An Examination of Assessment Arrangements and Service Use for Older People in Receipt of Care Management

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With anticipated greater demand for formal care services globally, this article examines the sociodemographic and health characteristics of frail older people in receipt of community support. Data were collected from audits of case files of older people receiving care management at two time points during which two government policy initiatives were implemented to promote greater standardization in health and social care provision for older people in England. Findings at Time 2 revealed that there were higher levels of physical and mental impairment and more health care assessments undertaken. There was a slight decrease in home care receipt but a marginal increase of more intensive home care provision. Service users living with a carer were less likely to receive home care but more likely to receive respite care or day care than those living alone. The policy goal of widening access to specialist health and social care services for older people with mental health problems was achieved. Guidance that focused eligibility criteria on the identification of older people with complex needs required the availability of appropriate support and services. Irrespective of policy initiatives, the sociodemographic characteristics of older people and the availability of informal support are principal determinants of service provision.

Keywords: care coordination; case mix; dependency; service mix

The promotion of strategies to permit older people to remain at home with support from appropriate community services is of longstanding international concern (Australian Government Productivity Commission, 2011; Kodner, 2006; Organisation for Economic Cooperation and Development, 2005; Stewart, Georgiou, & Westbrook, 2013). In England, there have been major reforms to both the structure and the delivery of adult social care in recent years in response to a growing ageing population, variations in access to care between localities, and to increase the range of support for service users and carers (Department of Health, 2012). This policy builds on two earlier initiatives designed to promote greater standardization in health and social

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http://dx.doi.org/10.1891/1521-0987.15.2.66

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care provision for older people, which span the time frame for the collection of data reported in this article.

First, Fair Access to Care Services (FACS) was a framework requiring local authorities to determine and make publicly available criteria on which eligibility for all adult social care services was judged (Department of Health, 1998; Department of Health, 2002a). The subsequent tightening of these criteria nationally caused concern about the exclusion of those with low-level needs from service receipt (Commission for Social Care Inspection [CSCI], 2008a; Lett, Sackley, & Littlechild, 2006). Second, the National Service Framework for Older People (NSFOP) was introduced to raise quality and reduce variation in service provision by specifying several standards (Department of Health, 2000b; Department of Health, 2001), one of which was designed to improve access to integrated specialist services, including both hospital and community-based services, for older people with mental health problems. Another related to assessment and was designed to place the service user at the center of the process, improve practice, develop more standardized approaches, and reduce duplication by enabling greater integration between different settings and different professional groups. It was subsequently referred to as the single assessment process (SAP; Department of Health, 2000b; Department of Health, 2002b).

These two policy initiatives were introduced in a context in which the demographic characteristics of the older population and service provision for people 65 years and older were changing and were anticipated to continue to do so. Several factors which may influence service receipt by older people have been identified and include physical and cognitive impairment, housing circumstances, and informal carer circumstances (Darton et al., 2006; Wanless, 2006). The numbers of older people with cognitive impairment are projected to increase at a faster rate than those with purely functional disabilities (Comas-Herrera, Wittenberg, Pickard, & Knapp, 2007). Furthermore, the likelihood of living alone increases as people age, with twice as many older women than older men living alone, and this proportion increases with advancing age. In 2011, in the United Kingdom, over three-fifths of women aged 75 years and older and around one-third of men lived alone (Office for National Statistics [ONS], 2013a). Regarding informal care, around 30% of carers older than 75 years in England provided at least 35 hr of support per week (ONS, 2013b). However, a decline in the number of informal carers is anticipated because of the ageing of this population and a reduction in coresidence (Wanless, 2006). In view of these changes in the characteristics and circumstances of older people in the coming decades, there are likely to be greater demands for formal care services.

National policy implementation is more likely to be successful when it is embedded in the practice of local organizations responsible for its delivery (Abendstern, Hughes, Clarkson, Tucker, & Challis, 2013; Clarkson, 2010; Fauth & Mahdon, 2007). Responsibility for the implementation of central government social care policy in England is devolved to localities, known as local authorities. Often, they have discretion to interpret national policies and procedures to fit their existing local practices and service provision (Mandelstam, 2005). Government guidance relating to eligibility for social care, assessment of older people, and the provision of old age mental health services, is consequently mediated by existing arrangements, which may have evolved differently in each local authority over time. Although the material examined in this article is derived from English local authorities, the interpretation of the findings has international relevance in terms of identifying determinants of service provision for frail older people and the influence of policy initiatives on this process.

AIMS

The purpose of this article is to explore variations over time in user characteristics, assessment arrangements and service use for frail older people referred for care management and receiving community support. Findings are appraised in the context of these policy initiatives, which were designed to promote greater standardization in the delivery of health and social services used by older people.

METHODS

Data were collected from audits of case files from three local authority adult social care services in predominantly urban localities, in Northern England at two time frames, in 2000 (Time 1) and again in 2005 (Time 2 data) using a quasi-experimental design. Ethical approval was obtained for both data collections. At both time frames, each authority was asked to select on a specified date and thereafter, the case files of consecutive referrals of older people in receipt of community support and who met specific criteria. These were that individuals needed to (a) have received an assessment and care plan and be eligible for review, (b) have received domiciliary or day care provided or purchased by the local authority for at least 2 weeks, and (c) be the responsibility of a team providing long-term care. This selection process ensured that differences between the groups in terms of their characteristics were minimized so that the samples were broadly equivalent each time. Information was

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collected from the case files by the study researchers using the most recent assessment or review and care plan and recorded onto a pro forma developed by the research team and used previously (Challis, Hughes, Jacobs, Stewart, & Weiner, 2007; Challis et al., 2000). Around 150 cases were analyzed at each time frame. To capture changes in health needs and service provision, data collected from each survey were compared, the first survey in effect providing a historical control group (Bowling, 1997).

Comparisons between time frames were made using information from several domains: living situation, level of dependency, cognitive function, needs assessments, social care provision, and health care provision. Living situation was recorded as either the presence or absence of a carer living in the same household as the service user. Dependency was assessed using the Katz Activities of Daily Living (ADL) Index (Katz & Akpom, 1976a, 1976b). Scores (1 = *dependent*, 0 = *not dependent*) in any of six activities (bathing, dressing, toileting, feeding, transferring, and continence) were summed and a total score between 0 and 6 calculated. Scoring 3 or more on this index constituted evidence of higher dependency for this study. Presence of any of four mental health problems including short-term memory problems, problems with cognitive skills, problems with communication, or problem behavior was also noted. Details were recorded of needs assessments undertaken within primary health care (e.g., a general practitioner or physiotherapist), secondary health care (e.g., a consultant geriatrician or old age psychiatrist), or occupational therapy, in addition to any assessment undertaken by a local authority care manager. The range and type of health or social care service receipt, in terms of type of community care support and level of input as detailed in the care plan, was also recorded. Higher intensity home care was defined in this study as home care provided eight or more times per week.

Statistical Analysis

Data were entered and analyzed using SPSS version 19. Cramer's V, Mann-Whitney tests, and *t* tests, depending on level of measurement, were used to measure differences in sample characteristics and service receipt by time point. A number of logistic regression analyses were employed to explore the impact of the variables selected on the probability/odds of being in receipt of these types of services when all the other variables in the model were held constant. In this, the six measures of service receipt provide the dependent variables: home care, higher intensity home care, day care/day hospital, respite care, community nursing, and community psychiatric nursing. All were dichotomous with a value of 1 indicating *receipt* and 0 *nonreceipt* of these services. All predictor variables were categorical in nature. Potential sources of multicollinearity were explored before and during the analysis by examining a correlation matrix of all explanatory variables, and no significant problems were found (Field, 2005). Backward elimination was used as the basis of model selection (Hutcheson & Sofroniou, 1999). A threshold of 10% rather than 5% was chosen as the level of significance because of the small sample size and the exploratory nature of the study to increase the probability of identifying effects (Kennedy, 2003).

RESULTS

Table 1 presents the characteristics of the sample of service users at Time 1 and Time 2 and shows there were few differences in respect of service users' age, gender, or living situation. There were, however, differences in levels of dependency and mental health problems, with services users at Time 2 significantly more dependent and having problems with cognition and communication compared to Time 1. Thus, although sociodemographic data was broadly similar, the sample at Time 2 constituted a frailer group of older people.

Table 2 reveals that there was an increase in the number of assessments undertaken in addition to those completed by the care manager. Information recorded at Time 1 showed that 13% of the sample received primary health care assessments with a modest increase to 18% at Time 2. There were significant increases in the number of secondary health care and occupational health assessments undertaken. Although the identity of the assessor was not routinely recorded in case files, where specified, it appeared that more of the secondary health care assessments at Time 2 were undertaken by members of old age psychiatry teams. With respect to service receipt, there was found to be a significant association between time period and day care/day hospital use, which was lower at Time 2. A significant difference was also found in relation to the mean number of social care services received, which was also lower at Time 2. Thus, there appeared to be an overall increase in the number of assessments of needs experienced by service users but a reduction in the number of services received at Time 2.

Table 3 presents summary findings from the logistic regression analyses. The regression analyses revealed that each dependent variable was significantly related to at least one of the outcome measures. Receipt of home care or higher intensity home care was positively associated with having no resident carer. Thus, service

TABLE 1. Sample Characteristics

	Time 1 *N* = 144	Time 2 *N* = 145	Significance
Age—mean (*SD*)	82.6 ± 7.2	81.5 ± 8.4	*ns*
Range	65–97	62–98	
Gender—% female	72%	65%	*ns*
Living situation—% with carer in household	32%	27%	*ns*
Dependency			
ADL score: (0–2/3–6)% dependent	30%	43%	$p = .017$
ADL score: range	0–5	0–6	
ADL score: mean (*SD*)	1.95 (1.5)	2.46 (1.8)	$p = .02$
Mental health problem %			
Short-term memory	46.1%	45.9%	*ns*
Cognitive skills	40.6%	52.4%	$p = .044$
Communication	19.7%	40.0%	$p < .001$
Behavior	21.0%	20.1%	*ns*
Any of above mental health problems	53.5%	62.1%	*ns*
Urinary incontinence	16.2%	18.6%	*ns*
Bowel incontinence	4.2%	9.1%	*ns*

Note. ADL = activities of daily living.

TABLE 2. Assessment Arrangements and Receipt of Services

	Time 1 *N* = 144	Time 2 *N* = 145	Significance
Receipt of assessment (documented in case file) %	*N* = 132–140	*N* = 142–144	
Primary health care assessment	13%	18%	*ns*
Secondary health care assessment	23%	35%	$p = .022$
Occupational therapy assessment	23%	39%	$p = .004$
Service receipt %[a]			
Home care	86.6%	81.4%	*ns*
Higher intensity home care[b]	49.0%	51.1%	*ns*
Day care/day hospital	38.9%	25.5%	$p = .015$
Respite care	8.3%	9.0%	*ns*
Community nursing	18.8%	17.9%	*ns*
Community psychiatric nursing	12.5%	13.1%	*ns*
Both health and social care services	36.8%	33.1%	*ns*
Number of health services received: mean (*SD*)	0.47 (0.68)	0.52 (0.80)	*ns*
Number of social services received: mean (*SD*)	1.9 (0.88)	1.5 (0.87)	$p < .001$

[a]Types of services available at both Time 1 and Time 2.
[b]Higher intensity of home care = eight visits or more per week.

TABLE 3. Logistic Regression Analyses of Service Use

	Home Care (n = 280)	Higher Intensity Home Care (n = 275)	Day Care/ Day Hospital (n = 264)	Respite Care (n = 290)	Community Nursing (n = 285)	Community Psychiatric Nursing (n = 282)
	β (*SE*)	β (*SE*)	β (*SE*)	β (*SE*)	β (*SE*)	β (*SE*)
Male	*ns*	*ns*	*ns*	*ns*	*ns*	−1.624*** (0.627)
Aged 85 years and older	*ns*	*ns*	*ns*	*ns*	0.612* (0.319)	*ns*
No resident carer	1.691**** (0.418)	1.257**** (0.334)	−0.799** (0.320)	−1.764*** (0.457)	*ns*	*ns*
Higher dependency	1.654**** (0.496)	1.295**** (0.315)	−0.550* (0.326)	*ns*	0.813*** (0.316)	*ns*
Memory problems	*ns*	*ns*	0.894*** (0.304)	0.857* (0.462)	*ns*	*ns*
Cognitive skills	*ns*	*ns*	*ns*	*ns*	−0.551* (0.324)	1.482*** (0.543)
Communication problems	*ns*	*ns*	0.648* (0.331)	*ns*	*ns*	*ns*
Behavioral problems	−0.806* (0.433)	*ns*	*ns*	*ns*	*ns*	2.059**** (0.487)
Urinary or bowel incontinence	*ns*	*ns*	*ns*	*ns*	*ns*	−1.561** (0.712)
Authority A			*ns*	*ns*	*ns*	
Authority B	−0.989* (0.565)	−0.621* (0.329)				2.155**** (0.574)
Authority C	−1.451*** (0.547)	−1.175**** (0.322)				0.609 (0.676)
Time 2 assessment	−0.913** (0.386)	*ns*	−0.692** (0.301)	*ns*	*ns*	*ns*
Constant	1.829 (0.612)***	−0.772* (0.398)	−0.350 (0.350)	−1.823*** (0.412)	−1.869**** (0.292)	−4.192**** (0.680)
Nagelkerke R^2	0.235	0.211	0.168	0.163	0.068	0.457

*$p \leq .1$. **$p \leq .05$. ***$p \leq .01$. ****$p \leq .001$.

users living alone or apart from their carer were more likely to receive home support. Similarly, having a higher level of dependency was also associated with a greater probability of being in receipt of home care or higher intensity home care, which suggests the targeting of care services on those with greater dependency. Conversely, problem behavior was associated with a lower probability of home care receipt.

Two types of care services received outside the home—overnight respite care or day care/day hospital—were positively associated with presence of memory problems in the study cohort. There was also an increased likelihood of receipt of day care/day hospital for older people with communication problems. In contrast, having no resident carer was associated with a lower probability of receiving day care, day hospital, or respite care, suggesting that this type of service was providing resident carers with respite from their caring role. A higher level of dependency was also associated with a lower probability of attending day care or day hospital services, although this was a small size effect within the regression model. Receipt of com-

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munity nursing was associated with a higher level of dependency and age (85 years and older) but also better cognitive functioning. Unsurprisingly, there was evidence of an association between the receipt of community psychiatric nursing and the presence of mental health problems. The analysis revealed that older people with either cognitive deficits or problem behaviors were more likely to be in receipt of the service. However, incontinence or being male was associated with a lower probability of being in receipt of this service.

There were some interauthority differences in service use holding the effect of other variables constant, more specifically differences in the receipt of home care (authority B and C compared to A), higher intensity home care (authority B and C compared to A), and community psychiatric nursing (between authority B and A). No differences were found for the impact of authority in respect of day care/day hospital, respite care, or community nursing services. Furthermore, at Time 2, there was a lower probability of receiving home care or day care/day hospital services compared to Time 1, confirming the reduction in service receipt noted in Table 2.

DISCUSSION

The six services represented in this analysis—home care, higher intensity home care, day care/day hospital provision, respite care, community nursing services, and community psychiatric nursing services—are core services regarding the support of frail older people in the community (Reilly, Hughes, & Challis, 2010). This article has described changes in the sociodemographic characteristics, assessment arrangements, and service uptake for community-dwelling frail older people. It used data collected during a period of transition in the configuration of health and social services, designed to promote greater standardization. However, there are two principal limitations to this study. First, data were derived from an audit rather than from direct contact with service users or social care professionals and were extracted from social care case files only. As a consequence, any omissions or failure to record contact with services within the selected case files could lead to underrepresentation of some health and social care contacts. Second, it was not possible to compare availability of some services such as low-level preventive services because they were not represented in the first data set. Nevertheless, outcomes from the study are further discussed in the context of two internationally relevant themes: eligibility and assessment and service receipt.

Eligibility and Assessment

Difficulties and inconsistency in the application of eligibility criteria for service receipt have been noted for many years in England (Audit Commission, 1996; Challis & Hughes, 2002; CSCI, 2008b) and in the European Union and other countries (Robbins, 2008). Differences between authorities were evident in this study, particularly in respect of receipt of home care. Furthermore, at Time 2, service users received fewer home care visits despite having significantly higher dependency levels. These findings suggest that the implementation of policy guidance on eligibility criteria influenced service receipt with a higher threshold applied to the allocation of service, although variations between localities in respect of this remained despite the introduction of FACS guidance. Indeed, it was subsequently reported that some local authorities applied stricter criteria, which resulted in higher thresholds for the provision of care, with the difference in expenditure being most apparent in respect of home care services (Audit Commission, CSCI, 2008). This supports the literature previously discussed regarding local variation in the implementation of national policy.

Evidence from this study has indicated an increase in the number of assessments undertaken, consequent on the implementation of the SAP. There was a significant increase in the number of occupational therapy and secondary health care assessments undertaken at Time 2. Very few assessments were carried out within primary health care at either time frame. However, a review of a new memory service and European research have both suggested that a more

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substantial role for primary health care in the assessment of need for older people with mental health problems could be beneficial. This would allow the opportunity for the assessment to be made in the context of wider health problems, provide access closer to home, and be more cost-effective compared to secondary health care (Greening, Greaves, Greaves, & Jolley, 2009; Jedenius, Wimo, Strömqvist, Jönsson, & Andreasen, 2010). Such a development would have the potential to further improve access to specialist services for older people with mental health problems, an objective of the NSFOP.

Service Receipt

In this study, there was evidence of a comparative reduction in the range and availability of social care services. There was a slight decrease in the percentage of older people in receipt of home care, but a marginal increase in intensive home care provision as reflected nationally (National Statistics, 2009). Furthermore, there was an association between dependency level and receipt of home care or intensive home care and community nursing indicating that these services were targeted on those having a higher level of need. Living situation appeared to be a factor in service receipt, with older people with resident carers less likely to be in receipt of home care but more likely to receive day care or respite care. Regarding the former, a bias of provision of home care toward older people not living with a carer has been reflected elsewhere (Moriarty & Webb, 2000; Parker, 1999; Pickard 1999, 2001, 2004) and is significant because it is projected that an increasing number of older people will be living alone in the future (ONS, 2013a). Regarding the latter, despite evidence of the value of day care for both older people and their carers nationally (Banerjee & Chan, 2008; Wanless, 2006) and internationally (Mossello et al., 2008; Schacke & Zank 2006), in this study, the use of both day care and day hospital decreased. This significant reduction in day care may reflect a national decline in service availability rather than a reduction in need (CSCI, 2008a). Furthermore, the subsequent introduction of a policy of personalized care, which has promoted individualized support (Her Majesty's Government, 2007), is arguably incompatible with the maintenance of day care provision. Overall, provision of carer-focused services such as respite and carer breaks may have substituted for home care services provided for those without a carer living in the household, suggesting that the NSFOP objective of increasing the range of services available to support older people at home had not been achieved.

There was an increase in the number of secondary health care assessments carried out at Time 2 and an association between the community psychiatric nursing service and mental health problems. Furthermore, there was a difference between authorities in respect of community psychiatric nursing service provision, suggesting different old age mental health service configurations. These findings may indicate that there were changes in secondary health care services provided for older people with mental health problems with increased use of old age psychiatry and community psychiatric nursing. Community-based support for such service users is typically provided by community mental health teams (Coles, von Abendorff, & Herzberg, 1991; Department of Health, 2001). Within these, the community psychiatric nurse is the team member most involved with continuing care and carer support for older people with dementia (Brown, Godber, & Wilkinson, 2005). The evidence from this study confirms their involvement in this. This suggests developments within specialist mental health services in response to the requirements of the NSFOP (Department of Health, 2001) by diverting care of older people with mental health problems toward secondary health care.

Similarly, having a higher level of dependency was also associated with a greater probability of being in receipt of home care or higher intensity home care, which suggests the targeting of care services on those with greater dependency.

CONCLUSIONS

Three key points emerge from this study. First, although more assessments were undertaken following introduction of the policies which formed the focus of the evaluation, study findings should be viewed in the context of underdetection of mental illness in older people because of the fact that many live alone and the nature of their symptoms with mental and physical problems interacting to make assessment and care more difficult (Department of Health, 2001). From this, it may be inferred that the goal of widening access to integrated specialist services for older people with mental health problems has been enacted. However, this study does not provide evidence of its nature or the appropriateness of the service response and other research in respect of this is equivocal (Tucker et al., 2007). Second, a reduction in the range and availability of social care services and an increase in the dependency levels of those in receipt of service were consequent on the introduction of the two policy initiatives. However, these findings cannot be solely ascribed to the introduction of eligibility criteria, which targeted assistance on those with high-level needs. The ramifications of this are difficult to evaluate because of the introduction of direct payments, a form of self-directed support for social care for older people, which occurred

around the same time as the policy initiatives that were the focus of this study (Department of Health, 2000a). Personal budgets, administered by service users with assistance from family, friends, or brokerage agencies, have become an established feature within adult social care in England (Department of Health, 2012). Although the objective is that support is tailored to need and is responsive, there is the possibility that services might not be in place to meet demand. In this context, it has been suggested that day care centers, found to be of particular value to older people and their carers, may be vulnerable to the effects of potential lower demand because of their high costs (Wilberforce et al., 2011). Third, this study demonstrated that an important determinant of service uptake were the sociodemographic characteristics of service users and the informal care they received. It confirms other research exploring variations in social care for older people, which showed that factors outside the control of the local authority such as age or living alone were a predominating influence on local service provision (Brand, Hughes, & Challis, 2012). Overall, despite policy initiatives to promote greater standardization in the application of eligibility criteria, assessment practice, and service delivery for frail older people requiring community support, evidence from this study suggests limited progress reflecting the relatively slow evolutionary development from national policy guidance to service change in localities.

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Acknowledgments. This work was undertaken by the Personal Social Services Research Unit and funded by the Department of Health for England. The views expressed are those of the authors and not necessarily those of the Department of Health. We are grateful to Graham Dunn, professor of biostatistics, and Dr. David Jolley, old age psychiatrist and honorary reader, both at the University of Manchester, who provided valuable advice and comments.

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