

How many community care plans measure their population's need for services against actual service provision? In theory, all local authorities should be able to quantify the needs of their population, stratified by age, sex and client group, and match needs to service provision. In practice, few community care documents show evidence of having done so.

The three key reasons for the poor planning information in community care plans are:

- the limitations of current data sources;
- the community care structure which fragments the population focus;
- the lack of national guidance on standardising the assessment processes, core data, data collection and eligibility criteria.

Most needs-assessment methodologies draw on existing epidemiological data sources. Thus, census data is used to derive socio-economic profiles of the population. National surveys, including the Office of Population Censuses and Surveys disability survey and the general household survey can be used to profile disability and other risk factors for health and social care. Health and social services provide important data on service provision for use at national and local level. But this data does not link service needs with provision. For this we rely on population-based surveys. Thirty years ago, detailed national and local community-based surveys set out to quantify met and unmet need for health and social services.¹ They also looked at triggers for services, such as dependency and social factors. These surveys have not been repeated in recent years so the impact of changing policies in community care on need and provision cannot be measured. The question is whether the market model of planning, with

Everybody counts

Health and local authorities need to use population-based data if they are to ensure equitable community services, say Sylvia Godden and Allyson Pollock

its emphasis on services responsive to individual needs met through the care-assessment process, lends itself to population monitoring.

Before 1991, planning for health and social care was undertaken on the basis of normative provision. Data on beds, staff and other services was linked to geographic populations, and service provision was calculated as rates per head of population. This data is still required from local authorities for national returns and is useful for monitoring trends.

Although normative provision is criticised for being service-based not needs-based, it has played an important role in moving towards equity in both health and social services.²

In 1948, the NHS inherited a fragmented and inequitable service. Planning tools for redistributing resources more equally included data on normative provision of beds, staff and services and use rates. These measures helped ensure more equitable resource and service allocation. Normative planning can also highlight sections and groups within the population that are not receiving care.

But the success of normative planning rests on the ability to include and count the whole population. Normative planning becomes difficult to interpret where significant numbers of the population use privately funded care, and responsibilities for funding and providing care are fragmented.

Service-use rates are difficult to interpret if even relatively small numbers of the population are not counted. For example, in areas where a large number of clients purchase services independently of the public sector, overall use rates may appear to fall since they undercount those using services. In contrast, areas where fewer people can afford private care may appear to be heavy users of services. There has always been a privately funded sector which has made provision difficult to monitor, but local authorities have faced much greater difficul-

Table 1: Measures of need used by eight social services departments (SSDs) reviewed in south-east England, 1993

DoH guidance need category	Number of SSDs recording	Number of SSDs using scales to measure level of need
Basic client details	8	N/A
Activities of daily living	8	5
Mobility	8	5
Mental health	8	4
Sensory impairment	8	5
Social support	8	2
Financial detail (includes benefits)	7	1
Employment/education/leisure	8	3
Transport/access	6	1
Housing conditions	8	2
Needs of carers: basic details	Complete only in one department, incomplete in 5	N/A
Carer needs: time caring	2	2
Care needs: type of caring	6	6
Risk assessment	4	4
Summary	5	N/A
Level of need	4	4
Outcome	8	N/A

ties with the fragmentation of public sector responsibilities.

The responsibilities for funding and providing long-term and social care have fallen to several agencies whose relative contributions have altered dramatically since 1948. Until 1991, the three public agencies responsible for funding long-term care from the public purse have been the NHS, local authorities and, since 1983, the social security budget. The first two budgets were used to fund public provision. From 1983 until 1993 the social security budget was open-ended public funding for residential and nursing home care provided in the private sector. The closure of long-stay local authority and NHS beds and the expansion of private sector provision has been well-documented and illustrates the importance of aggregating data on provision across the sectors.¹

The NHS and Community Care Act 1990 appears to have simplified the funding arrangements. The devolution of community care responsibilities to local authorities has virtually switched off NHS and social security-funded care. The NHS still has some continuing care responsibilities, but the level at which it draws its criteria is a source of tension for local authorities.

Faced with fewer resources and increased need, local authorities pursue a strict policy of targeting those in high need using eligibility criteria. This excludes many people who would formerly have been eligible for services. As a result of increasing pressure on capped budgets, local authorities have been forced to open up the only remaining source of funding available to them, ie local taxation, charges and means-testing of individuals. Many individuals with low levels of care needs find it cheaper to buy their own packages. At a national level government is consolidating this indirect policy of private funding by pursuing an active policy towards private long-term care insurance policies.

Opening up private sources of funding results in greater complexity. Although there is only one major public agency receiving funding for care (with a small residual contribution to the NHS and social security), the private purse makes up the rest through local taxation, direct payments for services, charges and means testing payments. But as more individuals pay for their own care or use private insurance it will become impossible to monitor the population's access to services. Private payers are under no obligation to undergo a local authority needs assessment or to provide data on their care, and so differences in the population profiles of private versus publicly funded care are unknown. For example, last year local authorities increased the volume of service provision, but the number of households receiving home care fell by 5 per cent and there was an 11 per cent decrease in the number of individuals receiving meals on wheels nationally.² It is not known how the service needs of these former clients are being met, but it is likely that an increasing number of individuals pay for their care out of their own pocket or go without.

It is also difficult to extrapolate what is known about publicly-funded groups to the private sector. Groups using private funding may have different health and social care needs from

Table 2: Age and sex profile of social services sample

Age band	Male	Female	Total	%	Rate per 1,000 pop
0-4	6	15	21	4	1
5-14	1	1	2	0	0
15-24	58	29	87	1.6	2
25-34	148	99	247	4.6	3
34-44	100	98	198	3.7	5
45-54	109	137	246	4.6	9
55-64	141	188	329	6.2	16
65-74	241	514	755	14.2	42
75-84	453	1332	1785	33.5	156
85+	303	1360	1663	31.2	381
Total	1,560	3,773	5,333	100	20
%	29.3	70.7	100	-	-

Table 3: Social services use by age on snapshot day

Age band	Homecare	Respite	Nursing	Residential	Daycare	Other	Total	%
0-4	13	2	-	4	8	-	27	0
5-14	1	1	-	-	1	-	3	0
15-24	5	29	1	40	34	11	120	2
25-34	31	52	1	111	146	29	370	6
34-44	72	22	-	55	96	15	260	4
45-54	114	18	1	63	102	16	314	5
55-64	210	9	7	51	120	12	409	7
65-74	602	1	18	53	152	9	835	14
75-84	1,518	4	35	143	221	7	1,928	32
85+	1,315	3	54	250	190	6	1,818	30
Total	3,881	141	117	770	1,070	105	6,084	100
%	64	2	2	13	18	2	100	-

Homecare includes homecare services, eg meals on wheels, laundry, personal care, shopping.

Respite care, nursing care and residential care includes private and voluntary nursing.

Day care can include meals, transport.

Other includes unique care packages, external equipment, education fees, outreach etc.

those in the public sector. In the past the public sector has kept costs low because of its ability to pool risks across most of the population. As local authorities and the NHS tighten their eligibility criteria, certain groups will be forced to use private funding to gain access to care.

The public payers will have smaller risk pools and may be left with the most vulnerable and expensive groups - those that cannot afford to pay for care will do so, and those that cannot will be paid for out of the public purse. This is known as adverse selection. For example, the local authority budget is funding nursing and residential home care for frail elderly people which would formerly have been NHS or social security-funded. Compared with 1994, in 1995 local authorities were supporting 15 per cent more residents in residential care (139,700) and 72 per cent more residents (43,200) in nursing home care.

The fragmentation of responsibility for planning and provision means that for local authorities the main obstacle to planning is the loss of data on the population. Without data on health and social care needs and use in the public and privately funded populations, comparative analysis at an area level becomes impossible. There are currently three to six-fold variations in the rates of provision of home care services and day centre attendances respectively across local authorities, but without data on privately funded care and NHS provision these variations are difficult to interpret.

In practice, it should be possible to aggregate data from individual needs assessments and quantify service needs and service responses at a population level. But this presupposes that the whole population can be counted – which it can't – and that there are objective, standardised measures of need in place, as well as standardised processes of assessment.

In 1993, we reviewed the eight social services departments in the south-east of England and discovered enormous variations in the assessment process and the measures of need. As table 1 shows, few authorities were using objective and consistent measures of need, and no authorities were using the same measures. The assessment process varied in each local authority, as did the screening criteria. Eligibility criteria were far from explicit or

quantifiable. Moreover, eligibility criteria were not linked to needs.

Our conclusion was that the assessment process which has the most important data on community care needs provides neither the public nor the service planners with the information they require from the assessment process, on how needs are met and the criteria for service delivery.⁵

Our preliminary recommendations included the need to develop and implement valid, repeatable, reliable and objective measures of need and standardised assessment processes.⁶

Sadly, they remain as pertinent today. The Department of Health has yet to issue national guidance.

In the absence of good data on need we set about trying to estimate and quantify the joint contribution of the NHS and local authorities to our inner city population. The objective was to establish a baseline for service provision and try to develop a framework for monitoring eligibility and service criteria as an aid to joint planning. The aim was to link health and social service data.

This study identified the clients of a social services department who were receiving community care management on a 'snapshot' day (30 November 1994). The two sources of data were:

■ **Social services data** – the clients who had received a community care assessment and who were being delivered a service on one specific 'snapshot' day.

■ **Community health service data** – contacts from community health trusts over a two-week period (one week forward and one week backward) to capture clients receiving a service on the snapshot day. (If the service was weekly, or every other day, looking at the same day would not capture this). The aim

was to develop a method of linking records to combine data items derived from independently created (computerised) files to create new files containing single person-based records, bringing together such items in one record. For this project social services data was linked with community health data, and then with hospital inpatient data, in order to profile the inputs from the different agencies on a person basis.

'Matching' is the process of comparing pairs of records to determine whether they should be linked – in this case matching records for different episodes or contacts which relate to the same person. 'Linking' is the process by which pairs of correctly matched records are brought together in such a way that they may be treated as a single record for one individual.

First, the specified data items were downloaded, and 'cleaned' to get the variables selected for the matching and linking into an identical format with common coding. Social services data is 'person'-based, but the health data sources are 'contact'-based

for community health.

To make the links it was necessary to get both sources of data into the common denominator of a 'person-based' record. A method was devised for organising records into a person-based format by assuming that if a record shares common markers of postcode, sex and date of birth, all such records can be aggregated on these markers to designate one person.

The linking process was then carried out by taking the person-based social services file and linking it with the community health services file to determine the matching people.

The community health and social services data sets were analysed separately to profile the population receiving services by age, sex and type of services received. Following

Table 4: Age and sex profile of community health services sample

Age band	Male	Female	Total	%	Rate per 1,000 pop
0-4	907	902	1,809	32.8	101
5-14	305	247	552	10.0	23
15-24	26	157	183	3.3	5
25-34	109	584	693	12.6	10
34-44	84	267	351	6.4	10
45-54	72	120	192	3.5	7
55-64	96	101	197	3.6	10
65-74	126	199	325	5.9	18
75-84	187	420	607	11.0	53
85+	117	494	611	11.1	140
Total	2,029	3,491	5,520	100	
%	36.8	63.2	100		

Table 5: Age profile showing community health service use

Age band	CPN*	DN*	HV*	OTH*	Total	%
0-4	10	2	1,777	27	1,816	33
5-14	28	117	394	19	558	10
15-24	25	22	134	4	185	3
25-34	140	41	507	14	702	13
34-44	108	43	192	11	354	6
45-54	107	67	9	13	196	4
55-64	71	119	3	8	201	4
65-74	57	265	2	9	333	6
75-84	91	515	5	10	621	11
85+	58	555	2	6	621	11
Total	695	1,746	3,025	121	5,587	100
%	12	31	54	2	100	

*CPN – community psychiatric nurse *DN – district nurse *HV – health visitor
*OTH – other specialist nurse

Table 6: Age profile of joint health and social services packages

Age band	Male	Female	Total	%	Rate per 1,000 pop
25-34	4	4	8	1.4	0
34-44	7	5	12	2.0	0
45-54	9	15	24	4.1	1
55-64	14	22	36	6.1	2
65-74	25	53	78	13.2	4
75-84	47	161	208	35.3	18
85+	28	195	223	37.9	51
Total	134	455	589	100	
%	22.8	77.2	100		

record linkage the same analysis was made on the subsample which had received both health and social services.

Results

Profile of the social services sample by age and sex: there were 5,333 identified clients. Table 2 shows the age profile and the use rates. Of people receiving services, 78 per cent were over 65 years old.

Services provided by age group broad categories: table 3 shows the breakdown of services. The 5,333 identified clients received 6,084 services. Home care and day care account for most care packages (81 per cent), but nursing home care and residential care now account for 15 per cent of care packages.

Profile of the community health services sample: there were 5,520 Wandsworth residents receiving services from the community health trusts in the two-week period. Table 4 shows a trimodal distribution with very high rates among women aged 25-34, and the over 65s.

Table 5 shows the age distribution of community health services and demonstrates that

health visiting services are the main ones provided to children and women, while district nursing services are concentrated on the elderly. Community psychiatric input is high in the very elderly and in the middle years.

Combined packages of care: table 6 shows that after linking health and social services data, 589 people were identified as receiving health and social services, 11 per cent of the social services sample. Eighty-six per cent of the joint packages go to the over 65s.

Table 7 shows that the main joint packages are for home care and district nursing services. District nursing accounts for 87 per cent of community health service input, and home care and day care account for 97 per cent of social services input.

At any one time health and social services in Wandsworth are serving similar numbers of residents, but the populations they serve differ. Community health services input is trimodal in distribution, whereas social services input is mainly to the over 65s. At any one time fewer than 11 per cent of individuals receiving a social care package are receiving community health services. These joint care packages are mainly for home care and district nursing input.

It would be interesting to review the length of time and the volume of services given as well as levels of dependency. We hope to use other data from the acute hospital system and therapy services to continue this work. This is a useful baseline for those working on joint commissioning for joint health and social services input. Unfortunately, without data on needs the dependency levels of this population cannot be estimated and compared.

If local authorities and HAs are to keep an important role in funding services and ensuring equitable delivery, the structural problems which make planning difficult need to be addressed. The complexity of the different agencies now responsible for funding and providing care potentially places pressure on private providers to avoid high-risk patients. The pressure on budgets is also increasing the tension between the NHS and local authorities as statutory agencies attempt to cost-shunt populations and

Table 7: Age profile of joint community health services packages

Age band	CPM	DN	HV	OTH	Total
25-34	1	—	—	—	1
34-44	—	9	—	2	11
45-54	5	17	—	2	24
55-64	10	25	—	2	37
65-74	8	70	—	3	81
75-84	27	186	—	2	215
85+	12	211	1	—	224
Total	63	525	2	12	602
%	10	87	1	2	100

Table 8: Age profile of joint social services packages

Age band	Homecare	Respite	Nursing	Residential	Daycare	Other	Total	%
25-34	3	2	—	—	3	—	8	1
34-44	10	—	—	—	1	1	12	2
45-54	18	—	—	1	4	1	24	4
55-64	31	—	—	—	5	—	36	6
65-74	64	—	—	2	12	—	78	13
75-84	181	—	1	4	20	2	208	35
85+	203	1	—	3	16	—	223	38
Total	510	3	1	10	61	4	589	100
%	87	1	0	2	10	1	100	—

responsibilities using continuing care and eligibility criteria. Monitoring systems are needed for the needs and service use of all residents.

At a minimum, clients using certain services – eg nursing home, residential care, day care and all types of health service – should have a regular assessment of their needs and service inputs regardless of funding stream. This is because, ultimately, the responsibility for funding when reduction in spending occurs will fall to the public sector.

Recommendations

- Local authorities must continue to collect data on all their residents, whether privately or publicly funded.
- Health and local authorities need to ensure that objective standardised measures of need are used, that eligibility criteria reflect levels of need, and that there is monitoring of how health and social care needs are met in the communities they serve. This will require agreement on core data sets at national level.
- The processes of assessment and screening need to be standardised, as do continuing care and eligibility criteria.
- There needs to be adequate staff training and support. National guidance and direction is required.

REFERENCES

- 1 Townsend P, Wedderburn D. *The Aged in the Welfare State*. Occasional papers on social administration No 14. G Bell and Sons, 1963.
- 2 Whitehead M. Who cares about equity in the NHS? *Br Med J* 1994; 308(6939): 1284-87.
- 3 Pollock AM. Where should health services go: local authorities versus the NHS? *Br Med J* 1995; 310(6994): 1580-84.
- 4 Community Care Statistics, 1995 *Statistical Bulletin*.
- 5 Leicester M, Pollock AN. Community Care in South Thames (west) region: is needs assessment working? *Public Health* 1996; 110(2): 109-13.
- 6 Leicester M, Godden S, Jones F, Pollock AM. *Sharing Information for Community Care in Merton Sutton and Wandsworth Health Authorities*. Report to IM&T Support for Care in the Community. Department of Health, 1996.
- 7 Gill LE, Baldwin JA. *Methods and Technology of Record Linkage: some practical considerations*. *Textbook of Medical Record Linkage*. Oxford: Oxford Medical Publications, 1987.

Sylvia Godden is research assistant and Alyson Pollock is consultant, department of public health, Merton Sutton and Wandsworth health authority.