Care Management for Older People: Access, Targeting and the Balance Between Assessment, Monitoring and Review

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Abstract

This paper explores three issues intrinsic to assessment and care management arrangements in older people's services: eligibility criteria, assessment, and monitoring and review. It includes data from a national study of care management arrangements and these findings are placed in the context of policy initiatives at the inception of community care and those arising more recently from the Government's modernisation agenda. The data presented highlight both the nature and extent of changes required to meet specified Government objectives in these key areas in order to improve services for vulnerable older people.

Key words: Social care, community care, care management, older people's services, social services departments.

Background

Care management involves the performance of a series of core tasks in long-term care (Steinberg and Carter, 1983; Social Services Inspectorate/ SWSG, 1991a,b; Department of Health, 2002a). There would appear to be a broad consensus across the literature on these core tasks: case finding and screening, assessment, care planning, implementing, and monitoring and reviewing the care plan (Challis, 1994). However, there has been a lack of consensus about the ways in which these components of care management have been implemented over the last decade Department of Health, 1998, 2001).

A focus on individual care management to enable more people to live in their own homes was central to the introduction of the community care reforms in 1993 and has been subsequently endorsed (Cm 4169, 1998; Department of Health, 2001, 2002a). The relationship between eligibility, screening and targeting is complex. However, in the context of the community care reforms it could be argued that the application of eligibility criteria was conceived of as a means to determine eligibility for assessment in which needs are screened in order to target services appropriately. With the implementation of these reforms, local authorities in England were advised to develop eligibility criteria, which would include definitions of what constituted a need for services. For local authorities, these criteria were intended to allow 'just enough people with needs to exactly use up their budget (or be prepared to adjust their budgets)' (Audit Commission, 1993, para. 15).

The importance of screening, that is ensuring that a high proportion of users have the appropriate characteristics for a particular service receive it (Challis and Davies, 1986), has been shown by debates on the relative effectiveness of care management services for older people. It has, for example, been suggested that the failure of a national series of case management demonstration projects in the US to substitute nursing home care with home-based care was, in part, attributable to problems of targeting service appropriately (Kemper, 1988). A study of eligibility criteria used by local authorities in England had three main conclusions: firstly, that the criteria varied greatly in terms of their content and quality; secondly, that they were difficult to operationalise, particularly in terms of their integration with screening and assessment; and thirdly, that it was difficult to determine consistency at a local level between local authority criteria and health authority criteria for continuing care services (Challis et al., 1997). Furthermore, it has been shown that there is a great deal of confusion within authorities between eligibility for assessment, eligibility for services and eligibility for care management (Department of Health, 1997a). Subsequently, the White Paper *Modernising Social Services* recommended that eligibility criteria should inform users about what services they can expect for different kinds of needs, and should help care managers to match services to assessed need, thereby leading to greater consistency in the provision of care (Cm 4169, 1998). Guidance has recently been issued to this effect (Department of Health, 2002b). However, in practice there is still currently inconsistency in the operation of eligibility criteria (Social Services Inspectorate, 2001, 2002a,b).

Assessment was identified as one of the cornerstones of community care in the 1989 White

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Paper *Caring for People* (Cm 849, 1989). It has a key role through the care management process: in determining eligibility for services, identifying care needs and later in reviewing needs. The Social Services Inspectorate undertook a study during 1993 of assessment procedures for older people in five local authorities (Department of Health, 1993). Four years after the inception of the community care reforms three approaches to care management were identified, each necessary in an integrated and comprehensive approach. These were: an administrative type providing information and advice; a coordinating type to deal with the large volume of simple requests for help; and an intensive type for users who have complex and frequently changing needs (Social Services Inspectorate, 1997). Reviewing subsequent developments in the UK, it has been noted that there is marked variation in the content of assessment (what information is sought about needs and how it is recorded) and the form of assessment (the personnel involved in conducting the assessment) (Challis, 1999). There were few examples of assessment documentation designed specifically for the needs of older people, which renders it difficult to precisely capture the needs of this group of people (Stewart et al., 1999). These concerns have led to new initiatives to improve quality and consistency under the auspices of the single assessment process (Department of Health, 2002a). This suggests that assessment systems in each locality are based on four types: contact assessment (including the collection of basic personal information); overview assessment; specialist assessment; and comprehensive assessment (recommended where admission to a care home, intermediate care or a substantial package of care at home is a likely outcome). Authorities are required to audit and develop their assessment systems in order to meet agreed standards within a specified timescale.

Moxley (1989) specified the various tasks of case management and within this described four functions of monitoring: ascertaining the degree to which the care plan has been implemented; identifying whether the objectives of the care plan have been achieved; determining the outcome of support; and identifying any new client needs requiring change to the care plan. Monitoring has been defined as a critical task enabling the case

manager to respond quickly to changes in client status and adjust services as appropriate (Applebaum and Austin, 1990). In the UK context it has been defined as 'To support and control the delivery of the care plan on a continuing basis' (Social Services Inspectorate/SWSG, 1991b: 77). In the UK, in line with earlier guidance, the role of providers in monitoring both the older person's needs and the effectiveness of the services they receive has been emphasised (Department of Health, 2002a). Interestingly, such an approach does not suggest that monitoring is a key role for care managers, although arguably it is in respect of users with complex and volatile needs who receive large packages of community-based care.

Review has been defined as 'To reassess, at specific intervals, needs and service outcomes with a view to revising the care plan' (Social Services Inspectorate/SWSG, 1991b: 83). The latter has been seen as particularly important in the context of care management whose key component is long-term support of people at home. Both monitoring and review however, have been traditionally afforded low priority in the provision of social services (Social Services Inspectorate, 1987). Although it was recognised that the new community care reforms should afford a higher priority to monitoring and review, a study in 1993 on assessment revealed that this has continued to be accorded a low priority, mainly due to the pressures of assessment responsibilities (Department of Health, 1993). Subsequent inspections by the Social Services Inspectorate and research findings have confirmed this (Department of Health, 1996, 1997a, b; Moriarty and Webb, 2000; Social Services Inspectorate, 2002a). Strategies for affording greater priority to monitoring and review have included a range of options, including the use of telephone or questionnaire in place of face-to-face contact, provider reviews, the employment of designated reviewing officers and the regular planned closure of cases (Department of Health, 1993, 1994). The White Paper *Modernising Social Services* (Cm 4169, 1998) recognised that once services are provided they are often not reviewed. It recommended that an initial review should be undertaken within three months and subsequent reviews should be carried out at least annually for both those admitted to a care home and those

receiving care in their own homes. This is endorsed in the guidance on the Single Assessment Process (Department of Health, 2002a) and in the Fair Access to Care initiative (Department of Health, 2002b). The latter recommends that reviews should be coordinated by professional staff, who are independent of those providing care for service users and that, whenever possible, reviews should consist of a meeting between the user and the 'council professional' responsible for the review, together with carers and other key members of the care network. Therefore, review is envisaged as a re-assessment of a user's circumstances. In this sense it is a distinct activity, which takes place within specified time frames and is therefore different to monitoring a care plan, which is an activity occurring more often and, for the most vulnerable service users, on a weekly basis.

The purpose of this paper is to inform the current debate about targeting and the balance between assessment, monitoring and review in care management for older people. It is significant because it presents data about the care management process prior to the implementation of the Government's modernising agenda in respect of coordinated care for vulnerable older people in the community, thereby providing a baseline picture of services before these reforms. The data presented in this paper are part of the first comprehensive study of care management arrangements for older people in England with representative national data. It details information about access to services, assessment, monitoring and review.

The Study Method

The study was commissioned from the Personal Social Services Research Unit (PSSRU) by the Department of Health to provide an evaluation of the different forms, types and models of care management that have emerged since the implementation in 1993 of the NHS and Community Care Act for two user groups: older people and those with mental health problems. This paper presents data relating to older people's services. It incorporates findings from two questionnaires: an initial overview questionnaire on care management arrangements for all adult service user groups distributed in April 1997; and a

detailed questionnaire, relating to older people's services sent to all respondents of the first questionnaire later in that year. The questionnaires were completed by staff with responsibility for policy formulation or management of community-based services. Postal and telephone reminders were made in order to increase the response rate. Of the 131 local authorities in existence at April 1997, a response rate of 77 per cent was achieved for both questionnaires. The response rate was slightly lower for London Boroughs compared with other types of authority.

Table 1. Eligibility criteria for older people		
	Authorities	
	Number	%
Eligibility criteria:		
Yes	83	82
No	18	18
Number of authorities	101	
Residential and community care:		
Separate criteria	26	26
Combined criteria	55	56
None	18	18
Number of authorities	99	
Eligibility criteria:		
Specific to older people	21	21
Generic across adult services	59	60
None	18	18
Number of authorities	98	

Results

Eligibility criteria
Table 1 shows the extent to which authorities reported having eligibility criteria for care management, and whether the criteria were separate or combined for residential and community-based care. Eighteen per cent of authorities, almost one in five, reported that they had no operational eligibility criteria in place. One-third of the authorities with criteria, or 26 per

cent of authorities overall, had separate criteria for residential and community-based care. Therefore, the majority of authorities used eligibility criteria that spanned residential and community-based care. Approximately one-quarter of authorities with criteria, or 21 per cent of authorities overall, had criteria that were specific to older people. Commentaries provided by the authorities indicated that there was much variation and a lack of clarity about both the purpose of eligibility criteria and their implementation.

Screening referrals

The proportions of referrals closed after initial screening is shown in Figure 1. Fifty-six of the 90 authorities provided information both on the number of referrals aged 65 and over and on the number closed after initial screening. Forty-three per cent of the authorities reported that they only closed up to 20 per cent of referrals. As a cumulative total, 71 per cent of authorities closed up to 40 per cent of referrals after initial screening. Less than one in five were being closed in a little under half the authorities. Furthermore, there appears to be a great deal of variation between the authorities in the proportion of referrals closed after initial screening. Data from the study revealed that this ranged from two to 94 per cent, with a mean of 29 per cent. The variation in part reflects the different interpretation of a 'referral' by different authorities. The data suggest that some authorities include all contact from members of the public as a referral and others do not.
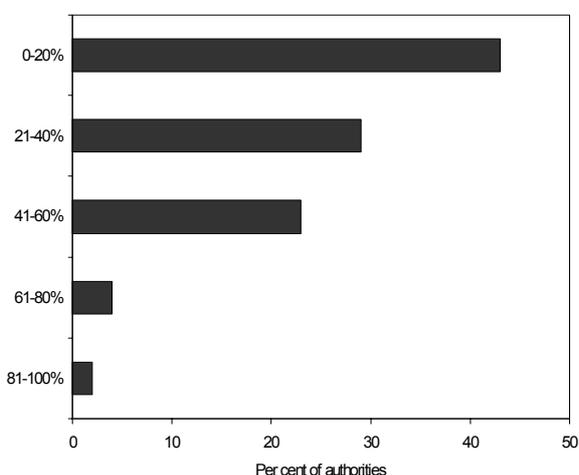
Figure 2 shows the staff responsible for screening community referrals. Respondents were asked to list those settings in which staff undertook screening of requests for assistance in the authority. A wide variety of approaches was evident. Staff from generic adult teams undertook responsibility for screening community referrals in just under half of the authorities. Slightly fewer, 40 per cent of authorities, used staff from older people's teams. Authorities indicated that this could be a specialist worker within the team rather than all members of the team undertaking screening. In about a third of authorities, administrative/reception staff could be responsible for screening community referrals. A similar proportion of authorities adopted a customer service department approach, with staff undertaking the screening of referrals as their primary task. A lower proportion of authorities, 16 per cent, reported using intake teams, ie staff who traditionally undertake the screening of referrals and short-term, task-centred practice in order to complete a more detailed assessment prior to transfer to a long-term team or undertake a short-term intervention prior to closure of the case. These data therefore indicate that a variety of staff in a variety of settings either undertakes the task on a part or full-time basis, thus militating against a consistent approach to the key component of care management both within and between authorities.

Figure 2. Staff responsible for screening community referrals

Figure 1. Percentage of referrals closed after initial screening
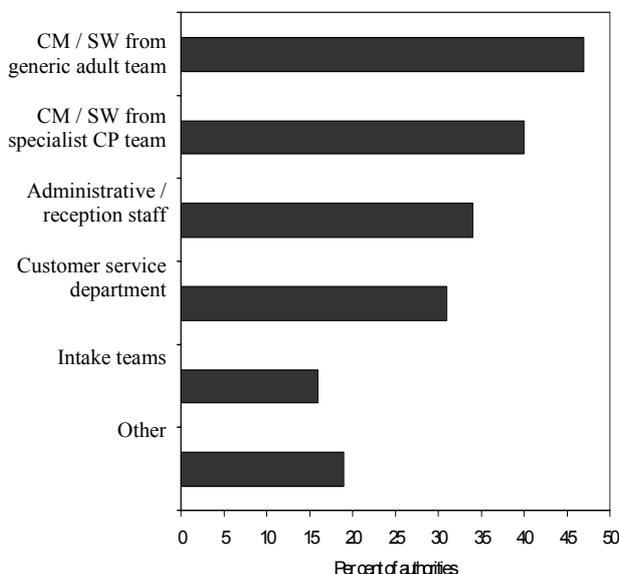
Assessment

The information in this section relates both to documentation and procedures. Sixty-one per cent of authorities reported using generic assessment documentation for all adult service user groups. Indeed only three per cent reported that they had specialist documentation for older people, compared with almost a third of authorities for mental health. This could significantly affect the identification of specific problems frequently experienced by older people, such as depression and confusional states.

The guidance on care management encouraged different levels of assessment, appropriate for different levels of need (Social Services Inspectorate/SWSG, 1991a,b). The guidance had suggested up to six levels, graded according to level and type of need and the types of staff and number of agencies involved. Authorities in this study were asked how many different levels of assessment they had. Only 38 per cent of authorities reported having three or more levels of assessment for older people, 47 per cent reported having two and 15 per cent per cent of authorities reported only having one level. This latter strategy in particular suggests an approach to assessment and care management in those authorities which is provided to the majority of users, irrespective of their level of need. Interestingly, only a small number of authorities, approximately a third of all respondents (32), could provide detailed information on the numbers of assessments undertaken.

The guidance had also described complex or comprehensive assessment as usually requiring the greatest investment of resources and therefore should be reserved for the minority of users with complex or severe needs, usually requiring the participation of a number of agencies (SSI/SWSG, 1991a, p44). The information indicated a considerable degree of variation between authorities, as shown in Table 2. It might be expected that less than 20 per cent of potential service users would require a complex or comprehensive assessment (Department of Health, 2002a). However, this appears to be the case in only 22 per cent of authorities. Forty-three per cent of respondents reported that complex or comprehensive assessments constituted over 40 per cent of their total number of assessments. Across authorities, complex or comprehensive assessments as a proportion of all assessments ranged from eight per cent to 94 per cent of assessments, with a mean of 40 per cent. This variation in assessment arrangements suggested some lack of clarity and common understanding about the nature of complex or comprehensive assessments and different criteria about which decisions relating to access to care are made.

Monitoring and review

Table 2. Complex/comprehensive assessments as a percentage of all assessments		
	Number	%
0 - 20 %	7	22
21 - 40%	11	34
41 - 60 %	8	25
61 - 80 %	3	9
81 - 100 %	3	9
Number of authorities	32	

In reporting the data the related activities of monitoring and review are explored separately. Figure 3 shows who has responsibility for monitoring care packages. Care managers or social workers are always or nearly always responsible for monitoring the progress of care packages in 87 per cent of authorities. Providers are involved to a similar extent in only 21 per cent of authorities and 57 per cent of authorities reported that providers are sometimes responsible for monitoring care packages. Other agencies were less likely to be involved. Interrogation of the individual returns revealed that this response referred mainly to contributions from colleagues in the health service, particularly in the context of multidisciplinary team working. Occasionally, relatives were identified as being responsible for monitoring care packages. Overall, this suggests that there are a plethora of arrangements for monitoring, even within an authority. Whilst this information is based on all adult service user groups, it is highly relevant for older people, the largest user group in receipt of care management.

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Figure 3. Responsibility for monitoring care packages
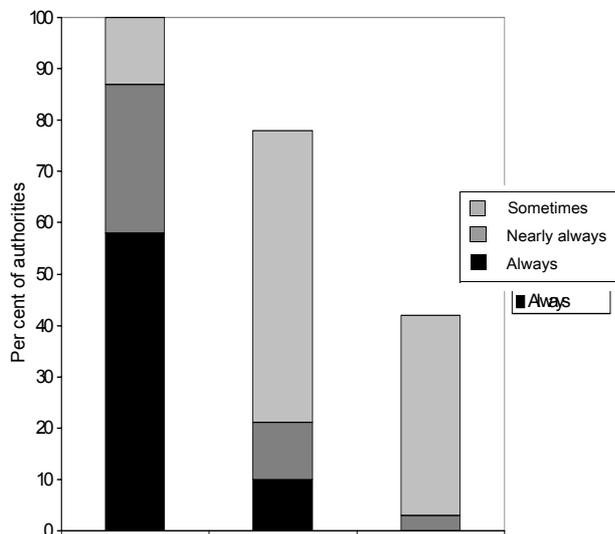
Note: Data based on all adult service user groups

Authorities reported that care managers or social workers were responsible in over 90 per cent of authorities for both community-based and residential and nursing home reviews. Providers, such as home care managers, could have responsibility for community-based reviews in about a third of authorities. Specially designated reviewing officers were only used in just under a quarter of authorities for older people living in the community and just under a third of authorities for residential and nursing home reviews.

In addition, authorities were asked what methods of reviewing cases were usually used, subsequent to an initial review, for community-based service users and for those in residential and nursing home care. Although the information is based upon all adult service user groups, it is noteworthy that in the vast majority of authorities, the method of review by face-to-face contact was reported by 87 per cent of authorities for community-based services and 80 per cent for residential and nursing home reviews. As part of the review process, obtaining information from the carer is a method used by 45 per cent of authorities for community-based services and 40 per cent of authorities for residential and nursing home reviews. Other methods of undertaking reviews were noted far less frequently.

Authorities were also asked to indicate particular aspects of their care management arrangements that were not working well and 26 per cent of authorities reported the conduct of reviews in this context. Examples of their responses are shown in Box 1. These illustrate the significant workload of a regular system of reviews and the difficulty of balancing this task with the assessment of newly referred cases.

Box 1. Description of the review process

'Demand for care management is greater than supply, threatening the quality of reviews'.

'Competing pressures from demand and consequent need for assessment versus care management of ongoing cases'.

'Volume of referrals… leads to inability to carry out the care management tasks effectively'.

Overall, most reviews were conducted by care managers or others undertaking this role by means of face-to-face interviews with users, whether they were living at home or in a care setting. This volume of work presented a challenge to most authorities, to which they had difficulty making an adequate response.

Conclusions

These findings are those of a postal questionnaire. Whilst there was a high response rate there are clearly some limitations in respect of the detail and quality of the information obtained. Since this research was designed to capture care management practice, it was inevitable that it reflects the strengths and weaknesses of the prevalent procedures and systems of data management. This is reflected in the use of estimates rather than exact figures in some key areas of data collection in authorities. This also led to some respondents finding certain questions impossible to complete, as is evidenced by the small number able to provide information about numbers and types of assessments (Table 2). Some of the data relates to all user groups, rather than vulnerable older people,

thereby reflecting current practice and procedural guidance within authorities. Moreover, since responsibility for data collection was vested in a single respondent, this, combined with the nature of the questionnaire, would have tended to militate against the inclusion of intra-authority variation. The trade-off was one between a detailed collection of information and that which could form part of a national dataset and it is inevitable that compromises had to be made in order to achieve the latter goal. For example, it would have been interesting to have been able to systematically collect more qualitative data to illuminate the quantitative findings, or to capture intra-authority variation highlighting, for example, small-scale innovations in practice. Finally, it is relevant to note that the data was collected during 1997-8. Whilst clearly care management arrangements have evolved during the intervening period, the significance of these findings are that they provide a record of care management arrangements shortly after their implementation and prior to the introduction of the present raft of reforms. As such the data provides important baseline information.

What then do these findings tell us about the balance of the core tasks in care management? Recent policy has stated that authorities should have clear rules, expressed as eligibility criteria, about who can get different types of support and in what circumstances, to promote greater equity in the provision of services (Cm 4169, 1998; Department of Health, 2002b). However, the research findings suggest that there is a lack of clarity in the application of eligibility criteria, with a focus more on eligibility for access, rather than on targeting for a type of service. Moreover the consistent application of eligibility criteria requires that staff have appropriate training for the task. Our data also shows a wide variation in the background and skills of staff currently undertaking this task, thus highlighting both the importance of securing improvement in this area and the scale of the task in order to achieve greater consistency. It will be interesting to explore the extent to which the Fair Access to Care initiative meets the twin objectives of consistency both in the content of criteria and their application. This invites local authorities to make a single decision as to whether they are eligible for help or not following an assessment of an individual's

presenting needs. The guidance provides a framework for this by prioritising the risks faced by individuals into one of four bands, based upon an assessment of risk (Department of Health, 2002b). These are not dissimilar to the four categories that it was anticipated would account for the majority of referrals for assessment requiring allocation for further intervention at the inception of the community care reforms (SSI/SWSG, 1991b).

With respect to assessment, the data suggests that in many authorities there was not a clear distinction between a standard and more complex types, as has been advocated in government guidance (SSI/SWSG, 1991a, b; SSI, 1997; Department of Health, 2002a). Indeed, the high proportion of authorities indicating that a large number of users receive a complex assessment perhaps suggests that care management is a process applied to all service users, rather than a discrete service applied to frail older people with complex needs. Furthermore, there was very little evidence of the use of assessment documentation designed specifically for the needs of older people. The findings are similar to those noted previously (Department of Health, 1993). The study reported here was unable to collect information relating to the content of assessment documentation. However, other research has demonstrated that this is extremely variable (Stewart et al., 1999), and falls well short of the assessment criteria specified in the National Service Framework for Older People (Department of Health, 2001). Together, these variations are likely to pose problems for the implementation of the Single Assessment Process, which specifies 9 assessment domains to be included in the process (Department of Health, 2002a). However, care must be taken not to regard this initial statement as definitive. Issues relating to the type and content of assessment are intrinsically linked and both are likely to be key areas of interest as the complexities of implementing the Single Assessment Process evolve. Interestingly, the English guidance for example differs from the Welsh guidance and in particular the latter has explicit domains relating to the needs of carers and activities of daily living and instrumental activities of daily living (SSIW, 2002), which are dealt with more by implication in the English guidance.

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Overall, it is important to note that over the last decade guidance in relationship to both levels of assessment and the content of assessment has become more specific. Moreover, guidance has been issued which is specific to older people. Together these developments provide greater clarity in a complex area of practice and may conceivably offer a realistic basis for greater consistency.

The importance of monitoring and review for frail older people with complex health and social care needs should not be underestimated, given the volatility of care packages for this service user group. Moreover, the importance of ascertaining the continued effectiveness of the services provided, particularly in the context of the White Paper *Modernising Social Services* should not be underestimated (Cm 4169, 1998). However, who coordinates the review and the manner in which it is undertaken are worthy of debate. Our data suggests that the review process appears to be predominantly a face-to-face activity. However, such an approach is costly if applied to all users in receipt of service. Moreover, authorities reported difficulties in responding to the volume of reviews and, consequently this task was often not completed. This contributes to the view of care management as an assessment orientated activity, with the review process characterised by neglect (Challis, 2000). To move this debate further the data suggests that more detailed thinking is required to identify in what circumstances a review should be conducted and by which means. Our evidence suggests that there is already extensive use made of providers and to a lesser extent NHS staff in the monitoring of care packages, suggesting there is scope for them to take a lead in the formal conduct of reviews. Although whatever method is adopted there will be pros and cons, including issues of relative costs. Interestingly, recent guidance has stressed the importance of the independence of those conducting reviews, militating against providers undertaking this task, although they would still contribute to the review by providing salient information (Department of Health, 2002a).

These stages of the care management process - assessment, monitoring and review - are important in that they provide mechanisms for targeting services in response to identified need. As such, how they are performed should facilitate identification of users with varying levels of need and triggering an appropriate care package, with ongoing monitoring and review where necessary. These are particularly valuable areas to operationalise within information systems to monitor performance at a local level (Clarkson and Challis, 2002). An effective care management service requires that the issue of targeting be addressed throughout the process and particularly in terms of determining eligibility for different types of service, assessment, monitoring and review. Our research indicates the variability and different definitions employed in these key areas and endorses policy guidance for greater consistency in practice.

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