Intensive care-management at home:
an alternative to institutional care?

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Abstract

Background: care management and assessment of need are the cornerstones of the community care reforms in the UK. Although much of the research base has been on highly vulnerable older people, in practice, care management has been implemented for a wider group.

Objective: to examine how intensive care-management at home has developed.

Design: postal survey of all local authority social services departments in England.

Method: we used an overview questionnaire (85% response) and an old-age services questionnaire (77% response). We classified local authorities according to the presence or absence of seven indicators of intensive care management at home.

Results: 97% of social services departments had a goal of providing a community-based alternative to residential and nursing-home care. However, only 5% had specialist intensive care-management services for older people. Other key indicators of intensive care-management, such as devolved budgets, health service care managers, small caseloads and clear eligibility criteria, were uncommon.

Conclusions: there was little evidence of intensive care-management at home in older peoples’ services. This is of concern, given the move towards community-based provision for frail older people. Closer links between secondary health-care services (such as geriatric medicine) and intensive care-management at home may promote more effective care at home for those who are most vulnerable.

Keywords: care management, community care, intensive care management at home, prevention, secondary health care

Introduction

Care management refers to the process of assessing need and arranging and co-ordinating services to enable people to continue to live at home. For the most vulnerable older people, this requires a multidisciplinary assessment, the co-ordination of substantial health and social care inputs in a flexible fashion within a care plan, and frequent adjustment of provision (as needs often fluctuate due to illness and disability). This level of service may be described as ‘intensive care-management at home’ (ICM) [1, 2]. Although in early policy documents the only formal linkage between care-management and health care was with hospital discharge [3], it is now recognized that closer links are required between health and social care to provide effective home-based support to vulnerable older people [4, 5].

In providing enhanced home care for more severely ill or dependent people, which is central to policies for older people in most countries, ICM [1, 2, 6] is important in both developing home care and contributing to the integration of health and social care. Here, we explore the extent to which characteristics of ICM are present in current care management arrangements.

The definition of care management provided in the official guidance for implementing community care was relatively broad, and permitted considerable discretion in the development of its form, content and target group [7, 8]. Consequently, agencies have tended to see care management as a model of care for most older people [9]. This gave rise to some concern in official quarters [3, 10, 11], not least because the available evidence suggested that the efficacy of care management was in more focused and targeted forms of intervention,
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involving the long-term support of very vulnerable people as an alternative to residential or nursing-home care [4, 12, 13]. This required care managers to control resources, providing flexible packages of care, a feature which has been only rarely evident [14].

More recently, however, there appears to have been an increasing desire to move towards more differentiated and focused care management, of which ICM is the most targeted form [1, 2]. This approach to the most frail would appear to be an important component of effective intermediate care, linking health and social care, and addressing the agenda of prevention central to government policy [15, 16].

Method

We collected the information presented in this paper in a study of care management arrangements for older people and those with mental health problems. In 1997/8, we sent two questionnaires to local authorities responsible for social services in England, one on care management arrangements in general and one on old-age services. The questionnaires used information collected in a preliminary study in five local authorities, selected to represent a range of styles of care management [17], a literature review [1] and input from a Department of Health reference group [18].

Of the 131 local authorities eligible to respond at the time of the survey, 111 (85%) returned the overview questionnaire and 101 (77%) returned the old-age services questionnaire. We present information mainly drawn from the general questionnaire from which a subset of information has been selected to explore the extent to which different components of ICM were present.

Results

We defined ICM as the presence of a specialist care management service working exclusively with people with high needs or at high risk, carried out by staff with small caseloads. In addition to this specific definition, we identified six organizational features from the literature as being associated with the presence of ICM [1, 2]. These seven indicators are listed in Table 1.

Many of these features are to be found in ICM demonstration programmes [4, 12, 13, 19–21]. These have highlighted that: (i) a specialist service should be targeted at the most vulnerable; (ii) ICM is likely to flourish in a setting where there were specialist teams focusing staff time and resources on a target group of the most vulnerable; (iii) devolved budgets can provide more flexible care packages [22]; (iv) the use of health-care professionals acting as care managers can be important for ICM, as support of the very vulnerable is associated with the need for health-care inputs; (v) small caseloads are another component of intensive support, enabling enough contact for review and care plan adjustment for cases with variable needs; and (vi) eligibility criteria specific to community care or to older people’s services and (vii) a policy of diversion from residential care would be expected to be associated with an attempt to focus resources specifically upon those high-risk cases at the margin of residential care [23, 24].

Table 1. Indicators of intensive care-management and provision by social service departments

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% of departments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist targeted service for older people&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5</td>
</tr>
<tr>
<td>Specialist teams for older peoples’ services</td>
<td>44</td>
</tr>
<tr>
<td>Alone&lt;sup&gt;b&lt;/sup&gt;</td>
<td>14</td>
</tr>
<tr>
<td>With other user groups</td>
<td>38</td>
</tr>
<tr>
<td>Devolved budgets to purchase social care</td>
<td>20</td>
</tr>
<tr>
<td>Social services department services&lt;sup&gt;c&lt;/sup&gt;</td>
<td>21</td>
</tr>
<tr>
<td>External providers&lt;sup&gt;d&lt;/sup&gt;</td>
<td>36</td>
</tr>
<tr>
<td>Presence of health service care managers&lt;sup*e&lt;/sup&gt;</td>
<td>48</td>
</tr>
<tr>
<td>&lt; 30&lt;sup&gt;e&lt;/sup&gt;</td>
<td>16</td>
</tr>
<tr>
<td>30–50</td>
<td>32&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>&gt; 50</td>
<td>26&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>97</td>
</tr>
<tr>
<td>Separate residential and community care criteria&lt;sup&gt;f&lt;/sup&gt;</td>
<td>32&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>Specific to elderly people&lt;sup&gt;g&lt;/sup&gt;</td>
<td>26&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>Policy of diversion from residential care&lt;sup&gt;h&lt;/sup&gt;</td>
<td>25&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Used in calculating Figure 1.

<sup>b</sup>Used jointly (presence of either) in calculating Figure 1.

<sup>c</sup>Of the 81 social services departments with eligibility criteria.

Indicators of ICM

Only 19% of social services departments had a specialist ICM service in their own organization and only 5% had such a service for older people. Forty-four percent of social services departments had specialist teams for older peoples’ services and another 14% combined older peoples’ services with another user group, predominantly services for people with a physical disability. Thus, slightly over half of social services departments provided evidence of specialisation in older peoples’ services.

We defined devolved budgets as existing where care managers were able to commit finance to and/or allocate services, such as domiciliary care, as part of a care package without consultation with a first-line manager or other more senior person. This was found in only 38% of authorities for services provided by the social services department, and in only 20% for care provided by external, independent-sector organizations.

The presence of care managers who were health service staff was only recorded by 21% of social services departments. Furthermore, in two-fifths of
social services departments there was relatively little involvement of consultants, general practitioners, nurses or other health staff in assessment for intensive home care. In authorizing admission to care homes, only a little over one-third of social services departments employed joint decision-making processes, such as a joint health and social care panel.

Just over one-third of social services departments stated that staff carried relatively small caseloads, defined as fewer than 30 cases. By comparison, small caseloads were reported by 44% of local social services departments for the physical disability user group, by 64% for mental health services and by 57% for learning disability services.

Eighty-two percent of social services departments stated that they had criteria in place to determine eligibility for community care. However, only 32% of these had separate criteria for residential and community care, which would be indicative of a policy of closely targeting services. Furthermore, only 26% of social services departments had eligibility criteria specific to older people, a reflection of a more targeted service. By contrast, 97% of social services departments stated that they had an explicit local policy goal of providing a community-based alternative to residential and nursing-home care.

Figure 1 shows the number of indicators of ICM which were found in the services provided by social services departments. Eighty-six of the responding local social services departments provided information relating to all seven indicators. However, four or more indicators were present in only 23% of these social services departments.

**Discussion**

Very few social services departments reported that they had a specialist care management service focusing exclusively upon people with high needs or at high levels of risk. This was even less likely in the case of older peoples’ services. Similarly, the key indicators we used in this paper provide little evidence of ICM, with the exception of policies to divert people from residential towards home-based care. The lack of evidence either of ICM or of features conducive to its effective operation in older peoples’ services contrasts with the policy statement from the Social Services Inspectorate on differentiated responses in care management. They identified three levels of differentiation:

1. The administrative type, undertaken by reception and/or customer service staff to provide information and advice;
2. The co-ordinating type, that deals with a large volume of referrals needing either a single service or a range of fairly straightforward services, which should be properly planned and administered; and
3. The intensive type, where there is a designated care manager who combines the planning and co-ordination with a therapeutic, supportive role for a much smaller number of users who have complex and frequently changing needs [2].

The data we collected provide little evidence of features of care management for older people that might permit such a form of differentiation. The lack of differentiation and the emergence of more generic models seemed to result from a failure to discriminate between the co-ordinating and intensive forms of care management [2]. Most social services departments reported a policy goal of diverting people from residential and nursing-home care, but the absence of key elements to implement it was noticeable: it would be difficult to achieve any material shift towards care at home in their absence.

To integrate health and social care more closely, particularly at the level of the individual patient or service user, was one of the key aims of care management [25]. The move towards a primary-care-driven health service [26] may paradoxically inhibit effective links between ICM and health care. Linking care managers with primary health care does appear to improve access and speed of referral [27]. However, effective targeting, a differentiated response and access to specialist assessment skills may be less readily achieved. Developing closer links between care management and secondary health care would offer a means of achieving some of these objectives, particularly links between ICM and secondary health care for a defined
target population. The Darlington study [5, 13, 28], which linked ICM to a geriatric multidisciplinary team, was one such attempt.

For many social services departments, improving integration with secondary health care will encourage them to achieve greater clarity in care-management arrangements [29]. Possible improvements include specialist clinical assessment before residential or nursing-home placement (as in Australia) [13] and new rehabilitation and preventative initiatives [30, 31] in conjunction with community-based developments in geriatric medicine which could help maintain frail older people at home.

Such links between ICM and secondary health care might be construed as an effective way to integrate health and social care [32] within the care trusts proposed in The National Health Service Plan [15]. Making effective links between ICM and secondary health care offers a pragmatic approach to the implementation of the policy of prevention [33] in respect of vulnerable older people.

Key points

- Very few social services departments have a specialist care management service for people with high needs or at high levels of risk, and even fewer have such a service for older people.
- Nearly all social service departments have an explicit policy of diverting people from residential to home-based care, but other indicators provided little evidence of intensive care-management at home.
- A lack of differentiation between levels of care management and the emergence of more generic models of care management are likely to inhibit the trend towards community-based provision. Practice therefore fails to address inappropriate admissions to hospital, residential and nursing-home care.
- Linking intensive care-management at home with secondary health care, such as geriatric medicine, may be more effective in promoting intensive home-based care than links with primary health care.

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References


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