Original article

Learning and performing care management: experiences of a newly formed interdisciplinary, assessment and rehabilitation team

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Abstract
Developments in primary and intermediate care services have enhanced interest in the notion of care management, the processes that it encompasses and the challenges that it poses to practitioners who are more used to working in a uni- or multidisciplinary manner. This article explores the way that a set of practitioners, new to care management, coped with the challenges of working within a newly created care-managed assessment and rehabilitation service for older people in one UK county. Data were gathered via non-participant observation, and group and individual interviews, as part of a wider action-research evaluation study. Three themes emerged from the data: the processes of 'learning' to become a care manager; 'doing' care management; and 'experiences' of the role. In order to 'learn' care management, staff needed to develop a range of new skills, establish supportive care-management processes, develop a new identity and work in an interdisciplinary way. 'Doing' care management involved working with a small group of patients with complex needs and precarious levels of homeostasis. Problem solving and crisis management were key activities and often required a creative approach to practice. Although care managers derived great satisfaction from their role, their 'experiences' were characterized by stress and anxiety. The practitioners from healthcare backgrounds needed more preparation to adapt to their new levels of responsibility and client risk. Successful management of the transition to care manager requires support from the key stakeholders and strong leadership within care manager teams. In-house competency-based training and induction programmes, and mentorship, can also play an important role, together with innovative forms of postqualifying education and training, for example, via job exchanges or an apprenticeship model.

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Introduction

'Care management' aims to ensure that the quickest match is made between a person's needs and the best skills and resources available, through the process of needs assessment, care planning and review (Ovretveit 1993). It is an approach to practice that seeks to enhance the quality of care for vulnerable people, by producing seamless service provision and ensuring that user and carer views are taken into account during the whole process. The care-management model is closely associated with developments in primary and intermediate care services and has been advocated in numerous Government documents, such as 'Caring for People' in the late 1980s (CM 849) and 'Better Services for Vulnerable People' (Department of Health 1997; Challis 1999). As well as being adopted with benefit in services for people with mental health problems (Holloway *et al.* 1995; Schmidt-Posner & Jerrel 1998; Marshall *et al.* 2003), care management has also been used in relation to frail, older people (Bernabei *et al.* 1998) where interdisciplinary working has been recognized as the blueprint for effective services.

Within the policy and research literature, much variation exists in the interpretation of the type of service user for which care management is appropriate and the actual process that it encompasses (Challis 1999). In the early 1990s, however, the activities and skills of the 'case manager' were set out in the 'Practitioners Guide to Assessment and Care Management' (Social Services Inspectorate 1991). Since that time, numerous studies have explored the nature of the care-management role. Ross & Tissier (1997) list needs assessment, care planning, implementing care plans, monitoring services and reviewing as some of the core tasks. Waite *et al.* (1997) uncovered several categories of main activity, as follows: planned direct client contact (25%); unplanned direct client contact (10%); liaison with other services (5%); administration (17%); family/carer work (1%); information sharing with team members (13%); and supervision and training (16%). Gorman (2000) identified essential care manager skills, such as communication, collaboration, partnership working, negotiation, conflict resolution, and reflective working. A detailed study of care managers' activities, carried out by Weinberg *et al.* (2003), found that the proportion of time spent on carer-related activities was small, whilst time spent on assessment, compared with monitoring and review, was fairly high.

An opportunity to explore some of the challenges posed by care management arose within a wider evaluation of the implementation of a new, care-managed assessment and rehabilitation service for older people with complex health and social care needs, aimed at maximizing their ability to live independently (Reid *et al.* 2002). The new service was introduced as part of a Joint Investment Plan between health and social care in one county (South Cheshire) in the United Kingdom. None of the post holders recruited to work in the new 'Rehabilitation Link Teams', bar social workers, had previously worked as care managers. This article provides an insight into the realities of working within this service, exploring staff experiences of learning to fulfil and develop the care-management role.

The new service

The 21-month pilot intervention scheme was based on a care-management model delivered by rehabilitation link teams (RLTs). It was planned that the teams would function in an interdisciplinary manner, and work across organizational boundaries by linking into a network of health, social and voluntary agencies (Marriott & Wright 2002). The service provided rehabilitation to clients, either in their own home or within a residential or nursing home, depending upon the level of support needed by the client. The rehabilitation packages, lasting in principle for up to 6–8 weeks, were client-centred and included a single comprehensive assessment. This was shared with service providers in order to reduce multiple assessments and improve communication and service delivery. The pilot project ran from July 2000 until March 2002.

Three RLTs were established across South Cheshire. Although each had a different composition, each team included a range of health and social care professionals, such as physiotherapists, occupational therapists, district and community psychiatric nurses, social workers and, subsequently, senior homecare

Table 1 Team composition at October 2000

Team 1	*Team 2*	*Team 3*
Team co-ordinator	Team co-ordinator	Team co-ordinator
5 Care managers	3.5 Care managers	4 Care managers
2 Occupational therapists (1 full-time and 1 for 28 h) 1 Nurse 1 Community psychiatric nurse 1 Social worker	1.5 Occupational therapists (1 full-time and 1 for 18.5 h) 1 Nurse 1 Community psychiatric nurse 1 Social worker (2 @18.0 h)	1 Occupational therapist 1 Physiotherapist 1 Community psychiatric nurse 1 Social worker
1 Practitioner Physiotherapist (20 h)	1 Practitioner (Occupational therapist to start 2nd. Jan)	4 Practitioners 2 Physiotherapists (2 @18.5 h) GP (2 sessions a week = 1 day) 0.5 wte nurse consultant
2 Associate posts 1 Social worker rapid response (does some care management for RLT) 1 Red Cross worker (20 h)	1 Associate post 0.5 wte Physiotherapy hours in community support centre 0.75 wte Physiotherapy hours in the community 0.5 wte vacant Physiotherapy	2 Associate posts 0.5 wte Occupational therapist in housing 0.85 wte Occupational therapist facilitating discharge
Admin/Clerical 1 Administrative, 1 Clerical	Admin/Clerical 1 Administrative	Admin/Clerical 1.5 Administrative

wte, whole time equivalent.

workers. Homecare workers were not initially core to the team, but contributed to client-care packages as part of mainstream social services care provision. Some team members worked as care managers, whilst others worked as 'practitioners' and carried out rehabilitation care plans. Table 1 provides details of the team composition as at October 2000, although these compositions changed during the lifetime of the pilot service. The variable core team composition resulted from initial recruitment difficulties, perhaps reflecting the wider national shortage of therapy staff, the non-permanent nature of posts (advertised on a 2-year secondment/temporary basis) and the novelty of the care-management role. Clients referred to the teams were characteristically those with complex needs, requiring longer term intervention and support from a range of professionals and organizations. Data collected on 165 clients found that the mean age was 82 years, with two-thirds being ≥ 80 years of age.

Study design and methods

The wider evaluation study explored the way in which the care-management model was applied by the RLTs and examined the extent to which it enabled independent living for clients. It took the form of a prospective before-and-after study, nested within a wider action research design, evaluating service processes (service delivery and team development), implementation (interagency working), outcomes from multiple perspectives (client, carer, clinical and service) and the cost-effectiveness of the service (Reid *et al.* 2002). A comparison group was not possible because the RLTs were phased in across the county at the same time, and all clients who met the agreed eligibility criteria were accepted into active rehabilitation packages. Ethical approval was obtained from the South Cheshire Research Ethics Committee, written consent was obtained from all clients and informal carers, and care was taken to

ensure the older person's rights to care, privacy and dignity. All data were maintained in accordance with provisions of the Data Protection Act(s).

To explore the workings of the care-management process, observational and interview methods were used. A large quantity of observational data was collected to examine the early workings, adoption and implementation of the service. Interest lay on examining how the new service was developed and the care managers' experiences. Observation focused on RLT members' activities, including team working, care manager–client interactions (at assessment, ongoing throughout the care period, at discharge) and training events. Observation took the form of recording every relevant event that occurred. Choice of locations, events and episodes of teamwork to observe were both opportunistic (depending on what happened during a period of fieldwork) and theoretically informed (choosing to attend particular team meetings or training events). In total, in the first 6 months of the pilot (July to December 2000), 36 complete days of fieldwork were undertaken, including attendance at eight patient allocation team meetings and nine county or other team training activities.

To gauge the developing experiences and implementation of care managing, a series of interviews and focus groups were undertaken with RLT members in two waves. The first wave occurred once the service had bedded in (≈ 7–8 months after starting the pilot study) and the second occurred ≈ 10 months later. Two sets of three focus groups were held, where RLT members (care managers and practitioners) explored their experience as a care manager and gave their perceptions of service quality and experiences of working across boundaries. Two further sets of focus groups (five in total) were held with senior link home care workers, asking for their views about working as part of the RLT and the impact of the service on clients. Similarly, each of the three team co-ordinators was interviewed on two occasions. Topics addressed ranged from their experience and role as a care co-ordinator, team working and interagency working, to factors facilitating or inhibiting service implementation.

All interviews and focus groups were tape-recorded and subsequently transcribed verbatim, taking care to remove the names of participants. Key aspects/summaries were sent back to all participants for verification and comments. For the open-ended, non-numerical data, a thematic data-analysis approach was adopted. Fieldnotes and transcripts were read independently by two researchers who attached codes and categories to key issues arising. The transcripts were then compared to look for patterns, commonalties and dissimilarities.

Findings

Three particular themes emerged from the observational and interview data. These related to the process of 'learning' to become a care manager, 'doing' care management, and 'experiences' of the role. Each is considered in turn.

Learning care management

Members of the rehabilitation link teams were previously employed in traditional practitioner roles, such as occupational therapy or nursing. As such, whilst social workers on the team were familiar with the care-management role, other team members had no previous experience of this model of practice. Consequently, the first 6 months of the service was characterized as a period of role development, learning and problem solving (Table 2). For example, the care managers learned from their social work colleagues and from performing care management. Part of this learning involved identifying what services existed in the locality and how to access them. Most importantly, they learned about working in an interprofessional manner, moving beyond their previous experience in uni- or multiprofessional working. During this 6-month period, team members worked closely together, discussing cases formally in team meetings and informally in the office, and carrying out joint visits to clients. They developed a capacity for joint decision making, sharing of knowledge and provision of mutual support.

Whilst the learning process was important within individual teams, it was also important for service development across the county. County training days (Table 3) became a venue where the care-management role was further defined through

Table 2 Areas of learning for the care manager role

Care managing
Learning how to be a care manager – from each other and from mistakes
Learning new decision-making skills and managing new levels of responsibility
Learning to cope with new forms of stress, for example, when unexpected events lead to a breakdown in the care package
Developing a new identity
Developing a new identity and reconciling the loss of opportunity to use many clinical skills. For some care managers, this transition was initially difficult and replacing the traditional dress code or uniform for civvy's became an emotive subject – 'I'm getting hassle from my manager saying "you're not a proper … [clinician] … I am a … [clinician] and I need my uniform"', 'I get into my uniform and I get into my role'. For others, there has been a felt need to continue with professionally related assessments and activities 'just to keep my sanity'
Setting up care packages
Finding out what services actually exist in the area: for example, drawing up lists of day care available or voluntary services operating
Learning how to access services and ensure services are put in place
Inter-agency working
Developing working practices with other organizations. For example, deciding whether/when the rehabilitation link team care manager should hand a client back over to the social worker, if the client only needed a social care package, rather than a wider social and rehabilitation package. Or, deciding whether/when the social worker should hand on a client to the rehabilitation link team care manager when rehabilitation needs are identified
Learning new policies and procedures in health and social services
Planning for and implementing education and training for home care staff
Team working
Learning about fellow colleagues within the team, their roles and their contributions
Learning how to work as an interdisciplinary team where 'no-one is the leader … everyone is their own leader'
Developing a wider range of skills and knowledge compared with traditional uni-professional knowledge
Developing a shared language as the teams are made up of people from different professions and organizations
Developing operational practices within the rehabilitation link team itself

Table 3 County training workshops

Workshop	*Purpose*
Care Management	Explore underlying theory: models, interagency working and benefits to clients
County Wide Induction	Identify team philosophy, core beliefs and values. Sharing hopes, fears and expectations
Income & Charging 1	Learn systems, and processes of income and charging in social services
Whole Systems	Explore whole systems approach
Practical Issues	Practical issues
Care Management	Explore cases seen by rehabilitation link teams, examine the care-management process
Stress Management and Managing Change	Develop strategies for coping: stress, managing change, challenging people
Referrals	Review referral criteria by examining acceptance and rejection of referrals over the previous month
Evaluation Feedback	Feedback from evaluation team
Roles/Skills Workshop 1	Explore core team roles and skills
Income & Charging 2	Revisit issues around income and charging
Roles/Skills Workshop 2	Explore core team roles and skills
Roles/Skills Workshop 3	Explore core team roles and skills

Table 4 Supportive procedures for care management

1. Allocation meetings	1. Reviewing clients
2. Assessment procedures	2. Screening procedures
3. Charging policies	3. Tracking clients
4. Learning to enter data on the social services and health databases	4. Transfers, discharge and placement procedures
5. Negotiating and liasing with other staff	5. Visiting clients
6. Planning rehabilitation programmes	6. Ways to purchase the care-managed package
7. Referral processes	
8. Using documentation effectively	

teams comparing their activities, working processes, reasoning and language. Over time, the teams also developed a multitude of operational systems and processes which enabled the care-management model to operate (Table 4). These included the procedures adopted in allocation and assessment sessions, data entry into the social services and health databases, tracking clients through the care-management process, and ways to purchase the care-managed package. Each took time and energy, as many were unusual in the 'mainstream' therapy and nurse roles, and thus had to be learned and/or developed afresh by team members. One of the key areas related to charging policies. The policy of charging for the social services component of the rehabilitation package after a free 2-week period caused confusion for some team members as they grappled with the relevant procedures.

Doing care management

Over time, care managers adapted to their new role requirements, such as being able to carry a case-load. Whilst a number of the care managers had previously carried a case-load, clients' fragile homeostasis, health and social care status, and the need to co-ordinate the provision of services across multiple providers, meant that the task was more challenging. At times, the need to 'close cases' in order to maintain capacity seemed to fit uneasily with the focus on developing an ongoing relationship with a client and their family. As care managers became more familiar with their role, they were able to identify a number of foci to it. Notably among these was the need for care managers to attend to the detail and minutiae of the clients' welfare. Care managers spent a substantial amount of time sorting out small problems that could potentially have far-reaching consequences for client welfare and independence. This was a draining task, as a visible 'product' or end-point to the care managers' work was not always obvious. However, attending to the 'minutiae' of clients' everyday needs was seen as one of the crucial ingredients in successful rehabilitation care packages:

> And things like, they have only one form of heating and it's a gas fire and the gas fire is in the room the bed's going to be in, so it has to be serviced, who is going to do that? … The (homecarers) are not allowed to actually light a gas fire with a match. They can only turn it on if it's automatic, and the gas fire has to be lit with a match so there's no heating. So you have to get an alternative form of heating.
>
> … it's the other things that we do as care managers that have meant that people who have perhaps been teetering on the brink have perhaps got home and it's worked. Because somebody has sat there and has sorted out all these different things that perhaps wouldn't have ever been looked at before. They may have been the one or two things that's meant that the care package would have broken down and they would have ended up coming back in, or would have ended up going back into hospital, or whatever.

In order to deal with these nitty-gritty details, care managers had to develop and utilize extensive problem-solving skills, and often acted as a stop-gap for missing services, such as laundry services, community physiotherapy or sufficient homecare provision. Whilst a short-term solution was often met by the care manager, the longer-term resolution of missing services was not always addressed. Whilst a mechanism was in place for issues, such as these, to be taken to strategic managers within the respective organizations, problems could not be solved overnight as there were historic legacies of poor resources and inflexibility. However, only by solving such problems were care managers able to avoid crises occurring in the client's care plan. With such vulnerable clients, crisis management was seen as a largely inevitable part of the care-manager role.

> People say in rehab. That there are no crises, but there are crises in this office every single day, because we are working with such vulnerable people. I think there is no understanding of the fact that there are no social workers involved, and so everything comes back to you, and you can't say, 'It's not my problem'. You've just got to deal with it.

Creating individualized rehabilitation care packages required care managers to work around and overcome structural barriers to client-led service provision. Care managers used the freedom offered by being part of a new service as the catalyst. They hoped that this more client-centred approach to service provision might have a positive impact on the thinking of colleagues working in other services.

> Person 1: Well, we're constantly hitting up against barriers with people saying, 'Oh, you can't do that because we don't do it that way' … you've got to try and work round it and, you know, you're bringing these things to the attention of people who are up there.
>
> Person 2: … and other teams and organizations have been going several years, and they've all got their own particular baggage and red tape, that does happen quite a bit. They've forgotten that you can be creative and they've got stuck in their own machines really. You just hope that we do rub off a bit on other organizations and we can open their eyes to the fact that sometimes you can change things, if you really want to. It is possible to do that.

Experiencing care management

Learning and performing care management in the early phase of the service development was a notably stressful time for care managers. As the extract in Table 5 illustrates, this was exacerbated by staffing and resource issues. Team members often appeared overwhelmed by the diversity and volume of tasks ahead and frequently expressed feelings of failure if unable to meet the needs of clients through lack of knowledge or failures in the current infrastructure. The rigid, historical systems and procedures already in place sometimes proved difficult for the RLTs. For example, simple procedures, such as ordering equipment, could not initially be fulfilled, as care

Table 5 Extract from fieldwork observations of care managers

Fieldwork note August 3rd 2000

Coping with the job: Some members of the team have been staying at work very late (until 10 pm) sorting out crises when things go wrong. Very stressful. Made more difficult as, because of the holiday period, teams are short staffed by one or two people … Team members are finding it hard to cope with care management and the 'world of the social worker', where care packages break down and clients are discharged when they shouldn't be and they get flack for things which are not really their fault. Team members are getting very distressed when things go wrong – not used to the level of responsibility of being a care manager in comparison with providing physio or occupational therapy treatment.

managers were not 'eligible' to make orders. Whilst such hitches were not insurmountable (care managers had to, and did, find a way through them), the time lag before solutions could be found led to frustration and anxiety. The fear of failure was also worsened by early tensions with other service providers who felt threatened by the new teams and the very public nature of Joint Investment Plan service innovation, itself seen as a 'flagship development'.

During the first 6 months of the service, care managers with 'health' backgrounds felt unprepared for the challenge of working with social services. Care managers felt that they lacked knowledge of how to purchase services, set up care packages or understand client eligibility criteria for services:

> I feel we should have been prepared more for the social side of the care management because it's completely new to us. I do not feel that I had enough knowledge of social services, and how they work. To start with I feel that was a really big stumbling block for me because we weren't given the knowledge of how to access certain services.

Indeed, some care managers indicated that they did not initially appreciate the scope of the role of care manager and held a rather limited conception of what it would involve:

> … being the care manager is actually quite different now to when we started off and what we envisaged when we started … I mean, I didn't see it very far different from being a therapist with perhaps a little bit added on – you know, we'll just order meals on wheels, or we'll just order a bed … It is so much (more) … it is a long way along the line when you are working properly as a care manager.

With hindsight, care managers recognized the added complexity of the role and felt that it carried far more responsibility than their previous traditional practitioner roles:

> Person 1: I think its the level of responsibility. We have professional responsibility as a (therapist/nurse), but the level of responsibility as a care manager – you are responsible for everything for that person for the next 6, 12, 16 weeks. Whatever goes wrong, up to dog walking, up to shopping, all sorts of things that mean that person copes at home, or is rehabbed at home, family crises, liasing with neighbours, just all, constantly liaising with agencies about what you want them to do …
>
> Person 2: It is the detail, it is the detail, you know, because as a hospital (therapist/nurse) you go out and you just decide if somebody is safe to go home. You don't really look further than that really.

Dealing with client risk became a case in point. Care managers acknowledged that in their previous practitioner roles they had largely devolved discussions, regarding the discharge from hospital of 'at risk' or 'unsafe' clients, to social work staff:

> If we felt that somebody was unsafe to go home we would say 'we don't think they are safe' and pass it on to a social worker, whereas they would give all the risk factors to (the client) and … at the end of the day it's their choice to go home.

In their current position, however, care managers now found themselves being the key professional to support the client's decision to go back to their own homes even when deemed 'at risk'. For some care managers, managing a new concept of risk, and the level of risk, seemed to be the crucial difference identified between previous roles and the mantle of care manager. For some, taking risks and developing their extended role led to concerns over liability and litigation. However, whilst learning and performing care management proved to be a stressful experience within the context of a developing service, RLT members also found the care-management role to

be very rewarding. Care managers gained satisfaction from taking responsibility for the welfare of a client, seeing the whole process through and overcoming obstacles:

> … when you're a (therapist or nurse), you've looked practically at somebody's skills… but then you have to feed all that back to their social worker. Whereas, I know I can go out and do a washing and dressing assessment, and I can go and write the goals myself, and I can go and train the homecarers. So, for me, it's really nice because I can actually see the whole process through from beginning to end. I really like that.

Care managers also expressed satisfaction with interdisciplinary team working, skill and knowledge sharing within the team. Through discussions as a team, they were able to develop an in-depth understanding of the roles of others, and greater awareness of the 'whole' client. For some, this was borne out in more holistic and efficient client assessments:

> I've definitely grown in confidence, and some competence as well. My understanding of the other disciplines … has shot right up. To be honest, when I first came, I couldn't really have described the difference between occupational therapy and physiotherapy. It's hard to believe now. I mean, I definitely could describe both in different ways … I feel much more confident and competent when I go out and do joint visits with people. That I can understand what is going on and why it's going on, and it makes me feel that I can do a better job than before – in terms of understanding more about the full person and what all their needs are, so that I know which way I'm going.

Discussion

A number of challenges to learning and performing care management are evident in these findings, centred on the need to successfully achieve the transition from practitioner to care manager. This has many parts.

First, the boundaries of the role were found to be flexible and could be pushed outwards, depending on the individual's confidence and desire. At times, the care manager needed to question their and others' previous assumptions about what might be best for older people, working around existing services or structures that acted as barriers to providing individualized client care.

Second, their knowledge and skills base needed to be extended. In their brokerage role, care managers coming from a 'health' background frequently felt unequipped, especially in relation to purchasing and financial matters. Care managers had to develop the ability to solve complex problems and develop a wider understanding of the nature of client risk.

Finally, the care managers needed to develop and adopt a range of supportive work processes to allow the teams to function effectively and the service to operate smoothly. A flow chart depicting the care-management model, and illustrating potential clients' journeys through the service, was designed to enhance the transparency of the service both to the care managers and to other services with which they worked. Given the developing nature of the service, changes had to be made in a dynamic manner. Whilst the supportive procedures were not unique in themselves, and many such procedures existed in most services in some form, they were new to the novice care managers. It took tremendous energy for the care managers to establish these as well as learn a new role and take responsibility for clients' wellbeing.

A further challenge lay in the area of interagency working. The complexity of interagency working was a surprise to many of the care managers – in particular, how to cope with the range of other services with which they needed to interact, identifying who the key personnel were and then developing a rapport. Sometimes, services were unsupportive of the new initiative or did not fully understand its remit. At other times, the care managers felt that they were stretching the goodwill of supportive staff. Care managers also had to come to an understanding of the remits of the other services and what support

they could offer. This was a painstaking and unanticipated activity. With multiple service providers across the county, including NHS, social services, private and voluntary services, and differences in the types of support services, this was a complex task.

Despite the complexities and difficulties encountered in care management, most respondents found the role rewarding and – of primary importance – beneficial to clients (Reid *et al.* 2002). Satisfaction was gained from the level of interdisciplinary team working and the improvements this brought to client assessment. Care managers shared skills by communicating with and working alongside each other in relation to specific clients. As Hudson (2002) notes, working in close proximity to each other in a shared office aids this communication process. Apart from the benefits to clients, team communication and training could also enable care managers to reflect on and cope with stressful situations (Waite *et al.* 1997).

Successful management of the transition to care manager requires support from key stakeholders and strong leadership within care-manager teams. When new, innovative teams are introduced into well-established services, they tend to be scrutinized in more detail, and more critically, than mainstream, established services. Moreover, such changes to provision are not always welcomed, particularly if the new service poses a threat or competes with the work of existing services alongside which it is to function. Staff delivering the new service may experience hostility or unhelpfulness from other practitioners in key positions, leading to feelings of vulnerability and stress. This was a frequent occurrence in the early phase of this service and added to care managers' difficulties in adopting the new role. This highlights the importance of ensuring that, when new services are introduced, potential sources of tension are anticipated and addressed early on at a senior management level.

Additional sources of support are also needed. First, a major role can be played by an in-house, competency-based training programme; here this was introduced as this service progressed. Part of this induction/training might involve the new care managers visiting neighbouring services of a similar nature. In our study, however, despite the county training days, most team members felt that more should have been done to facilitate their transition to care manager and to reduce the anxiety produced by evolution of the role. Indeed, it is interesting to note that new staff joining the care-management teams did not experience the same levels of pressure and anxiety as the original members, following their induction programme. Second, as a client-led, social model of rehabilitation (Young *et al.* 1999) was being espoused, focusing on community living, care managers were being encouraged to think more broadly than using just mainstream hospital and community services. This suggests the need for a comprehensive and systematic mapping exercise of existing services as a prelude to the introduction of a care-management model. Gaps in provision may then be noted. Practitioners can quickly become disheartened if the shortfalls in services they locate are not taken heed of and used to the benefit of future services (Ovretveit 1993).

Working in an interdisciplinary manner requires further and different skills from working within a particular profession. While multidisciplinary team working is premised on professional communication to share information on assessments and treatments, team members function independently. Interdisciplinary team working assumes a high level of team communication, mutual goal planning and evaluation, and working alongside one another (Hibbert, St Arnaud & Dharampaul 1994; Proctor-Childs, Freeman & Miller 1998; Long, Kneafsey & Ryan 2003). Accordingly, as care management, interdisciplinary team working and joint working between health and social services become more central to service delivery, structured programmes of preparation for the care-manager role may well be required. Studies of collaborative and multiprofessional practice highlight the challenges for health and social care staff working together as a result of personal, cultural, professional and organizational constraints within which different practitioners work (Higham & Spooner 1998), and the variations in management and funding arrangements (Sims *et al.* 1997). Joint training at both pre- and postqualifying levels is an important mechanism for sharing of skills and expertise (Stanley *et al.* 1999; Haywood & Porter 2001). Such training also needs to embrace

the issue of professional accountability, with the practitioner working as care manager.

Innovative forms of education will be needed to provide for the type of work-based learning necessary to develop local services and practitioners with the right skills (Finch 2000). The initially limited conception of the new care managers of the new role suggests the potential of a system of mentorship, especially in the context of a pilot and developmental service. A core aim would be to ensure that practitioners feel secure in order to practise effectively and to reduce the sense of anxiety associated with working in a new service and adopting a novel approach to practice. Additionally, job exchanges with others working in a care-management role might be undertaken, or adoption of an apprenticeship model. The NHS Skills Escalator (Department of Health 2003) may also play an important role in enabling effective career planning in the future. Its implementation will require the development of skills and competency frameworks to make explicit the skills and abilities needed to deliver patient-centred care, including care management. The new skills and knowledge that the care managers in our study developed might then be more fully recognized, utilized and further developed. In addition, the NHS Knowledge and Skills Framework (NHS Pay 2003) could help to identify the knowledge and skills that individuals need to use within their roles and help to structure and guide personal development.

Finally, it is interesting to note that the care managers in our study did not report concerns with the amount of administration they undertook, or the need to focus on the minutiae of clients' care. This was perhaps because the service was still in its infancy. Care managers may have viewed these aspects of their work as only temporarily time-consuming, owing to their novelty. As the care managers became more adept in the role, they might however, have been expected to have taken on a larger case-load, potentially limiting the amount of patient contact and compromising their own previous training and experience as active-therapy practitioners. The minutiae might then achieve a heightened significance. For example, surveys by Parry-Jones *et al.* (1998) and Ramcharan *et al.* (1999), of care-management practitioners, point to the effects of a decrease in client-contact time being associated with perceptions of de-skilling through the administrative and gate-keeping role, leading to stress and potential burnout. Similarly, Gorman (2000), applying the concept of emotional labour to care management, observed that care managers often felt that their patient contact and relationship-building skills were not being used effectively, with greater focus being paid to administration. Further research is needed to provide insight into these issues.

Conclusion

Developing a new service takes time, and staff members need substantial support from line managers during the early implementation phase. Line managers themselves also need adequate support. Care management is a complex activity which carries increased levels of responsibility. It bears little resemblance to traditional practitioner roles where care and treatment can be compartmentalized and responsibility handed on or shared with other members of staff. Team members from nursing and therapy backgrounds require considerable help and support to successfully manage their role transition and to develop new levels of decision-making and problem solving.

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