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Care management for older people: Does integration make a difference?

DAVID CHALLIS¹, KAREN STEWART¹, MICHAEL DONNELLY²,
KATE WEINER¹, & JANE HUGHES¹

¹*Personal Social Services Research Unit (PSSRU), University of Manchester, and* ²*Department of Epidemiology and Public Health, Queens University, Belfast, UK*

Abstract

England and Northern Ireland provide examples of different degrees of integration of health and social care within broadly similar administrative and funding frameworks. This paper examines whether integrated structures appear to impact upon the operation of care management, a key approach to providing coordinated care for vulnerable older people. There appeared to be more evidence of integrated practice between health and social care in Northern Ireland than England, although some key features, such as intensive care management, were no more evident. It is concluded that further investigation is required as to the extent to which integrated structures have impacted upon patterns of professional working and underlying beliefs about roles.

Keywords: *Integration, care management, older people, England, Northern Ireland*

Introduction

There are developments designed to achieve greater integration between health and social care in the care of older people in many countries (Bergman et al., 1997; Bernabei et al., 1998; Commonwealth Department of Health and Aged Care, 1999). The expectation is that greater integration will result in improved care for people who will receive more “joined-up” services. In England the NHS Plan (Cm 4818-I, 2000) stressed the need for greater integration and established proposals for the creation of integrated Care Trusts (joint health and social care organizations). Similarly, the Health Act (House of Commons, 1999) enabled health and social care organizations to have the flexibility to evolve over time and make new arrangements between them. The Health and Social Care Act 2001 (House of Commons, 2001) provided the legislative basis for the creation of Care Trusts. Although Care Trusts are in their infancy, they have significant implications for secondary services, such as old age psychiatry, in terms of allowing budgets to be pooled, the integration of commissioning and provision, and joint lead commissioning of mental health services. The fundamental assumption that underlies these policy developments is that increasingly such structures relating to commissioning and providing services will lead to increasingly integrated forms of care.

In England health care is provided through NHS Trusts which are responsible for providing hospital and community based health services in conjunction with general practitioners. Social care services, such as home support and the purchase of residential care, are provided or commissioned mainly by local government. Conversely, in Northern Ireland, joint Health and Social Services (HSS) Trusts provide community services and the full range of social care services, including the purchase of residential and nursing home beds. Whilst there are varying degrees and types of integrated organisations for vulnerable older people requiring community based services, there is an administratively integrated care system. Hence, health and social care in England are broadly separate, managed respectively by the NHS and local government, whereas in Northern Ireland a single Trust is responsible for both forms of care. This unique difference in the configuration of services makes it possible to compare the different arrangements and the potential impact of this form of integrated system.

Thus, in Northern Ireland incentives to integrated working are not seen to be required to the same degree, since it has one of the most structurally integrated and comprehensive models of Health and Personal Social Services in Europe (Down Lisburn Trust, 1997; McCoy, 2000). Social and health services are jointly administered and this arrangement should, in theory, promote collaborative working and interdisciplinary arrangements (Campbell & Pinkerton, 1997). Since Direct Rule was imposed in 1972, Health and Personal Social Services in Northern Ireland have been delivered through four Health and Social Services Boards, based on local authority districts. The Department of Health, Social Services and Public Safety, established by the Departments (NI) Order 1999 is responsible for the administration of health and social care. It was argued at the time, that integration would increase understanding between professional groups and services would become more needs led rather than shaped by particular professional perspectives (McCoy, 2000). At the same time in England, coordination, rather than integration between health and social services was encouraged (Webb & Wistow, 1986). One other difference is that health and social care expenditure in Northern Ireland appears to be significantly higher than in England (Department of Finance and Personnel, 1998; Department of Health, 2001a). Consequently, per capita, Northern Ireland has more general practitioners, hospital consultants, social services staff, nursing staff, allied health professionals and home help hours than England (DHSSPS, 2004).

Care management and coordination can be seen to be one part of the long-term care reforms for older people in many different countries (Challis et al., 1994). The aim of care management was to enable a shift in the balance of care away from institution based provision towards care at home and to render care at home more tailored to the requirements of individuals. In both England and Northern Ireland care managers were accorded the responsibility for assessing need in respect of care at home and placement in care homes, therefore assigning public funding towards this goal. Care management can be seen to consist of the integrated performance of a series of core tasks—case finding, assessment, care planning, monitoring and review—often undertaken by a designated worker for the most vulnerable individuals (Challis et al., 1995, 2002a,b). Both the White Paper *Caring for People: Community Care in the Next Decade and Beyond* (Cm 849, 1989) in England and the Northern Ireland White Paper *People First: Community Care in Northern Ireland for the 1990s* (DHSS, 1990) proposed the implementation of case or care management. It would be reasonable to assume that processes associated with care management might display differences between England and Northern Ireland, which could be attributed to the different form and extent of integrated services which have emerged.

A key theme in the development of care management has been the need to differentiate the response in relation to the level of need of different service users. This was noted in the implementation guidance in England, which stated that: "...it would not be logistically feasible for all users to have their own care manager" (SSI/SWSG, 1991, p. 24). However, implementation of care management would appear to have demonstrated little evidence of differentiation (Challis, 1999), perhaps reflecting the very broad definition of care management given in the summary of the practice guidance "...the process of tailoring services to individual needs" (SSI/SWSG, 1991, p. 11). By contrast, in Northern Ireland *care management* was defined as a general concept covering assessment, care planning, coordination and reviewing of services and distinguished from the term *case management*—a specific activity of advocacy and coordination of services for an individual client who needs this level of support (DHSS, 1991, para. 2.4). This distinction in terminology is not present in English guidance and is indicative of a more differentiated response to older people with complex needs compared to those whose needs can often be met by a single service response.

Implementation of care management in England was monitored by a number of SSI and research studies. A series of core messages emerged from these studies, including the importance of a differentiated approach to care management so that different levels of response are associated with different levels of need (Department of Health, 1994, 1995a,b, 1996, 1997a,b). This inevitably requires explicit eligibility criteria and different types of care management response to different levels of need to assist in targeting resources appropriately. One of these types of care management, appropriate for the most vulnerable, has been described as intensive care management (Department of Health, 1994; Challis et al., 1995, 2002a,b). Other key issues include problems in the quality of assessment and the extent of multidisciplinary working (Caldock, 1993; Department of Health, 1993; Stewart et al., 1999). There are also other themes in the care of older people, linked to care management arrangements, which might be expected to be shaped by the degree of integration between health and social care. These include the development of intermediate care (Department of Health, 2001b), enhanced hospital discharge, a perennial theme of concern since 1990 (Gostick et al., 1997), and the care of older people with dementia (Department of Health, 1997c; Audit Commission, 2000, 2002). A recent overview of performance (SSI, 2003) noted that assessment remained of variable quality and that care management arrangements were frequently bureaucratic and not effective.

To a certain extent policy documents and inspections in Northern Ireland have identified similar issues. A major inspection of assessment and care management arrangements raised concerns about the quality of assessment and the extent of inter-professional involvement, monitoring of care and training (NISSI, 1995). The concerns about assessment were reiterated in the consultative document *Fit for the Future* (DHSS, 1998). This latter document also noted the need for further progress on integration in Northern Ireland, stating the need to develop and cement the existing level of integration (p. 14) and suggested that services still remain fragmented given the presence of 19 Trusts, four Health and Social Services Boards and five health and social service agencies (DHSS, 1998, para. 5.13). It is planned to replace the four Boards by a single Health and Social Services Authority and to reduce the number of Health and Social Services Trusts to five (DHSSPS, 2006).

Integration has gradually moved up the policy agenda in England from a focus upon joint planning towards one based upon collaboration and incentives (Webb & Wistow, 1986). Later the emphasis shifted towards multidisciplinary working (Department of Health, 1997d; Department of Health, 2001a) and then to integrated provision and partnership working (Hudson & Henwood, 2002). However, whether or not integration at an

organisational level yields integrated practice is unclear. In a review of peer reviewed UK literature from 1990–2001 (Challis et al., 2005), it was concluded that there was greater evidence of integration in old age mental health services than in mainstream old age services. In the latter the benefits of social worker placement in GP surgeries is well documented, both for users and their carers (ease of access) and for the staff involved (closer inter-professional working). However, barriers to interprofessional working remain including professional mistrust, threats to professional identities and problems associated with information sharing. Integrated systems of care management, where health staff assume responsibility for coordinating care packages as suggested in the early guidance (SSI/SWSG, 1991), have been slower to develop. The study presented here investigated a practice-level activity, care management and services for older people, and the extent to which integration is associated with more joined up practice. In particular, the study attempts to illuminate the extent to which care management is more differentiated in an integrated system, where the different responses to need in, for example, primary and secondary care are more visible.

On the basis of these different structural arrangements it was deemed reasonable to hypothesize that certain practice-level features would be more evident in a service system with greater integration. Hence the aim of the study was to examine how the integrated system of health and social care in Northern Ireland influenced assessment and care management arrangements compared with practice in England where health and social care were provided by separate organizations. Three main areas were identified where it was considered likely that these differences would be apparent: the process of care, including multidisciplinary working, assessment and care planning; differentiation of care management; and specialist services. A number of broad hypotheses, either implicit or explicit in the literature, about the nature of integrated services may be formulated by which England and Northern Ireland can be compared (SSI/SWSG, 1991; Challis, 1998; Audit Commission, 2000; 2002; Johri et al., 2003). These suggest that Northern Ireland compared to England would have:

- A more integrated approach to assessment and associated documentation;
- Greater involvement of health care staff in undertaking care management;
- A more differentiated approach to care management;
- A closer link between care management and specialist provision, in respect of rehabilitation services and more generally hospital discharge arrangements; and
- A greater extent of specialist dementia services.

Method

The study was undertaken as part of a programme of work undertaken by the Personal Social Services Research Unit (PSSRU) and funded 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, that is those over 65 years of age. Whilst previous papers have reported data relating to services in England (Challis et al., 2001; Stewart et al., 2003; Weiner et al., 2002, 2003), this is the first publication which seeks to compare provision in England and Northern Ireland.

The study adopted a cross sectional survey design. Information for this paper was provided by two postal questionnaires distributed to the 130 English local authority social services departments then in existence and to the 11 Trusts providing community based

services in Northern Ireland at the end of the 1990s. The first questionnaire covered aspects of care management arrangements for all adult service user groups, and the second focused on arrangements for older people, adults over the age of 65. The questionnaires were completed by staff with responsibility for policy formulation or management of community based services in the respective agencies. The majority of the information presented in this paper relates to old age services, although a small amount refers to services for all adult users where this information was not user group specific. This is indicated in the findings section where appropriate. Of the 131 local authorities responsible for social services in existence at the time of the survey in the late 1990s, 101 completed both questionnaires, a response rate of 77% (Stewart et al., 2003). All local authority types were represented, although the response rate for London Boroughs was slightly lower than the rest. All 11 Trusts in Northern Ireland with responsibility for community health and social services, including care management, completed both questionnaires, a response rate of 100%.

Data were analysed using SPSS for Windows (version 12). The unit of analysis was the local authority or the health and social services trust. Statistical comparisons were made using chi-squared and *t*-tests and were conducted at the 5% level of significance. Two summary measures were developed. The first was an indicator of targeting, described in the findings. The second consisted of eight key features of integrated working were identified (listed in Box 1) so as to provide an overall summary measure of integrated practice. Each was given the value of 1 or 0 depending upon whether the attribute was present or absent for the responding local authority or trust. This gave a possible score of between 0 and 8, where a higher score represented a higher degree of integration.

Findings

The process of care management

Information relating to the process of care management is examined in two areas—multidisciplinary working and assessment and care planning.

Multidisciplinary working. Table I shows the extent to which a health contribution to assessment from a hospital consultant, general practitioner, nurse or other health care professional was usually required for nursing home care, residential care and intensive home care services. Health contributions to assessment for both residential care and intensive domiciliary care were significantly higher in Northern Ireland compared to England ($p < .05$). Unsurprisingly, a significantly higher percentage of Northern Ireland Trusts

Box 1. Care management arrangement: Indicators of integrated practice.

- Health contribution to assessment for intensive domiciliary care (Table I)
- Shared assessment documents (Table I)
- Joint access to computerized info systems (Table I)
- Health staff undertaking assessment and care planning (Table II)
- People with complex needs receive help different in nature and scope to other service users (Table III)
- Specialist care management in rehabilitation (Table IV)
- Special home care service dedicated to hospital discharge (Table IV)
- Specialist dementia service (Table IV)

shared assessment documents between health and social care staff than in England ($p < .05$). Joint access to computerized information systems was very low in England, 12% and a little higher in Northern Ireland, 27%. The majority of Trusts in Northern Ireland and local authorities in England reported arrangements for sharing information between health and social care professionals within the assessment and care management process (91%, 10 Trusts and 86%, 87 of English local authorities) respectively. However, the exchange of written material was the preponderant means of information sharing in both.

Assessment and care planning. Table II shows the main staff groups responsible for co-ordinating assessments and implementing care plans for all adult user groups, the largest number of whom were older people. A greater range of staff were involved in both

Table I. Multidisciplinary working.

	England N (%)	Northern Ireland N (%)
<i>Health contribution to assessment</i>		
Nursing home care	94 (97)	11 (100)
Residential care*	62 (64)	11 (100)
Intensive domiciliary care*	57 (59)	11 (100)
Total number	97	11
<i>Formal arrangements for sharing information</i>		
Exchange of written documentation	86 (87)	10 (91)
Multidisciplinary locality meetings	72 (73)	8 (73)
Shared assessment documents*	59 (60)	10 (91)
Via a designated person	23 (23)	4 (36)
Joint access to computerized information systems	12 (12)	3 (27)
Total number	99	11

* $p < .05$.

Table II. Assessment and care planning: Staff groups responsible.

	Assessment		Care planning	
	England N=101 (%)	NI N=11 (%)	England N=100 (%)	NI N=11 (%)
Care manager	64 (63)	9 (82)	68 (68)	8 (73)
Social worker	88 (87)	8 (73)	84 (84)	7 (64)
Social work assistant	*40 (40)	*0 (0)	50 (50)	2 (18)
Occupational therapist (OT)	*69 (68)	*2 (18)	74 (74)	6 (55)
OT assistant	27 (27)	0 (0)	*34 (34)	*0 (0)
Community care worker	15 (15)	0 (0)	13 (13)	0 (0)
Review officer	18 (17)	0 (0)	12 (12)	0 (0)
Home care manager	24 (24)	0 (0)	34 (34)	1 (9)
Other				
SSD	18 (18)	0 (0)	26 (26)	2 (18)
Health	25 (25)	5 (45)	**15 (15)	**8 (73)
Independent sector	5 (5)	0 (0)	0 (0)	0 (0)

* $p < .05$; ** $p < .001$.

assessment and care planning in England than in Northern Ireland. In terms of assessment, it can be seen that in England there was a significantly greater use of social work assistants ($p < .05$) and also occupational therapists ($p < .05$). In Northern Ireland there was a greater use of health staff in assessment, although this was not significant. The information relating to care planning shows a greater use of occupational therapy assistants in England ($p < .05$). There was also a significantly greater involvement of health staff in care planning in Northern Ireland ($p < .001$).

Differentiation within care management arrangements

Table III shows a range of aspects of arrangements that may be associated with a differentiated approach to the provision of care management. A significantly higher percentage reported in Northern Ireland that care management was a response provided only to a limited number of service users, compared to English authorities ($p < .05$). Moreover, a higher proportion of Trusts in Northern Ireland, about three-quarters, said that care management was a specific job undertaken by staff called care managers, compared with half

Table III. Differentiation within care management arrangements.

	England N (%)	Northern Ireland N (%)
<i>Service description</i>		
A specific job undertaken by staff called care managers	50 (50)	8 (73)
People with complex needs receive help different in nature and scope to other service users	39 (39)	7 (64)
A response provided only to a limited number of service users*	19 (19)	6 (55)
An activity to a degree of complexity such that caseloads are consequently small	9 (9)	1 (9)
Total number	100	11
<i>Specialist teams</i>		
Yes	36 (36)	11 (100)
No	65 (64)	0 (0)
Total number	101	11
<i>Eligibility criteria</i>		
Yes	83 (82)	11 (100)
No	18 (18)	0 (0)
Total number	101	11
Separate for community-based/residential care	26 (26)	5 (46)
Combined for community-based/residential care	55 (56)	6 (55)
None	18 (18)	0 (0)
Total number	99	11
Specific to older people	21 (21)	4 (36)
Generic across adult services	59 (60)	7 (64)
None	18 (18)	0 (0)
Total number	98	11
<i>Caseload size**</i>		
<30	29 (31)	0 (0)
30–50	49 (52)	2 (18)
>50	17 (18)	9 (82)
Total number	95	11

* $p < .05$; ** $p < .001$.

the authorities in England. Similarly a higher percentage, 64%, of Trusts (7) in Northern Ireland said that people with complex needs received help of a different nature and scope to other service users, compared with 39% of authorities (39) in England.

All Trusts in Northern Ireland provided services to older people through specialist teams, whilst only 36% of English authorities (36) had specialist older people's teams, but at the time this was in the process of changing, with an increasing trend towards specialization.

Information on eligibility (who is deemed to need services) was collected prior to the implementation of the Fair Access to Care Services (FACS) guidance in England (Department of Health, 2002a). All Trusts in Northern Ireland operated explicit eligibility criteria, compared with 82% in English authorities (82) (Table III). Similarly, a higher percentage also had separate criteria for community-based and for residential care. There was also a slightly greater use of criteria that were specific to older people in Northern Ireland, over a third of Trusts (36%, 4) compared with a fifth of English authorities (21%, 21). Interestingly, it was also found that in terms of assessing needs, four per cent of English authorities (4) had specialist assessment documentation for older people, compared with 18% of the Northern Ireland Trusts (2).

Northern Ireland Trusts reported significantly greater caseload sizes compared with England ($p < .001$), with 82% (9) reporting caseload sizes of over 50, compared with 18% of English local authorities (18) (Table III). The reporting of caseload size in England was complicated because of differences in practice among the authorities, for example, whether workers carried generic or specialist caseloads, and whether cases remained open to individuals, to teams, or were closed following assessment. Furthermore, caseload size is an average and therefore hides possible variation within, and hence it is possible that some staff had small caseloads and others large ones. The data also revealed that 5% of authorities (5) in England reported having a specialist care management service working exclusively with older people with high level needs, carried out by staff who carry small caseloads. None of the Northern Ireland trusts reported having this arrangement for older people.

Another way that an agency can differentiate its response to user need is by targeting care management resources, both in terms of the grade of staff involved and the allocation of resource or staff time. An indicator was created to examine the degree of targeting of care management resources (not shown in Table III). This included: whether different levels of assessment were undertaken by different grades of staff or were associated with either the cost or type of care packages; whether different expenditure ceilings or indicative care packages were associated with different levels of need; and whether an intensive care management service involving small caseloads was available. The presence of any of these was taken to indicate a differentiated care management service for older people. On this basis evidence of targeting was found in over half of authorities in England (52%, 52), compared with almost two thirds of Trusts in Northern Ireland (64%, 7).

Specialist services linked to care management

Table IV shows the use of specialist services within the English authorities and Northern Ireland Trusts. Overall, 58% (58) of English authorities and 73% (8) of the Northern Ireland Trusts reported having specific community-based resources dedicated to the rehabilitation of older people. The table shows that there was a significantly greater role for specialist care management in rehabilitation services in Northern Ireland Trusts compared with English authorities ($p < .05$). More generally, a larger proportion of Northern Ireland Trusts reported using occupational therapists and social workers in rehabilitation services

Table IV. Specialist services linked to care management.

	England N (%)	Northern Ireland N (%)
<i>Rehabilitation services</i>		
Occupational therapists	24 (24)	5 (50)
Social workers	6 (6)	2 (20)
Domiciliary services	29 (29)	5 (50)
Specialist care management*	7 (7)	4 (40)
Residential care	36 (36)	3 (30)
Day care	19 (19)	4 (40)
Adult placement scheme	5 (5)	0 (0)
Total number	100	10
<i>Hospital discharge</i>		
Special home care service	63 (63)	9 (82)
Short-term residential/nursing home care	30 (30)	5 (46)
Adult placement scheme	4 (4)	1 (9)
Total number	100	11
<i>Dementia service</i>		
Specialist dementia service*		
Yes	44 (46)	10 (91)
No	51 (54)	1 (9)
Total number	95	11

* $p < .05$.

than in English local authorities and also made more use of dedicated resources such as domiciliary services and day care services. Seventy-two per cent (72) of English authorities and 91% (10) of the Northern Ireland Trusts reported having special services dedicated to hospital discharge. Table IV reveals that in these services there was a greater use of both specialized home care (46%, 5 compared with 30%, 30) and short-term residential and nursing home care in Northern Ireland (82%, 9 compared with 65%, 65). A significantly higher percentage of Northern Ireland Trusts also had a specialist dementia service ($p < .05$), and this covered the whole catchment area more frequently than in English local authorities ($p < .05$).

Overall indicator of integrated practice

As noted in the introduction, it might be reasonable to suppose that an integrated system of care would promote more integrated practice overall. Using the measure of integrated practice from the items shown in Box 1 there was a statistically significant difference between England and Northern Ireland. Northern Ireland Trusts had a higher score indicative of more integrated practice than English local authorities (a mean score of 5.36, compared with 2.98; Mann-Whitney $U = 93.50$, $p < .001$).

Discussion

Box 2 summarizes the results which are statistically significant. This reveals that integrated health and social care provision influences both multi-disciplinary working and assessment and care management arrangements in the context of services for vulnerable older people. It demonstrates that there is little evidence within the findings reported to reject the five

Box 2. Indications of greater integration between health and social care provision in assessment and care management arrangements in Northern Ireland compared with England.

Summary of hypothesis	Evidence supporting	Evidence not supporting
Greater involvement of health care staff	More involvement of occupational therapists in assessments More involvement of health staff in care planning More health staff involved in assessments for residential care and intensive domiciliary care	
A more integrated approach to assessment	Greater use of shared assessment documents	
A more differentiated approach to care management	More respondents indicated that care management was a response provided only to a limited number of service users	Larger average caseload size
A closer link between care management and specialist provision	More specialist care management within rehabilitation services	
A greater extent of specialist dementia services	More specialist dementia services More evidence of specialist dementia services throughout an authority/trust	

hypotheses which sought to unravel the influence of integrated health and social care provision, as illustrated by a comparison of assessment and care management arrangements in England and Northern Ireland. Moreover, the data suggests that the delivery of health and social care by a single organization as is the case in Northern Ireland enables a more integrated approach to meeting the needs of vulnerable older people through assessment and care management arrangements. This was confirmed by the overall indicator which sought to capture the key features of integrated working practices. By contrast, just one factor, larger caseload size appeared to potentially facilitate greater differentiation in England. It was expected that the integrated system of health and social care in Northern Ireland would promote a more differentiated approach to care management. By contrast, this hypothesis was not supported in terms of the available data on caseload size, eligibility criteria or other aspects of care management arrangements. It was noteworthy that neither in England nor Northern Ireland was there any substantial evidence of the presence of intensive care management, which could reasonably be seen as a strong indicator of differentiation. Moreover, as detailed in the findings, a weakness of the average caseload size indicator is that it does not capture possible variations in caseload size according to need at the individual worker level within organizations. Nevertheless, in general terms, employing several indicators, it was found that there was more evidence of integrated practice in Northern Ireland old age social care services than in England.

Nonetheless, the study has certain limitations. The high response rates to the surveys mean that the analyses are in effect based upon populations rather than samples, and therefore that external validity is high. Thus, of necessity we have compared groups of very unequal sizes and this is likely to have reduced the statistical power of significance testing and potentially increased the likelihood of Type II errors (concluding that there is no significant difference when there is one) (Rossi, 2003). Hence our conclusions can be seen as inherently conservative. Furthermore, although the response rates were very high, within trust and local authority variation was not captured. It is clear that this exists and indeed, our data reveals that. For example, with regard to dementia services, these covered the whole catchment area in 82% of Trusts (9) in Northern Ireland, compared with 37% (37) of English local authorities. Notwithstanding these caveats, the findings provide evidence to contribute to the debate about the virtues, or otherwise, of integrated health and social care provision for vulnerable older people. Three issues are identified for further consideration: the skill-mix of practitioners; a comparison with specialist old age mental health services; and, more generally, the influence of structural factors and particularly the different roles of primary and secondary health care.

It was noteworthy that the assessment process appeared to be a more professionally dominated approach in Northern Ireland as evidenced by the lower proportions of social work assistant and occupational therapy assistant staff undertaking assessments. There also appeared to be a different pattern of use of occupational therapists in England and Northern Ireland. Whereas in England occupational therapists would appear to contribute mainly to the assessment process, in Northern Ireland their role appears more common later in the care management process, at the level of care planning. The question of the extent to which the more integrated system raises workforce configuration issues, including new forms of interprofessional working requires further investigation. In particular, the greater use of professionally qualified staff in the assessment and care planning process within an integrated structure is worth of further debate. Whilst it may simply be a reflection of historical differences in workforce strategies it does raise the interesting question of whether or not an integrated service structure assists professional staff from different backgrounds to work together in the assessment and care planning process. In England in particular this is an issue particularly relevant in the context of current debates about recruitment, retention and the roles of staff in teams in the health and social care workforce (Cm 6737, 2006), the recent attention paid to measuring the efficiency of service configurations (Gershon, 2004) and more generally the drive to promote a more multidisciplinary approach to assessment (Department of Health, 2002b). The evidence from this study suggests the possibility that organizational arrangements surrounding the delivery of health and social care are a significant factor in pursuit of these three goals, although a necessary but not sufficient condition.

The evidence of greater integration at the practice level, revealed in this study of services for older people receiving community based care, does appear to contrast with a comparative study of old age psychiatry services in England and Northern Ireland (Reilly et al., 2003). This latter study suggested that integration between health and social care in Northern Ireland was more evident at the level of management and strategy, rather than at the level of practice. One explanation might be that the discrepancy between the two sets of findings may lie in the different trusts in Northern Ireland, which provide different services. Thus, for example, there may be a high degree of integration between community nursing services and care management within community trusts but much poorer linkages with secondary care services, such as old age psychiatry, based in different trusts. However, 11 of the 14 old age psychiatry respondents were based in the same health and social service trusts as respondents to the social care questionnaires, suggesting that the different interpretations

of the data may lie in the different perceptions of integration of the different respondents. The present study relied upon health and social care managers responsible for care management as the respondents, whereas the old age psychiatry survey relied on the perspective of consultant psychiatrists.

Interestingly, only part of the debate about the impact of integration can be addressed in reviewing the impact attributable to structural factors (Hudson & Henwood, 2002). Perhaps more problematic, and an area requiring further investigation is the extent to which within integrated structures significant changes have occurred in patterns of professional working and assumptions about roles (Hiscock & Pearson, 1999). In Northern Ireland, the absence of intensive care management, evidence of greater integration overall and the discrepancy between old age psychiatry and social care perspectives on integration would together seem to indicate that integration was predominantly occurring between nursing and social care at a primary level, with perhaps poorer linkages with secondary care. For intensive care management to develop within an integrated structure would require closer linkages between care management and secondary care services, such as old age psychiatry and geriatric medicine as demonstrated in the UK and elsewhere (Challis et al., 1995, 2002a,b; Johri et al., 2003; Howe, 1997). The importance of this is highlighted in the development of services to meet the needs of people with long term conditions in England (Department of Health, 2005; Cm 6737, 2006). Overall, from this study it is possible to conclude that, despite the difficulties in comparing two settings with different structures, it is surprising that there have not been other comparisons of the potential gains associated with the integrated system in Northern Ireland in relation to services in the rest of the UK since developments in the former provide evidence to inform both policy and practice in the latter.

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