or as a process is inadequate (Buglass 1993).

The benefits of continuity and small caseloads have been demonstrated in the provision of intensive care management for older people with long-term care needs (Challis and Davies 1986; Challis *et al.* 1990, 1995). The continuity of care is highly valued by older service users, and this is reflected in its nomination as a topic in the current programme of government funded health research (Fulop and Allen 2000). However, where a care management approach is applied to a broad range of service users, continuity and small caseloads may not be necessary or desirable. The effectiveness and, more particularly, the efficiency of providing these for all service users have not been rigorously explored. While SSI reports have discussed the benefits of continuity of providers for older people's services, no recommendations have been made about the appropriate level of staff continuity across the care management tasks, or about appropriate caseload size in the differentiated care management approach (Department of Health 1996, 1997a, 1997b). This may be reflected in the variation of these two

indicators in the survey's findings. On the other hand, there has been continued emphasis on the need for reviews and for consistent review procedures (Department of Health 1996, 1997a, b; Cm 4169 1998). If authorities are required to be explicit about which staff should undertake reviews for which service users, this could also lead to greater clarity about continuity across the tasks of care management.

The little evidence of health service staff acting as care managers and their low degree of involvement in the core tasks indicates a lack of integration of the heath and social care services. This is despite the early guidance that stressed the importance of inputs by health service professionals at key decision points in a user's care career, such as the discharge from hospital, the provision of intensive home support, or the entry into residential or nursing home care (SSI/SWSG 1991a, 1991b).

The integration of health and social care provision remains a key aim of the current government's agenda (Department of Health 1997d; Cm 4169 1998; Cm 4818-I 2000). *The National Service Framework for Older People* links the successful provision of person-centred care to the integrated commissioning and delivery of older people's services (Department of Health 2001). Reference is made to the provisions of the Health Act 1999, which provides for pooled budgets, lead commissioning, integrated provision, and care trusts. Such trusts will be able to commission primary and community health care and social care. They will have the capacity to provide assessment and care management through integrated health and social care teams, employing a single budget and a single management structure. Furthermore, where multiple professionals and agencies are involved, the accompanying guidance advises that who undertakes care co-ordination and what tasks are involved is agreed locally (Department of Health 2002). There is clearly an expectation that in some cases health staff will fulfil these roles. Indeed, for vulnerable older people with multiple and long-term needs, it is recommended that the care co-ordination role is best fulfilled by community nurses or social workers, as the professionals who have had long-term involvement.

Specialisation has for long been evident in the provision of social care services (Challis and Ferlie 1988). The provision of services to older people through teams that focus on the age group has to an extent occurred by default as funding initiatives separated mental health, learning disability and children's services from generic teams. The extent to which these teams can be described as purposively specialist requires clarification. It has been shown that only just over one half of social service authorities had teams providing services to older people with a degree of specialisation: that is to say, they were not generic (but, to repeat, the low response rate from London boroughs may have

slightly under-estimated the extent of specialisation (and our follow-up work suggests that it is increasing). Any trend towards specialisation is likely to be strongly reinforced by the development of integrated modes of provision such as care trusts (Department of Health 2001). Moreover, further development of old age mental health teams can be expected following the recommendation that older people with mental health problems should have access to integrated mental health services. For the most complex cases, these services should be provided by multi-disciplinary teams whose core members include consultant old age psychiatrists, community mental health nurses, occupational therapists and social workers (Department of Health 2001: para. 7.44–7.48).

This paper has demonstrated that great variation in care management arrangements exists, and has suggested that that is partly due to the lack of clear guidance. The extent to which the variations can be grouped by clusters of features is discussed elsewhere (Challis *et al.* 2001b). The relative efficiency and effectiveness of the different approaches to care management that are in place, in terms of cost, and the outcomes for service users and the providing organisations, requires further investigation. There is no suggestion in our findings that the observed patterns of variation are a response to geographical variations in needs. In other words, it is likely that service users with similar needs but in different local authorities will have very different experiences of the care management process. The inconsistency among authorities in their approaches to assessment and care management greatly concerns the current government. The White Paper, *Modernising Social Services* (Cm 4169 1998), gave high priority to increasing consistency in access to and the provision of services, and to the process and outcomes of care. The need for clarity about what sorts of people and what kinds of needs qualify for different services was emphasised to establish consistent links (within and across authorities) among referrals, assessments and services (Cm 4169 1998: para. 2.26). Clearly, for care management to contribute to the modernisation agenda, the differentiation of approaches to different needs must be better planned. To achieve greater congruence between policy goals and agency outcomes requires the managed implementation of differentiated care management.

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NOTE

1 The population of London boroughs varies from 140,000 to 330,000; that of metropolitan districts (high population density provincial urban areas) from 150,000 to one million; that of counties (mixed rural, small town and suburban areas) from 700,000 to 1.6 million; and that of the post-1995 unitary authorities (in the sense of providing the full range of local government services, formerly split between counties and local districts) from 35,000 to 400,000. Two of the 14 indicators considered in the paper (record of innovation and purchaser/provider split) refer to periods either prior to or spanning the mid-1990s local government reorganisation which resulted in the creation of the new authorities. They have therefore been excluded from the analysis.

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